

Report of the Special Committee on Financial Institutions and Insurance to the 2020 Kansas Legislature

CHAIRPERSON: Senator Robert Olson

VICE-CHAIRPERSON: Representative Jim Kelly

OTHER MEMBERS: Senators Rick Billinger, Bruce Givens, Eric Rucker, and Mary Ware; and Representatives Elizabeth Bishop, Tom Cox, Leo Delperdang, Cindy Neighbor, Bill Rhiley (substitute, October 3, 2019, meeting only), and Jene Vickrey

STUDY TOPIC

The Committee is directed to:

- Identify policies and approaches that have failed to address the high costs of healthcare benefits;
- Identify measures that could be expected to lead to more affordable and accessible healthcare benefits;
- Consider the implications of the recent *Hilburn v. Enerpipe Ltd.*, No. 112,756 (*Hilburn*) decision on healthcare costs on Kansas;
- Conduct an interim hearing on 2019 SB 238—privilege tax deduction for interest from certain business loans; and
- Conduct an interim hearing on 2019 SB 239—imposing the privilege tax on certain state credit unions.

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Special Committee on Financial Institutions and Insurance

HEALTHCARE BENEFITS AND COSTS

Conclusions and Recommendations

The Special Committee on Financial Institutions and Insurance recognizes the broad scope of the assigned healthcare benefits and costs topics and appreciates the information provided to the Committee by a representative group of healthcare providers, insurers, agencies, and other stakeholders.

The Committee submits its final report for consideration to standing committees of the 2020 Legislature.

Proposed Legislation: None

BACKGROUND

The charge to the Special Committee on Financial Institutions and Insurance was to review and make recommendations on two topics assigned by the Legislative Coordinating Council (LCC):

- Identify policies and approaches that have failed to address the high costs of healthcare benefits, identify measures that could be expected to lead to more affordable and accessible healthcare benefits, and consider the implications of the recent *Hilburn v. Enerpipe Ltd.*, No. 112,756, (*Hilburn*) decision on healthcare costs on Kansas (healthcare benefits and costs topic); and
- Conduct hearings on 2019 SB 238—privilege tax deduction for interest from certain business loans, and 2019 SB 239—imposing the privilege tax on certain state credit unions (privilege tax topic).

The Special Committee was authorized to meet on three days. [*Note:* The request for interim study of healthcare benefits was made by the Chairperson of the Senate Committee on Financial Institutions and Insurance. The LCC assigned the

other topic of this report, which pertains to implications of *Hilburn*.]

COMMITTEE ACTIVITIES

The Special Committee met September 12, October 3, and October 29, 2019. The Committee considered the healthcare benefits and costs topic at its September 12 and October 29, 2019, meetings. As part of its review of the healthcare benefits and costs topic, the Committee received a presentation on the State Employee Health Plan (SEHP), information from stakeholders on cost-containment strategies and healthcare benefits, and information on the Kansas Supreme Court decision in *Hilburn*.

State Employee Health Plan

The Director of the SEHP provided an overview of the SEHP on September 12, 2019. He discussed the evolution, structure, and functions of the SEHP, which provides benefits and services to approximately 85,000 covered lives (employees, retirees, Consolidated Omnibus Budget Reconciliation Act [COBRA] participants, and their dependents). He stated the SEHP was founded in 1984 with the legislative creation of the 5-member Kansas State Employees Health Care Commission (HCC), which is supported by a 21-

member Employee Advisory Committee. Since July 1, 2011, the Kansas Department of Health and Environment (KDHE) has had oversight over the SEHP. He noted more than 140 different entities participate in the SEHP, including school districts, cities, counties, public libraries, public hospitals, and water districts.

The Director summarized SEHP member benefit offerings, including medical benefits (offered through Aetna and Blue Cross and Blue Shield of Kansas [BCBSKS]); Medicare plans for direct bill members (Aetna and BCBSKS); dental benefits (Delta Dental of Kansas); pharmacy benefit management (CVS Caremark); vision benefits (Surency Vision, wholly owned by Delta Dental); voluntary benefits (MetLife); health savings accounts (HSAs), health reimbursement accounts (HRAs), and flexible spending accounts (FSAs) (NueSynergy); preferred lab program (Quest Diagnostics and Stormont Vail); COBRA administration (Total Administrative Services Corporation); long-term care insurance (ACSIA Partners LLC); on-site health clinic (Marathon Health); and the HealthQuest program (Cerner). He also highlighted various transparency tools and programs in detail.

Cost-containment Strategies and Healthcare Benefits

Over the course of the two meetings dedicated to the healthcare benefits and costs topics (held September 12 and October 29, 2019), the Committee heard from a variety of interested parties on cost-containment strategies and healthcare benefits. Presentation topics included drivers of healthcare costs; hospital pricing, reimbursement, and cost shifting; prescription drugs; pharmacy benefit managers (PBMs); health platforms; the health insurance market; market regulations; Patient Protection and Affordable Care Act (ACA) regulations; Medicaid expansion; surprise medical billing; additional policy options; and community health access and care.

Drivers of healthcare costs. A health program policy specialist from the National Conference of State Legislatures (NCSL) attributed the trend of increasing healthcare benefit costs to two cost drivers: population-based factors (*e.g.*, aging population, population growth, and chronic disease, including obesity, unhealthy behaviors,

mental illness, and substance use disorder) and systems-based factors (*e.g.*, industry consolidation, utilization, hospital costs and pricing, and prescription drugs).

A BCBSKS representative also cited prescription drugs and other cost drivers: the 132 percent increase in the cost of prescription drugs since 2008, expensive new technology, an aging population, lifestyle choices (*e.g.*, tobacco use, obesity, lack of exercise), an increasing demand for services, and the effect of ACA requirements.

Hospital pricing, reimbursement, and cost shifting. The NCSL policy specialist provided information on hospital prices and noted charges differ not only across the United States, but vary within a region. She provided information on how other states are addressing hospital pricing, including global budgeting (*e.g.*, Maryland), reference-based pricing (*e.g.*, Montana and North Carolina), and a community purchasing collaborative (*e.g.*, Colorado).

Representatives of the Kansas Hospital Association (KHA) provided information on the distribution of Kansas discharges by payer: Medicare (42.8 percent), commercial (33.0 percent), Medicaid (14.2 percent), and other (10.0 percent). They also provided information on hospital pricing, including charge, payment, and cost. They said although every hospital payer is charged the same, no two payers pay the same rate because government payers pay below the cost of care, commercial payers negotiate rates based on their market share and ability to negotiate, and charity care and other payments impact the overall cost for everyone else. Payer mixes can be different across regions in Kansas because some regions have a higher mix of government payers and a lack of commercial business. They described the challenges facing rural hospitals and communities, including low patient volume, payer mix, workforce shortages, behavioral health, violence in communities, and the opioid epidemic.

The KHA representatives explained the primary income sources for hospitals are from inpatient and outpatient services; stated some hospitals also derive revenue from gift shops, cafeteria sales, donations, grants, and investments; and stated about 70 percent of hospitals in Kansas receive some type of tax subsidy, mill levy, or

sales tax to offset the cost of operations. They reviewed deductions or adjustments to hospital revenues as charity care (when the patient has no insurance or is not able to pay co-pay or deductible amounts), bad debt (when the patient is unable or unwilling to establish a payment plan), and contract adjustment or write-off (the difference between what is charged and what is actually received in payment).

The KHA representatives discussed key revenue drivers, internal (*e.g.*, flu season) and external (*e.g.*, natural disasters). They stated most Kansas hospitals rely heavily on payments for services provided to Medicare and Medicaid patients. They stated Medicare pays based upon the type of service rendered and with different methodologies for critical access hospitals (CAHs), sole community hospitals, Medicare dependent hospitals, and special rural payments. Medicare reimburses 101 percent of allowable costs to the 82 CAHs in Kansas. They noted, in 2017, the average Medicare margin for Kansas hospitals was a negative 4.88 percent and only 18 percent of Kansas hospitals had a positive margin. They noted a 4 percent positive margin overall is the standard for a hospital to remain viable.

The KHA representatives provided information on cost shifting and stated there are negative margins in hospitals because there is not enough money to cost shift. They stated shortfalls and losses impact the ability of hospitals to attract and retain staff; contain health costs; update technology, infrastructure, and facilities; and contribute positively to the local economy. They summarized specific challenges in rural hospitals, including that rural hospitals have a higher proportion of Medicare and Medicaid patients and rural areas have smaller and aging populations. They also noted the burden of administrative costs.

A representative of America's Health Insurance Plans (AHIP) stated one issue with healthcare is the federal government provides lower reimbursement rates to hospitals and physicians, which shifts costs to states. He suggested a short-term solution would be to increase the amount of money available for healthcare and to utilize telemedicine.

A representative of BCBSKS referenced cost shifting as a driver of increased premium costs. He

explained hospitals are required to shift costs to private insurers in order to cover the difference between low reimbursement rates (*i.e.*, Medicaid, Medicare, and uncompensated care) and the costs of medical services. Another representative of BCBSKS noted cost shifting is inevitable due to an aging population.

Prescription drugs. The NCSL policy specialist provided information on prescription drugs, noting the U.S. Food and Drug Administration approves drugs, but it does not get involved in the pricing of drugs.

A representative of the Pharmaceutical Research and Manufacturers of America (PhRMA) stated the pharmaceutical industry has invested more than \$800 billion in research and development since 2000, including \$71.4 billion in 2017. She noted it can take 10 to 12 years to bring a drug to market, costing more than \$2.6 billion for a single drug. She provided information on the pricing of medicines, noting it is a complex process that includes factors such as capital costs, discounts and rebates, utilization, research and development costs, and clinical trial costs.

The PhRMA representative noted 4,000 drugs were in development; there are 535 clinical sites in Kansas with 13,255 clinical study participants; the Medicine Assistance Tool is a web platform providing patients, caregivers, and providers with cost and financial assistance information for brand name medications; manufacturer coupons are helpful to patients; the list prices of certain drugs, such as insulin, are reported in the media, but those prices do not account for negotiated rates and discounts; drug rebates are important; there is a debate on whether the rebate structure should change; insurance benefits should promote health and not inhibit it (*e.g.*, first dollar coverage for chronic conditions such as diabetes); coupons and discounts should be counted toward the patient out-of-pocket cost; and PhRMA is taking note of potential changes related to bulk pricing and subscription-based models. She also provided information on the federal requirement for drug manufacturers to pay a rebate for all drugs dispensed to Medicaid beneficiaries; this rebate amount is 23.1 percent of the drug's average manufacturer price.

PBMs. The NCSL policy specialist provided information on PBMs, including on the pharmacy supply chain and the role of PBMs. She noted three diverse companies controlled the PBM market in 2017 (Express Scripts—28 percent, CVS Caremark—26 percent, and OptumRx—19 percent). She provided examples of state action related to PBMs, including comprehensive bills in Louisiana, Maine, and Minnesota to prohibit gag clauses and clawbacks, prohibit spread pricing, require licensure and registration of PBMs, require transparency and reporting, and assert fiduciary duties on the PBM. She also noted price transparency is an emerging theme for cost containment and provided information on action related to capping co-payments for prescription drugs (*e.g.*, California, Colorado, and the District of Columbia).

A pharmacist and representative of the Kansas Pharmacists Association expressed concerns with PBMs, including that PBMs control almost every aspect on the cost of the drug; PBMs receive money from drug manufacturers, pharmacies, sponsors, and payors; the three largest PBMs process nearly 90 percent of prescriptions in the country; PBMs have no fiduciary responsibility or liability to the pharmacy business or the consumer; PBMs are not transparent; PBMs are experiencing record profits; and savings promised by PBMs have not been realized by consumers. He suggested the Legislature should remove gag clauses so pharmacies can talk to sponsors and employers and new requirements be placed on PBMs to make them more transparent, require them to treat providers at a reasonable rate, prohibit clawbacks from inside the store, and prohibit price spreading.

A pharmacist and representative of Prime Therapeutics, a PBM contracted with BCSBKS, described a PBM as a healthcare organization that contracts with plan sponsors and payers (*e.g.*, insurers, employers, unions, and government) to administer the prescription drug health benefits. She explained plan sponsors contract, create, and audit PBM agreements that extend buying power and competitive prices through the selection of a PBM and plan design. She reviewed the core services of a PBM as claim processing, formulary management, drug utilization review, disease management and adherence initiatives, negotiation with manufacturers and pharmacies, pharmacy

networks, and mail-service and specialty pharmacy services.

The representative of Prime Therapeutics stated the drug manufacturer sets the price for the drug, whether it is a brand name, specialty, or generic drug; the ability for a PBM to go to a manufacturer for a lower price depends on a competitive market; and prescription drugs are paid by two entities: the consumer (*i.e.*, co-pay) and payers. She also provided information on the drug supply chain, noting a majority of profits reside with manufacturers. She stated 80 percent of independent pharmacies contract with PBMs through pharmacy services administrative organizations (PSAOs). The PSAOs pool purchasing power of many independent pharmacies to negotiate contracts with PBMs. She noted drug wholesalers (McKesson, AmerisourceBergen, and Cardinal Health) own the three largest PSAOs.

The representative of Prime Therapeutics provided information on 2018 Kansas law related to information a pharmacy may provide to a consumer (known as “gag clauses”) and clawback for PBMs; federal gag legislation was passed in 2019; rebates depend on the contract but, nationally, 98 to 99 percent of rebates go back to the plan sponsor; pharmacies do not receive rebates; pharmacies contract directly with PSAOs; audits must adhere to state law; enacted Kansas PBM-related laws apply to the commercial market and not to self-insured plans; and requirements for contracts, including transparency, depend on the services the plan sponsor has selected for its PBM benefit.

Committee staff from the Kansas Legislative Research Department (KLRD) noted the PBM contract for the SEHP is a three-year contract that was discussed by the HCC in Summer 2019; CVS/Caremark is the PBM for the SEHP through December 31, 2019; and, in February 2015, the Kansas Legislative Division of Post Audit conducted an audit on whether Kansas had sufficient controls to minimize the State’s costs and enhance benefits through its PBM.

Health platforms. A representative of NuWin Care and its associates (medZERO, ModRN Health, SPEC*KC, and Springbuk) gave a joint presentation on their health platforms. The NuWin

Care representative noted the U.S. healthcare system requires innovative transformation and has problems related to affordability, accessibility, and outcomes. He stated hospitals, insurance carriers, and brokers have aligned incentives to encourage increasing prices and fees, which are passed to the consumer; medical bills are causing financial distress for American families; and the “fee-for-service” model for hospitals encourages a focus on the number of services provided instead of the quality of the health outcome for patients. He stated NuWin Care has developed a comprehensive platform of services they believe will lower costs and increase healthcare outcomes. The associated representatives provided information on their health platforms, which are focused on care coordination (ModRN Health), price transparency (SPEC*KC), payment of medical costs (medZERO), and data (Springbuk).

Health insurance market. Representatives of the Kansas Health Institute (KHI) provided information on the health insurance market in Kansas in 2017, noting the number of Kansans receiving private coverage (1,813,373), receiving public coverage (815,529), and uninsured (243,305). They stated the basic formula for what drives healthcare spending is the number of people multiplied by the volume of services per person multiplied by the price per service.

Market regulations. A representative of Americans for Prosperity-Kansas stated the cost of health insurance has skyrocketed; since 2014, the average cost of an individual health insurance plan had increased 131 percent, from \$196 to \$453. She stated restrictive market regulations that do not impact public safety also drive up the costs of medical care, including Kansas’ scope of practice laws.

ACA regulation. A representative of BCBSKS stated health insurance changed once the ACA was enacted in 2010. She provided a timeline and the major milestones that have occurred since the enactment of the ACA. She noted on September 23, 2010, a number of consumer protections for non-grandfathered plans took effect, including coverage for dependents to age 26, essential health benefits, first-dollar preventative services without cost sharing for the patient (e.g., annual wellness visits without co-payments, co-insurance, or deductibles), and no

lifetime benefit maximums on a policy (including for high-risk policyholders).

The BCBSKS representative stated the most significant change in the individual market took place on January 1, 2014, with guaranteed issue (a requirement on health insurers to issue a plan to an applicant regardless of the applicant’s health status or other factors). She noted the Kansas Insurance Department (KID) has determined and approved seven rating factors, including geography, tobacco usage, and age. She noted subsidies also became available January 1, 2014, for those who qualify for such subsidies.

The representative of BCBSKS stated the ACA required all non-grandfathered fully insured individual and small group plans to cover ten essential health benefits. These benefits are unlimited as long as they are medically necessary. She also provided information on uninsured rates in Kansas and the United States before and after the enactment of the ACA.

The representative of BCBSKS provided information on the types of private health plans; noted large group plans are regulated by the ACA, but their rating factors are different; and stated self-funded groups are not regulated by KID and state mandates do not apply to these plans. She provided information on association health plans (AHPs) and compared AHPs with plans meeting requirements of the ACA. She also compared and contrasted “health insurance” with a “health benefit plan.”

The representative of BCBSKS provided information on required eligible providers and benefit mandates in Kansas and discussed other possible mandates. She noted, under the ACA, if a state legislature adds a new benefit mandate, the state must pay the additional cost of that mandate. She provided information on the statutory process for assessing a mandate in Kansas (KSA 40-2248, 40-2249, and 40-2249a).

Medicaid expansion. A representative of BCBSKS commented BCBSKS could not subsidize all of Medicaid expansion, but also wants to provide Kansans with access to care. She stated it is not possible to predict the impact of an influx of 150,000 new Medicaid expansion consumers until a specific plan is implemented;

BCBSKS has not completed an intense study to determine how Medicaid expansion would affect the private insurance market. A KHA representative stated there is uncertainty on how Medicaid expansion would impact hospital costs, revenues, and the payer mix.

Surprise medical billing. A KHA representative stated surprise medical billing is an issue on the federal agenda to provide transparency to patients. A BCBSKS representative indicated surprise medical billing is confusing and, if the problem cannot be solved at a federal level, she hoped it could be solved at the state level.

Additional policy options. The KHI representatives noted various states have addressed controlling healthcare costs and quality, including public health and cost outcomes scorecards, adopting payment and delivery system reform goals, instituting global budgets for hospitals, and launching all-payer claims databases.

The KHI representatives suggested the Committee consider what perspective is being discussed when attempting to control healthcare costs: State General Fund moneys, private insurance, the SEHP, the cost of the uninsured, or some other combination. They provided some policy options, including suggestions by the American Enterprise Institute and Brookings Institute (*e.g.*, improve incentives for cost-effective private insurance, remove state regulatory barriers to provider market competition, and improve the choice environment for buying insurance), options that would require new federal law, and other options (*e.g.*, right-to-shop programs, direct patient care models, reinsurance programs and high risk pools, association health plans, and short-term limited duration insurance).

Community health access and care. The Director of Community Health Access, KDHE, stated the mission of Community Health Access is to aid Kansas' rural and medically underserved communities in building sustainable access to quality, patient-centered primary health care services. She expressed a commitment to work through key partnerships to support the retention of a quality rural workforce and strengthen performance improvement capacity systemwide.

She provided information on various KDHE programs.

A representative of Community Care Network of Kansas (Community Care) provided information on Community Care, noting the organization represents 37 State-funded clinics with 100 sites and is committed to providing all Kansans access to high quality, whole-person healthcare. She stated one in ten Kansans rely on a community care clinic for their healthcare; in the past five years, the number of patients served increased by 25 percent and visits increased by 20 percent; and, in 2018, the clinics provided \$46 million in uncompensated care. She stated these clinics receive funding from the State, patient payments, local contributions, grants, and fundraising; in 2018, state funding accounted for 12 percent of total revenue for Kansas community health centers. She also provided information on school-based and telehealth services. She stated these clinics are a cost-effective alternative to expensive healthcare services, especially unnecessary emergency room visits.

***Hilburn* Decision**

The Committee heard information on the June 14, 2019, *Hilburn* decision at its October 29, 2019, meeting.

Topic overview. Committee staff from KLRD noted the Special Committee on Judiciary discussed the decision at its October 2, 2019, meeting, and the Health Care Stabilization Fund Oversight Committee discussed the decision at its October 24, 2019, meeting. Committee staff from the Office of Revisor of Statutes summarized the *Hilburn* decision, noting the Kansas Supreme Court held the cap on noneconomic damages in civil actions (for personal injury or death) imposed by KSA 60-19a02 was facially unconstitutional because it violated Section 5 of the *Bill of Rights* within the *Kansas Constitution*. The senior assistant revisor explained the Court held the statute violates the right protected by Section 5 because it intrudes upon the jury's determination of the compensation owed to plaintiffs to redress their injuries; provided the historical background of noneconomic damages caps; and noted the 3-1-2 plurality decision of the Court was indicative of the complexity of the decision.

Stakeholder comments. A representative of the Kansas Medical Society (KMS) provided comment on behalf of KMS and the Kansas Medical Mutual Insurance Company (KAMMCO). She stated the Health Care Stabilization Fund (Fund), enacted in 1976, was designed to ensure all medical independent health care providers could purchase professional liability insurance; noted the Legislature passed a cap on noneconomic damages following the establishment of the Fund; and provided information on the history of the cap placed on noneconomic damages.

The KMS and KAAMCO representative stated a common-sense reading of *Hilburn* would be the cap has been struck down, but the opinion does not specifically overrule *Miller v. Johnson* (2012) or state the cap does not apply to medical malpractice. She expressed concerns the *Hilburn* decision and press release from the Office of the Supreme Court make it difficult to ascertain the outcome of future medical malpractice cases. She stated the medical community is awaiting further clarification from the Supreme Court to see how future cases, including medical malpractice, would be ruled upon by the Court.

A representative of the Kansas Trial Lawyers Association noted Section 5 of the *Bill of Rights* of the *Kansas Constitution* and the Seventh

Amendment of the *Bill of Rights* within the *U.S. Constitution* entrust power with citizens and allow jurors to decide a multitude of complex issues and disputes. He stated when a plaintiff's recovery is limited, it is more likely the burden will shift to society. He also stated 14 or 15 states have a constitutional provision related to jury trials; of those states, half have found the cap on noneconomic damages to be contrary to their state constitutions.

Written-only comments were received from representatives of Kansas Advocates for Better Care, the Kansas Association of Property and Casualty Insurance Companies, the Kansas Chamber, KHA, and Mothers Against Drunk Driving.

CONCLUSIONS AND RECOMMENDATIONS

The Committee recognizes the broad scope of the assigned healthcare benefits and costs topics and appreciates the information provided to the Committee by a representative group of healthcare providers, insurers, agencies, and other stakeholders.

The Committee submits its final report for consideration to standing committees of the 2020 Legislature.

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Special Committee on Financial Institutions and Insurance

KANSAS FINANCIAL INSTITUTIONS' PRIVILEGE TAX

Conclusions and Recommendations

Following public hearings and Committee discussion:

- The Committee makes no recommendation on **2019 SB 238**; and
- The Committee does not recommend **2019 SB 239**.

The Committee directs its report to the House Committee on Financial Institutions and Pensions, the Senate Committee on Financial Institutions and Insurance, the Senate Committee on Assessment and Taxation, and the House Committee on Taxation.

Proposed Legislation: None

BACKGROUND

The charge to the Special Committee on Financial Institutions and Insurance was to review and make recommendations on two topics assigned by the Legislative Coordinating Council:

- Identify policies and approaches that have failed to address the high costs of healthcare benefits, identify measures that could be expected to lead to more affordable and accessible healthcare benefits, and consider the implications of the recent *Hilburn v. Enerpipe Ltd.*, No. 112,756, (*Hilburn*) decision on healthcare costs on Kansas (healthcare benefits and costs topic); and
- Conduct hearings on 2019 SB 238—privilege tax deduction for interest from certain business loans, and 2019 SB 239—imposing the privilege tax on certain state credit unions (privilege tax topic). The Special Committee was authorized to meet on three days.

Both 2019 SB 239 and 2019 SB 239 were introduced by the Senate Committee on Assessment and Taxation and, on April 5, 2019, the bills were referred from that committee to the Senate Committee on Financial Institutions and Insurance. [*Note:* The request for interim study of the privilege tax topic was made by the Chairperson of the Senate Committee on Financial Institutions and Insurance.]

SB 238—Privilege Tax Deduction for Interest from Certain Business Loans

SB 238 would permit national banking associations, state banks, trust companies, and savings and loan associations, for all taxable years commencing after December 31, 2019, to deduct from net income the interest received from business loans to the extent such interest is included in the Kansas taxable income of a corporation. The bill would create definitions for the term “interest” and “business” and assign “net income” its definition from KSA 79-1109 as updated in the bill.

These definitions are as follows:

- “Business” would mean any entity operated primarily for commercial or agricultural purposes and is not an individual obtaining a loan primarily for personal, family, or household purposes;
- “Interest” would mean interest on indebtedness incurred in the ordinary course of the active conduct of any business; and
- “Net income” would mean the Kansas taxable income of corporations, as defined in KSA 79-32,138, and amendments thereto, and the provisions of KSA 79-32,117(c)(xiv), and amendments thereto, plus income received from obligations of this state or a political subdivision of this state that is exempt from income tax under the laws of this state, less dividends received from stock issued by Kansas Venture Capital, Inc., to the extent such dividends are included in the Kansas taxable income of a corporation, interest paid on time deposits or borrowed money, and dividends paid on withdrawable shares of savings and loan associations to the extent not deducted in arriving at Kansas taxable income of a corporation.

Fiscal information — programming.

According to the fiscal note prepared by the Division of the Budget, the Kansas Department of Revenue (KDOR) indicates the bill would require a total of \$147,745 from the State General Fund (SGF) in fiscal year (FY) 2020 to implement the bill and modify the automated tax system.

Fiscal information — privilege tax. In this fiscal note, issued in April 2019, KDOR also indicates interest income is one of the largest revenue sources for financial institutions and an interest income deduction would result in a decrease in taxable income and SGF privilege tax collections beginning in FY 2020. KDOR notes privilege tax collections totaled \$45.5 million in FY 2018; however, the overall reduction in tax collections could not be estimated due to a lack of data on interest income from business loans.

SB 239—Imposing a Tax on Certain State Credit Unions for the Privilege of Doing Business

SB 239 would impose a privilege tax on those state credit unions located or doing business within the state having assets equal to or exceeding \$100.0 million. The tax would be measured by the credit union’s net income attributable to interest income it received from all business loans for the next preceding taxable year.

The bill would require the tax to consist of a normal tax and a surtax that would be computed as follows:

- The normal tax would be an amount equal to 2¼ percent of such net income; and
- The surtax would be an amount equal to 2⅞ percent of such net income in excess of \$25,000.

The definitions for “business” and “interest” would be identical to those found in 2019 SB 238.

Fiscal information — programming.

According to the fiscal note prepared by the Division of the Budget, KDOR indicates the bill would require a total of \$147,745 from the SGF in FY 2020 to implement the bill and modify the automated tax system.

Fiscal information — privilege tax. In this fiscal note, issued in April 2019, KDOR also indicates enactment of the bill would increase revenue to the SGF in FY 2020 and beyond. However, the fiscal effect cannot be estimated because of insufficient data regarding credit unions in Kansas. [Note: This report includes revised fiscal information presented at the time of the bill hearing for SB 238 and SB 239.]

COMMITTEE ACTIVITIES

The Special Committee met October 3, 2019, to consider the privilege tax topic. The Special Committee made its formal recommendations on this topic at its October 29, 2019, meeting.

History of the Privilege Tax, Permissible Credits, and Receipts; Overview of Privilege Tax Legislation

Committee staff from the Kansas Legislative Research Department (KLRD) provided an overview of the Kansas financial institutions' privilege tax (privilege tax), which was enacted in 1963 and became effective January 1, 1964, imposing this tax on banks, savings and loan associations, and trust companies "for the privilege of doing business within the state" (KSA 79-1106 and 79-1107). The privilege tax is placed on income earned the preceding year. Financial institutions subject to the tax are exempted from the payment of a corporate income tax (KSA 79-32,113). Information presented by KLRD staff also included collection requirements and discussion of the tax base, the definition of net income, historical and present rates, and credits against and the calculation of a financial institution's tax liability. The analyst also provided prior legislative study responses and a summary of relevant privilege tax law.

Net collections and tax filer data. The KLRD memorandum also highlighted the FY 2000-FY 2019 actual tax receipts and the Consensus Revenue Estimating Group's April 2019 estimates for FY 2020 and FY 2021. Net collections ranged from a low of \$16.5 million in FY 2010 to \$48.7 million in FY 2019. In tax year 2016 (the most recent reported data), privilege tax filers included banking institutions (339) and savings and loan associations (25), for a total of 364 filers.

The KLRD analyst noted conferees to the bills were asked to provide relevant comment and data, where available, on local, state, and federal taxes applicable to their member institutions.

Overview and fiscal information. A representative of the Office of Revisor of Statutes provided an overview of the two bills (described previously in this report). A KLRD analyst discussed the fiscal impact of both of the bills, stating specific numbers were not yet available for SB 238. The analyst discussed the updated background, assumptions and methodology, and fiscal impact of SB 239. The updated analysis from KDOR indicated there are 60 state-chartered credit unions, including 2 Missouri-based credit unions, in Kansas. Additionally, there are 19

federally chartered credit unions (which would be exempt from the proposed privilege tax). Of the eligible credit unions, only 12 would meet the assets' threshold established in SB 239. KDOR estimates the bill would increase SGF privilege tax collections by \$0.1 million annually.

SB 238 and SB 239 Hearing: Proponents

A combined bill hearing was held October 3, 2019, with proponents appearing on both SB 238 and SB 239 in the morning session and opponents to SB 238 and SB 239 appearing in the afternoon session.

The Committee received proponent testimony from representatives of the Kansas Bankers Association and the Community Bankers Association of Kansas and officials from the Citizens Bank of Kansas, Farmers & Drovers Bank, First National Bank, Freedom Bank, Heartland Tri-State Bank, and Kaw Valley Bank.

Proponent testimony. Proponents indicated their support for a "level playing field" for Kansas financial institutions, noting Kansas community banks are competing with financial institutions that enjoy preferential tax treatment. This treatment includes: 1) Kansas credit unions are exempt from paying state and federal income taxes on their retained net income; 2) Farm Credit System lenders are exempt from state and federal taxes and are exempt from paying federal income taxes on income derived from real estate lending; and 3) Kansas banks are required to pay state income taxes in the form of the privilege tax (4.375 percent) and C corporation (C-Corp) banks are also required to pay federal corporate income taxes (21 percent). A conferee further pointed out the majority of Kansas banks are Subchapter-S (Sub S) banks and pay the privilege tax before any distributions are passed on to bank shareholders, whose personal incomes are taxed at rates as high as 37 percent at the federal level. A banking association conferee stated it was not necessary for both bills to be passed to achieve tax equity and fairness on business loans, as SB 239 would level the playing field by requiring all competing financial institutions to pay the privilege tax on commercial loans, while SB 238 would achieve tax equity without raising taxes on any financial institutions.

Various bankers provided examples of the costs of the separate tax treatment:

- Regarding one loan scenario, a banker estimated the privilege tax assessed on his institution can represent a 0.26 percent to 0.44 percent difference in the loan rate and an additional cost of \$4,000 to \$6,500 over the course of a farm real estate loan of an average amount (\$145,500);
- While the amount paid by banks is not a large sum, one banker commented, to the consumer it can translate to 28 basis points in a loan or maybe 2 additional employees to her bank;
- Credit unions do not contribute to the local communities in the same manner the banks do, another banker stated, and take money out of both the local economy and the Kansas tax base by undercharging on loans and overpaying on deposits; and
- Large credit unions are acting like commercial banks and are larger than many community banks, one banker noted, further explaining the large credit unions can spend as much as ten times more on marketing and more on key-person salaries than a privilege-tax-paying community bank can afford.

Speaking to the ability to compete with the Farm Credit System, one banker shared an account of how Farm Credit converted a long-time agricultural borrower with lower rates, a higher line of credit, and less paperwork. The banker called for the removal of a portion of taxes imposed on banks, which would in turn allow his bank to offer lower loan rates and higher deposit returns for rural consumers. A banking association representative distributed three maps illustrating the representation of financial institutions statewide, highlighting the commercial and agricultural lending concentration of community banks in rural areas: (1) 228 charters and 1,200 branches of commercial, savings and loan, and savings banks; (2) 80 charters and 159 branches of credit unions; and (3) 19 Kansas Farm Credit System institutions.

SB 238 and SB 239 Hearing: Opponents

The Committee received opponent testimony from representatives of Heartland Credit Union Association and officials from Azura Credit Union, Catholic Family Federal Credit Union, Credit Union of America, Farmway Credit Union, Frontier Community Credit Union, Kansas Cooperative Council, Mainstreet Credit Union, Meritrust Credit Union, Skyward Credit Union, and Stearns Super Center.

Written-only opponent testimony was submitted by representatives of Ark Valley Credit Union, Bluestem Community Credit Union, Farmers Credit Union, Forbes Field Credit Union, Kansas Teachers Community Credit Union, MidAmerican Credit Union, Midwest Regional Credit Union, Stutzmans Greenhouse and Garden Centers, Topeka Firemen's Credit Union, and Topeka Police Credit Union. Written testimony was also submitted by a military retiree's spouse from Fort Leavenworth.

Opponent testimony. Opponents addressed the separate and distinct corporate structures of financial institutions and taxation policy. A credit union association representative noted, as not-for-profit cooperatives, credit unions are subject to different taxation than banks, but are also subject to a different set of structural rules than banks. The conferee highlighted key structural features of credit unions, including they are member-owned and managed by a volunteer board of directors; return earnings to members; are prohibited from having outside investors or raising outside capital; are subject to limitations that are not applicable to banks, such as the federal business lending cap of 12.25 percent on the portion of a credit union's assets that may be used for commercial and agricultural loans; and are limited by field of membership laws on geography and persons served. The conferee also noted Kansas law does not allow public entities to deposit local tax dollars in a credit union. The conferee noted banks' market share of commercial lending in Kansas, which she estimated at 99.06 percent of the \$29.9 billion marketplace. The conferee also spoke to the decline of credit unions in Kansas, from 322 in 1969 to 78 today, and regulatory and market changes, including compliance with Dodd-Frank regulations and the emergence of fin-tech and companies such as Walmart and Amazon in the

digital payment sector (“non-FIs”). Finally, the conferee noted SB 238 could make the case for other for-profits to seek not-for-profit status, while SB 239 similarly would set the stage for other not-for-profit cooperatives (e.g., agricultural, electric, and grocery) to be taxed as for-profit entities regardless of purpose or structure.

Various credit union officials commented on credit union organization and business lending:

- One credit union’s member business portfolio is less than 2 percent of its total loan portfolio, with an average balance of \$29,000; nearly 75 percent of these loans do not meet the minimum threshold to be considered business loans by regulators;
- Credit union earnings are paid to members and members work, live, and pay taxes. Credit unions, another official noted, are transparent and held accountable by regulators and members; and
- A tax increase on credit unions would reduce a credit union’s ability to meet its not-for-profit mission and provide such services (SB 239) and a tax exemption of entities like banks (SB 238) would shift more of the tax burden onto families that

credit unions seek to protect and serve. Conferees spokes to “neighbors helping neighbors,” including assistance to particular employees and industries, such as aviation.

One additional cost noted by the credit union association representative, should SB 239 be enacted, is the move of credit unions to a federal charter (exempted from state taxation), costing the State revenue from taxes and regulatory exam fees.

CONCLUSIONS AND RECOMMENDATIONS

Following public hearings and Committee discussion:

- The Committee makes no recommendation on SB 238; and
- The Committee does not recommend SB 239.

The Committee directs its report to the House Committee on Financial Institutions and Pensions, the Senate Committee on Financial Institutions and Insurance, the Senate Committee on Assessment and Taxation, and the House Committee on Taxation.