# MINUTES

# SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

October 29, 2019
Room 548-S—Statehouse

## Members Present

Senator Robert Olson, Chairperson
Representative Jim Kelly, Vice-chairperson
Senator Rick Billinger
Senator Bruce Givens
Senator Eric Rucker
Senator Mary Ware
Representative Elizabeth Bishop
Representative Tom Cox
Representative Leo Delperdang
Representative Cindy Neighbor
Representative Jene Vickrey

## Staff Present

Melissa Renick, Kansas Legislative Research Department
Whitney Howard, Kansas Legislative Research Department
Edward Penner, Kansas Legislative Research Department
Eileen Ma, Office of Revisor of Statutes
David Wiese, Office of Revisor of Statutes
Jason Thompson, Office of Revisor of Statutes
Michael Welton, Committee Assistant

## Conferees

Rachelle Colombo, Director of Governmental Affairs, Kansas Medical Society, and Kansas Medical Mutual Insurance Company
David Morantz, Shamberg, Johnson and Bergman, Kansas City, on behalf of the Kansas Trial Lawyers Association
Sunee Mickle, Vice President of Government Affairs and Community Relations, Blue Cross and Blue Shield of Kansas
Brad Smoot, Attorney and Government Affairs Counsel, Blue Cross and Blue Shield of Kansas
LuGina Mendez-Harper, PharmD and Government Affairs Principal, Prime Therapeutics
Tish Hollingsworth, Vice President of Reimbursement, Kansas Hospital Association
Amy Swanson, Director, Community Health Access, Kansas Department of Health and Environment
Amy Falk, President of the Board of Directors, Community Care Network of Kansas, and and Chief Executive Officer, Health Partnership Clinic, Inc.

## Others Attending

See Attached List.

## MORNING SESSION

### Welcome

Chairperson Olson called the meeting to order at 9:04 a.m. and welcomed Committee members, conferees, and attendees.

### Follow-up from October 3, 2019, Meeting

Chairperson Olson called upon Melissa Renick, Kansas Legislative Research Department (KLRD), to provide follow-up information from the October 3, 2019, meeting of the Committee.

Ms. Renick referenced the written response from the Kansas Bankers Association, which provided information on the top ten Kansas banks and profit data. The response also included information regarding mergers and closures, rate comparisons between banks and credit unions, and a list of all banks structured as Subchapter S corporations in Kansas (Attachment 1).

Ms. Renick stated KLRD would require more time to complete the requested broad picture of lending by financial institutions in Kansas, including agricultural, commercial business, personal signature, payday, title, and other supervised loans.

### Discussion and Recommendations on 2019 SB 238 and SB 239

Chairperson Olson opened discussion on 2019 SB 238 and SB 239. He stated his opinion that SB 239 should not move forward and indicated he would prefer a "non-recommendation" on SB 238 to allow the Senate Committee on Financial Institutions and Insurance and the House Committee on Financial Institutions and Pensions to consider the bill during the 2020 Session.

Vice-chairperson Kelly agreed with Chairperson Olson regarding SB 239, and requested the standing committees consider SB 238 in the fairest manner possible. A Committee member also pointed out an updated fiscal note on SB 238 was not yet available to the Committee.

*Representative Neighbor moved for the Committee to not recommend both SB 238 and SB 239. Senator Ware seconded the motion.*

Further discussion ensued. Ms. Renick clarified the motion was an adverse recommendation of both bills. Vice-chairperson Kelly asserted he would rather not make an adverse recommendation on SB 238.

*Representative Cox offered a substitute motion for the Committee to not recommend SB 239 and to make no recommendation on SB 238. Representative Vickrey seconded the motion. The motion was adopted by the Committee.*

Ms. Renick asked whether the Committee would like its final report to be forwarded to the Senate Committee on Financial Institutions and Insurance, House Committee on Financial Institutions and Pensions, Senate Committee on Assessment and Taxation, and House Committee on Taxation. *The Committee agreed to this recommendation by consensus*.

Chairperson Olson encouraged members to work with their respective chairpersons to craft and work bills through the committee process.

## Overview of *Hilburn v. Enerpipe Ltd.*, No. 112,765

Chairperson Olson called upon Whitney Howard, KLRD, and Jason Thompson, Office of Revisor of Statutes, for an overview of *Hilburn v. Enerpipe Ltd.*, No. 112,756 (*Hilburn*).

Ms. Howard reviewed the charges of the Committee and referenced the minutes, testimony, and draft recommendations of the October 2, 2019, meeting of the Special Committee on Judiciary. She noted the Health Care Stabilization Fund Oversight Committee also discussed the *Hilburn* decision at its October 24, 2019, meeting. She introduced Mr. Thompson for an overview of the decision.

Mr. Thompson 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*. He 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. He also provided the historical background of noneconomic damages caps. He noted the 3-1-2 plurality decision of the Court was indicative of the complexity of the decision (Attachment 2).

Vice-chairperson Kelly asked whether the Court's press release on the decision caused some confusion because it indicated the decision did not apply to medical malpractice actions. Mr. Thompson responded that he is focused on the decision and, in his analysis of the case, there is no longer a cap on noneconomic damages because the Court struck down the statute as unconstitutional.

## Implications of *Hilburn* on Healthcare Costs on Kansas

Chairperson Olson called upon Rachelle Colombo, Director of Government Affairs, Kansas Medical Society (KMS) for comment on behalf of KMS and the Kansas Medical Mutual Insurance Company.

Ms. Colombo cited the malpractice crises of the 1970s when medical professional liability coverage for Kansas physicians was unaffordable and there was less access to medical care. She stated the Health Care Stabilization Fund, enacted in 1976, was designed to ensure all medical independent health care providers could purchase professional liability insurance. She noted that following the establishment of the Fund, the Legislature passed a cap on

noneconomic damages. She stated the Kansas Supreme Court, in the 2012 decision of *Miller v. Johnson*, upheld the constitutionality of the $250,000 cap on noneconomic damages which had been in place for 25 years. She stated SB 311 (2014) increased the cap from $250,000 to $350,000 in three increments over an eight-year span. She noted Kansas was in the bottom five states in rural healthcare access at the time these reforms were enacted; today it operates in the top five.

Ms. Colombo stated a common sense reading of *Hilburn* would be that the cap has been struck. However, she noted, the *Hilburn* case involved personal injury. She stated the cap is no longer constitutional as it applies to personal injury, but the opinion does not specifically overrule *Miller* or state that the cap does not apply to medical malpractice. She noted the press release from the Office of the Supreme Court left to question whether the ruling applied to both personal injury and medical malpractice cases.

Ms. Colombo expressed concerns that the *Hilburn* decision and press release make it difficult to ascertain the outcome of future malpractice cases. She stated the Health Care Stabilization Fund Board of Governors had already decided to increase its surcharge rates on healthcare providers by 6 percent due to many factors, including an increase in high severity claims (prior to the June 2019 *Hilburn* decision). She also stated uncertainty and volatility in the market is not positive for the insurance industry. 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 (Attachment 3).

Chairperson Olson called upon David Morantz, Shamberg, Johnson and Bergman, Kansas City, on behalf of the Kansas Trial Lawyers Association.

Mr. Morantz stated his law firm was involved in some of the briefings for *Hilburn*. He pointed out Section 5 of the *Bill of Rights* of the *Kansas Constitution* is the state counterpart to Seventh Amendment of the *Bill of Rights* within the *U.S. Constitution*. He provided historical information on the Seventh Amendment. He noted Section 5 and the Seventh Amendment entrust power with citizens and allow jurors to decide a multitude of complex issues and disputes. He stated not allowing a jury to decide the full measure of a personal injury victim's damages would be counter to the *Kansas Constitution*.

Mr. Morantz explained damage caps were enacted out of fear of "runaway juries," but the common sense of Kansans and the inherent judicial power of *remittitur* (the judge's ability to lower amount of damages granted by a jury) stop "runaway juries" from happening. He noted the Committee is charged with considering the implications of *Hilburn* on healthcare costs in Kansas. 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 (Attachment 4).

In response to Committee questions and comments, Mr. Morantz explained *Hilburn* related to noneconomic damages. He stated economic damages can be easily quantified. He stated noneconomic damages are subjective, which is why it is important for a jury to make a decision on those damages. He stated five other states (Alabama, Florida, Georgia, Missouri, and Washington) have struck down these caps specifically on the inviolate basis, but he is unaware of impacts those decisions have had on insurance premiums in those states. He stated workers compensation would not be directly affected by *Hilburn* and press releases have no precedence value of law.

In response to Committee questions and comments, Ms. Colombo stated tort reforms have had a direct impact on the number of physicians who practice in Kansas and the premiums paid by those providers. She stated economic damages are not capped in Kansas, but the cap on noneconomic damages primarily covers pain and suffering. She clarified future medical costs would be considered economic damages. She stated the dissenting opinion of Justice Luckert noted *Hilburn* could affect workers compensation. She stated there has been upward pressure on premium rates for professional liability insurance.

Written-only testimony was provided by the following:

- Chad Austin, Kansas Hospital Association (KHA) (Attachment 5);
- Marlee Carpenter, Kansas Association of Property and Casualty Insurance Companies, Inc. (Attachment 6);
- Christopher Mann, Mothers Against Drunk Driving (Attachment 7);
- Mitzi McFatrich, Kansas Advocates for Better Care (Attachment 8); and
- Eric Stafford, Kansas Chamber (Attachment 9).

**Presentations on Healthcare Benefits Topic**

Chairperson Olson called upon Brad Smoot, Attorney and Government Affairs Counsel, and Sunee Mickle, Vice President of Government Affairs and Community Relations, Blue Cross Blue Shield of Kansas (BCBSKS).

Mr. Smoot stated BCBSKS was created in 1942 and has evolved into a customer-owned mutual insurance company that operates in 103 of 105 Kansas counties (all but Johnson and Wyandotte) and serving about 900,000 Kansans. He referred to illustrations in his written testimony depicting the authority of the Legislature to affect about 25 percent of the sources of health insurance. He stated, for BCBSKS, 91 percent of premiums pay for providers and 9 percent of premiums pay for business expenses (*e.g.,* customer services, claims administration, taxes, and reserves). He provided a 10-year overview of claims by provider type and the amount of claims paid out in 1987, 1997, 2008, and 2018.

Mr. Smoot 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. He cited 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 Affordable Care Act (ACA) requirements.

In response to Committee questions and comments, Mr. Smoot clarified that the BCBKS population base is stable but his information related to claims paid was not adjusted for population.

Ms. Mickle stated health insurance changed once the ACA was enacted in 2010. She provided a timeline and the major milestones that have occurred since the passage 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 maximums on a policy (including for high-risk policyholders). She noted BCBSKS is the carrier of choice for the Ryan White Program in Kansas, which is a state-federal program to purchase private insurance coverage for low income HIV/AIDS patients.

Ms. Mickle 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 stated she has spoken with BCBSKS actuaries, who have noted the biggest factor for cost is when insurance plans cannot underwrite or charge premiums based on health conditions. She noted the Kansas Insurance Department has determined and approved seven rating factors, including geography, tobacco usage, and age. She noted subsidies also became available on January 1, 2014, for those who qualify for such subsidies.

Ms. Mickle 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.

Ms. Mickle 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 the Kansas Insurance Department and state mandates do not apply to these plans. She provided information on association health plans (AHP) and compared AHPs with plans meeting requirements of the ACA. She also compared health insurance with a health benefit plan.

Ms. Mickle 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).

Ms. Mickle provided information on federal health care cost concerns, including reinsurance for state individual markets (Section 1332 or State Innovation Waiver), Medicare for all, Medicaid expansion, prescription drug costs, and surprise medical billing (consumer goes to in-network facility and receives treatment from an out-of-network provider). She noted BCBSKS provides 10 to 13 percent of the revenue for hospitals in rural areas (Attachment 10).

In response to Committee questions and comments, Ms. Mickle stated BCBSKS is concerned with patients, communities, and hospitals; the cost of prescription drugs is one of the biggest drivers of health care costs; cost shifting is inevitable based on an aging population; and value-based programs are being deployed to pay the provider a single set amount based upon a positive outcome. She provided information on actuarial value levels and maximum allowable payments to hospitals and providers, commented that BCBSKS could not subsidize all of Medicaid expansion but also want to provide Kansans with access to care, and 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.

Committee members expressed concerns with hospital reimbursement rates; the closure of rural hospitals, such as Mercy Hospital in Fort Scott; and cost shifting.

Chairperson Olson recessed the meeting at 11:55 a.m. for lunch.

## AFTERNOON SESSION

Chairperson Olson reconvened the meeting at 1:37 p.m.

### Presentations on Healthcare Benefits Topic, continued

Chairperson Olson called upon Ms. Mickle to continue the question and comment segment of her presentation.

Ms. Mickle 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; an issue for hospitals is collecting unpaid medical bills, including deductibles on private insurance; and BCBSKS has not completed an intense study to determine how Medicaid expansion would affect the private insurance market.

Ms. Mickle explained an “ASO” is an administrative services only organization that supports an employer self-funded plan. The ASO might be a third party administrator (TPA) that administers and pays claims on behalf of the employer. It usually operates under a stop-loss policy to help a client negate risk. She provided information on the current status of AHPs, noting a final rule expanding AHPs to sole proprietorships was struck down by the courts. She clarified small businesses with common interest can still band together to attain a large company rating.

Chairperson Olson called upon LuGina Mendez-Harper, PharmD and Government Affairs Principal, Prime Therapeutics.

Ms. Mendez-Harper described a pharmacy benefits manager (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 manufacturer, pharmacy networks, and mail-service and specialty pharmacy services. She noted Prime Therapeutics covers 26 million lives.

Ms. Mendez-Harper provided information on the value of PBM; stated the drug manufacturer sets the price for the drug, whether it is a brand, 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.

Ms. Mendez-Harper 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 contacts with PBMs. She noted drug wholesalers (McKesson, AmerisourceBergen, and Cardinal Health) own the three largest PSAOs. She stated Health Mart, the largest PSAO, represents more participating pharmacies (4,800) than Walmart.

Ms. Mendez-Harper stated plan sponsors choose to contract with a PBM. She stated plan sponsors choose to work with PBMs to save money and negotiate with drug manufacturers. She stated one endeavor of PBMs is to maximize the use of generic drugs. She noted plan sponsors have the final say in the structure of their drug benefits (Attachment 11).

In response to Committee questions and comments, Ms. Mendez-Harper provided information on 2018 Kansas law related to gag 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 their PBM benefit.

Ms. Renick noted the PBM contract for the State Health Employee Plan (SEHP) is a three-year contract that was discussed by the Kansas State Employees Health Care Commission in summer 2019. CVS/Caremark is the current PBM for the SEHP through December 31, 2019. She noted, in February 2015, the Kansas Legislative Division of Post Audit conducted an audit on whether Kansas had sufficient controls to minimize state costs and enhance benefits through its PBM. Chairperson Olson requested KLRD provide a copy of this audit to the Committee.

Chairperson Olson called upon Tish Hollingsworth, Vice President of Reimbursement, KHA.

Ms. Hollingsworth provided information on hospital reimbursement and financing. She explained the primary income sources for hospitals are from inpatient and outpatient services. She stated some hospitals also derive revenue from gift shops, cafeteria sales, donations, grants, and investments. She 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.

Ms. Hollingsworth 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);
- 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).

Ms. Hollingsworth discussed key revenue drivers, internal (*i.e.,* flu season) and external (*i.e.,* natural disasters). She stated hospitals are reimbursed for their services by a variety of

payers, all of which have differing rules and regulations. She stated most Kansas hospitals rely heavily on payments for services provided to Medicare and Medicaid patients. She stated 58 percent of average payments to hospitals are below what it costs the hospital to provide those services (40 percent of payments are from Medicare patients, 12 percent are from Medicaid, and 6 percent are self-pay or charity care). She noted hospitals are not paid the same, especially under the Medicare program.

Ms. Hollingsworth 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 the 82 CAHs in Kansas 101 percent of allowable costs. These allowable costs are determined by Medicare and there is an additional sequestration of 2 percent deduction that has occurred since 2010 with enactment of the ACA. She stated 103 Kansas hospitals receive special Medicare payments. She 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. She noted a 4 percent positive margin overall is the standard for a hospital to remain viable.

Ms. Hollingsworth stated the enacted Medicare cuts since passage of the ACA in 2010 totals $1.4 billion for Kansas hospitals. She defined key financial vocabulary for hospital operations:

- "Charge" is the amount listed as the price for its services;
- "Payment" is the amount actually received in cash for services; and
- "Cost" is the actual overall cost to provide the services (including overhead costs).

Ms. Hollingsworth noted hospitals charge everyone the same rates, but no two payers pay the same rates: government payers pay less than costs, commercial payers negotiate rates based on market share, and charity care and underpayment impacts overall costs for everyone. She provided an example of an X-ray and how much each payer would pay for this service.

Ms. Hollingsworth provided information on cost shifting and stated there are negative margins in hospitals because there is a lack of ability to cost shift. She stated the impact of shortfalls and losses impacts the ability of hospitals to attract and retain staff; contain health costs; update technology, infrastructure, and facilities; and contribute positively to the local economy. She summarized specific challenges in rural hospitals, including that rural hospitals have a higher patient mix of Medicare and Medicaid and have smaller and aging populations.

Ms. Hollingsworth provided information on why healthcare is so expensive and noted the burden of administrative costs. She stated Medicaid and Medicare are heavily regulated and require compliance with regulations. She also referenced the costs of technology, defensive medicine, prescription drug costs, the mix of treatment and use of specialists, wages, and branding (Attachment 12).

In response to Committee questions and comments, Ms. Hollingsworth stated Medicaid pays based upon a set fee schedule and Medicare pays based on a predetermined allowable cost; Medicaid and Medicare can provide access to health care that may prevent catastrophic illness; and there are resources for financial payment arrangements and charity care at hospitals for patients to utilize to pay their medical bills instead of the hospital incurring bad

debt. She stated uncertainty on how Medicaid expansion would impact hospital costs, revenues, and the payer mix.

Chairperson Olson expressed concern with Medicaid expansion and the potential for cost shifts, including an increase in premiums and deductibles. Ms. Hollingsworth noted non-ACA compliant health plans are entering the market.

Chairperson Olson called upon Amy Swanson, Director, Community Health Access, Kansas Department of Health and Environment (KDHE).

Ms. Swanson 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. Ms. Swanson introduced Ashley Wallace, Program Analyst, Community Health Access, KDHE.

Ms. Swanson highlighted the following agency programs:

- Medicare Rural Hospital Flexibility (known as FLEX)—this program supports CAHs;

- Small Hospital Improvement Program—this program supports the 96 small rural hospital (49 or fewer available beds) activities and investments related to quality improvement and health technology;

- Community-Based Primary Care Clinic Program—this program assists safety net clinics to improve access to quality healthcare and reduce health disparities for underserved populations;

- Health Professional Shortage Area (HPSA) Designations—Fort Hays State University compiles this information and submits it to the federal government in order to receive federal moneys;

- State Loan Repayment Program—this program offers education loan repayment programs to healthcare providers for a two-year commitment to work in a federally-designated HPSA;

- J-1 Visa Waiver Program—this program allows non-citizen physicians to work in a HPSA area by waiving the two-year home residency requirement in exchange for a commitment to practice in a targeted area;

- Charitable Health Care Provider Program—this program allows enrolled healthcare professionals providing care to medically indigent clients to be indemnified for liability purposes under Kansas Tort Claims Act; and

- Unused Medication Repository Program—this program distributes approximately $1.4 million in unused medications to annually serve 23,000 individuals.

Ms. Swanson noted the agency also maintains the Kansas Rural Health Information Services, which includes four listservs open to the public (Attachment 13).

In response to Committee questions and comments, Ms. Swanson and Ms. Wallace provided clarification on grants and programs related to rural health.

Chairperson Olson called upon Amy Falk, President of the Board of Directors, Community Care Network of Kansas (Community Care), and Chief Executive Officer, Health Partnership Clinic, Inc.

Ms. Falk stated Community Care represents 37 State-funded clinics with 100 sites and is committed to providing all Kansans access to high quality, whole-person healthcare. She stated 1 in 10 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; and in 2018, state funding accounted for 12 percent of total revenue for Kansas community health centers.

Ms. Falk noted Community Care specializes in serving the most vulnerable underserved individuals and families. She stated, in 2018, Community Care served more than 301,000 Kansans through 900,000 visits; more than 2 of 3 patients did not have any health insurance or were on Medicaid; and 9 of 10 patients had incomes less than 200 percent of the federal poverty level.

Ms. Falk provided information on school-based services, noting this partnership has grown to 15 clinics serving 28 school districts. She stated, in 2017, these clinics provided primary and preventative care, dental and oral health services, and behavioral services to more than 37,000 students. She also provided information on telehealth services provided by 8 of the community health centers.

Ms. Falk stated these clinics are a cost-effective alternative to expensive healthcare services, especially unnecessary emergency room visits. She cited the average cost of one emergency room visit of $1,423 compared to providing care for an entire year to four patients ($382/patient/year) for $1,528. She stated clinics work to provide quality healthcare and provide extended hours to keep patients out of the emergency room (Attachment 14 and Attachment 15).

A Committee member expressed thanks to the organization for all they do for their communities.

**Approval of October 3, 2019, Minutes**

Chairperson Olson called for discussion and approval of the October 3, 2019, minutes.

*Representative Neighbor moved to approve the Committee minutes of October 3, 2019, as written. The motion was seconded by Representative Cox. The motion carried.*

### Discussion and Recommendations for the Committee Report to the 2020 Legislature

Chairperson Olson asked Committee members to work with their committee chairpersons to craft legislation and bring legislation before committees of the 2020 Legislature. He commented the Committee's report would not contain formal recommendations on legislation, but would serve as an information resource on the healthcare and insurance topics presented over the two days. A Committee member stated her desire for there to be legislation related to PBMs. Following discussion, *Senator Rucker moved the final Committee report be forwarded to the standing committees of the 2020 Legislature. The motion was seconded by Vice-chairperson Kelly. The motion carried.*

During Committee testimony, the Committee discussed the February 2015 Legislative Post Audit's *Performance Audit Report on Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefit Management System*. In response to Chairperson Olson's request, KLRD provided the official report and the report's highlights (Attachment 16 and Attachment 17).

### Adjourn

Chairperson Olson adjourned the meeting at 3:36 p.m.

Prepared by Michael Welton

Edited by Whitney Howard and Melissa Renick

Approved by the Committee on:

January 3, 2020
(Date)