1.1 .... moves to amend the .... amendment (A23-0106) to H.F. No. 2680 as
1.2 follows:

1.3 Page 1, line 22, delete "261,230" and insert "261,230,000"

1.4 Page 3, line 18, delete "paragraph (e)" and insert "paragraphs (e) and (g)"

1.5 Page 3, line 21, delete "banking" and insert "financial"

1.6 Page 3, line 22, delete "bank" and insert "depository institutions"

1.7 Page 3, line 23, delete "branches"

1.8 Page 4, after line 5, insert:

1.9 "(h) No later than July 15, 2024, and annually
1.10 thereafter until the appropriations provided
1.11 for under paragraphs (e) and (g) have been
1.12 exhausted or canceled, Exodus Lending must
1.13 submit a report to the commissioner of
1.14 commerce on required activities of Exodus
1.15 Lending under paragraphs (e) and (g). Until
1.16 July 15, 2027, the report must detail, at
1.17 minimum, each of the following for the prior
1.18 calendar year, and, after July 15, 2027, the
1.19 report must detail, at minimum, each of the
1.20 following that relate to the activities of Exodus
1.21 Lending under paragraph (g) for the prior
1.22 calendar year:

1.23 (1) the total number of loans granted;

2.1 (2) the total number of participants granted
2.2 loans;

2.3 (3) an analysis of the participants' race and
2.4 ethnicity, gender, and geographic locations;

2.5 (4) the average loan amount;

2.6 (5) the total loan amounts paid back by
2.7 participants;

2.8 (6) a list of the trusted community-based
2.9 partners described in section 2;

2.10 (7) the final criteria developed for
2.11 character-based small dollar loan program
2.12 determinations under paragraph (g); and

2.13 (8) summary data on the significant barriers
2.14 to mainstream financial products faced by
2.15 participants.

2.16 (i) No later than August 15, 2024, and
2.17 annually thereafter until the appropriations
2.18 provided for under paragraphs (e) and (g) have
2.19 been exhausted or canceled, the commissioner
2.20 of commerce must submit a report to the chairs
2.21 and ranking minority members of the
2.22 legislative committees of the senate and house
2.23 of representatives with primary jurisdiction
2.24 over commerce and consumer protection. The
2.25 report must detail the information collected
2.26 by the commissioner of commerce under
2.27 paragraph (h)."

2.28 Page 8, delete section 1 and insert:

2.29 "Sec. ...Minnesota Statutes 2022, section 60A.08, subdivision 15, is amended to read:

2.30 Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related
2.31 information filed with the commissioner under section 61A.02 shall be nonpublic data until
2.32 the filing becomes effective.

3.1 (b) All forms, rates, and related information filed with the commissioner under section
3.2 62A.02 shall be nonpublic data until the filing becomes effective.

3.3 (c) All forms, rates, and related information filed with the commissioner under section
3.4 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

3.5 (d) All forms, rates, and related information filed with the commissioner under section
3.6 70A.06 shall be nonpublic data until the filing becomes effective.

3.7 (e) All forms, rates, and related information filed with the commissioner under section
3.8 79.56 shall be nonpublic data until the filing becomes effective.

3.9 (f) All forms, rates, and related information filed with the commissioner under section
3.10 65A.298 shall be nonpublic data until the filing becomes effective.

3.11 ~~(f)~~ (g) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review
3.12 under section 2794 of the Public Health Services Act and any amendments to, or regulations,
3.13 or guidance issued under the act that are filed with the commissioner on or after September
3.14 1, 2011, the commissioner:

3.15 (1) may acknowledge receipt of the information;

3.16 (2) may acknowledge that the corresponding rate filing is pending review;

3.17 (3) must provide public access from the Department of Commerce's website to parts I
3.18 and II of the Preliminary Justifications of the rate increases subject to review; and

3.19 (4) must provide notice to the public on the Department of Commerce's website of the
3.20 review of the proposed rate, which must include a statement that the public has 30 calendar
3.21 days to submit written comments to the commissioner on the rate filing subject to review.

3.22 ~~(g)~~(h) Notwithstanding paragraphs (b) and (c), for all proposed premium rates filed with
3.23 the commissioner for individual health plans, as defined in section 62A.011, subdivision 4,
3.24 and small group health plans, as defined in section 62K.03, subdivision 12, the commissioner
3.25 must provide public access on the Department of Commerce's website to compiled data of
3.26 the proposed changes to rates, separated by health plan and geographic rating area, within
3.27 ten business days after the deadline by which health carriers, as defined in section 62A.011,
3.28 subdivision 2, must submit proposed rates to the commissioner for approval."

3.29 Page 9, line 22, delete "August 1, 2023" and insert "January 1, 2024"

3.30 Page 13, after line 11, insert:

3.31 "**EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
3.32 plans offered, issued, or renewed on or after that date."

4.1 Page 13, after line 16, insert:

4.2 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.3 offered, issued, or renewed on or after that date."

4.4 Page 13, after line 24, insert:

4.5 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.6 offered, issued, or renewed on or after that date."

4.7 Page 14, after line 16, insert:

4.8 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.9 offered, issued, or renewed on or after that date."

4.10 Page 15, after line 6, insert:

4.11 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.12 offered, issued, or renewed on or after that date."

4.13 Page 16, after line 3, insert:

4.14 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.15 offered, issued, or renewed on or after that date."

4.16 Page 18, line 18, strike "or"

4.17 Page 18, line 24, strike the period and insert "; or"

4.18 Page 18, before line 25, insert:

4.19 "(8) the individual was enrolled in a state public program and is losing coverage due to
4.20 the unwinding of the Medicaid continuous enrollment conditions as provided by Code of
4.21 Federal Regulations, title 45, section 155.420(d)(9) and (d)(1), and Public Law 117-328,
4.22 section 5131 (2022)."

4.23 Page 21, after line 16, insert:

4.24 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.25 offered, issued, or renewed on or after that date."

4.26 Page 21, after line 21, insert:

4.27 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
4.28 offered, issued, or renewed on or after that date."

4.29 Page 21, after line 30, insert:

5.1 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
5.2 offered, issued, or renewed on or after that date."

5.3 Page 25, after line 18, insert:

5.4 "**EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies
5.5 offered, issued, or renewed on or after that date."

5.6 Page 35, line 6, delete "14-member" and insert "15-member"

5.7 Page 35, after line 21, insert:

5.8 "(9) one member who is an oncologist;"

5.9 Renumber the clauses in sequence

5.10 Page 43, delete lines 13 to 17

5.11 Page 44, delete lines 20 and 21

5.12 Page 46, after line 9, insert:

5.13 "**EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
5.14 plans offered, issued, or renewed on or after that date."

5.15 Page 49, line 28, delete ": (i)"

5.16 Page 49, line 30, delete everything after "256L" and insert a period

5.17 Page 49, delete line 31

5.18 Page 51, delete lines 5 to 8 and insert:

5.19 "**EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
5.20 plans offered, issued, or renewed on or after that date."

5.21 Page 51, line 31, delete "2024" and insert "2025"

5.22 Page 57, after line 9, insert:

5.23 "Subd. 3. **Exclusions.** This section does not apply to managed care plans or county-based
5.24 purchasing plans when the plan provides coverage to public health care program enrollees
5.25 under chapter 256B or 256L."

5.26 Renumber the subdivisions in sequence

5.27 Page 58, line 4, delete "2024" and insert "2025"

5.28 Page 58, line 9, delete "the"

5.29 Page 58, line 10, after "standards" insert "that include a hail supplement as"

6.1 Page 58, line 16, after "submit" insert "and maintain"

6.2 Page 58, line 18, after the period, insert "At the time of policy renewal an insurer may
6.3 require evidence that the issued certificate remains in good standing."

6.4 Page 58, line 26, delete "An" and insert "A participating"

6.5 Page 58, line 29, delete "An" and insert "A participating"

6.6 Page 59, line 1, delete "An" and insert "A participating"

6.7 Page 59, line 10, after the period, insert "A rating plan, rating classification, and territories
6.8 applicable to insurance written by a participating insurer and any related statistics are subject
6.9 to chapter 70A."

6.10 Page 59, line 16, delete "An" and insert "A participating"

6.11 Page 59, line 18, delete "must" and insert "may"

6.12 Page 63, line 5, delete "credit" and insert "discount"

6.13 Page 70, after line 27, insert:

6.14 "Sec. .... Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

6.15 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
6.16 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
6.17 may issue separate contracts with requirements specific to services to medical assistance
6.18 recipients age 65 and older.

6.19 (b) A prepaid health plan providing covered health services for eligible persons pursuant
6.20 to chapters 256B and 256L is responsible for complying with the terms of its contract with
6.21 the commissioner. Requirements applicable to managed care programs under chapters 256B
6.22 and 256L established after the effective date of a contract with the commissioner take effect
6.23 when the contract is next issued or renewed.

6.24 (c) The commissioner shall withhold five percent of managed care plan payments under
6.25 this section and county-based purchasing plan payments under section 256B.692 for the
6.26 prepaid medical assistance program pending completion of performance targets. Each
6.27 performance target must be quantifiable, objective, measurable, and reasonably attainable,
6.28 except in the case of a performance target based on a federal or state law or rule. Criteria
6.29 for assessment of each performance target must be outlined in writing prior to the contract
6.30 effective date. Clinical or utilization performance targets and their related criteria must
6.31 consider evidence-based research and reasonable interventions when available or applicable

7.1 to the populations served, and must be developed with input from external clinical experts
7.2 and stakeholders, including managed care plans, county-based purchasing plans, and
7.3 providers. The managed care or county-based purchasing plan must demonstrate, to the
7.4 commissioner's satisfaction, that the data submitted regarding attainment of the performance
7.5 target is accurate. The commissioner shall periodically change the administrative measures
7.6 used as performance targets in order to improve plan performance across a broader range
7.7 of administrative services. The performance targets must include measurement of plan
7.8 efforts to contain spending on health care services and administrative activities. The
7.9 commissioner may adopt plan-specific performance targets that take into account factors
7.10 affecting only one plan, including characteristics of the plan's enrollee population. The
7.11 withheld funds must be returned no sooner than July of the following year if performance
7.12 targets in the contract are achieved. The commissioner may exclude special demonstration
7.13 projects under subdivision 23.

7.14 (d) The commissioner shall require that managed care plans:

7.15 (1) use the assessment and authorization processes, forms, timelines, standards,
7.16 documentation, and data reporting requirements, protocols, billing processes, and policies
7.17 consistent with medical assistance fee-for-service or the Department of Human Services
7.18 contract requirements for all personal care assistance services under section 256B.0659 and
7.19 community first services and supports under section 256B.85; ~~and~~

7.20 (2) by January 30 of each year that follows a rate increase for any aspect of services
7.21 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking
7.22 minority members of the legislative committees with jurisdiction over rates determined
7.23 under section 256B.851 of the amount of the rate increase that is paid to each personal care
7.24 assistance provider agency with which the plan has a contract~~.~~; and

7.25 (3) use a six-month timely filing standard and provide an exemption to the timely filing
7.26 timeliness for the resubmission of claims where there has been a denial, request for more
7.27 information, or system issues.

7.28 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
7.29 include as part of the performance targets described in paragraph (c) a reduction in the health
7.30 plan's emergency department utilization rate for medical assistance and MinnesotaCare
7.31 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
7.32 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
7.33 year, the managed care plan or county-based purchasing plan must achieve a qualifying
7.34 reduction of no less than ten percent of the plan's emergency department utilization rate for

8.1 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
8.2 in subdivisions 23 and 28, compared to the previous measurement year until the final
8.3 performance target is reached. When measuring performance, the commissioner must
8.4 consider the difference in health risk in a managed care or county-based purchasing plan's
8.5 membership in the baseline year compared to the measurement year, and work with the
8.6 managed care or county-based purchasing plan to account for differences that they agree
8.7 are significant.

8.8 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
8.9 the following calendar year if the managed care plan or county-based purchasing plan
8.10 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
8.11 was achieved. The commissioner shall structure the withhold so that the commissioner
8.12 returns a portion of the withheld funds in amounts commensurate with achieved reductions
8.13 in utilization less than the targeted amount.

8.14 The withhold described in this paragraph shall continue for each consecutive contract
8.15 period until the plan's emergency room utilization rate for state health care program enrollees
8.16 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
8.17 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
8.18 health plans in meeting this performance target and shall accept payment withholds that
8.19 may be returned to the hospitals if the performance target is achieved.

8.20 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
8.21 include as part of the performance targets described in paragraph (c) a reduction in the plan's
8.22 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
8.23 determined by the commissioner. To earn the return of the withhold each year, the managed
8.24 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
8.25 than five percent of the plan's hospital admission rate for medical assistance and
8.26 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
8.27 28, compared to the previous calendar year until the final performance target is reached.
8.28 When measuring performance, the commissioner must consider the difference in health risk
8.29 in a managed care or county-based purchasing plan's membership in the baseline year
8.30 compared to the measurement year, and work with the managed care or county-based
8.31 purchasing plan to account for differences that they agree are significant.

8.32 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
8.33 the following calendar year if the managed care plan or county-based purchasing plan
8.34 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
8.35 rate was achieved. The commissioner shall structure the withhold so that the commissioner

9.1 returns a portion of the withheld funds in amounts commensurate with achieved reductions
9.2 in utilization less than the targeted amount.

9.3 The withhold described in this paragraph shall continue until there is a 25 percent
9.4 reduction in the hospital admission rate compared to the hospital admission rates in calendar
9.5 year 2011, as determined by the commissioner. The hospital admissions in this performance
9.6 target do not include the admissions applicable to the subsequent hospital admission
9.7 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
9.8 this performance target and shall accept payment withholds that may be returned to the
9.9 hospitals if the performance target is achieved.

9.10 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
9.11 include as part of the performance targets described in paragraph (c) a reduction in the plan's
9.12 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
9.13 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
9.14 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
9.15 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
9.16 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
9.17 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
9.18 percent compared to the previous calendar year until the final performance target is reached.

9.19 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
9.20 the following calendar year if the managed care plan or county-based purchasing plan
9.21 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
9.22 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
9.23 so that the commissioner returns a portion of the withheld funds in amounts commensurate
9.24 with achieved reductions in utilization less than the targeted amount.

9.25 The withhold described in this paragraph must continue for each consecutive contract
9.26 period until the plan's subsequent hospitalization rate for medical assistance and
9.27 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
9.28 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
9.29 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
9.30 accept payment withholds that must be returned to the hospitals if the performance target
9.31 is achieved.

9.32 (h) Effective for services rendered on or after January 1, 2013, through December 31,
9.33 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
9.34 this section and county-based purchasing plan payments under section 256B.692 for the

prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02."

Page 78, line 5, delete "$2,000" and insert "$1,300"

Page 78, line 6, reinstate the stricken language and delete the new language

Page 81, line 16, delete "January 1" and insert "July 30"

Page 81, line 23, delete "January 1" and insert "July 30"

Page 131, line 22, before "persons" insert "(1)"

11.1 Page 131, line 23, before the period and insert ", and (2) an institution of the Farm Credit
11.2 System established and authorized in accordance with the Farm Credit Act of 1971, as
11.3 amended, United States Code, title 12, section 2001, et seq"

11.4 Page 147, line 14, before "that" insert "by a motor vehicle dealer"

11.5 Page 161, line 30, delete "immoral,"

11.6 Page 161, line 31, delete everything after "consumers" and insert a period

11.7 Page 161, delete line 32

11.8 Page 194, after line 17, insert:

11.9 "Sec. .... Laws 2022, chapter 93, article 1, section 2, subdivision 5, is amended to read:

11.10	Subd. 5. **Enforcement and Examinations**	-0-	522,000

11.11 $522,000 in fiscal year 2023 is for the auto
11.12 theft prevention library under Minnesota
11.13 Statutes, section 65B.84, subdivision 1,
11.14 paragraph (d). This is a onetime appropriation
11.15 and is available until June 30, 2024."

11.16 Renumber the sections in sequence and correct the internal references

11.17 Amend the title accordingly