Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. Today is April 21st, 2026, and I'm in Topeka, Kansas to interview Matt All. Matt is the president of Blue Cross and Blue Shield of Kansas, and he's a lawyer and from Augusta, Kansas. Thanks for being here today.

Matt All: It's really a pleasure to be here.

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 funded from donations by generous donors, and in some cases, a grant from the United Methodist Health Ministry Fund. Our videographer is former Kansas State Representative Dave Heinemann. Matt, thanks for being here.

MA: Happy to be here.

BSP: Tell me a little bit about how your family got to Kansas and your early years and sort of what led you to the career that you had.

MA: I wish I could tell you exactly why my ancestors came to Kansas. I think it's probably the same story from a lot of families whose ancestors got here in the 19th century. I assume they're just looking for opportunities. I used to think I was a fifth-generation Kansan. I trace that to my mom's great-grandfather, my great-great-grandfather, Russell Scott Osborn who settled in Rooks County. But when the pandemic occurred, I think I began to contemplate my own mortality because I immediately got on to Ancestry.com and really pulled together a large family tree. I've got about a thousand people on the family tree. I'm actually a sixth-generation Kansan. I've got a family buried in Neodesha, Kansas,, six generations ago.

So, I grew up in Augusta. My dad grew up in McPherson. My mom grew up in Stockton. We're kind of the quintessential, multigenerational, small-town Kansas family.

BSP: I had no idea your family settled in Rooks County, your mom's side. My family homesteaded in the 1870s in Rooks County.

MA: Almost exactly the same time. Russell Scott Osborn was an officer in the Union Army. He was in Illinois and then eventually made his way to Rooks County and was a stone mason. The church in Stockton where I was baptized, he built that church. There are lots of churches and other buildings there. He ended up being elected secretary of state. I think he was a Populist. If you go to the old secretary of state's office and look at all of the photos, he's very distinctive. They all look just like normal people from the 19th century, and you see this guy with this crazy grey beard. That's Russell Scott Osborne. He served one term, and he got back to Rooks County.

BSP: That's a relative on your mother's side.

MA: My mom's side. That's her great-grandfather, yes.

BSP: That's awesome. So, you grew up in Augusta.

© 2026 Kansas Oral History Project, Inc.

MA: In Augusta, yes. I have nothing but the fondest memories of Augusta. I was born in Wichita, but my parents, my family lived in Augusta. They moved there a few years earlier. My dad was an attorney there in town, kind of a classic small-town attorney, wills and trusts and contracts. He was also city attorney for about thirty years. My mom was eventually a schoolteacher in the public schools. She was my teacher for a period of time, which is not easy. It sounds good, but you don't want your mom as a teacher. There's a lot of accountability there.

But I had just a great time. I think that at that moment in Augusta, we had this nucleus of great teachers, and my mom was one of those. She taught a humanities class, a sort of Western civ, Greek mythology, and things like that, which you didn't necessarily get in a small town. Great music teachers. I did theatre. We had a great theatre director, math teachers, and English teachers. I think it really allowed a generation of students from Augusta to go out into the world and do some really interesting things. You can find across Kansas and really across the country people from that period in Augusta, Kansas that have gone on to do really great things. I trace it all back to the teachers and the public schools.

BSP: That's awesome. Continuing with that education theme, you then went to the University of Kansas and debated between theatre and political science, I learned.

MA: Yes. The plan when I showed up as an eighteen-year-old—what do you know at eighteen—was to be a political science major and probably go to law school. I then when on a journey. I always sang. So, I sang throughout my four years there and briefly thought about beoming a theatre major. My sophomore year, on my arts form, I was an undeclared theatre major and took Acting 1, and it became really clear that this was not going to be a good idea. I went back to the original plan with a few other detours along the way, and ended as a political science major, planning to go to law school.

It was a great next step for me as a small-town kid going to KU. It's mostly Kansans, but you start to broaden your horizons. I also have fond memories of KU. I live in Lawrence now. I love to be a part of that community.

BSP: Then you went from KU to Yale.

MA: I did.

BSP: A prestigious law school on the East Coast. What was that transition like for you?

MA: I'd love to tell you that there was a great plan there, but I still remember the day going to Watson Library at KU. There were magazines, paper. I got the *US News and World Report* .and looked at the law school issue and started listing off a few, writing down a few that I would apply to. I started getting into these law schools, which was a little bit of a surprise. This was the early nineties. Bill Clinton had just been elected. Yale Law School was kind of in the news a lot, and one of my professors said, "That's where you should go," but I never visited. I showed up as a twenty-two-year-old, really green, with my suitcases in New Haven, Connecticut, but I'm so glad I did. As it was supposed to be, it was a transformative experience. I think when you're

© 2026 Kansas Oral History Project, Inc.

somebody like me that comes from a small town, I think it's important to have experiences like that where you really broaden your horizons, and that absolutely was that for me.

BSP: I'm guessing there weren't a lot of kids from small towns that went to state schools in law school there?

MA: There were a few of us. There was a kid, not small town, but there was a guy in my class from Wichita. We had never met, either in Wichita or at KU. They do try to make it diverse in a variety of ways. You would find people kind of like me, but I was unusual there. That was definitely my identity, a kid from Kansas. The people there were great. There were so many bright, public-regarding, interesting people with different backgrounds. The bigger transition for me was more social and cultural than it was academic. I felt perfectly ready to do fine in the classroom. I really loved the experience in the classroom, but when you go from small-town Kansas to the East Coast, and you're with a whole different swath of the country, there's a different way of having conversations, a different way of interacting with people on the East Coast. I loved it, and I'm so glad it happened.

BSP: Have you maintained any contact back there with classmates?

MA: Absolutely. I've got a text chain with a couple of my classmates, just dear friends. I go back every five years. I'll go back this fall for my 30th Alumnae Weekend, which is hard to say. I'm one of the two people that writes the class notes. I do one a year. It's nothing but love for the people there. They were so good to me. It was just a great experience.

BSP: That's awesome. After that very broadening experience, you ended up coming back to Kansas. Tell me how that happened.

MA: I never gave it a second thought. I always wanted to come back to Kansas and contribute in some way. I didn't have a particular plan in mind. I've come to believe that it's probably a bad idea to plan your life too much. I came back as a lawyer and went to work with a general thought that I want to find a way to contribute to my home state. I never really considered staying out on the East Coast or going anywhere else. I'm glad I did.

BSP: And you worked for a small law firm, you said?

MA: I started out in a big law firm. I had big student loans. It was time to start paying those down and get on with my life. So, what you do, I guess, is go to a big law firm in Kansas City. I tell this story to all my new employees. I meet with all of them, usually about ten or twelve at a time. This law firm doesn't exist in its current form anymore. It's merged multiple times. What surprised me about that first job was how much I hated it. It was really surprising. It had nothing to do with the people. They treated me well. It was as advertised. I just don't think I read the advertisement well enough. I could tell very early on that this wasn't what I was supposed to do with my life and my career.

So, I left that firm pretty quickly, and they were very nice to me about that. I went to a small law firm in Lawrence. Also, they were great to me, but I could still tell—I liked it more, but I never

© 2026 Kansas Oral History Project, Inc.

loved it. I wanted to find something where I could contribute more. I ended up after just a few years in state government. I'm glad that happened.

BSP: Yes. Tell me about that transition. You went to the Kansas Insurance Department.

MA: Right, I went to a salad bar at a Dillon's in Lawrence. It just so happened that somebody who was close to Kathleen Sebelius was also getting a salad in Lawrence. He said, "Hey, you need to talk to Kathleen Sebelius. She's looking for a new assistant insurance commissioner." She had just gotten re-elected. This would have been 1999, just after the '98 election, and I said okay.

Six weeks later, I went to work for her there. What surprised me about that job was how much I loved it. I thought the work was more interesting than I imagined. It felt like I was doing something important and contributing in some way. The people there were amazing. They could have done anything with their careers, but they chose to spend it in public service. You don't do that to make a big salary. You do that because it's the kind of job you want to spend your career on.

It made my whole life better. I don't think I realized just how, I don't know, sort of disappointed I was in how things were going until I got there, and then I felt energized. It was a great experience there.

BSP: So, thinking of the Kansas Insurance Department, it's led by a commissioner who's independently elected in a statewide election.

MA: Correct.

BSP: It's not part of the governor's administration or anything, and you were the assistant commissioner.

MA: Right, the assistant commissioner, which is the one other position that's contemplated in statute.

BSP: Is that a Senate-confirmed position?

MA: No, it's not, thank goodness. It was just appointed by her. So, I was sort of an all-purpose assistant to her. I knew enough about insurance to be a little bit dangerous, but you learn pretty quickly.

BSP: Yes.

MA: I helped her run the department. I was sort of a thought partner for her for big decisions. It was a great education in state government, in public service, and then specifically in insurance.

BSP: What does the Kansas Insurance Department do?

© 2026 Kansas Oral History Project, Inc.

MA: It licenses all insurance companies, whether it's health or life or property or whatever. If you want to sell in Kansas, you have to have a license from the insurance commissioner. Primarily what they do is ensure that you're solvent and you're following Kansas law. So, they'll do financial examinations. If it's a domestic company, they'll license agents that will enforce the consumer protection laws, things like that. Depending on the line of insurance, they might review the rates to make sure they're reasonable and things like that. They want to make sure that insurance companies act for the benefit of their members, of their customers.

So, when I think about insurance, I think about it this way. When you go to buy insurance, you don't really know nearly as much as the insurance company does. If you ever read your auto insurance policy, you might say, "Why is it written this way?" It's not written for normal people to understand. There's a power disparity there. The insurance commissioner is there to address that in a variety of ways.

Then when you need insurance, something terrible has happened. You've totaled your car. Your house is damaged, or. your loved one has passed away, or you're sick or injured, and you need health care, also in a difficult position. So, the insurance commissioner is there to make sure you get what you paid for.

It became really clear to me at the beginning that this was an important office, and that Kansans sometimes in the biggest moments of their lives need somebody to stand beside them. So, I was proud to do the work.

BSP: And it covers all aspects of insurance, not just health insurance.

MA: Correct.

BSP: I know you've used an interesting phrase there, something about to make sure that insurance companies are operating in the best interest of people, citizens of the state. One of the big issues that I remember coming through and landing on the commissioner's desk was when Blue Cross and Blue Shield was considering selling itself, and the commissioner, and I'm imagining you, got very involved in thinking about that whole decision. Talk a little bit about that.

MA: Yes, it was part of a wave of consolidation within the Blue system. Anthem is now called Elevance although they're still using the Anthem brand name. They are a different type of Blue Cross plan in that they are for-profit shareholder owned. All the rest of them are some versions of not-for-profit mutual including Blue Cross & Blue Shield of Kansas. They purchased lots of plans around the country. They came to Kansas.

The thing that was different about the Kansas plan is that it was in good shape. It was robust financially. The consumer scores were great. It had a great reputation. It was a different type of transaction. The ones that they had purchased before were like in financial distress. They were troubled companies.

© 2026 Kansas Oral History Project, Inc.

When they met with us at first, I don't think we had a sense that necessarily it would be declined, but as time went on, it didn't seem to have consumers in mind. If you compared what Anthem did back then and what Blue Cross did back then, Anthem didn't do anything better than the Blue Cross plan, and the only difference appeared to be that Anthem was going to use some of the reserves to drain the reserves down a little bit, and they probably were going to charge higher premiums because they had a margin expectation.

So, when you begin to look at it, you're like—what the insurance commissioner was there to do by statute was to protect the consumers. It wasn't clear how this would make consumers any better off. In fact, she came to believe that it would make consumers worse off in Kansas. They would lose their local company. They would lose it to a for-profit large company. So, she ended up declining the transaction, which was an unusual move at the time. That hadn't really been done before.

BSP: I remember the number being thrown around was around 250 million or something like that was the anticipated potential increase in premiums for Kansas policyholders.

MA: Yes, it was going to be substantial, at least a few percentage points. For Commissioner Sebelius, it just didn't make sense for consumers to do that. They weren't going to get anything better for paying more for their premiums.

BSP: Then it turns out that her decision was then challenged and had to go through the court system and eventually the Kansas Supreme Court weighed in and determined that the commissioner did have the authority to deny that sale. What were some of the legal principles that were in play in that?

MA: So, it was in some ways kind of a classic administrative law case. They looked at it, and they tend to defer to the agency involved, and they deferred to her. Basically, the Insurance Department had to show there was a substantial basis for the findings, and they were able to do that. I wasn't surprised that it was upheld by the Supreme Court. I don't think it created any new law. Basically, they just said, "Look, we have an expert here. That expert is supposed to weigh the evidence and make a decision. Unless it's an unreasonable decision in some way, unless there is no evidence for the decision, we're going to defer to that agency." That's what they did.

BSP: Have there been implications of that ruling here in Kansas, either in other states or—how has that decision impacted the insurance industry in the years since?

MA: There have been consolidations since. Anthem has had fewer. In fact, they had one that probably was going to be denied just recently in Louisiana. I do think that it set a precedent that this can happen. You don't have to approve these, and you should look at this from the consumer's perspective. Is this going to be good for them or not? I think it probably encouraged some insurance commissioners. It sent a signal to whether it's Anthem or anybody else that these things are not necessarily a done deal when you propose them.

For Kansas, what it did is it meant that we still have a mutual not-for-profit local company here that serves just Kansas.

© 2026 Kansas Oral History Project, Inc.

BSP: Yes. This whole issue and the public discussion around it have really elevated the profile of the commissioner, Kathleen Sebelius. She then ran for governor and was elected governor, and you followed her to the governor's office. Tell me a little bit about your role there, and how that was.

MA: Sure. First off, I'd just like to say that it surprised me, the big public issue that it became. Commissioner Sebelius had a series of listening sessions around the state. The first one was a Hays, at Fort Hays State University in this enormous room. I thought, "No one's going to show up to this. This is like an insurance transaction." Then about twenty minutes before it started, people just started pouring in, and we had to get more chairs and more chairs. It was a packed house, and it became clear to us, this is something that Kansans really care about, more than we imagined.

BSP: Yes.

MA: So, I wasn't surprised by the end that it became a big news story. She got elected governor that year, 2002. Of course, we're in a very difficult position as a country at that point. She was nice enough to take me along with her as her chief counsel. What an honor that was. It was truly the privilege of a lifetime to be able to serve in the governor's office. Because I had been her assistant commissioner, I had a little bit different role than a chief counsel might have had. I was both the lawyer for the governor's office but served in a broader advisory role. Occasionally, we'd help write speeches and things like that.

It was a small group. So, you had to do a lot of different things, but it was great. She's a great client as a lawyer. She listens. Her husband's a lawyer. She's used to that. It was truly just a glorious four years for me. I felt like it was a privilege to be there.

BSP: You were working for the same person, but in one role, she was commissioner of insurance and in the other as governor. How was that different?

MA: First of all, like I said, she was my client at that point. There's a difference in the relationship if you are like her chief assistant. Those specific roles are all encompassing. When you're her lawyer, you have kind of a more defined role, and it's one that was great just from my relationship with her. We were able to draw some lines there that I think just deepened our relationship, and it was great.

But, of course, working for the governor is a more broader swath of activities that you're dealing. There's a much greater weight to that office. Anything you do can be in the newspapers. It was a consequential time in Kansas. There were a lot of things going on, school funding.

BSP: Lots of challenges.

MA: It was a great time to be there. I think you felt the weight of responsibility differently in that office than you did in the insurance department.

© 2026 Kansas Oral History Project, Inc.

BSP: At the end of her first term, it was clear she was going to run for re-election. That's about the time that you left the governor's office and actually went to Blue Cross and Blue Shield. Tell me a little bit about that decision.

MA: She got re-elected. At that point, it felt like it was probably time to go. Everybody has to answer that for themselves. A lot of people stayed on for the second term. She, of course, ended up going to Washington, DC, and many people followed her there. But for me, it felt like it was time to go on a different path. We left on the best of terms. It was very emotional when I left because I really appreciated her so much as a mentor and as a great boss.

It was truly just a stroke of luck that there was a job open at Blue Cross that I was actually qualified for. I admired the company a lot, having been a regulator, having had a Blue Cross card as a state employee. Their general counsel position was open. I applied for it, and before I knew it, I was working that at Blue Cross.

BSP: You mentioned a few years later when the governor was appointed to the Cabinet in the Obama administration, many people from Kansas did go there. I think a lot of people were surprised in some ways that you didn't go with her at that time. I know that the potential of thinking about a political career for you has come up even recently, people trying to recruit you to run for governor. Are you done with politics?

MA: Probably. Honestly, it's not even something I think about. Someone called me and heard that I was running for governor. I said I have literally never thought about running for governor. We all got a good chuckle out of it. They said I had declined to run. I'm like, "To decline, you've had to actually consider it, or someone has to tell you it's a good idea. Neither of those things happened."

I'm very happy contributing in a different way. I think politics is a tough business. There are things that you have to do, especially nowadays in a polarized environment that I just don't think I would succeed in that environment. So, I'm very, very happy to be doing what I'm doing.

I didn't go because I really loved the job I had. I had a family here, and I didn't want to uproot my family. The plan has always been to stay in Kansas. So, I never even considered it.

BSP: Well, that's awesome. We're glad you did.

MA: Thank you. Me, too.

BSP: This is the time when you went to Blue Cross and Blue Shield. First, tell me about the company itself. It's obviously the largest health insurer in the state of Kansas. Tell me a little bit about the history of the company, how it's organized, and what people would be interested in knowing about it.

MA: It was founded in 1942 by a guy named Sam Barham who was from Alabama but happened to be living in New York. This was around the time that a lot of these Blue Cross/Blue Shield—originally a Blue Cross plan—were being set up around the country. So, he had an opportunity to

go to Topeka and set up a Blue Cross plan in Kansas. I never met Sam Barham, but especially when I got there, there were some people who had worked with him. I think his spirit in many ways was still there. He was a very service-oriented person. He believed that we were there to serve the communities and the people of Kansas. He was very service oriented towards his employees as well. I think that kind of culture still lives on inside the company.

He founded that in 1942. He was its first CEO all the way into the seventies. I'm just the eighth CEO there, even though it's been around for eighty-four years now, but he took up several decades.

It is today a mutual not-for-profit company. It's basically a company that is set up not to make a profit. Of course, we have to be sustainable and strong enough financially to withstand the volatility of health care, but we're there ultimately to serve our members who live here in Kansas.

We're in basically anywhere there is health insurance risk in Kansas. We're in those markets. That's unusual for us. Most of the big for-profit nationals will be in this market or that market. We'll be in every county that we serve in any market.

BSP: And you serve all the counties in Kansas except for Johnson and Wyandotte?

MA: Except for Johnson and Wyandotte. So, 103 of the 105 counties of Kansas. There used to be a lot of these municipal plans. Kansas City is one of the last of those. We serve what I call the Kansasy part of Kansas and proud to do it. That's where I come from.

BSP: Yes. Being the largest insurer, there are lots of numbers that get thrown around.

MA: Yes.

BSP: Things I've read suggests that Blue Cross has about 70 percent of the commercial insurance market. Over a million people in our state are insured by Blue Cross and Blue Shield, about 1 in 3 Kansans. So, it has an outsized sort of impact and presence in the state. What does that mean to you as a company and particularly to you as the leader of that company?

MA: It's important to get specific about numbers like that. I think what you're probably referring to is the employer-based, fully insured market. So, the large and small group markets, where people actually pay premiums, and then we pay claims. We take the risk on that.

So, it is true we have large market shares there in both of those markets, small and large because we're willing to do it, and the large nationals tend not to want to be in the small group market in Ellsworth. It's volatile. It's very risky. Their scale advantages don't help them. But we feel that it's part of our mission to be there.

Most Kansans get their health insurance, if they get it through an employer, what's known as the self-insured market. So, the risk is really on the employer. We're in that market, too. We sort of go toe to toe. It's a much more competitive market.

© 2026 Kansas Oral History Project, Inc.

I don't think having a large market share is either good or bad. It just sort of depends how you deal with that and why you have a large market share. The reason why we do is that it's part of who we are. We're going to be anywhere in Kansas. We have a service orientation toward our members. It's important for us to be there.

For me, it's why I love being at Blue Cross is that I want to serve the state. I want to be part of the solution in health care. There's no better place for me to be than where I am.

BSP: You talk about your presence in the community. I know from some of the work that I used to do that you guys have been involved in funding some community programs that look at health promotion sorts of activities. What compels an insurance company to do that sort of thing?

MA: I think it's part of our service orientation. One of our core values is service. We talk about that all the time. It definitely means traditional things like customer service and community service, but I think it answers a fundamental orientation—the question about how you're fundamentally oriented towards the world. The question is: Am I out here to serve myself, or am I out here to serve others? The core value means that for us.

We also organize our work around four big themes. One of them is invest in healthy communities. So, when I talk about that, I talk about the history of the company. We were raised by the communities of Kansas, town by town, and putting our network together back in the 1940s and 1950s. So, we still feel like we have a responsibility to serve them.

So, we do it in a variety of ways. Some of it is very traditional community service like the United Way in various parts of the state, donations to worthy causes. But I think the more compelling activities comes to what we call Blue Health Initiatives. This is a program that our board set up ten years ago where they have earmarked millions of dollars of reserves to go directly into communities to fund public health projects.

So, the signature program there is the Pathways Program. Over the past ten years, we've helped fund things around the state. These are led by community coalitions because we think they know best what will help the health in their communities. There are walking trails. There are farmers markets. There's better food on school menus or in local restaurants. There are things like that that allow people to live better lives.

So, we're proud to do that. I think it's part of our service orientation. It's part of our responsibility to the state. It certainly is part of our culture.

BSP: We'll talk about insurance in general in a little bit. One of the theories back in the era maybe when managed care was really on the rise was that insurance companies doing that, managing the health of the population in the area they serve would somehow come back and benefit the insurance company financially, and the people paying premiums financially because it would save money. Has that really played out? Is that why you do it? Or is it some other reason that you do it?

© 2026 Kansas Oral History Project, Inc.

MA: We certainly hope that it will bring down the cost of health care long term, but that is a really hard thing to measure, and we never like in our premiums or in our financial expectations add any of that in. We're doing it because we think it's the right thing to do. We think it's part of our role in the state.

All of those things you're talking about are long-term bets that you hope come true and are extremely difficult to measure. There are so many factors in public health. Specifically, we get down to the individual. Is someone not going to have heart disease because we've invested in a farmers' market and a walking trail in their community? You hope so, but there's so many other things that are going on in somebody's life.

BSP: And patients may switch insurance companies every once in a while.

MA: They do.

BSP: Maybe that benefit wouldn't accrue to the company that invested money in the first place.

MA: For sure. You should do it because it's the right thing to do. You should be in public health because you're there to improve the health of people that you serve and not expect it for them to have a financial benefit.

BSP: One more thing just about Blue Cross/Blue Shield and Kansas specifically. You don't use brokers to sell your product, and people comment on that a lot, that's it's unusual. Talk about that. You mentioned before the strong culture within the company. Talk a little bit about that.

MA: So, we use them more than we used to. We've always used them to some extent, but it is true that we have an internal sales force more than most companies do. The idea there is that they know our company. They know our benefits. They know the way that we do things, and they can develop a relationship especially with like a small group. I mentioned like a small group in Ellsworth. You have that same person coming to you year after year, you can develop a relationship and some trust. They know us, but we also know them.

But there's some markets, like the large, self-insured market where you have to use brokers, and usually an employer will employ those brokers. Then what we've learned actually over time is especially in the senior markets, people really want to have a local agent, someone they know from the community. They go to church with or something. That's usually how you get those relationships. So, we found that to reach more Kansans, we need to have more relationships with more brokers. That's within the last couple of years we've done that.

BSP: Okay.

MA: But it is unusual. We are atypical. Most plans have a very, very small sales force. We have a pretty large one. The thing I'm proudest about, other than the fact that they're really great people is they're spread throughout the state. We have an office in Pittsburg. We have an office in Garden City, an office in Hays. You just aren't going to get that from somebody else.

© 2026 Kansas Oral History Project, Inc.

BSP: Yes. Let's move to thinking about insurance more generally, not just Blue Cross/Blue Shield of Kansas. Insurance is a very big part of a family's budget. It's a big part of the state budget, as you learned.

MA: It's too big.

BSP: And it's a big part of the federal budget.

MA: Yes.

BSP: Yet I think a lot of people don't really understand some of the basics, the fundamentals of how the insurance industry, the insurance market works. Tell us a little bit about how insurance works. Why do we have insurance?

MA: Wow. This may take up the rest of our time. At the most fundamental level, insurance, whether it's in health care or in anything else, is a way to pool risk. None of us could afford replacing our house, for example, if it burns down. It would financially harm us. So, you pool risk, hoping that moment never happens, but it might. The same goes for health at the most basic level.

What a health insurance company does is you pool that risk, evaluate it, and eventually you have to have a price. This is what it costs to cover this pool. You convert that into a premium.

But health insurers do a lot more than that. We assemble a network. Our calling card has always been to have the broadest possible—

BSP: Network? Explain—

MA: A network of doctors and hospitals and nurses and physical therapists.

BSP: So, a patient that buys Blue Cross/Blue Shield insurance has places that they can go, doctors and hospitals.

MA: Right, some health insurance companies will have a narrow network, and they'll try to get a better price for that, but your doctor might not be in network. That can be an issue. Our approach has always been to try to have a very broad network. So, anywhere you go in Kansas, you can get care.

We evaluate the risk. We try to manage care in many ways. If you have a chronic illness, we would try to find ways to help you get the right type of care that you're adhering to medication, protocols, and so forth. We provide customer service. There are all sorts of things that we do, but fundamentally what we're trying to do is evaluate the cost of care and control it in some way so that it is affordable. You have access to care when you need it at a price that you can afford, but that cost issue and the affordability issue remains the biggest issue in health care.

© 2026 Kansas Oral History Project, Inc.

BSP: Yes. We'll talk a little bit about where we may be going. People tend to talk about their doctor and their health care provider generally positively. "I like my doctor. I like that hospital. I had a great experience there." I haven't heard a lot of people just volunteer to me how much they love their insurance company. Tell me a little bit about that. You occupy a space within the health care system that's different than a lot of the other players.

MA: And it's not surprising, and it doesn't bother me. I do like to think that our members appreciate us. We ask that question a lot. We survey our members and really take a look at ourselves when we get negative responses. But it's not surprising that they would look at us with frustration because we are often there in friction points when there's a question about whether something is covered, whether it's medically necessary.

The other big thing that we do is we present the price tag for the health care system to the people who are paying for it, and that is often where the frustration comes. I love my doctor. I have nothing but admiration for people who go into health care and provide health care. One of the reasons I'm in this is I think health is so important. This is not a critique of doctors or people in hospitals. They largely exist in a market where there isn't the same type of price discipline that you see in other types of markets.

When you go to a hospital, you may pay a deductible. You may pay a copay, the same if you go to the doctor. But you don't see the full cost of what's happening. You don't see the cost of the salaries of the doctors and of the administrators and of the upkeep of the building and all the other costs that go into it, the medication that's administered.

So, when you see that cost, it is in your premium. That is why. I don't expect for consumers to piece all of that together, but it is one of the harder parts of our job because, especially in times when health care costs are going up, we're the ones that have to deliver that news to employers sometimes to individuals. So, I'm not surprised that oftentimes they're frustrated with us.

BSP: So, the price that you have to put on the insurance product, the premium, is really reflecting the underlying costs of the health care that the insurance is providing.

MA: Correct.

BSP: You're the one that has to put that price tag on that.

MA: Premiums are high because health care costs are high.

BSP: Yes. You mentioned sometimes people in the health care system aren't as tuned into those health care costs. I can remember when I was a resident, they came up with this idea that all the residents should carry a little pocket care that had the price of all the lab tests and x-rays and common things that we would order. There were days-long debates about the ethics of that. Should physicians actually consider what it costs to order this blood test, to order that x-ray, or should we just do what's best in the interest of the patient. Introducing that sensitivity to price is a very delicate issue.

© 2026 Kansas Oral History Project, Inc.

BSP: It is really delicate. It's one that we take really seriously. We were, as we talked about before, a mutual not-for-profit plan, and we take that really seriously. There's nobody in the company that has any financial incentive, whether it's the individual employee all the way to people like me and my colleagues who have any financial incentive to deny care, but we still have to sometimes. We have to shape care in a certain way to try to keep it somewhat affordable. But I am fully attuned with the ethical issues that are involved there.

We have to make a choice as a society what we want to give Americans access to in their health, and we have to make some decisions of how much that should cost. We've never really grappled with that issue. We have at pockets—there's moments that we have. There are provisions of the ACA. There are provisions of Medicare. But for most Americans, we sort of allow it to be determined by the interactions between the insurance companies and doctors and hospitals. That system has not shown itself to be able to control costs in a way that are satisfying to consumers. That is the central issue in health care today.

BSP: Cost of health care.

MA: Cost. If we could solve the cost problem, you could solve lots of other problems. You could begin to address access, quality, all that kind of stuff. But until you get costs at least predictably under control, it is always going to be really difficult.

BSP: I agree. People talk of the three-legged stool with cost, access, and quality. I would agree with you that if you solve the cost issue, that makes the other two much easier to address.

MA: Let me describe the situation from kind of a market perspective that insurance companies are in. We're in a two-sided market. On one side, we have consumers, and we hope that they appreciate the serve that we give, the network that we have, and there's a price tag on that, the premium.

The other side of this market is the providers. We want to let people in network. We have to set reimbursement rates. "This is how much we're going to pay you, Dr. Smith, for seeing somebody in your office." The same thing with hospitals and so forth.

So, we have to sort of navigate that kind of midpoint between these two markets and find a way to make it work, both for providers and for consumers. That's a real challenge.

There's a third part to this market that doesn't have the same type of price discipline and that's what I've been describing. When you go to—let's say you're sick, and you need pretty significant care. This is a big difficult moment in your life. You didn't imagine this was going to happen to you, and you're stressed out. You don't have a good way to evaluate where to go, and you're not really thinking about price at that point. You're not able to put a price tag on all of these different things, and you're not even sure you should. I think at that point we should allow people to get the best health care they can, but that market doesn't have the same type of price discipline. When we go buy a car, go buy an office chair, you know the quality or have some sense of it, and you can put a price tag on it. It is impossible for consumers to do that. So, those three things together make it really difficult to control the cost.

BSP: Yes. I want to come back in a little bit to what some of the approaches are to maybe begin to do that. But you mentioned a couple of different times different markets, different segments of the market. You talked about large employers. It seems like in our country, for many people, maybe the majority of people, our insurance is tied to where we work. Talk about that relationship, how that developed. Is that a good thing or a bad thing?

MA: It's an accident of history. It happened in World War II. There were wage controls during World War II. One of the ways that employers were able to buy better benefits was through health insurance. That's its genesis. It's since been changed with the tax code or fortifications of the tax code that make that preferable for employers.

BSP: If employers couldn't pay their employees more directly in wages, they could buy them insurance coverage, which would also then be a deductible expense to the company and not taxable to the employee.

MA: That's right. That has lasted this long. Not everybody gets their insurance from their employer, but most do, if they're not in the senior market. There are some benefits of it. It provides some stability. It allows employers to provide certain benefits to their employees. It's a way to organize the care. But there are a lot of downsides to it. It gets employers in the business of health care. They want to run their business. It's a huge stressor especially for small businesses. Sometimes, it prevents people from taking different jobs or leaving a job because they don't want to lose their health care.

I think when we solve this, and I say "when" because I think eventually, we will, in the long run, I imagine part of that will be at least starting to moving away from the employer-based system. But that's probably a long way in the future.

BSP: Not next year.

MA: No, almost certainly not.

BSP: You mentioned a couple of times assessing risk and sort of trying to understand, anticipating what the costs are going to be for a certain group, whether it's a company, a certain type of person that's looking for insurance, talk to me a little bit about how that varies, and how insurance companies handle that variation. The fancy word I guess is "underlying actuarial risk" for those groups of people.

MA: It varies dramatically depending on the market. One of the great things about the ACA is that you are not able to evaluate someone who's in the individual market on the basis of their health. So, the idea there is we want to cover everybody and rate it based on the health of a population.

BSP: Compare that to how it was before the ACA, just for people who may not know.

© 2026 Kansas Oral History Project, Inc.

MA: It was an underwritten market. That means that you would take in a health application, and first of all, decide whether you wanted to cover that person at all. Then you set the rate.

BSP: And if the person had certain conditions that you were afraid might cost a lot of money to get care, then the insurance company could not offer them coverage.

MA: Either not cover that particular condition, a pre-existing condition, or they might rate them up, or not cover them at all. It's just no way to organize health care.

BSP: So, the ACA did away with that.

MA: It did away with that. What that means is it turns out that that pool is pretty expensive. ACA coverage, especially if you don't have a subsidy, is really expensive. So, there is still some work to do in that market.

In the large group market, you can evaluate the group's experience. As a group, what is their experience going to be? Then the premium is broadly speaking based on the experience of that group.

If you have a group of 500 and it's a really healthy group, then you may have a really good premium. If it's a really unhealthy group, if you have people with chronic conditions, there's lots of different ways for it to be expensive. Then you would rate it higher, and that makes sense from an insurance perspective, and there's no way to be in that market without doing that work.

But I think the fundamental philosophical question that we have to ask as Americans is "Is that how we want to do this?" Health care, this is different from property insurance or auto insurance where you get in some wrecks, you probably have to pay a premium. If you get a lot of speeding tickets, you probably ought to have higher premiums. I think health care from an ethical perspective is different. I hope that someday we get away from this business. I think part of what is so frustrating about health care even for large groups is that even though it is not arbitrary, it is based on the numbers, it feels arbitrary to them. It's also so core to living a good life, having access to high-quality health care that I hope that someday we're able to get to a different place.

BSP: Yes. You mentioned things that can affect the underlying cost of care. I can't help but think of the pandemic. You were the head of the company when we went through the pandemic. Tell me how that impacted your company and the insurance industry more broadly.

MA: I mean, it was a seismic moment for all of us, not just us. It certainly affected us a lot because we're in health care. We were tremendously worried about our provider partners. Being a local company, I know who runs Stormont Vail. I know who runs LMH or Wesley, and I know what they're going through. I talk with these people. So, you had a really keen sense of the trauma that was going on in those institutions, in those hospitals, in those ICUs. I don't think any of us had any idea what this was going to mean for the health of Kansans, what it was going to mean for the health of the health care system, the stability of the health care system, but we got through it.

© 2026 Kansas Oral History Project, Inc.

BSP: And the cost.

MA: And the cost. We were not even thinking about cost at that point. In fact, in a strange way, it lowered the cost temporarily because people weren't going in for elective services. That all came back later, which it should have, but it was a traumatic experience. For me personally, what surprised me is that although I thought about all those issues, we had a lot of great people working on it, probably the thing that kept me up most at night was my role as an employer. Back then we had very few people who worked at home. We had very few remote employees. This was before all of us knew what Zoom was and teams and things like that. We had 1,450 people coming to work on a campus in Topeka every day. We weren't well equipped to send them home. I realized that my first responsibility was the health and safety of my employees. So, we found a way in a few weeks to begin sending people home.

We are much more spread out. In the long run, I think it's been good for us as a company because we have somebody answering the phone in Dodge City as opposed to everybody be in Topeka. We're able to get better people, and I think they're a better representation of Kansas because we're more flexible in the way people can work. In the moment, I was really worried about it.

So, what we did is we decided we just need to be a force for good in this. We did a variety of things. We made grants to plus up the infrastructure for telehealth. If you were a small provider in Plainville, Kansas, you could make an application for us to do a grant to establish better telehealth communications infrastructure and various things like that, just to try to help us through that. I was very proud of the work we did.

The question we asked, what we established as a team was, "How do we want to be remembered during this moment?" I don't know that anybody's thinking about what we did back then, but to the extent that we look back on it, we're proud of the role we were able to play.

BSP: It was a seismic event for all the aspects of the health care system, that's for sure.

MA: Yes.

BSP: When I think of insurance companies now, and again, this may not be Blue Cross/Blue Shield of Kansas specifically, but a lot of insurance companies are very large. There's a lot of integration, consolidation across insurance providers as well as integration with other parts of the health care system. Talk to me a little bit about that, and then I'll come back and ask a little bit about your role, your company's role in particular.

MA: For sure. That is definitely a role, and it's both kind of horizontal consolidation where companies have merged together, but also, as you described, vertical integration where they're purchasing practices, to some extent, even hospitals.

BSP: CVS and Aetna are now one company.

© 2026 Kansas Oral History Project, Inc.

MA: Yes, and they're huge organizations. We don't look at this in a tremendously competitive way, but our top two competitors aren't just Fortune 500; they're Fortune 10. These are enormous organizations that are investing a lot in research and development. And there's a place for that. It does make us more distinct than probably we were back when the Anthem merger was on the table. These are huge organizations.

So, what they're trying to do is just integrate all of it. They're trying to have a more seamless experience and just try to keep people in their system united with their providers and so forth.

BSP: They would argue both to control cost and improve outcomes.

MA: Yes. I don't know if they can prove that, but that's certainly what they're trying to do. So, we have a different approach. We think that health care is fundamentally local, and we do think we need to have sufficient scale so that our administrative costs aren't high. So, we have various partnerships with other Blue plans to try to share costs around certain things. But we believe that health care ought to be at the local level, and that we should try to support that. It's just a different worldview.

BSP: Where do you think this is heading? You have a trajectory here in Kansas that's worked for a considerable amount of time. A lot of trends are evolving around the country. Let's start with health care more broadly, and then maybe I'll come back specifically to the insurance industry.

MA: I think we're in a tough spot now. The trends in health care in terms of costs have not slowed down. In fact, I think we're going to see that 2025 was a big spike just by all the early indications. It was for us. We're happy to pay those claims. We're happy to pay for that health care. It's what we do, but it has to be sustainable. So that system that I described has not shown itself to be capable of making those trends match what we needed them to match, the growth in the economy or wage growth and so forth.

So, there's a day of reckoning that I think is coming in health care. That sounds dramatic. I don't think it's going to happen just in one big moment, but we're going to have to get control of these costs because it's getting to the point where employers don't want to do it anymore. It's the largest source of our structural federal deficit. It is something we're going to have to deal with, and I don't think that we've shown the discipline as a system to do that.

I'm optimistic about us as a company, but I worry a lot about the health care system. What has typically happened in the US is in a pivotal political moment, Congress will act. They'll change the structure in some way. In the mid-sixties, you had a couple of wave elections. So, Medicare and Medicaid were passed. I'm so glad they did because they addressed issues for seniors and for the poor and for people in various parts of our community. And then you had the '06 and '08 election, and the ACA was passed. I'm glad it was, too. I think it made things for a lot of people a lot better. It's an incomplete solution.

So, I do think what's going to happen, I hope is—it doesn't have to be the Democrats winning. There are many ways to do this. But I think we're going to have another moment where there are

© 2026 Kansas Oral History Project, Inc.

enough momentum and a coalition that's willing to have some ideas that pass Congress. That's probably not going to happen this year. It's going to be another few years down the road.

BSP: For certain policies, people advocate incremental changes and maybe slow change. Would that work in the health care system? Would it take a large comprehensive sort of approach?

MA: It could help. We do have the pieces and parts there. You can fortify the ACA. You can fortify and expand Medicare and Medicaid and at least fill some gaps. What I don't think any of the laws have done is get a hold of the costs. So, that is probably going to take something that is brand new.

There are a variety of bad ways to do it because what you have to understand is we depend on the health care system, and we have the health care system that we currently have and getting from here to a more kind of cost sustainable system is going to be difficult. It's going to be a difficult transition, and it's not just the doctor salaries that they're paying. I mean, Stormont Vail employs thousands of people. It's a great institution. It does tremendous things for the community. There are technicians and janitors and families that are affiliated with that organization.

What we want to do is control costs in a way that allow these institutions to remain vibrant and allow the health care system to give great access to high-quality care. So, it's really easy for me to say, "Let's just say 150 percent of Medicare," but that's probably a bad idea. There's probably a more nuanced way to do it, and it's going to take time to do it.

BSP: Yes. Let me talk about a specific aspect of cost, and that's the explosion of knowledge and technology and the availability of new drugs and the ability to individualize and personalize treatment for rare conditions. Those things aren't cheap.

MA: Right.

BSP: An individual that may be afflicted with one of these conditions isn't going to be able to pay $100,000 a year for ongoing treatment. How does our system balance the promise and the advancement of science with cost?

MA: I don't think it balances it well. You're getting at exactly the type of issue that the system has not dealt with well from an ethical perspective, from just a human's perspective. I want that person to get that care, but it has to be in a way that allows the system to be sustainable. I don't have a sort of easy answer to that. It's something we're sort of finding our way through.

GLP-1s are another one. These drugs like Ozempic that a lot of people lose weight apparently have tremendously positive benefits for a lot of people so early—

BSP: Beyond just losing weight.

© 2026 Kansas Oral History Project, Inc.

MA: Yes, potentially, but they're really expensive. So, there are a lot of employers that don't cover that anymore because they can't. So, finding a way to make that happen is sort of the central challenge of our time.

One thing I haven't said that's really important to understand about health care is, it is highly concentrated about health care costs. So, we spend about 20 percent of our health care costs on 1 percent of the population. We spend about half of it on—5 %

BSP: Say that again. Twenty percent of health care costs—

MA: On 1 percent of the population each year, about half on 5 percent. So, if you're in the less expensive half of health care consumers, you take up less than 4 percent of the overall spend in health care.

BSP: Yes.

MA: So, what that means is that the people we're spending our money on really need the care, people with chronic conditions. These are people who have been in traumatic accidents. These are people with metastatic cancer. These are premature babies. What makes this so hard is the question of how you make that care available but affordable. That's why this is so hard.

BSP: The first response you gave when I asked what does insurance do, you said it pools risk.

MA: Yes.

BSP: Which is basically getting right to the point that you just made again. How do you make the cost for the care of 1 percent of that 5 percent, how do you spread that out across enough people to make it affordable, not just for the patients that are affected, but for everybody else who's paying premiums as well?

MA: That's right. You mentioned the wonders of science. It's truly inspiring. We talked about the individualized medicine and gene therapy. I want that for people. I've been lucky to be in good health so far, knock on all sorts of wood here. My family has been in good health. It may not always be that way. Very likely at some point in my life, I will be one of those people that want the best of care. So, I want that for our members as well. But I also know how difficult it is when one of our members or a small employer gets their premium. So, finding our way through that—that's why I think we're going to need as a society, as a country, we're going to have to find a way to grapple with that issue. We just haven't done it yet.

BSP: You've described a daunting scenario for us to face as a state and as a country as a health care system. Let me step back a little bit outside of the insurance world and just talk about how healthy we are as a state and as a community. I'm sure you've seen the reports from America's health rankings put out by the United Health Foundation every year that have showed the relative ranking of Kansas has slipped quite a bit compared to other states. At one point in 1991, we were ranked the 8th healthiest state in the country. Over the subsequent years, we decreased to a low point of 31st in 2022. We've come back up to around 27th in the last rankings from 2025.

© 2026 Kansas Oral History Project, Inc.

But Kansas isn't the only state that's faced the challenges that you've been describing. As you're heading a company that thinks of the health of our state, that serves such a large proportion of our state, how do you see that? Are rankings helpful to you? Does it get your attention? How do you think about that?

MA: We don't think a lot about the rankings. I think we observe them, but it's not why we do our work Even if we're the #1 state, we\d be doing the same type of work because the work never ends. But I do think its something we also need to grapple with here in Kansas.   Why has our ranking dropped so much? I think we need a broader strategy as a state around public health. There are things relatively easy we could do around health coverage, some decisions that the state hasn't made to cover more people that would at least help some. There's also, I think, we're not particularly good at behavioral health in the state. We don't have enough providers which is really integral to all of the things that you're describing.

My hope is in the coming decades that there'll be a coalition around the state that will really grapple with this. I wouldn't just base it on rankings. I would look at kind of a broader set of information about how we evaluate this, but I don't think we're doing well enough. The public health infrastructure in Kansas isn't strong enough, and there are things we can do to make it better, but it's going to take a concerted effort.

BSP: You mentioned providers. I think you were talking particularly around behavioral health, mental health issues, but we know that providers in general, not just physicians, but advanced practitioners, bedside nurses, lots of technical staff in the health care system, how do you think of the health care workforce challenges that we face as a state?

MA: It's one of the biggest challenges we have, especially in rural Kansas. It is hard to recruit a doctor to a small town in Kansas and keep them there. It always has been. It's hard to keep your hospital open. The structure isn't there to allow that to happen as easily as it used to be. That's part of the problem.

But we're not going to solve that easily. So, given the world that we have and the issues with the decline of parts of rural Kansas, how do we make health care available? That's going to take a concerted effort. Advanced practitioners may be a way to go, but there's not going to be one silver bullet solution that makes it happen.

BSP: You mentioned telehealth as sort of an outcome of the whole pandemic situation. There's been a lot of controversy about telehealth's place and the appropriate reimbursement for the sorts of services. Do you see telehealth as an opportunity for the rural parts of our state?

MA: Sure, but I think it's no substitute for seeing a doctor. I think most people want to actually be in the room with their doctor, but it can serve a good purpose. Let me tell you, during the pandemic, we expanded telehealth dramatically. I may get these numbers wrong, but I don't think so. We began to look at who—we had a spike in telehealth, of course. We began to look at what codes are being built in telehealth. I believe it's true that sixteen out of the top twenty codes were related to behavioral health in some way during the pandemic. Now, maybe that's because

© 2026 Kansas Oral History Project, Inc.

it was during the pandemic, but I also just think there were a lot of people hurting, and that's care that they needed right then. It's not something where if they scheduled something two months down the road that that was going to be satisfactory. They needed to talk to somebody right then.

So, there are moments like that that are helpful. My parents, my dad had Alzheimer's at the end of his life, and it was hard for my parents always to go in and see their specialist. So, they were able to get on my mom's iPad and have a conversation and not get on the highway. So, there are moments where it's helpful. But it can't be the only solution, as you know. You still need to have a good enough infrastructure, a physical infrastructure in those communities.

BSP: Yes. You mentioned mental health providers. The other way, in thinking of the ranking again where Kansas fares relatively poorly, is oral health providers around the state. We have a real shortage there, and in particular, pediatric children's behavioral health/mental health services are areas where we really stand out.

MA: For sure. I mean, if you're a parent and you've got a child that's struggling in some way, it is really difficult to find an appointment, and that shouldn't be acceptable to us. We can only do so much as an insurance company. We can try to set our reimbursement in a way that allows a psychologist or a psychiatrist to have a good practice and see a lot of patients, but at some point, there's got to be a more structural or sort of concerted way to recruit and retain more of those folks in Kansas.

BSP: Yes. I'm thinking back to the rankings. The other area where we tend to not do as well, below average, is in some of the behaviors around being physical in activity, diet, and tobacco use.

MA: Yes. That's exactly why we have Blue Health initiatives and the Pathways program is to try to get people moving more, to have better food available to them. Smoking cessation has been a big part of that as well. I think the whole country is doing better around smoking than it was back when we were young. There were a lot of people who smoked. But we're just one player, and obviously we can't do it all ourselves. There are others who are trying to do that as well.

But, look, the point there is—it drives home the point that this is a complex, multifaceted issue, and we can have all the doctors and nurses and behavioral specialists and fantastic hospitals in every community in Kansas, but there are broader societal issues around the way we eat, the way that we exercise, how we take care of ourselves that are going to have a huge impact on that as well. It's got to be kind of a global comprehensive effort to make Kansans healthier.

BSP: Perhaps those are the kinds of challenges that more appropriately belong in the offices of some of your previous bosses, like our insurance commissioner and our governor. Those really are very large, global sorts of society wide issues that have to be addressed.

MA: They do. They belong in the Statehouse. They also belong in Washington as well. I do think health care ought to be done locally. So, there's an important role—each state's different. The challenges of Kansas are going to be different than the challenges of California. My hope is in time that the state government will take this on, that there is a broader public health approach.

© 2026 Kansas Oral History Project, Inc.

I will tell you, I have so much admiration for the people in state government who work on these issues, not just the state government, but in local government, your county and public health officers. These are tough jobs. They're tougher now than they ever have been.

BSP: They're all—and large employers, too.

MA: For sure.

BSP: They're having to provide, pay those insurance costs for their employees.

MA: That's right. The people who go into those careers, I admire greatly because they're hard jobs.

BSP: Yes. We've talked about public health and thinking of maybe bending this cost curve, the cost of health care, is public health a viable sort of approach to make an impact on that? One we haven't talked about, I just want to wrap up with, thinking of data and electronic medical records. I know the insurance industry for decades has been one of the leaders in the use of data and information to try to manage costs, improve outcomes. How are we going to bend the cost curve? What role does data and public health approaches play in maybe getting to make an impact there?

MA: I think it's going to have to be a multifaceted approach. Public health has to play a part. It's not just to bend the cost curve. I think we just want people to be healthier. You hope in time that it's going to bring down the incidence of chronic disease—fewer people with diabetes, fewer people with heart disease. I do think in time if we do well, it will, but that's a long-term play. You're not going to see the results of that for a decade or longer, really. It's always going to be hard to measure. We should do it anyway because it's the right thing to do.

The use of data is important. We use it in everything that we do. But health data is really fragmented in Kansas and everywhere, whether it's insurance or just public health information. So, I think having a public effort to really understand the data in Kansas would be helpful, but it's going to be hard work. But absolutely, data is going to inform all of this.

BSP: My view is that health care is so expensive. We spend so much on health care, and maybe having better data isn't going to fix everything, but even if you make some marginal improvements in cost and in outcomes, you're making a small percentage improvement on a very large base of expenditures.

MA: Yes, I don't mean to suggest that I'm not excited about small improvements. I love small improvements, but we're going to need a lot of small improvements and probably some big improvements over time.

BSP: Yes, and I think people are getting—both health care providers and patients are getting more accustomed to the concept of "There's a lot of my data out there."

© 2026 Kansas Oral History Project, Inc.

MA: For sure.

BSP: "And people have access to my data." Maybe ten or twenty years ago, that was a lot more of a controversial sort of a position.

MA: There is. We still need to be careful, and I think that's something that the health care system generally does pretty well is protect people's data. The few significant data leaks that you've seen out there have been big news, and they should be, but I think we've protected sort of the personal health data pretty well. Look, data's helpful, but it's not going to solve all of this. We're going to have to probably get more serious about controlling costs in different ways than just looking at data.

BSP: I don't disagree. There are opportunities, not just in personal clinical data but even like the things we've learned about looking at CVS and Walgreens, when they start seeing a run on certain types of medication, suggesting that there may be population-level issues with respiratory disease.

MA: Sure.

BSP: Or gastrointestinal disease, those sorts of things.

MA: That's a great use of data. We do that as well. We see indicators that suggest that something's going to happen. That's a great way to use data.

BSP: You can anticipate that.

MA: We can, yes.

BSP: What else should we cover in thinking about health in Kansas and the role that the insurance industry plays?

MA: I sound like sort of the voice of doom and gloom. I actually am really optimistic in the long term. I'm inspired by the work that I'm allowed to do and that so many people do in health care. I do think we'll get to a better place someday. I think it's going to take a mixture of actions in the existing private market but also some movement by our state and federal government to make it better, but I think we will because I think it's too important for us not to get this right.

So, in the short term, it's frustrating. I love the work I do. I wouldn't want to be anywhere else in the world, truly, but we know how difficult it is for people out there to get the care they need in a way that they can afford. But I'm optimistic in the long term. We will find our way to a better place because we have to.

BSP: And I think getting people to focus on the core issue that you talked about of cost and not necessarily just reacting to specific numbers that they see typically in the form of an insurance premium, but it's a difficult thing to educate people about, and not something easy for policy

© 2026 Kansas Oral History Project, Inc.

makers to address, but I'm with you We don't really have a choice. It's going to have to be addressed in the long run.

MA: But I don't think we should underestimate the intelligence of our fellow citizens. We have found that when that issue has been out in the public sphere, when there's a hospital that we're negotiating with and that becomes public, people know why health care costs a lot. They don't always think about it in the moment when they're getting care, but if you ask them to sit back for a second, they understand this is a broader issue. So, that gives me a lot of hope that we'll solve this in the long run.

BSP: Great.

MA: Yes.

BSP: Well, that's an optimistic place to end.

MA: Always.

BSP: Thank you very much for joining me.

MA: It's my pleasure.

[End of File]

© 2026 Kansas Oral History Project, Inc.