Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. Today is May 11, 2026, and I'm in Lawrence, Kansas to interview two giants of health policy: Kathleen Sebelius and Sandy Praeger. Thank you for being here.

Ms. Sebelius served as a Kansas state legislator, was elected to two terms as the Kansas insurance commissioner and then was elected to two terms as governor of Kansas before being asked to serve as the secretary of the US Department of Health and Human Services by President Barack Obama.

Ms. Praeger started her public service as a city commissioner and mayor. She spent time in both the House and a long time in the Senate of the Kansas legislature and then was elected to three terms as Kansas insurance commissioner. Welcome. Thank you both for being here.

Kathleen Sebelius: Thank you.

Sandy Praeger: Thanks.

BSP: This interview is part of the Kansas Oral History Project, exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves oral histories of Kansans. The series is supported by donations from generous individuals and a grant from the United Methodist Health Ministry Fund. Our videographer is former State Legislator Dave Heinemann.

I'm really looking forward to this conversation. First just tell me a little bit about yourselves and your connection to Kansas, however long this may be. Governor?

KS: Well, Bob, nice to see you again.

BSP: Great to see you.

KS: I am a Kansan by marriage. I met Gary Sebelius, Keith Gary Sebelius, who was born in Norton, Kansas when he came from K-State University to Georgetown Law School. I was living and working in Washington. When we got married, we came to Kansas for just a few years. That was in December of 1974. I have been here ever since.

BSP: That sounds like a familiar story

SP: And I was raised in Kansas. I was actually born at Fort Bragg, North Carolina, where my dad was serving during World War II, but we moved back here when he was able to manage to get back from the Pacific and be in one piece. He went into the family business in Paola, Kansas, the business that my grandmother had started at a used furniture store during the Depression. She had her two sons, my dad and his brother, went into the business and built it into a nice, sustaining business for probably forty years.

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Mark and I, my husband and I, met at KU on a blind date. He went then on to med school. We had our family. We had ten years away from the state and decided that we were going to move back home, and we've been back in Kansas since 1977.

BSP: Great. The story of having your spouse say that you were going to be here just for a certain amount of time. Commissioner Praeger was involved in recruiting me and my wife, mainly my wife, to be convinced that she could be here in Kansas. That was just for three years, and then we were going to move back to the East Coast. That was 1997, I guess.

SP: We did a good job, didn't we?

BSP: It's been awesome. One of the things that we're exploring through this whole series is the concept of how healthy we are in Kansas, and how does Kansas compare to other states in terms of health and well-being? You may be familiar with America's health rankings that are put out by the United Health Foundation. They've done it every year for decades. At one point in 1991, Kansas ranked as the 8th healthiest state in the country. It decreased over the subsequent decades to a low point of 31st in 2022. We've gone back up a couple of spaces. We're at 27 right now. But just over that period of time, Kansas experienced the largest decline of any state in the country in terms of these comparative measures. And I want to be clear; it's not that health in Kansas got worse. It's just that our relative ranking compared to the other states has worsened. So, other states are making more progress faster.

I want to just cover in this conversation a lot of the things that have happened over that period of time. Let's just start with, "What's your reaction to the concept of rankings?" You've both been in very highly influential public positions. When you hear about rankings like this—somebody might hear that Kansas is falling or where they are now, how do you think of that as a policy maker?

SP: Well, your comment about it, the ranking has to take into consideration, and people need to understand what the background is from the ranking. There can be a lot of things going on. I think clearly our health ranking has gone down because we didn't participate in the Medicaid expansion when other states did. So, it's not just us coming down, but it's those other states being able to increase faster than Kansas can because we're one of, I think, ten states. It's really a shame.

KS: But I also—I mean, rankings, I always sort of liked just because it gives you some measurement of where other people are and what's going on. It can be helpful competition. It can be helpful in driving a message. It sometimes can be a real black mark. I think employers looking at where to locate a new business look at health rankings, education rankings. They want a healthy, educated work force. So, it can be a negative or a positive.

But I would agree with Sandy. Not only I think has the Medicaid decision been one that has cost us hundreds of millions of dollars over the last now twelve years. It really has impacted our citizens as has the rural part of the state has grown older and poorer, and that rural America is less healthy than urban America. So, we have that. A large contingency of our population is in more rural areas, and that's true across the country.

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And third, I think we don't have policymakers who feel that health is a worthwhile investment. Too often, they don't prioritize health. They don't look at health. We've got a kind of confluence of negative factors that have impacted Kansas health.

BSP: Yes. To follow up on a couple of those things, from an insurance coverage perspective, if you look at the uninsured rate, Kansas used to fare better than the country. Again, our uninsured rate has actually improved over time, but because other states expanded Medicaid, their uninsured rates improved even faster than Kansas. So, now we're about average, maybe in some measures, some groups, even a little bit below the national average in insurance coverage. So, that's a good example of what you're talking about.

The other is this concept that you just brought up of leaders thinking about health. I don't know, ten years ago or so, I was still at the Kansas Health Institute. It struck me that we weren't really having the same conversations in Kansas at a high level, a broad perspective, on health and health care and the health system. There was the Health Care Cost Commission that you convened as governor. Senate President Kerr convened a broad-based Medicaid reform. There have been some task forces on very important issues like modernizing the behavioral health system and substance use and those types of things but not really the same amount of conversation at the state level at a broad policy—it sounds like you maybe feel that way, too. Talk a little bit about that. Why is that that we're not having those conversations in Kansas as much?

SP: I think it's become very political. Kathleen was at the NAIC [National Association of Insurance Commissioners] when she was insurance commissioner, and I was.

BSP: That's the National Association of Insurance Commissioners that all states participate in.

SP: Right, and when I first joined, and I'm sure when Kathleen was there, we hardly knew what the political background was of the commissioner because things were so focused on insurance and making sure we were good policy makers. But, boy, that changed with the Affordable Care Act. It became very, very politicized.

BSP: Health care as a policy issue. I'm going to come back to that. There are some interesting things that occurred around that time.

SP: Yes. That made it hard to address the issues. We did a health care reform requiring that we get rid of the limits on mental health coverage. It was $7,500. That's not a year. That was lifetime.

BSP: The lifetime benefit for behavioral health.

SP: For behavioral health outpatient services. Oh, my goodness. It finally passed during the veto session, I think.

BSP: That was 2001?

SP: I think so. It wasn't perfect parity, but the idea was, mental health shouldn't be treated different than physical health. It should be all encompassing. I mean, just going through that battle was a real eye-opener for me.

KS: I think Sandy's correct in health becoming a real partisan issue and a political hot issue. Should government—it really was about "Should government be involved, or is this really up to other people? What is the right stance?"

But even prior to that, I remember—you talked about rankings at the beginning, Bob. I always like to layer where your health ranking was—Annie Casey [Annie E. Casey Foundation] did a children's—

BSP: KIDS COUNT.

KS: KIDS COUNT.

SP: I remember that.

KS: That had some health measures in it that were always terrifying about Kansas. We had a very high rate of teen pregnancy. We had a very high level of maternal deaths and infant mortality. I think put together long before the Affordable Care Act became political, those issues should have been a rallying call for Kansans, regardless of your political party or your economic status, the fact that babies were dying in Kansas, that moms could die giving birth to children, that we had children's deaths that were higher than other places, but it just wasn't.

We didn't have a lot of leaders from the business community who said, "This is a priority." They did in early childhood education. They did in some other areas, but the lack of a real coalition of business leaders and faith leaders and others helping to drive health statistics was not here in Kansas, and it was present in other states.

BSP: You are touching on this aspect of health that health isn't determined just by the medical care that you get in a short doctor's visit. It's determined by—

KS: What happens—the air you breathe, the water you drink, where you eat and work and live and pray has more to do with your health than what happens in a clinical setting. Other states have major investments in the so-called social drivers of health, way ahead of Kansas. That I think impacts people's health in a way that measuring insurance numbers and measuring how many people get a flu shot doesn't really tell you. It's that underlying community and environment that people live in.

BSP: Education, economic opportunity, all those sorts of things are important, and these rankings—both the America's health ranking that compare states and also the county health rankings that looks at the relative rankings of counties within Kansas, both of those rely on that broad framework of thinking of health.

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KS: Yes.

BSP: So, that's a good point. I'm going to go into a little bit of depth on something that is really important to me. So, excuse me. You're probably going to say, "Oh, there's that data nerd guy again."

KS: We might ask you to answer the question.

BSP: I have some ideas. But health care is expensive. It's a lot of our economy, almost a quarter of the state budget. A lot of money is spent; a lot of data is collected. I think that people understand that having good data is necessary to have an effective and an efficient and a safe health care system. Some states have done more than Kansas on harnessing data to be able to inform policy and do evaluation and understand what's the impact of policy changes that you're making. Both of you with your insurance commissioner background, this concept of an all-payer claims database, where you have all the data from all the types of insurance—state, big companies, small companies, all—Medicare, Medicaid—all together to try to analyze that data and use it.

Kansas on the books has an all-payer claims database, known by the acronym of KHIIS [Kansas Health Insurance Information System], that is managed by the Insurance Department—overseen by the Insurance Department, on a day-to-day basis managed by KDHE. My experience is that we don't use those data nearly as much as we could to inform policy change. And I will say since the two of you served consecutively as insurance commissioner, there's been little progress made in using that, even though it's been on the book since before 2000. We were one of the early states to put it on the books, but we haven't really realized the value of those data to guide policy and evaluate change.

Why is that? Why is it that we have such a hard time making the investment, developing the political will to use data in that way?

SP: Well, you just said "developing the political will." It's all about politics. You can have the data that demonstrates if we could do some of these things, we'd have better health outcomes, but it's become, as Kathleen said earlier, it's become so politicized. People would frequently ask me, "Why hasn't Kansas expanded Medicaid? What's the reason behind it?" I said, "There's no reason. It's all politics."

KS: But I also think—I think just where the data is stored is a good indication of why it doesn't work. Both Sandy and I served as insurance commissioners, an independent agency at least in our day. It was pretty self-funded because you collect premium taxes. So, you could interact with the legislature, but typically, you're operating to keep an industry solvent and to protect consumers who buy policy so they can get their benefits.

There isn't a huge policy role out of the commissioner's—I mean, you can put yourself in a policy seat, and people can listen or not listen. Policy really has to be driven out of the governor's office or out of legislative leaders' offices. They are in the legislature, which both

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Sandy and I served in every day. That's where the bills come from. That's where the money comes from.

It's like having a library that nobody visits. The commissioner is often not the person to drive health policy. They may collect data. They may give information. It should be a repository at the state level driven by the people reporting to the health committees to be really integrated. And Kansas has never been set up that way.

BSP: I know you were involved in sponsoring a piece of legislation in the mid-nineties that said that a health policy institute that was going to be set up at the University of Kansas at the time would have access to this healthcare database that was managed by the Insurance Department. For various reasons, that policy institute wasn't at the university. It was an independent entity, and that never came to fruition. But I think in some ways we have the worst of both worlds where we're having insurers pay for the database and sending the data to the state agency; collecting it and spending all the time and resources to put it together, but then we're not really using it for anything particularly valuable.

And we'll come back to some of the points you made in thinking about some of the initiatives around health reform in Kansas maybe to address some of the issues that you were talking about. I'll point out the latest numbers I saw: We spent about 5.7 billion dollars on Medicaid in Kansas. About 2 billion of that is state money, and the savings that could be realized if you even have a tenth of 1 percent increase in efficiency, then you would really have tremendous savings on that large base of health care spending. So, it's just been something that's been stuck in my mind. I've never quite been able to understand why we haven't made more of an investment in that.

But, anyway, okay, major health reform efforts at the state level since you guys were involved in state policy, one of the big ones we were talking before we started was the conversion of KU Hospital from a state entity to a semi-independent authority, a Hospital Authority. Talk to me a little bit about that. Why did that happen? Has that been a good thing?

SP: Well, you look at the ranking of KU Med Center now. It's one of the top medical schools in the country. For a long time, it was considered the Medicaid hospital. It was where the indigent went. The other hospitals in Kansas City had a much higher rating and acceptance in the general public. People just didn't go to the KU Med Center. It's considered now the hospital in Kansas City.

BSP: What were some of the obstacles when they were a part of state government that kept them from excelling, doing the things that they're doing now?

SP: I think one of the biggest was that they were under the state purchasing process and had to go through that whole competitive bid process. So, they couldn't make decisions quickly and efficiently. I think that was a big thing, getting them out from under that state government was really—

KS: I think it was hard to be nimble. It was hard to be flexible. It was hard to focus. The whole cancer initiative, which again is a distinguishing feature of the KU Med Center now in being one

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of the comprehensive cancer centers. I think there are only thirty-seven in the country. It would have never happened, I don't think, ever if it had stayed under state direction just because it was hard—the legislature is—if nothing else, they want to be balanced, and KU Hospital was always associated with KU and extra money to KU was seen as a parochial initiative by Lawrence and Kansas City. There was always a state battle over funding and over resources, and it was hard to say, "These guys should get a lot more money" and making the entity independent and having a different reporting mechanism and getting them out from under not only the state purchasing system, but the state allocation system I think has been a huge boon.

SP: And the Health Authority was put in place as an oversight because of the reluctance, taking too much authority away from the state, but that gradually was phased out.

KS: Right.

SP: It certainly was not needed. The thought that it was ever part of state government I think is a kind of surprise to people.

BSP: I think it's one of the great stories of the last thirty years of just the transformation of KU Hospital and Medical Center.

KS: You couldn't do that with another location, with another kind of hospital, but where the location was, the talent that was on board, the patient population that they could draw from immediately, and then as they developed more and more expertise, drew from a very regional and national patient population. But all of that would have been much more difficult if it had stayed under—

SP: And it was bipartisan. There was bipartisan support for it.

BSP: It's interesting that the reasons you cited that were sort of holding it back weren't related to the quality of the people, the resources, all those sorts of things. It was all the sort of political and maybe funding—

KS: It was the framework. They were operating in a framework that really was holding them back, not necessarily the individuals, but the overall expertise of the legislature was far exceeded by the expertise of the hospital folks, and they could not do what they needed to do.

SP: Right.

BSP: It seems like everybody agrees, not just here, but broadly, it's been a big success.

SP: Huge.

KS: Yes. If there are people who disagree, I don't know who they are.

BSP: We're not hearing them.

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SP: No. Nobody's going to touch the hospital.

BSP: Another thing that happened in this period of time that was sort of a—definitely a federal/state joint effort was the implementation of CHIP, the Children's Health Insurance Program, that was passed by Congress in 1998 and implemented in Kansas in 1999. It was basically designed to expand coverage, health insurance coverage, to children in families that were just above the poverty line, not eligible for enrolling in Medicaid. It has enrolled a lot of children, provided very good quality of care to them.

One of the interesting things that happened in Kansas with the implementation of CHIP, the Children's Health Insurance Program, was a decision that it should be a statewide managed care program. That always was interesting to me. I came back to the state just about the time it was being implemented after working on it in the Senate when I was there, and Kansas isn't a state that is set up well to do a lot of what we would consider "managed care" back in those days. Do you remember any reasons—why was the legislature so intent that this would have to be implemented in a managed care system?

KS: I can start this. I was insurance commissioner at that time. The first interesting decision was Republican Governor Bill Graves came to the Insurance Department and to me and said, "Why don't you lead the effort to figure this out?" not out of the Governor's Office, but out of the Insurance Department, which I think was very helpful, but in this day and age, would probably never happen, if you think about the pitched battles.

BSP: If they were of different parties.

KS: You bet. The politics may not have worked.

BSP: And you were the first Democratic insurance commissioner ever.

KS: Yes.

SP: And the first woman.

BSP: And the first woman.

KS: So, we put together a pretty broad-based statewide group to really talk to providers and legislators and policymakers and children's advocates and looked at the whole situation in terms of implementation. We had and continued to have a very difficult divide where children were eligible. Many of their parents were not.

BSP: Right.

KS: So, you had a situation where you were really trying to ensure children had the benefits and access, they needed, knowing that their parents weren't going to the—it isn't like parents going and say, "Oh, you're my—sign up my kids." It was almost the reverse of how you set a system up that doesn't rely directly on the parents' relationship, on the parents' initiative. And so part of

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the structure really was that anomaly, and that's still the case—thousands of children enrolled in CHIP, which is really a Medicaid-like operation, and their parents still are not eligible for health insurance.

SP: And it's hard to get the child to the doctor when the parents aren't going.

KS: You bet.

BSP: There's been a lot of studies done now that show that insuring families as a unit helps a lot.

KS: You bet.

BSP: Versus having everybody covered in a piecemeal fashion.

KS: And having them covered by different benefits and different doctors. You bet.

BSP: That program, the CHIP program, was designed to cover children up to about two-and-a-half times the federal poverty level. Just to give people some context, that's in today's—in 2026, for a family of four, that's about $80,000 of family income. So we're not talking about wealthy people, but we're also not talking about people not working. These are people earning money.

KS: It would be the expanded population under Medicaid expansion.

BSP: We'll get to that.

KS: That's how they got to those numbers.

BSP: We'll get to that, yes. You mentioned already the Mental Health Parity Law that was passed in 2001. I think you said something pretty simple, which is that "Why should mental health, behavioral health services be covered any different than any other kind of medical services?" Well, why had it been that way all those years?

SP: You know, I don't know. I think it was partly an insurance issue. Insurance didn't want to cover mental health issues. They're harder to diagnose. They're harder to understand. Appendicitis, that's easy. You go in, and you get your appendix out, done. Mental health services are harder to identify and harder to come up with organized treatment plans.

KS: I also think in this instance Kansas was ahead of the country. The national parity law was one of the first things that President Obama signed into law. So, it wasn't until 2009 that the federal government finally said, "There needs to be health parity in mental health." Kansas had, I think, because of—this is the good side of it—because of the Menninger Foundation being here, because of attention—we'd gone through major hospital closures in the early day when I was in the legislature where people were expected and hoped to be in the least restrictive environment, and the money was to follow the patients. So, Topeka State Hospital was closed.

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Kansas was actually at the forefront of many of the mental health reform movements in 2001, eight years before the feds moved on this. I think this was an example of Kansas actually taking a lead and looking out for patients. Unfortunately, the money never followed the patient in the early days of the legislature.

BSP: Once those facilities were closed, the patients moved to the community, the money didn't necessarily follow them into the community.

KS: Correct. So, people started living under bridges. You ask any local sheriff or police official or jail official—

BSP: School principal.

KS: How many people are in your facilities that suffer from mental health issues, and it's skyrocketed.

SP: The money that was being spent on mental health services, especially the mental health hospitals, was supposed to flow back to the communities where these people were going to be living, and that never happened.

KS: It never did. I always look back and think that is a vote I regret.

SP: Yes.

KS: There was an amount of money spent on mental health in Kansas, and it never has even barely reached that level twenty-five years later. It just plummeted and never was reinforced and just dissipated into all kinds of other areas.

SP: I mean, it was hard to justify having the mental health hospitals when we knew community mental health services could be much more effective.

KS: And efficient.

SP: And efficient. But it never happened. We closed the hospitals, but the rest didn't happen.

BSP: And you're talking largely about state-funded programs and some federal-funded programs that provide those services. The thing that the Parity Act did do though was for commercial insurance, for people with private insurance, it ensured that they were able to get those sorts of services covered just like they could for a broken leg.

SP: In a limited way.

KS: That's right. They could, but unfortunately, if the state money wasn't there, you didn't have facilities for people in crisis to be treated. You often had a serious lack of providers, particularly for pediatric issues. That has really just grown and grown. So, having commercial insurance, having government insurance cover provider services, hospitalizations, whatever, is great, but if

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you don't have a hospital, if you don't have a crisis center, and you don't have a provider to go to, the insurance coverage doesn't do much.

SP: And often in hospitals, the people would end up—the people with mental issues, would end up in the hospital emergency rooms. Many do not have the capacity to treat them. They would be taking up valuable space in the emergency rooms, and there was no way to really provide the care that they needed.

BSP: The impact on the corrections systems, jails, and on schools for the unmet behavioral health needs is just a huge impact. And going back to the health rankings, one of the areas where Kansas is significantly below average is in the availability of behavioral health providers, especially for children around the state. That's one of the areas. We know some of the challenges with providers all around the state, but behavioral health and oral health, dental health providers, are areas where Kansas really does lag.

KS: This can't be done in dental health, but at least in the behavioral health area, the impact of telemedicine and the explosion of finally payment for telemedicine can help particularly a lot of those pediatric areas. But that's what I'm saying, without the state investment, even if you have commercial coverage for insurance, you need a state backbone. So, the transfer of those dollars from institutional settings to community settings was a huge failure of Kansas.

SP: And behavioral health with young people especially today with the social issues around cell phones. It's frightening.

BSP: What we know about the importance of those things on overall health certainly could be expected to have an impact on overall health and well-being.

KS: The trauma, I still think we're at least a decade or a decade and a half away from fully understanding the COVID trauma. When you take even healthy young people and cut them off from social interaction, from teachers, put kids who are already in precarious situations in far more precarious situations 24/7. You don't have food coming on a regular basis. You don't have a caring adult looking out for them. I think we have a generation, not just in Kansas, but across this country that we haven't even begun to cope with yet. And on that optimistic note—

BSP: We'll move on. Around 2003, there was a Medicaid reform task force put together, I believe, by the Senate President Kerr at the time, about the time you came in as governor. You began developing a comprehensive, broad-based initiative around health reform. One of the things I remember, I think you were the first governor to hire a director of health policy actually in the Governor's Office. Bob Day was that person. I don't know if he reported directly to you.

KS: He did.

BSP: That was a new approach to thinking about—

KS: Bob Day just died recently, unfortunately.

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BSP: Yes. We'll stay on the positive side. But Bob was very influential in that. What made you decide to appoint that position in your office reporting to you?

KS: Again, as I've said earlier, I think that part of the Kansas effort has to be led by the executive branch. It can't be the insurance—I had served for eight years as insurance commissioner before coming to the Governor's Office. I'd been in the legislature. I knew what was possible in that realm. It became very clear to me that if you wanted health policy to be moved, if you wanted health reform to be moved, it had to come out of the Governor's Office. There was certainly talent running the Department of Health and Environment, but it was a combined department dealing with broad-based things.

BSP: They were running a lot of programs.

KS: Running a ton of programs. So, to have just a policy expert to inform—what I didn't know, and when I got to DC, learned a better terminology for it, that we used to talk about "health in all policies." There are roles that the Housing Department can play, roles that the Transportation Department can play. There are roles that the education system plays. We did that at a Cabinet level, I think not knowing that that terminology even existed. That's sort of what I was trying to do was having people look around, how do you have a healthier state. What are the policy changes that could be made across the board?

BSP: I've heard you say that one of the things that attracted you to the job at HHS in particular was the opportunity to have the impact on that broad set of policies and programs, not just health care and health insurance.

KS: You bet because when Barack Obama announced for president, he said, "We are going to pass a major health reform." I had the unique situation of my father had been in Congress when Medicare and Medicaid were passed, and he talked a lot about that. I knew that was the last really big initiative. The Children's Health Insurance Program that you talked about was really borne out of the failure of the Clinton health plan. Congress failed to pass that, and so they thought we could at least expand coverage for some kids, which was wildly successful in many ways. So, we were filling gaps a bit at a time but having that opportunity—HHS went from every place from cradle to grave and ran the biggest insurance programs in the country was really exciting.

BSP: A great opportunity.

KS: Yes.

BSP: Going back to—you're relatively new in the Governor's Office, and you decide this is going to be a focus. You appoint a director of health policy. Then somewhere along the line, these flyers started appearing. I'd see TV coverage of both of you, a Democratic governor and a Republican insurance commissioner—

KS: We did some road shows.

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BSP: Showing up around the state talking about health reform. How did that come about?

SP: Part of the health reform had to include changes in insurance and additions to insurance coverage. It was a great opportunity. I think I was really happy to be a part of it. Kathleen had a vison for how we could make the state better and healthier, and it was a great opportunity to show bipartisan initiatives, that people can work together for a common goal.

KS: Sandy and I had been in the legislature together. We knew each other, which really helped. I wish we could have brought a few more friends along the way. We had a pretty small bus going around the state. We were the choirmasters, but we never had quite the robust choir that we needed to have.

SP: No. Things really politically started to disintegrate, not just in Kansas, but—

BSP: I don't know if you have brushed up on this recently, but thinking back to that period of time, what were some of the really important things that you wanted to accomplish for Kansas through that health reform initiative that you set into motion?

KS: From my point of view, we definitely needed more health care providers in various parts of the state. I think in some ways, that aspect was somewhat of a success because we developed some state programs to pay off medical debt for people, have scholarship programs, more residency programs.

BSP: What other things were part of that health reform initiative?

KS: We definitely were talking of Medicaid expansion of adults. We had already done it with children. We had a Medicaid expansion for adults that we were trying to—and make it clear to local communities, if I recall, what the impact would be, how positive it could be. We didn't have the kind of federal carrot that was offered then years later.

BSP: Enhanced matching.

KS: You bet, like 100 percent. It wasn't even matching.

BSP: For the first year.

KS: I know that was expansion of coverage, telling providers and hospitals what a good deal that could be.

SP: And especially I think the most interest was in rural Kansas, western Kansas especially, where the whole issue of hospitals closing was frightening.

BSP: I have some of the notes I went back and looked up on this—a focus really on rural areas and pregnant women and prenatal, trying to address some of the issues around that and including behavior change around tobacco use, diet, exercise, those sorts of things.

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KS: I think there's been a lot of studies done, as you probably know, about how much payment policies and taxing policy, not directly at health, but things like alcohol and tobacco tax.

BSP: Sin taxes.

KS: What kind of impact that then has on people's health. Kansas was always sort of a slow adopter. We were reluctant to the table. But those policies, as we go back to the comparisons with other states, produces pots of money that then could be used directly in health care and indirectly. It turns out kids are pretty sensitive to taxes. You have far fewer teen smokers if you have a high tax than if you have a low tax. It has a double whammy that we often didn't get in Kansas.

BSP: There was a large element in your proposal around consolidating, streamlining, making more efficient purchasing, healthcare purchasing on behalf of the state through all of the different health insurance programs that the state's involved in and better using the data to get back to the point I was talking about earlier.

KS: And we ended up, even though some of the initiatives weren't codified, we did a lot of that at the governor's level. There's the state employees' health plan. There was the prison system health plan. There were university health plans, individuals, and we started doing things like opening up contracts. So, the state would bid on something and get a pretty good price. Then we'd say to smaller jurisdictions and local communities, "Do you want to join in, throw your dollars in? We can leverage the state-buying power to get you better bang for your buck." So, those kinds of things, even though it was never codified formally because the legislature was always very nervous and then wanted to micromanage the whole damn thing, and it was like, "No, thank you." But we had a lot of that collaborative purchasing and using the state as an active purchaser rather than a passive payer.

BSP: There were some initiatives particularly targeting state employees as I remember, some trying to incentivize healthy behavior through financial means and premiums and those sorts of things.

KS: And using choices in health care to allow people to actually get the care that they and their family—so, younger and healthier families could get a potentially higher deductible, a lower cost overall because they didn't need a lot of the medications. They weren't so concerned about network. They weren't kind of mixing and matching for the first time what people could take advantage of.

BSP: This was a very broad-based approach to try to improve the healthcare system in our state. And then you were governor at the time when the legislature, both Chambers were controlled by the majority of Republicans.

SP: As they always have been.

KS: I was in the majority once.

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BSP: One time.

SP: And I was there with you.

BSP: But what happened politically? What were the machinations that then led to a legislatively driven initiative around creating the Kansas Health Policy Authority? How did you dovetail those sorts of initiatives?

KS: I think there were people like Dave Kerr who was very interested in sort of structural initiatives, and we had two authorities—we had a Bioscience Authority, which was really aimed at bringing new investment and cutting-edge technologies into the state. That was set up. So, the Policy Authority was kind of a companion, and I really think we might have stolen Dave's idea or collaborated or co-opted it. We had willing Republican participants in trying to drive some kind of public private group that would look at overall policy and make recommendations, not just on cost, but on overall—looking at it more globally than just what was going on within state government. That was really the goal. It has to be the private sector because a lot of employers provided their own insurance coverage, draw out their own programs that had to include the school districts. If you wanted to make a dent, you really needed a much broader look than just the state.

SP: That drove the change of direction for the KU Medical Center and getting them out from under the weight of the purchasing. It really opened the door for big change at the Med Center.

BSP: Did you view—at this point in time, you were in the Commissioner's Office. You were in the Governor's Office when this initiative was being put together. Did you view it as trying to block or make more difficult what you were doing? Did you see it as building on that or expanding on that?

KS: I was enthusiastic about it. I thought it was a good additional entity. I think the way it was constructed—you probably have better notes than my brain could provide. I remember helping to recruit Marci Nielsen as the head of it. I had a very hands-on role in appointing members and getting some of the leadership. I saw it as a great addition because the business community could be directly involved. We had some federal partners who were directly involved. The state got very little information about federal programs and federal policies even though most Kansas seniors were involved in Medicaid, and the dual eligible, Medicare, but the dual eligible were in both.

So, we were running programs for the lowest income seniors, nursing homes and others. The feds were running the overall Medi—and they were not sharing Medicare benefits or data or anything with us. So, it was a really black hole.

BSP: I don't remember the number, but it was a large number of people were appointed to oversee the Health Policy Authority that you could bring in experts from lots of different areas to participate in that decision-making process. I think one of the theories of the Health Policy Authority was that by creating a governing board like that and having an agency not directly under the control of the governor, that it would insulate the governor and potentially the

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legislature from making tough decisions that have to be made around Medicaid and the budget issues primarily, and that maybe having this more independent—

KS: Quasi-independent.

BSP: Quasi-intendent entity would provide some insulation. Do you think that was a pipe dream? Did that happen at all to protect the governor or the legislature from those tough decisions?

KS: Thinking back on it, I never had a lot of disputes with what the recommendations were. We just couldn't get them—most of the recommendations still had to go through the legislature.

BSP: Absolutely.

KS: If they were coming from Mars or from the Health Policy Authority or from Salina, it didn't matter. It still had one route to get into law. There were things I could not do by executive order. I did what I could by executive order with my buddies in other areas, but that still was the flow-through. So, it wasn't so much about protecting me. It was like how you get this immovable body who isn't particularly interested or committed to these topics to do something helpful. That was my hope, that having proposals not come out of the Governor's Office, but come out of an entity with business leaders and federal officials and others, maybe that would have a different audience in the legislature. Maybe there'd be more uptick, but my recollection is they were met with much of the same lack of interest or lack of initiative.

SP: It's easy to say no.

KS: Yes.

SP: Easier to say no than to try and understand so you can say yes.

KS: It wasn't like school closure or base closure or whatever. Those were very tough calls that legislators didn't want to make, and commissions set up to sort of automatically implement what was happening unless the legislature decided to intervene. It was always about protection, but they did it. I didn't do it. But this was about initiatives that were forward looking and had to be affirmatively agreed to and funded, and that's a tougher thing to do from the outside.

BSP: That's sort of a list of things that I came across in thinking of big health reform initiatives over this period of time in the last twenty-five, thirty years in the state. Let's move to the federal level a little bit. Before we talk about the Affordable Care Act, the ACA or Obamacare, however you want to call it, describe to me what the insurance market was like, how insurance worked before the ACA and then how it's worked after the ACA. I think that's really an important distinction and a fundamental change in our health insurance system that occurred at that time. Tell me about that.

SP: Well, for one thing, if you went to buy insurance and you had a pre-existing condition, you could get insurance, but that pre-existing condition wouldn't be covered, and that's where all

your money was going to go to provide your healthcare. There were so many inequities in the private insurance marketplace that just made it really difficult for families. And even the employer-based coverage still had similar issues. It wasn't a marketplace that really worked.

KS: And particularly if you were an individual buying your own coverage or a Mom and Pop store. If your insurance was provided by a large group, if you worked for Ford Motor Company, if you were a part of a union that was nationalized, you had great insurance, and it didn't matter if you were healthy or unhealthy. You were part of the group immediately. By being hired, your benefits were paid in a group pool. You might be far less healthy than I am, but we paid the same amount. We sat side by side on a projection line or whatever.

BSP: You used the word "pool," that whole concept of "pool."

KS: You bet.

BSP: Pooling risk.

KS: Healthier and sicker people were all together. They paid rates based on age, often based on some other things, but not based on health condition. If you were individuals purchasing your own insurance, if you ran a small business, you then were individually health rated. Every pre-existing condition—cancer survivor, heart attack, did you have a genetic predisposition to—I remember they used to say a kid who had taken Accutane to get rid of acne was more likely to be at risk. It was the Wild West. The insurance companies could lock you into an expensive plan, take you out of an expensive plan, cancel your policy, charge basically anything they wanted.

SP: And that's what the Insurance Department was there for, to help those consumers who really had issues and were struggling to try to keep their coverage or get their coverage to pay for the things they thought should be and was covered.

KS: Sandy will remember. There was a so-called "high-risk pool."

BSP: Many states tried those.

KS: For cancer survivors—most states had them in place. The problem was that the cost was prohibitive. If you were a cancer survivor and wanted coverage, you'd better be in the upper 5 percent of the population because there was no overall ceiling about what could be charged. There were no real rules about what could be covered or not. Somebody would call and say, "I need health insurance," and you'd say, "Well, you can go in the high-risk pool but empty out your bank account and your kids' bank accounts and whatever else you need." It was a real Catch-22. It was like selling toasters, but if you ever used the toaster, then you're a bad customer, and you're going to be kicked out.

SP: I want to mention a reform that had occurred earlier in the late nineties when Senator Kassebaum was in the US Senate, and we got the Health Insurance Affordability and Accountability Act. She did get it passed with Ted Kennedy. There's a good example, too, of bipartisanship working together. But the portability aspect of it was really important. If you were

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covered in a job and you were moving to another job, sometimes that coverage kept people in jobs they really weren't happy in because they couldn't afford to leave the company because they were going to lose their insurance if they did. And to try to get new coverage in another company, they could be subjected to that pre-existing condition that had occurred during the prior coverage. It was a small step, but it did make a change so people could change jobs.

BSP: Most people think of that as privacy and security around information, but there's the other part of that.

SP: Right. Absolutely.

BSP: At the beginning, you talked a little bit about the difficulty of conversations around health care policy. I may not have all the details of this right, the details aren't relevant, but when the ACA was passed, there were on the final bills, there were no votes by Republicans for–

KS: Oh, I do remember.

BSP: Do you remember that?

KS: Yes, sir.

BSP: That were in favor of the bills, and not even all the Democrats voted for it. There were some dissenters from the Democratic side. There was a lot of gyrations in the legislative process of moving a bill back and forth and not having a bill. You'd have to go back to conference committee, all those sorts of things. It was a very rough and tumble political move to get that bill passed. What are some of the repercussions at the federal level and the state level of how that process played out in Congress? Are there any implications?

KS: I think there's no doubt that President Obama wanted a bipartisan bill and did everything but mow Republican senators' lawns.

BSP: A lot of the ideas were Republican ideas.

SP: Mitt Romney's.

KS: Absolutely.

BSP: Five years before.

KS: There were hundreds of amendments added to the bill. There were dozens of hearings. Actually we had five bills. Three passed in the House of Representatives. Three came to the floor and two in the Senate, full of Republican concepts as Sandy said, the Massachusetts bill when signed into law by Mitt Romney as governor, was the framework of a lot of the basic advantages. But as the process went on, it became very clear, and I remember very distinctly a quote by Senator Mitch McConnell who was then the Republican Senate Minority Leader saying that

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"Our #1 job is to make sure that President Obama not only does not get a second term, but this is his top priority. It has to be stopped."

It became the litmus test for senators. If you vote yes on this, you're out of the caucus. You're out of the Good Guy Club. It became a litmus test on the House side. So, even though the bill is full of Republican amendments, what a lot of us have said going back is "If we had known what the vote would be, this bill would look a whole lot different." It would look a lot more like a Bernie Sanders proposal than it did because the attempt was to bring along Republicans, put in a lot of private sector initiatives, and that never happened.

SP: And it translated down into state insurance departments. As I said earlier, we all of a sudden were very polarized in an environment which never really looked at your political affiliation. We all kind of had the same goal, and that was to keep insurance companies honest and keep coverage fair for the consumers. But, boy, after the Affordable Care Act passed, states were looking for ways to block it.

KS: The day that President Obama signed the bill, sixteen Republican attorneys general sued about the constitutionality. They didn't even allow a twenty-four-hour celebration. It was a war, a partisan war.

BSP: The next day, the Republican Congress introduced a bill to repeal it.

KS: They did that 400,000 times. You had the lawsuit. You had the re-election campaign. The lawsuit was finally decided in July 2012. Then you had a re-election campaign where Mitt Romney said Day One, he would repeal the bill based on his own framework. It went on and on and on. But the opening salvo was filed the day he signed the bill by the states because states are still—I mean, I think this is a widely held misconception. There was nothing in the bill that changed the state regulation of insurance. The federal government did not and does not regulate insurance. We run some insurance programs, but the state regulation of insurance was not harmed. So, the fight went immediately to the state level.

SP: Mark Parkinson—you had moved on. Mark Parkinson was governor, and we applied for a grant to establish our own exchange for people to sign up for it. We received the grant. Neil Woerman who worked in our department was brilliant in terms of setting up, putting the framework together for the Exchange, which we in fact shared with other states, and other states were able to do it. We lost the grant when the new governor came in. Sam Brownback decided to send the money back.

BSP: That was an important part built into the bill that states had the option of running their own exchange or using the federal exchange.

KS: And it was designed that way in part by me because I kept saying, "We will be much more successful if we give states the option of running their own thing. They may hate the bill, but they get to run it. We're paying for the expanded coverage. They get to run the rules based on their own pools, based on their small group market," and I think it's very ironic still to this day that the most vocal opponents did it at their own detriment because the law went into place. They

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didn't collect the money that other states were getting. They didn't run their own exchanges. They didn't have that kind of economic benefit, and their citizens suffered the health consequences.

BSP: I think your perspective having regulated insurance at the state level obviously informed a lot of that thinking. I don't know how many of the previous secretaries had been insurance commissioner.

KS: Well, they didn't. The federal government had never regulated private insurance. So, we built a whole office inside of HHS made up of my former colleagues who were insurance commissioners who had run markets, who had done that. Medicare, which is federal benefits across the board administered at the federal level, 100 percent federal, nobody had ever run a private insurance plan. So, we had to establish a whole framework within HHS.

BSP: So, running the exchanges was one thing where flexibility for the states was built in. An area where states got flexibility, but it was not part of the bill, but the Supreme Court got involved and decided that states would have the flexibility of whether or not to implement the Medicaid expansion that was part of the ACA. Why was that not given out of the chute as an option to states? Was it just too integral a part of what you were trying to do?

KS: Well, the bill was written to fill a gap in coverage, and that gap was low income, working adults who didn't qualify in states like Kansas for Medicaid. If you're a pregnant woman, you could get Medicaid, but we had one of the lowest eligibility rates based on income. So, low-income adults and some younger disability folks, and the theory was that Medicaid was by far the most efficient way to provide comprehensive coverage, and those folks were likely as they changed jobs or moved up the ladder to move into the business market. So, it was looked at as seamless coverage. Their children often were already eligible for the CHIP program. So, again in the notion that you wanted to insure whole families and not, say, parents are in one pool, and you have these doctors, and the kids are in another pool. It was written as a continuous coverage from lowest income through the working market, some subsidies for people to buy into public coverage, and then all the way into Medicare. You could have insurance match the health needs and the age and the ability of people to pay.

BSP: So, it wasn't designed to have a big hole in the middle?

SP: No.

KS: That was not the design.

SP: Without the Medicaid expansion, as in Kansas, there was a big gap.

KS: You bet.

SP: Think of the sort of ironic statement that people would make, "You're too poor to qualify for Medicaid" because Medicaid was at 138 percent of the federal poverty level. Well, we had people in Kansas—

KS: They were too poor to qualify for the health subsidies.

SP: I'm sorry, for the health subsidies, right, to qualify for subsidies. So, you were too poor to qualify for the subsidies.

BSP: And you made too much to qualify for Medicaid under the existing rules.

KS: So, state rules were all over the board. The goal was to have state rules come up to a ceiling of 138 percent. Some states exceeded that and still do, but most of the states were below that. So, it was to bring the lowest income workers to a ceiling, and then people would qualify for federal tax incentives to help buy their own insurance, the way a worker at Ford Motor Company has an employer contribution, and they make a contribution. People buying their own insurance, paid 100 percent out of their own pocket. So, this was trying to fill that gap.

But when the court said, "You cannot mandate this. You have too much leverage over the state. You cannot mandate it. You can offer it." Then we have this wildly inequitable system.

SP: And we had such low Medicaid eligibility in Kansas traditionally. We could have benefited to a greater extent than many states.

KS: Enormously.

SP: Because other states had higher eligibility rates. It was just to get you up to that 138 percent.

KS: You bet.

BSP: Through the various expansions with CHIP and other bills, kids were covered uniformly across states, but there was this gap for adults and especially childless adults that varied widely across the state.

SP: They had no coverage, yes.

BSP: What do you think are the lasting impacts of the ACA? You can tell me if this was true. You were in the room. The goal of expanding insurance coverage and helping to control health care costs. I think that now we've had some years since the implementation of the ACA. Even though it was passed in '10, it really became implemented in 2014 to 2016.

KS: January of 2014. All the benefits went into effect.

BSP: We have a lot of information now, and I think there's good evidence that through a combination of the Medicaid expansion and the individual market reform, there's been large increases in people with insurance coverage.

KS: That's true.

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BSP: The uninsured rate has been cut in about half.

SP: Right.

BSP: This is a little more controversial maybe, but it seems like we have reduced the increase—the legislators love that term—but reduced the rate of increase of health care spending. If those were two major goals, there's some pretty good evidence that that worked. How do you view the success of that initiative?

KS: We've already talked about the gap for states. Now we're down to only ten states, but unfortunately, we're sitting in one that has failed to take up the—what is the most lucrative federal-state offer ever made in the history of the United States of America. It still has resisted. So, that creates this gap. I think in many ways, Medicare overall costs rose at the lowest levels ever seen in the Medicare program during the points of at least the Democratic administrations' efforts on this bill. A lot of state expenditures were held steady. Reducing costs has still not happened. We need a much more global effort. That can't just involve the government programs.

BSP: Yes.

KS: What we're doing now is sort of pushing Jell-O around. The private sector is picking up costs that are pushed to somebody else. But in terms of public expenditures and cost efficiencies if you look at medical inflation, it ran well below the overall rate of inflation during the years that somebody really wanted the program to work. I think the evidence is pretty good that that framework can be helpful.

SP: And now we're losing the subsidies.

KS: Yes.

SP: For those people that were signing up for the Affordable—

BSP: The enhanced subsidies that were implemented during the pandemic.

KS: And we're going to see a big hit in Kansas for that since we have fewer people eligible for Medicaid. More people in that mixed income level came to the federal marketplaces for subsidies. And now they're going to lose their insurance.

SP: We're talking about young families.

KS: Yes.

SP: Having to spend close to $2,000 a month.

KS: Farm families, all kinds.

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BSP: Hospitals and providers are seeing that in the increase in their uncompensated care that they're providing.

SP: And people will just drop coverage. They can't afford it.

KS: But will still come through the doors of the emergency rooms.

SP: And part of the Affordable Care Act also was getting rid of the uncompensated care because it was going to be compensated because there were no gaps.

BSP: This has been a fascinating conversation. There's are a lot of elements of the ACA obviously that we haven't even begun to touch on, but it's very interesting to hear about the interplay between the state level and federal level, particularly around insurance coverage and some of these big challenges. So, thank you very much for joining us today.

SP: One comment. I know Kathleen saw this a lot, too. People would be interviewed, "What do you think about the Affordable Care Act?" "You know, I think it's really probably a good idea." "What about Obamacare?" "Oh, no, I don't like Obamacare." It became so political. People didn't even know what they were saying.

KS: I would say the flip side of that is healthcare is the most personal benefit that people look for. It terrifies people that they will not be able to take care of themselves or their families if they get sick. It is a very frightening situation if somebody says, "Your benefits aren't going to pay if your house burns down." But healthcare, oh my. I still get stopped at airports, in grocery stores, get phone calls from people who said, "I never had health insurance, and now I do. I can run my own small business because of what you did at the federal level." It is something that is a lasting benefit that people allow them to live their lives.

BSP: And probably a lot of parents who thank you that our kids are able to stay on our insurance for a little bit longer like our two kids.

SP: Yes.

KS: I used to say, "I don't know what John Sebelius is doing, but I know it doesn't come with health care."

BSP: Thank you very much.

KS: Thank you.

[End of File 2]

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