a reciprocating state bank holding company. This section shall not prohibit the bank holding company from being granted a charter for a de novo bank or from establishing de novo detached facilities pursuant to Minnesota law.

Sec. 2. **EFFECTIVE DATE.**

This act is effective the day following final enactment.

Approved April 21, 1988

CHAPTER 592—S.F.No. 1388

An act relating to health; setting forth requirements for statements of exclusions and limitations; requiring detailed statement when coverage is denied; clarifying statement of enrollee bill of rights; setting forth requirements for marketing materials; requiring membership card; requiring written denial of service; prohibiting denial of coverage in certain circumstances; prohibiting retaliatory action; specifying procedures for prior approval; prohibiting a threat of denial of emergency health care services in collection of delinquent accounts; requiring report; amending Minnesota Statutes 1986, sections 62D.06, subdivision 1; 62D.07, subdivision 3; 62D.09, subdivision 1, and by adding subdivisions; 62D.11, by adding subdivisions; 62D.12, by adding subdivisions; 62D.20 and 325D.44, subdivision 1; Minnesota Statutes 1987 Supplement, section 332.37.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 62D.06, subdivision 1, is amended to read:

Subdivision 1. The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.29 for one year, at least 40 percent of the governing body shall be composed of consumers elected by the enrollees from among the enrollees.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.29 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

Sec. 2. Minnesota Statutes 1986, section 62D.07, subdivision 3, is amended to read:

Subd. 3. ~~An evidence~~ Contracts and evidences of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading or deceptive as defined in section 62D.12, subdivision 1; and

(b) A clear, concise and complete statement of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health maintenance contract;

(2) Any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature and requirements for referrals, prior authorizations, and second opinions;

(3) Where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) A description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom grievances may be registered.

(c) On the cover page of the evidence of coverage and contract, a clear and complete statement of enrollees' rights as consumers~~, including but not limited to a description of each of the following:~~. The statement must be in bold print and captioned "Important Consumer Information and Enrollee Bill of Rights" and must include but not be limited to the following provisions in the following language or in substantially similar language approved in advance by the commissioner:

CONSUMER INFORMATION

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of the health maintenance organization) providers.

(3) REFERRALS: Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non-(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered only if proper procedures are followed. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non-(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

ENROLLEE BILL OF RIGHTS

(1) ~~based upon the delivery system of each health maintenance organization, a statement which describes any type of health care professional as defined in section 145.61, whose services may be available only by referral of the health maintenance organization's participating staff;~~

~~(2)~~ Enrollees have the right to available and accessible services ~~which can be secured as promptly as appropriate for the symptoms presented, in a manner which assures continuity and, when medically necessary, the right to~~ including emergency services ~~available~~ 24 hours a day and seven days a week;

~~(3)~~ (2) Enrollees have the ~~consumer's~~ right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

~~(4)~~ (3) Enrollees have the right to refuse treatment~~;~~, and

~~(5)~~ the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

~~(6)~~ (4) Enrollees have the right to file a grievance with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;

~~(7) the right to initiate a legal proceeding when dissatisfied with the health maintenance organization's final determination regarding a grievance;~~

~~(8) the right of the enrollee and dependents to continue group coverage in the event the enrollee is terminated or laid off from employment, provided that~~

~~the cost of such coverage is paid by the enrollee and furthermore, the right of the enrollee to convert to an individual contract at the end of the continuation period;~~

~~(9) the right for notification of enrollees regarding the cancellation or termination of contracts with participating primary care professionals, and the right to choose from among remaining participating primary care professionals;~~

~~(10) the right to cancel an individual health maintenance contract within ten days of its receipt and to have premiums paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days; and~~

~~(11)~~ (5) Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;

(6) Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and

(7) Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

Sec. 3. Minnesota Statutes 1986, section 62D.09, subdivision 1, is amended to read:

Subdivision 1. (a) Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of consumer rights as described in section ~~62D.07~~ 2, subdivision 3, ~~paragraph~~ paragraphs (b) and (c). Prior to any oral marketing presentation, the agent marketing the plan must inform the potential enrollees that any complaints concerning the material presented should be directed to the health maintenance organization, the commissioner of health, or, if applicable, the employer.

(b) Detailed marketing materials must affirmatively disclose all exclusions and limitations in the organization's services or kinds of services offered to the contracting party, including but not limited to the following types of exclusions and limitations:

(1) health care services not provided;

(2) health care services requiring copayments or deductibles paid by enrollees;

(3) the fact that access to health care services does not guarantee access to a particular provider type; and

(4) health care services that are or may be provided only by referral of a physician.

(c) No marketing materials may lead consumers to believe that all health care needs will be covered. All marketing materials must alert consumers to possible uncovered expenses with the following language in bold print: "THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED." Immediately following the disclosure required under paragraph (b), clause (3), consumers must be given a telephone number to use to contact the health maintenance organization for specific information about access to provider types.

(d) The disclosures required in paragraphs (b) and (c) are not required on billboards or image, and name identification advertisement.

Sec. 4. Minnesota Statutes 1986, section 62D.09, is amended by adding a subdivision to read:

Subd. 7. Every health maintenance organization shall provide the information described in section 2, subdivision 3, paragraphs (b) and (c), to enrollees or their representatives on request, within a reasonable time. Information on how to obtain referrals, prior authorization, or second opinion shall be given to the enrollee or an enrollee's representative in person or by telephone within one business day following the day the health maintenance organization or its representative receives the request for information.

Sec. 5. Minnesota Statutes 1986, section 62D.09, is amended by adding a subdivision to read:

Subd. 8. Each health maintenance organization shall issue a membership card to its enrollees. The membership card must:

(1) identify the health maintenance organization;

(2) include the name, address, and telephone number to call if the enroller has a complaint;

(3) include the telephone number to call or the instruction on how to receive authorization for emergency care; and

(4) include the telephone number to call to appeal to the commissioner of health.

Sec. 6. Minnesota Statutes 1986, section 62D.11, is amended by adding a subdivision to read:

Subd. 3. **DENIAL OF SERVICE.** Within a reasonable time after receiving an enrollee's written or oral communication to the health maintenance organization concerning a refusal of service or inadequacy of services, the health maintenance organization shall provide the enrollee with a written statement of the

reason for the refusal of service, and a statement approved by the commissioner of health which explains the health maintenance organization complaint procedures, and in the case of Medicare enrollees, which also explains Medicare appeal procedures.

Sec. 7. Minnesota Statutes 1986, section 62D.11, is amended by adding a subdivision to read:

Subd. 4. **COVERAGE OF SERVICE.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received:

(1) solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained; or

(2) from a nonparticipating provider, if (i) the service was ordered or recommended by a participating provider; (ii) the service would otherwise be covered, or was part of a discharge plan of a participating provider; and (iii) the enrollee was not given prior written notice stating that this service by a nonparticipating provider would not be covered, and listing the participating providers of this service available in the enrollee's area.

Sec. 8. Minnesota Statutes 1986, section 62D.12, is amended by adding a subdivision to read:

Subd. 15. **RETALIATORY ACTION PROHIBITED.** No health maintenance organization may take retaliatory action against a provider solely on the grounds that the provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of an enrollee's contract or accurate interpreted provisions of the provider agreement that limit the prescribing, providing, or ordering of care.

Sec. 9. Minnesota Statutes 1986, section 62D.12, is amended by adding a subdivision to read:

Subd. 16. **PRIOR AUTHORIZATION AND APPROVAL.** Each health maintenance organization shall establish a telephone number, which need not be toll-free, that providers may call with questions about coverage, prior authorization, and approval of medical services. The telephone number must be staffed by an employee of the health maintenance organization during normal working hours during the normal work week. After normal working hours, the telephone number must be equipped with an answering machine and recorded message to allow the caller an opportunity to leave a message. The health maintenance organization must respond to questions within 24 hours after they are received excluding weekends and holidays. At the request of a provider, the health maintenance organization shall provide a copy of the health maintenance contract for enrollees in the provider's service area.

Sec. 10. Minnesota Statutes 1986, section 62D.20, is amended to read:

62D.20 **RULES.**

Subdivision 1. **RULEMAKING.** The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.29. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.

Subd. 2. **PRIOR AUTHORIZATION.** The commissioner shall adopt rules that address the issue of appropriate prior authorization requirements, considering consumer needs, administrative concerns, and the nature of the benefit.

Sec. 11. Minnesota Statutes 1986, section 325D.44, subdivision 1, is amended to read:

Subdivision 1. A person engages in a deceptive trade practice when, in the course of business, vocation, or occupation, the person:

(1) passes off goods or services as those of another;

(2) causes likelihood of confusion or of misunderstanding as to the source, sponsorship, approval, or certification of goods or services;

(3) causes likelihood of confusion or of misunderstanding as to affiliation, connection, or association with, or certification by, another;

(4) uses deceptive representations or designations of geographic origin in connection with goods or services;

(5) represents that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation, or connection that the person does not have;

(6) represents that goods are original or new if they are deteriorated, altered, reconditioned, reclaimed, used, or secondhand;

(7) represents that goods or services are of a particular standard, quality, or grade, or that goods are of a particular style or model, if they are of another;

(8) disparages the goods, services, or business of another by false or misleading representation of fact;

(9) advertises goods or services with intent not to sell them as advertised;

(10) advertises goods or services with intent not to supply reasonably expectable public demand, unless the advertisement discloses a limitation of quantity;

(11) makes false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions; ~~or~~

(12) in attempting to collect delinquent accounts, implies or suggests that health care services will be withheld in an emergency situation; or

(13) engages in any other conduct which similarly creates a likelihood of confusion or of misunderstanding.

Sec. 12. Minnesota Statutes 1987 Supplement, section 332.37, is amended to read:

332.37 **PROHIBITED PRACTICES.**

No collection agency or collectors shall: (1) in collection letters or publications, or in any communication, oral or written threaten wage garnishment or legal suit by a particular lawyer, unless it has actually retained the lawyer;

(2) use or employ constables, sheriffs or any other officer authorized to serve legal papers in connection with the collection of a claim, except when performing their legally authorized duties;

(3) use or threaten to use methods of collection which violate Minnesota law;

(4) furnish legal advice or otherwise engage in the practice of law or represent that it is competent to do so;

(5) communicate with debtors in a misleading or deceptive manner by using the stationery of a lawyer, forms or instruments which only lawyers are authorized to prepare, or instruments which simulate the form and appearance of judicial process;

(6) exercise authority on behalf of a creditor to employ the services of lawyers unless the creditor has specifically authorized the agency in writing to do so and the agency's course of conduct is at all times consistent with a true relationship of attorney and client between the lawyer and the creditor;

(7) publish or cause to be published any list of debtors except for credit reporting purposes, use shame cards or shame automobiles, advertise or threaten to advertise for sale any claim as a means of forcing payment thereof, or use similar devices or methods of intimidation;

(8) refuse to return any claim or claims and all valuable papers deposited with a claim or claims upon written request of the creditor, claimant or forwarder after tender of the amounts due and owing to the agency within 30 days after the request; refuse or intentionally fail to account to its clients for all money collected within 30 days from the last day of the month in which the same is collected; or, refuse or fail to furnish at intervals of not less than 90 days upon written request of the claimant or forwarder, a written report upon claims received from the claimant or forwarder;

(9) operate under a name or in a manner which implies that the agency is a branch of or associated with any department of federal, state, county or local government or an agency thereof;

(10) commingle money collected for a customer with the agency's operating funds or use any part of a customer's money in the conduct of the agency's business;

(11) transact business or hold itself out as a debt prorater, debt adjuster, or any person who settles, adjusts, prorates, pools, liquidates or pays the indebtedness of a debtor, unless there is no charge to the debtor, or the pooling or liquidation is done pursuant to court order or under the supervision of a creditor's committee;

(12) violate any of the provisions of the Fair Debt Collection Practices Act of 1977 while attempting to collect on any account, bill or other indebtedness; ~~or~~

(13) communicate with a debtor by use of a recorded message utilizing an automatic dialing announcing device unless the recorded message is immediately preceded by a live operator who discloses prior to the message the name of the collection agency and the fact the message intends to solicit payment and the operator obtains the consent of the debtor to hearing the message; or

(14) in collection letters or publications, or in any communication, oral or written, imply or suggest that health care services will be withheld in an emergency situation.

Sec. 13. **QUALITY ASSURANCE.**

The commissioner of health shall prepare a report to the legislature before January 15, 1989, that describes the state's efforts to assess and to improve quality assurance standards of health maintenance organizations licensed under chapter 62D. The commissioner of human services shall contribute information and data from the state's programs to enroll medical assistance recipients in prepayment plans. The report shall provide recommendations for improvement of health maintenance organization quality assurance mechanisms and operating procedures to the legislature and the health maintenance organizations.

Sec. 14. **MANDATED BENEFITS.**

The commission on health plan regulatory reform, established by Laws

1987, chapter 370, shall address the issues related to mandated benefits. Consumer choice and access to the most appropriate and cost-effective health care providers must be investigated and considered in light of the structure of managed care plans that are being designed and offered currently. The commission shall consider the long-term savings associated with a broad choice of provider groups available to consumers.

Sec. 15. **EFFECTIVE DATES.**

Section 3, subdivision 1, paragraph (a) is effective August 1, 1988. Section 2 and the remaining provisions of section 3 are effective January 1, 1989. Section 8 is effective the day following final enactment.

Approved April 21, 1988

CHAPTER 593—S.F.No. 1582

An act relating to marriage dissolution; providing for child support enforcement; specifying conditions for judgment by operation of law; amending Minnesota Statutes 1986, sections 256.87, subdivisions 1, 1a, 6, and by adding a subdivision; 257.66, subdivision 5; 518.55, subdivision 2, and by adding a subdivision; 518.551, subdivision 9; 518C.17, subdivision 1; 548.091, subdivisions 2, 3, and by adding subdivisions; Minnesota Statutes 1987 Supplement, section 548.091, subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 256.87, subdivision 1, is amended to read:

Subdivision 1. **ACTIONS AGAINST PARENTS FOR ASSISTANCE FURNISHED.** A parent of a child is liable for the amount of assistance furnished under sections 256.72 to 256.87 to and for the benefit of the child, including any assistance furnished for the benefit of the caretaker of the child, which the parent has had the ability to pay. Ability to pay must be determined according to chapter 518. The parent's liability is limited to the amount of assistance furnished during the two years immediately preceding the commencement of the action, except that where child support has been previously ordered, the state or county agency providing the assistance, as assignee of the obligee, shall be entitled to judgments for child support payments accruing within ten years preceding the date of the commencement of the action up to the full amount of assistance furnished. The action may be ordered by the state agency or county agency and shall be brought in the name of the county by the county attorney of the county in which the assistance was granted, or by the state agency against the parent for the recovery of the amount of assistance granted, together with the costs and disbursements of the action.