1 A bill to be entitled
2 An act relating to plans, policies, contracts, and
3 programs for the provision of health care services;
4 amending s. 408.909, F.S.; revising eligibility
5 requirements for participation in health flex plans;
6 amending s. 627.4236, F.S.; redefining the term "bone
7 marrow transplant" for purposes of required coverage for
8 certain procedures to include nonablative therapy having
9 life-prolonging intent; amending s. 627.642, F.S.;
10 requiring an identification card containing specified
11 information to be given to insureds who have health and
12 accident insurance; requiring certain insurers to provide
13 to certain service providers by an Internet website
14 certain information relating to a covered person;
15 providing criteria; specifying time requirements for such
16 insurers to implement such requirements; amending s.
17 627.657, F.S.; requiring an identification card containing
18 specified information to be given to insureds under group
19 health insurance policies; requiring certain insurers to
20 provide to certain service providers by an Internet
21 website certain information relating to a covered person;
22 providing criteria; specifying time requirements for such
23 insurers to implement such requirements; amending s.
24 627.6699, F.S.; revising a provision relating to
25 applicability and scope of the Employee Health Care Access
26 Act; amending s. 636.204, F.S.; revising a license
27 application provision for discount medical plan

28 organizations; amending s. 636.206, F.S.; revising
29 examination and investigative authority; amending s.
30 636.210, F.S.; providing an exception to prohibited
31 activities; amending s. 636.216, F.S.; providing exception
32 to review of certain charges to members of the plan;
33 amending s. 636.218, F.S.; removing certain information
34 from the annual report; amending s. 636.220, F.S.;
35 revising certain minimum capital requirements of discount
36 medical plan organizations; amending s. 636.232, F.S.;
37 revising commission rulemaking authority; repealing s.
38 636.230, F.S., relating to the bundling of discount
39 medical plans with other products; amending s. 641.31,
40 F.S.; requiring an identification card to be given to
41 persons having health care services through a health
42 maintenance contract; requiring certain health maintenance
43 organizations to provide to certain service providers by
44 an Internet website certain information relating to a
45 covered person; providing criteria; specifying time
46 requirements for such health maintenance organizations to
47 implement such requirements; amending s. 641.316, F.S.;
48 redefining the term "fiscal intermediary services
49 organization"; revising registration requirements for
50 fiscal intermediary services organizations; amending ss.
51 383.145, 641.185, 641.2018, 641.3107, 641.3922, and
52 641.513, F.S.; conforming cross-references to changes made
53 by the act; providing application; providing an effective
54 date.

55

56 Be It Enacted by the Legislature of the State of Florida:

57

58 Section 1. Subsection (5) of section 408.909, Florida
59 Statutes, is amended to read:

60 408.909 Health flex plans.--

61 (5) ELIGIBILITY.--Eligibility to enroll in an approved
62 health flex plan is limited to residents of this state who:

63 (a)1. Are 64 years of age or younger;

64 2.~~(b)~~ Have a family income equal to or less than 250 ~~200~~
65 percent of the federal poverty level;

66 3.~~(c)~~ Are eligible under a federally approved Medicaid
67 demonstration waiver and reside in Palm Beach County or Miami-
68 Dade County;

69 4.~~(d)~~ Are not covered by a private insurance policy and
70 are not eligible for coverage through a public health insurance
71 program, such as Medicare or Medicaid, unless specifically
72 authorized under subparagraph 3. ~~paragraph (c)~~, or another
73 public health care program, such as KidCare, and have not been
74 covered at any time during the past 6 months; and

75 5.~~(e)~~ Have applied for health care coverage through an
76 approved health flex plan and have agreed to make any payments
77 required for participation, including periodic payments or
78 payments due at the time health care services are provided; or

79 (b) Are part of an employer group where at least 75
80 percent of the employees have a family income equal to or less
81 than 250 percent of the federal poverty level and the employee

82 group is not covered by a private health insurance policy and
83 has not been covered at any time during the past 6 months. If
84 the health flex plan entity is a health insurer, health plan, or
85 health maintenance organization properly licensed under Florida
86 law, only 50 percent of the employees must meet the income
87 requirements for the purposes of this paragraph.
88 Section 2. Subsection (1) of section 627.4236, Florida
89 Statutes, is amended to read:
90 627.4236 Coverage for bone marrow transplant procedures.--
91 (1) As used in this section, the term "bone marrow
92 transplant" means human blood precursor cells administered to a
93 patient to restore normal hematological and immunological
94 functions following ablative or nonablative therapy with
95 curative or life-prolonging intent. Human blood precursor cells
96 may be obtained from the patient in an autologous transplant or
97 from a medically acceptable related or unrelated donor, and may
98 be derived from bone marrow, circulating blood, or a combination
99 of bone marrow and circulating blood. If chemotherapy is an
100 integral part of the treatment involving bone marrow
101 transplantation, the term "bone marrow transplant" includes both
102 the transplantation and the chemotherapy.
103 Section 3. Subsections (3) and (4) are added to section
104 627.642, Florida Statutes, to read:
105 627.642 Outline of coverage.--
106 (3) In addition to the outline of coverage, a policy as
107 specified in s. 627.6699(3)(k) must be accompanied by an
108 identification card that contains, at a minimum:

109 (a) The name of the organization issuing the policy or
110 name of the organization administering the policy, whichever
111 applies.
112 (b) The name of the contract holder.
113 (c) The type of plan only if the health plan is filed with
114 the state, an indication that the plan is self-funded, or the
115 name of the network.
116 (d) The member identification number, contract number, and
117 policy or group number, if applicable.
118 (e) A contact phone number or electronic address for
119 authorizations.
120 (f) A phone number or electronic address whereby the
121 covered person or hospital, physician, or other person rendering
122 services covered by the policy may determine if the plan is
123 insured and may obtain a benefits verification in order to
124 estimate patient financial responsibility, in compliance with
125 privacy rules under the Health Insurance Portability and
126 Accountability Act.
127 (g) The national plan identifier, in accordance with the
128 compliance date set forth by the federal Department of Health
129 and Human Services.
130
131 The identification card must present the information in a
132 readily identifiable manner or, alternatively, the information
133 may be embedded on the card and available through magnetic
134 stripe or smart card. The information may also be provided
135 through other electronic technology.

136 (4)(a) An insurer that issues a health insurance policy
137 shall provide a hospital, physician, or other person rendering
138 services covered by the policy electronic access to the covered
139 person's eligibility and benefits information through a secure
140 Internet website. The eligibility and benefits information shall
141 comply with the transaction standards specified in ANSI ASC X12N
142 270 for health care claim eligibility inquiries and ANSI ASC
143 X12N 271 for health care claim eligibility responses, or
144 successor transaction standards, pursuant to the Health
145 Insurance Portability and Accountability Act.
146 (b) An insurer shall develop an implementation plan to
147 comply with paragraph (a) no later than March 31, 2007, and
148 shall make the eligibility and benefits information described in
149 this subsection available through a secure Internet website no
150 later than July 1, 2007.
151 Section 4. Present subsection (2) of section 627.657,
152 Florida Statutes, is renumbered as subsection (4), and new
153 subsections (2) and (3) are added to that section, to read:
154 627.657 Provisions of group health insurance policies.--
155 (2) The medical policy as specified in s. 627.6699(3)(k)
156 must be accompanied by an identification card that contains, at
157 a minimum:
158 (a) The name of the organization issuing the policy or
159 name of the organization administering the policy, whichever
160 applies.
161 (b) The name of the certificateholder.

162 (c) The type of plan only if the health plan is filed with
163 the state, an indication that the plan is self-funded, or the
164 name of the network.
165 (d) The member identification number, contract number, and
166 policy or group number, if applicable.
167 (e) A contact phone number or electronic address for
168 authorizations.
169 (f) A phone number or electronic address whereby the
170 covered person or hospital, physician, or other person rendering
171 services covered by the policy may determine if the plan is
172 insured and may obtain a benefits verification in order to
173 estimate patient financial responsibility, in compliance with
174 privacy rules under the Health Insurance Portability and
175 Accountability Act.
176 (g) The national plan identifier, in accordance with the
177 compliance date set forth by the federal Department of Health
178 and Human Services.
179
180 The identification card must present the information in a
181 readily identifiable manner or, alternatively, the information
182 may be embedded on the card and available through magnetic
183 stripe or smart card. The information may also be provided
184 through other electronic technology.
185 (3)(a) An insurer that issues a group health insurance
186 policy shall provide a hospital, physician, or other person
187 rendering services covered by the policy electronic access to
188 the covered person's eligibility and benefits information

189 through a secure Internet website. The eligibility and benefits
190 information shall comply with the transaction standards
191 specified in ANSI ASC X12N 270 for health care claim eligibility
192 inquiries and ANSI ASC X12N 271 for health care claim
193 eligibility responses, or successor transaction standards,
194 pursuant to the Health Insurance Portability and Accountability
195 Act.
196 (b) An insurer shall develop an implementation plan to
197 comply with paragraph (a) no later than March 31, 2007, and
198 shall make the eligibility and benefits information described in
199 this subsection available through a secure Internet website no
200 later than July 1, 2007.
201 Section 5. Paragraph (a) of subsection (4) of section
202 627.6699, Florida Statutes, is amended to read:
203 627.6699 Employee Health Care Access Act.--
204 (4) APPLICABILITY AND SCOPE.--
205 (a)1. This section applies to a health benefit plan that
206 provides coverage to employees of a small employer in this
207 state, unless the coverage is marketed directly to the
208 individual employee, and the employer does not contribute
209 directly or indirectly to the premiums or facilitate the
210 administration of the coverage in any manner. For the purposes
211 of this subparagraph, an employer is not deemed to be
212 contributing to the premiums or facilitating the administration
213 of coverage if the employer:
214 a. Does not contribute to the premium and merely collects
215 the premiums for coverage from an employee's wages or salary

CODING: Words stricken are deletions; words underlined are additions.

216 through payroll deduction and submits payment for the premiums
217 of one or more employees in a lump sum to a carrier; or
218 b. Directly or indirectly establishes or administers a
219 health reimbursement account plan for its employees.
220 2. A carrier authorized to issue group or individual
221 health benefit plans under this chapter or chapter 641 may offer
222 coverage as described in this paragraph to individual employees
223 without being subject to this section if the employer has not
224 had a group health benefit plan in place in the prior 6 months.
225 A carrier authorized to issue group or individual health benefit
226 plans under this chapter or chapter 641 may offer coverage as
227 described in this subparagraph to employees that are not
228 eligible employees as defined in this section, whether or not
229 the small employer has a group health benefit plan in place. A
230 carrier that offers coverage as described in this subparagraph
231 must provide a cancellation notice to the primary insured at
232 least 10 days prior to canceling the coverage for nonpayment of
233 premium.
234 Section 6. Paragraph (i) of subsection (2) of section
235 636.204, Florida Statutes, is amended to read:
236 636.204 License required.--
237 (2) An application for a license to operate as a discount
238 medical plan organization must be filed with the office on a
239 form prescribed by the commission. Such application must be
240 sworn to by an officer or authorized representative of the
241 applicant and be accompanied by the following, if applicable:

242 (i) A copy of the applicant's most recent financial
243 statements audited by an independent certified public
244 accountant. An applicant that is a subsidiary of a parent entity
245 that is publicly traded and that prepares audited financial
246 statements reflecting the consolidated operations of the parent
247 entity and the subsidiary may submit ~~petition the office to~~
248 ~~accept~~, in lieu of the audited financial statement of the
249 applicant, the audited financial statement of the parent entity
250 and a written guaranty by the parent entity that the minimum
251 capital requirements of the applicant required by this part will
252 be met by the parent entity.
253 Section 7. Subsection (1) of section 636.206, Florida
254 Statutes, is amended to read:
255 636.206 Examinations and investigations.--
256 (1) The office may examine or investigate the business and
257 affairs of any discount medical plan organization if the
258 commissioner has reason to believe that the discount medical
259 plan organization is not complying with the requirements of this
260 act. The office may order any discount medical plan organization
261 or applicant to produce any records, books, files, advertising
262 and solicitation materials, or other information and may take
263 statements under oath to determine whether the discount medical
264 plan organization or applicant is in violation of the law or is
265 acting contrary to the public interest. The expenses incurred in
266 conducting any examination or investigation must be paid by the
267 discount medical plan organization or applicant. Examinations
268 and investigations must be conducted as provided in chapter 624.

269 Section 8. Subsection (1) of section 636.210, Florida
270 Statutes, is amended to read:
271 636.210 Prohibited activities of a discount medical plan
272 organization.--
273 (1) A discount medical plan organization may not:
274 (a) Use in its advertisements, marketing material,
275 brochures, and discount cards the term "insurance" except as
276 otherwise provided in this part or as a disclaimer of any
277 relationship between discount medical plan organization benefits
278 and insurance;
279 (b) Use in its advertisements, marketing material,
280 brochures, and discount cards the terms "health plan,"
281 "coverage," "copay," "copayments," "preexisting conditions,"
282 "guaranteed issue," "premium," "PPO," "preferred provider
283 organization," or other terms in a manner that could reasonably
284 mislead a person into believing the discount medical plan was
285 health insurance;
286 (c) Have restrictions on free access to plan providers,
287 except for hospital services, including, but not limited to,
288 waiting periods and notification periods; or
289 (d) Pay providers any fees for medical services.
290 Section 9. Subsections (1), (3), and (4) of section
291 636.216, Florida Statutes, are amended to read:
292 636.216 Charge or form filings.--
293 (1) All charges to members must be filed with the office.
294 ~~and~~ Any charge to members greater than $30 per month or $360 per
295 year for access to healthcare services, other than those

296 provided by physicians licensed under chapter 458 or chapter 459
297 or by hospitals licensed under chapter 395, must be approved by
298 the office before the charges can be used. Any charge to members
299 greater than $60 dollars per month or $720 per year for
300 healthcare services that include services provided by physicians
301 licensed under chapters 458 and 459 or by hospitals licensed
302 under chapter 395 must be approved by the office before the
303 charges can be used. The discount medical plan organization has
304 the burden of proof that the charges bear a reasonable relation
305 to the benefits received by the member.
306 (3) All forms used, including the written agreement
307 pursuant to subsection (2), must first be filed with ~~and~~
308 ~~approved by~~ the office. Every form filed shall be identified by
309 a unique form number placed in the lower left corner of each
310 form.
311 (4) A charge ~~or form~~ is considered approved on the 60th
312 day after its date of filing unless it has been previously
313 disapproved by the office. ~~The office shall disapprove any form~~
314 ~~that does not meet the requirements of this part or that is~~
315 ~~unreasonable, discriminatory, misleading, or unfair.~~ If such
316 filing is ~~filings are~~ disapproved, the office shall notify the
317 discount medical plan organization and shall specify in the
318 notice the reasons for disapproval.
319 Section 10. Subsection (2) of section 636.218, Florida
320 Statutes, is amended to read:
321 636.218 Annual reports.--

322 (2) Such reports must be on forms prescribed by the
323 commission and must include:
324 ~~(a) Audited financial statements prepared in accordance~~
325 ~~with generally accepted accounting principles certified by an~~
326 ~~independent certified public accountant, including the~~
327 ~~organization's balance sheet, income statement, and statement of~~
328 ~~changes in cash flow for the preceding year. An organization~~
329 ~~that is a subsidiary of a parent entity that is publicly traded~~
330 ~~and that prepares audited financial statements reflecting the~~
331 ~~consolidated operations of the parent entity and the~~
332 ~~organization may petition the office to accept, in lieu of the~~
333 ~~audited financial statement of the organization, the audited~~
334 ~~financial statement of the parent entity and a written guaranty~~
335 ~~by the parent entity that the minimum capital requirements of~~
336 ~~the organization required by this part will be met by the parent~~
337 ~~entity.~~
338 (a)~~(b)~~ If different from the initial application or the
339 last annual report, a list of the names and residence addresses
340 of all persons responsible for the conduct of the organization's
341 affairs, together with a disclosure of the extent and nature of
342 any contracts or arrangements between such persons and the
343 discount medical plan organization, including any possible
344 conflicts of interest.
345 (b)~~(c)~~ The number of discount medical plan members in the
346 state.

347 (c) ~~(d)~~ Such other information relating to the performance
348 of the discount medical plan organization as is reasonably
349 required by the commission or office.
350 Section 11. Subsection (1) of section 636.220, Florida
351 Statutes, is amended to read:
352 636.220 Minimum capital requirements.--
353 (1) Each discount medical plan organization must at all
354 times maintain a net worth of at least $150,000 and each
355 discount medical plan organization shall certify in writing
356 under oath at licensure and annually that the minimum
357 capitalization requirements of this part are satisfied.
358 Section 12. Section 636.232, Florida Statutes, is amended
359 to read:
360 636.232 Rules.--The commission may adopt rules to
361 administer this part, including rules for the licensing of
362 discount medical plan organizations; ~~establishing standards for~~
363 ~~evaluating forms,~~ advertisements, marketing materials,
364 brochures, and discount cards; providing for the collection of
365 data; relating to disclosures to plan members; and defining
366 terms used in this part.
367 Section 13. Section 636.230, Florida Statutes, is
368 repealed.
369 Section 14. Present subsections (5) through (40) of
370 section 641.31, Florida Statutes, are renumbered as subsections
371 (7) through (42), respectively, and new subsections (5) and (6)
372 are added to that section, to read:
373 641.31 Health maintenance contracts.--

374 (5) The contract, certificate, or member handbook must be
375 accompanied by an identification card that contains, at a
376 minimum:
377 (a) The name of the organization offering the contract or
378 name of the organization administering the contract, whichever
379 applies.
380 (b) The name of the subscriber.
381 (c) A statement that the health plan is a health
382 maintenance organization. Only a health plan with a certificate
383 of authority issued under this chapter may be identified as a
384 health maintenance organization.
385 (d) The member identification number, contract number, and
386 group number, if applicable.
387 (e) A contact phone number or electronic address for
388 authorizations.
389 (f) A phone number or electronic address whereby the
390 covered person or hospital, physician, or other person rendering
391 services covered by the contract may determine if the plan is
392 insured and may obtain a benefits verification in order to
393 estimate patient financial responsibility, in compliance with
394 privacy rules under the Health Insurance Portability and
395 Accountability Act.
396 (g) The national plan identifier, in accordance with the
397 compliance date set forth by the federal Department of Health
398 and Human Services.
399

400 The identification card must present the information in a
401 readily identifiable manner or, alternatively, the information
402 may be embedded on the card and available through magnetic
403 stripe or smart card. The information may also be provided
404 through other electronic technology.
405 (6)(a) A health maintenance organization shall provide a
406 hospital, physician, or other person rendering services covered
407 by the policy electronic access to the covered person's
408 eligibility and benefits information through a secure Internet
409 website. The eligibility and benefits information shall comply
410 with the transaction standards specified in ANSI ASC X12N 270
411 for health care claim eligibility inquiries and ANSI ASC X12N
412 271 for health care claim eligibility responses, or successor
413 transaction standards, pursuant to the Health Insurance
414 Portability and Accountability Act.
415 (b) A health maintenance organization shall develop an
416 implementation plan to comply with paragraph (a) no later than
417 March 31, 2007, and shall make the eligibility and benefits
418 information described in this subsection available through a
419 secure Internet website no later than July 1, 2007.
420 Section 15. Paragraph (j) of subsection (3) of section
421 383.145, Florida Statutes, is amended to read:
422 383.145 Newborn and infant hearing screening.--
423 (3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE
424 COVERAGE; REFERRAL FOR ONGOING SERVICES.--
425 (j) The initial procedure for screening the hearing of the
426 newborn or infant and any medically necessary followup

427 reevaluations leading to diagnosis shall be a covered benefit,
428 reimbursable under Medicaid as an expense compensated
429 supplemental to the per diem rate for Medicaid patients enrolled
430 in MediPass or Medicaid patients covered by a fee for service
431 program. For Medicaid patients enrolled in HMOs, providers shall
432 be reimbursed directly by the Medicaid Program Office at the
433 Medicaid rate. This service may not be considered a covered
434 service for the purposes of establishing the payment rate for
435 Medicaid HMOs. All health insurance policies and health
436 maintenance organizations as provided under ss. 627.6416,
437 627.6579, and 641.31(32) ~~(30)~~, except for supplemental policies
438 that only provide coverage for specific diseases, hospital
439 indemnity, or Medicare supplement, or to the supplemental
440 polices, shall compensate providers for the covered benefit at
441 the contracted rate. Nonhospital-based providers shall be
442 eligible to bill Medicaid for the professional and technical
443 component of each procedure code.
444 Section 16. Paragraphs (b) and (i) of subsection (1) of
445 section 641.185, Florida Statutes, are amended to read:
446 641.185 Health maintenance organization subscriber
447 protections.--
448 (1) With respect to the provisions of this part and part
449 III, the principles expressed in the following statements shall
450 serve as standards to be followed by the commission, the office,
451 the department, and the Agency for Health Care Administration in
452 exercising their powers and duties, in exercising administrative

453 discretion, in administrative interpretations of the law, in
454 enforcing its provisions, and in adopting rules:
455 (b) A health maintenance organization subscriber should
456 receive quality health care from a broad panel of providers,
457 including referrals, preventive care pursuant to s. 641.402(1),
458 emergency screening and services pursuant to ss. 641.31(14)~~(12)~~
459 and 641.513, and second opinions pursuant to s. 641.51.
460 (i) A health maintenance organization subscriber should
461 receive timely and, if necessary, urgent grievances and appeals
462 within the health maintenance organization pursuant to ss.
463 641.228, 641.31(7)~~(5)~~, 641.47, and 641.511.
464 Section 17. Subsection (1) of section 641.2018, Florida
465 Statutes, is amended to read:
466 641.2018 Limited coverage for home health care
467 authorized.--
468 (1) Notwithstanding other provisions of this chapter, a
469 health maintenance organization may issue a contract that limits
470 coverage to home health care services only. The organization and
471 the contract shall be subject to all of the requirements of this
472 part that do not require or otherwise apply to specific benefits
473 other than home care services. To this extent, all of the
474 requirements of this part apply to any organization or contract
475 that limits coverage to home care services, except the
476 requirements for providing comprehensive health care services as
477 provided in ss. 641.19(4), (11), and (12), and 641.31(1), except
478 ss. 641.31(11)~~(9)~~, (14)~~(12), (17)~~, (18), (19), (20), (21), (23),
479 and (26)~~(24)~~ and 641.31095.

480 Section 18. Section 641.3107, Florida Statutes, is amended
481 to read:
482 641.3107 Delivery of contract.--Unless delivered upon
483 execution or issuance, a health maintenance contract,
484 certificate of coverage, or member handbook shall be mailed or
485 delivered to the subscriber or, in the case of a group health
486 maintenance contract, to the employer or other person who will
487 hold the contract on behalf of the subscriber group within 10
488 working days from approval of the enrollment form by the health
489 maintenance organization or by the effective date of coverage,
490 whichever occurs first. However, if the employer or other person
491 who will hold the contract on behalf of the subscriber group
492 requires retroactive enrollment of a subscriber, the
493 organization shall deliver the contract, certificate, or member
494 handbook to the subscriber within 10 days after receiving notice
495 from the employer of the retroactive enrollment. This section
496 does not apply to the delivery of those contracts specified in
497 s. 641.31(15)~~(13)~~.
498 Section 19. Paragraph (a) of subsection (7) of section
499 641.3922, Florida Statutes, is amended to read:
500 641.3922 Conversion contracts; conditions.--Issuance of a
501 converted contract shall be subject to the following conditions:
502 (7) REASONS FOR CANCELLATION; TERMINATION.--The converted
503 health maintenance contract must contain a cancellation or
504 nonrenewability clause providing that the health maintenance
505 organization may refuse to renew the contract of any person

506 covered thereunder, but cancellation or nonrenewal must be
507 limited to one or more of the following reasons:
508 (a) Fraud or intentional misrepresentation, subject to the
509 limitations of s. 641.31(25)~~(23)~~, in applying for any benefits
510 under the converted health maintenance contract.~~;~~
511 Section 20. Subsection (4) of section 641.513, Florida
512 Statutes, is amended to read:
513 641.513 Requirements for providing emergency services and
514 care.--
515 (4) A subscriber may be charged a reasonable copayment, as
516 provided in s. 641.31(14)~~(12)~~, for the use of an emergency room.
517 Section 21. Paragraph (b) of subsection (2) and subsection
518 (6) of section 641.316, Florida Statutes, are amended to read:
519 641.316 Fiscal intermediary services.--
520 (2)
521 (b) The term "fiscal intermediary services organization"
522 means a person or entity that ~~which~~ performs fiduciary or fiscal
523 intermediary services to health care professionals who contract
524 with health maintenance organizations other than ~~a fiscal~~
525 ~~intermediary services organization owned, operated, or~~
526 ~~controlled by~~ a hospital licensed under chapter 395, an insurer
527 licensed under chapter 624, a third-party administrator licensed
528 under chapter 626, a prepaid limited health service organization
529 licensed under chapter 636, a health maintenance organization
530 licensed under this chapter, or physician group practices as
531 defined in s. 456.053(3)(h) and providing services under the
532 scope of licenses of the members of the group practice.

533 (6) Any fiscal intermediary services organization, other
534 than ~~a fiscal intermediary services organization owned,~~
535 ~~operated, or controlled by~~ a hospital licensed under chapter
536 395, an insurer licensed under chapter 624, a third-party
537 administrator licensed under chapter 626, a prepaid limited
538 health service organization licensed under chapter 636, a health
539 maintenance organization licensed under this chapter, or
540 physician group practices as defined in s. 456.053(3)(h), and
541 providing services under the scope of licenses of the members of
542 the group practice, must register with the office and meet the
543 requirements of this section. In order to register as a fiscal
544 intermediary services organization, the organization must comply
545 with ss. 641.21(1)(c), ~~and~~ (d), and (j), ~~and~~ 641.22(6), and
546 641.27. The fiscal intermediary services organization must also
547 comply with the provisions of ss. 641.3155, 641.3156, and
548 641.51(4). Should the office determine that the fiscal
549 intermediary services organization does not meet the
550 requirements of this section, the registration shall be denied.
551 In the event that the registrant fails to maintain compliance
552 with the provisions of this section, the office may revoke or
553 suspend the registration. In lieu of revocation or suspension of
554 the registration, the office may levy an administrative penalty
555 in accordance with s. 641.25.
556 Section 22. This act shall take effect January 1, 2007,
557 and shall apply to identification cards issued for policies or
558 certificates issued or renewed on or after that date.