IMPLICATIONS FOR HEALTH CARE PROVIDERS RESULTING FROM THE SALE OF KANSAS BLUE CROSS BLUE SHIELD

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Preface

This report was prepared for submission to the Kansas Insurance Department for the Department's consideration as it evaluates the public interest in the potential sale of the Kansas Blue Cross Blue Shield plan (the "Kansas Blue Plan") to Anthem, Inc., a publicly-traded Blue Cross affiliate that owns and operates Blue plans in eight states.

The report considers the general implications for health care providers (doctors and hospitals) in the event that the Kansas Blue Plan is sold. Specifically, how will a proposed sale of a non-profit health insurance company of the magnitude of the Kansas Blue Plan to a for-profit entity, affect the economic conditions that govern the practice of medicine in the State's hospitals and by physicians in Kansas? Because of the traditional non-profit nature of Blue Cross plans and their long-recognized quasi-public mission, these considerations are closely related to several public policy issues.

The report takes an economic perspective on the implications for providers as well as the public policy issues. It builds on the economic analysis performed by the author as part of an ongoing study of similar transactions in other jurisdictions and their implications on markets for health care and insurance.

The author is an economist and lawyer by training. He served as a professor of health management and policy at The Johns Hopkins University School of

Hygiene and Public Health and founded the Johns Hopkins Center for Hospital Finance and Management. Mr. Schramm served as Chairman of the Maryland Health Services Cost Review Commission, the agency that regulates Maryland hospital prices. He currently serves as a member of the Maryland Health and Higher Education Facilities Authority, the agency that issues debt on behalf of non-profit hospitals. Mr. Schramm has served as President of the Health Insurance Association of America and as President of Fortis Healthcare, a commercial health insurance company, as well as Executive Vice President of Fortis, Inc. He is Vice-Chairman of the board of Patient Choice Healthcare, Inc., in Minneapolis, and Chairman of Greenspring Advisors, a consulting and economic research firm specializing in health care.

Findings

This report finds as follows:

1. Kansas Blue Cross Blue Shield was founded and has operated as a non-profit entity to serve a special function in the State's insurance market. Given the continuing failure of the insurance market to provide available and affordable insurance coverage to all citizens, the State and its health care providers have a long history of encouraging Blue Cross to provide coverage to citizens who otherwise would have no option in the marketplace. Blue Cross was established and continues to exist, in part, to mitigate a classic situation of market failure.

2. The Kansas Blue Plan is the largest economic force in the Kansas health care economy. The manner in which it will operate in the future is of enormous consequence to the hospitals and doctors of the State and the citizens who are covered by the Plan, as well as to its competitors. Hospitals and doctors will be affected directly by a change in the managerial objectives within the Kansas Plan; in addition, there will be critical changes in the market for health insurance that will produce significant secondary effects. Such changes in the insurance market will produce significant public policy issues for the State related to the availability of insurance and the price at which it is offered to Kansas citizens.
3. Conversion from non-profit to investor-owned status will result in a reduction of the medical claims cost ratio, the percentage of premium dollars paid in Kansas that are returned as payments to providers of care, doctors and hospitals. The resulting outcome will be reduced payments to providers for the population covered by the Kansas Blue Plan, and/or higher premiums to be paid by businesses and individuals than if the Blue Plan were to remain a non-profit organization.
4. Health insurance is an industry characterized by market failure. Price does not operate with the same signaling effect in health care. The very presence of insurance distorts markets. The intense service nature of the product, relating in many instances to life and death, influences the transactions between and among patients, providers and insurance

companies in ways not to be found in other industries. The arguments that economies of scale will only come with enormous size, that investor capital is necessary to meet future competition and to finance information technology, are advanced as if they are self-evident. In fact, there is scant evidence that larger carriers are more efficient or more competitive.

5. Attending all past Blue plan conversion transactions is an implicit or explicit case that the historic nationwide organization of Blue plans as non-profit entities no longer can survive in current insurance industry dynamics. This argument overlooks the facts, suggested in finding 4 above, that larger carriers are not more efficient or more competitive. In addition, this thesis overlooks what economic policy makers have long understood to be the need for a mix of economic models of service delivery in the American economy. The founders and past managers of the Kansas Blue Plan – and other Blue plans across the U.S. – were not "do-gooders" who were naïve regarding the rigors of internal economics and external competition in the health insurance business, as this pro-conversion argument implies. Rather, they were persons who as social entrepreneurs consciously formed special service companies to meet the need to provide a non-profit model for the most public of private services. In the face of sixty years of competition from commercial carriers, most Blue plan managers built strong and successful businesses and made their non-profit Blue Cross Blue Shield franchises the predominant insurance carrier in many states. The economics and mission of non-

profit Blue plans was and is a viable combination, perhaps, in the long run, the most viable form of providing coverage.

History. The history of Kansas Blue Cross Blue Shield is well understood, as is the history of the Blue Cross movement in the United States. The most important aspects of the Kansas Plan's history, particularly as it relates to the State's hospitals and doctors, are recited here as groundwork for subsequent discussion.

Kansas Blue Cross was formed as a non-profit charitable service corporation in 1941. Originally known as the Kansas Hospital Services Association, the company was the creation of the Legislature at the behest of the State's charitable hospitals. The company was organized by the hospitals as a means of ensuring a steady source of income for these financially-fragile institutions, a critical issue in the Depression decade in which the Blue Cross idea emerged. The Kansas company was a "pan-charitable" organization in every respect, *i.e.*, a charitable entity formed by charities for a charitable purpose. The company was to provide health insurance, operating as a community corporation without "owners," for the principal benefit of the charitable hospitals and the "subscribers" who bought coverage. The company was encouraged as a *de facto* quasi-public entity by the Legislature through exemptions from premium, income and property taxes. In addition, the State's hospitals provided the Plan with special discounts and embraced its success as a condition of their own future stability. Physicians formed a sister company, also chartered by the Legislature, which also operated

as a non-profit charitable entity and became known over time as Blue Shield. The two organizations merged in 1983.

Over the last twenty years three major changes to the corporate status of the Kansas Blue Plan were accomplished that bear on the current proposed transaction. These events are somewhat exceptional in comparison to the corporate histories of other Blue plans around the country. In 1969 the company, through legislation, shed its identity as a “charitable and benevolent” company, a characterization appearing in its original chartering legislation. While the consequence of this change appears to have had little immediate operational impact on the Plan, it was the first indication that the company could have a future somewhat different than that envisioned by its founders.

The second corporate change was the recasting of the Plan’s ownership status from presumptive ownership by the citizens of Kansas to that of mutual ownership by policyholders, who, perforce of this change, acquired equity interests in the Plan. The mutual structure settled the value of the Plan on the policyholders in the event of a change of ownership. What makes the mutualization of the Kansas Plan of particular interest is the statutory provision that, should there be a change of ownership, the value to be received by the policyholders is to be fixed as the statutory surplus of the Plan. This provision transfers the future value of the Plan from all Kansas citizens, as represented by the State, to policyholders. The provision, developed in the context of a life

insurance company conversion, did not contemplate that the difference between the actual market value of the Plan to a potential acquirer and the value of the Plan to the policyholders might be lost to both the State and the policyholers.

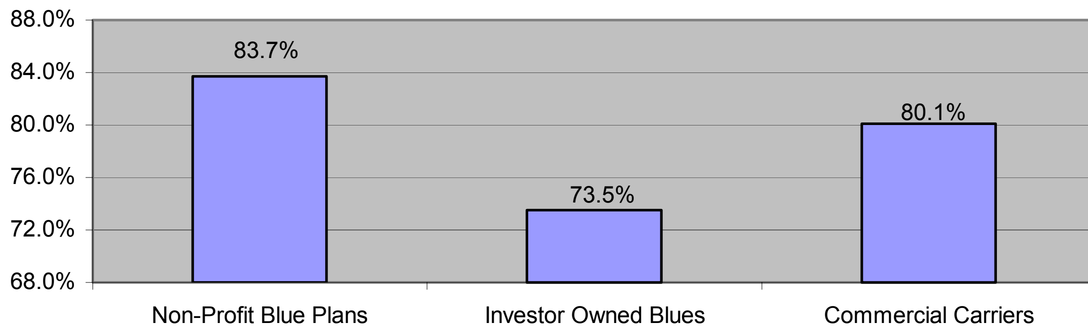
The third, and most unusual, event in this saga was the 1997 legal action where the parties sought to define the residual "charitable value" of the Plan. The legal contest resulted in the Plan transferring $75 million to a charitable foundation as a settlement of the question of charitable value. What makes this aspect of the Kansas Plan's history exceptional is the non-market context in which the ultimate value of the Plan was settled. Without a real buyer in place to set a real sale price for the assets of the Plan, as well as the valuable intangible assets that such a robust, well-capitalized concern represented, it appears that the Plan's value was negotiated outside the context of an actual bid. In other states, the process of establishing the charitable value generally has not been determined outside of an actual contemplated transaction.

Implications for Providers. Any proposed transaction involving the conversion of the Kansas Plan from a non-profit company operating in the public's interest to an investor-owned insurance company has significant and substantial economic implications for Kansas hospitals and doctors. Many of these economic implications bear on the way in which hospitals and doctors will deliver medical care. Through the likely impact that such a transaction may have on premium levels, the transaction can reasonably be seen as resulting in a reduction in the

number of people covered by health insurance, thus leading to a higher bad debt burden on the State's health care providers.

1. Economic Implications. There is substantial evidence that the conversion of a non-profit Blue plan to a for-profit, investor-owned company will mean that at least three new financial burdens will fall directly on the providers of health care in Kansas, and indirectly to the citizens of Kansas. The first cost relates to the percentage of the Blue Plan's premium dollars or total revenues (premiums plus other income, *e.g.*, investment returns on reserves) that are returned to the community in the way of payment for health care to policyholders. To perform this analysis, we constructed a comparative population of health insurance companies and Blue Cross plans by type of ownership, using total revenue data for the period 1997 to 2000. For non-profit Blue plans, the universe of all plans for which public data relating to premium income and total revenues are available (n = 26) was constructed. Four Blue plans that are now investor-owned comprised a second study group. (Anthem is not included.) In addition, a third study group, the ten largest commercial investor-owned health insurance carriers by 2000 revenues was assembled. Exhibit 1 shows medical claims cost ratios, defined as claims paid as a percentage of all revenues, for each of the three groups.

Exhibit 1: Percent of Total Revenue Spent on Health Care Claims, by Organizational Type (1997-2000)



Non-Profit Blue Plans, n=26; Investor Owned Blues, n=4; Commercial Carriers, n=10.

It seems apparent that, in the journey from non-profit status to investor-owned status, the medical claims cost ratio falls substantially. Interestingly, it seems that the ratio of claims paid out for converted Blue plans is lower than for commercial carriers. Clearly, the driving force for a reduction in percentage pay out is the pressure exerted by investors to achieve higher earnings. It appears that investor-owned Blue plans may be required to demonstrate to the capital markets that their claims costs compare more favorably to commercial publicly traded companies. Adding to the pressure to lower claims costs are the higher overhead costs in investor-owned companies. In the same four year period, administrative expenses as a percentage of premium revenues was 13 percent in the non-profit Blues, 23.4 percent in the investor-owned Blue plans, and 15.3 percent in the commercial carriers.

The reduction in claims payments represents the most direct harm to Kansas hospitals and doctors in the potential conversion of the Kansas Plan from non-

profit to for-profit investor-owned status. Fewer dollars will be returned to the community for health care. The dollars once paid to providers to fund medical attention and hospital care, in a static model, will be required to pay dividends to investors, fund the growth of and future acquisitions by the parent, and be applied to a continuous demonstration of the parent's ability to improve overall earnings so as to attract new investors. In a dynamic model, if the hospitals and physicians are able to retain the same level of patient care revenues adjusted for inflation, the parent Blue Plan will be forced to raise premiums to its customers. This is axiomatic. If Kansas providers are able to exert leverage and secure real growth in their revenues – an unlikely scenario given the leverage of any consolidated Blue plan that would acquire the Kansas Plan – then the new parent would have to raise premiums yet further. Only one alternative exists, namely, the new parent can effect administrative efficiencies of such significance that the need for premium increases is offset by internal operating savings. As suggested by the data above, however, consolidated companies are likely to be less efficient administratively. (See below for a discussion of why the health insurance industry provides a special case where scale efficiencies, normally expected in industrial consolidations, do not necessarily obtain.)

2. Clinical Implications Driven By Altered Insurance Economics. A lower medical claims cost ratio has direct implications for the way in which medicine will be practiced after a conversion to for-profit ownership. Because of the pressure exerted by investors, historically claims costs have more often been aggressively

controlled within for-profit carriers. Commercial carriers pioneered what is now thought of as “managed care”. To compete with Blue plans, commercial carriers responded to the demands of large, self-insured employers for lower health benefit costs by creating mechanisms to control patient access to care and to influence clinical practice once treatment of a covered individual was underway. Some of these methods found their origins in the intensive patient management methods of the early closed-group health maintenance organizations (HMOs).

Generally, managed care consists of pre-admission certification by which full coverge can be obtained only if the insurance company has approved care before it is undertaken. A second managed care method is concurrent review, in which clinical professionals employed by the carrier continuously monitor the care being delivered by local physicians and hospitals to persons covered by the insurer. Case audit or post-discharge review is instituted after treatment is completed, which permits the carrier another opportunity to examine the course of treatment and potentially deny coverage. The standard used in these approaches to managing care relate to the medical necessity of the treatment. Generally, non-profit Blue plans have been more respectful than have commercial insurers of the decisions made by local physicians and hospitals in the course of treating their covered patients. In part, this reflects the historic role that the providers played in developing the Blue plans and also reflects the long standing commitment of most locally-based Blue plans to good relationships with providers. Any local Blue plan, because it has a limited geographic area, has

had a strong reason to make good provider relations an important part of its success. Thus, in determining the medical necessity standard, local Blue plans generally have exhibited more deference to the professional decisions of doctors and hospitals.

Some carriers, as well as Blue plans, have thought it necessary to become more aggressive in controlling access to medical care. Many have created or bought for-profit health maintenance organizations with the view that the insurance company could control costs more effectively by operating the organization that delivered the care. Such carriers, especially for-profit companies, which often elect to be known as “managed care organizations,” believe that one critical way to maintain and grow the earnings that investors demand is through aggressive medical management at the point of service. In large insurance companies, the medical necessity standard becomes much more mechanistic and rigid; the medical management function often is centralized with little input from local physicians and hospitals. One of the most persistent criticisms of the HMO model now seen as synonomous with managed care is that medical necessity criteria are applied with such rigor that it appears that necessary medical attention is being withheld. This view has become so common that federal legislation has been proposed to permit members of HMOs and managed care organizations to initiate legal claims for deficient care based on the carriers’ overly enthusiastic application of medical necessity standards.

3. Rising Premiums Yield More Hospital-Physician Bad Debt. For over twenty years, the National Association of Insurance Commissioners, among other groups, has recognized the relationship between rising health insurance premiums and the disproportionate rate of growth in the number of persons without insurance. This relationship has been demonstrated many times by respected academic commentators and has been examined extensively by Congress. One result of this relationship is of enormous consequence to hospitals and doctors, namely, when premiums outpace the rate of change in health care costs, the number of persons with comprehensive coverage declines, and hospitals' and doctors' bad debt grows. As a result, hospitals are often not able to maintain margin levels that existed in the past. Two negative consequences flow from this outcome. First, hospitals are less able to afford new buildings and new clinical technology. Over time, the quality of care available to all patients is likely to erode. Much worse, however, is the draconian alternative. When hospital profits and reserves decline policy analysts worry that uncovered persons are more likely to find it harder to be admitted for care or to receive medical attention.

Because it is unacceptable to refuse admission or medical treatment to patients in need of care, the ultimate welfare loss to the community will manifest itself in one or more ways reflecting public and private policy actions. First, there will be increased pressure on the Kansas Legislature to extend public coverage to those who can no longer access the private market. Thus, some of the costs of care

now embedded in the Blue Plan pool eventually will surface as increased Medicaid expenditures. Second, State government may act to impose the costs of care for persons who are no longer able to access private insurance by implicitly shifting these costs into the covered pool, which ultimately settles on employers. The enactment of the Health Insurance Portability and Accountability Act of 1996 bears witness to the willingness of the federal legislative branch to impose the costs of uncovered persons on other customers of an insurance company. Finally, employers may meet higher premium demands by cost-shifting to their employees in the form of increased deductibles and co-payment obligations.

Taken together, the reduction in the medical claims cost ratio, the more aggressive constraints on claims payment related to medical management driven by more vigorous expense control, and the growth of premium costs will result in rising bad debt for hospitals and doctors and more persons without health insurance. These results offer human dimensions to the economic welfare loss likely to be suffered by the community as a result of the conversion of its non-profit health carrier.

Rationale for Transaction Without Economic Justification. Healthcare providers, faced with the extraordinary consequences that are likely to result from the transformation of the Kansas Blue Plan, are appropriately concerned that the reasons commonly offered to justify such a transaction are not well founded.

Kansas providers are at risk of watching their non-profit plan become part of a company whose strongest economic interest is to develop returns for investors. If the underlying rationale is faulty, if the business reasoning that is motivating the transaction is not well grounded, then, from the provider's perspective, the risks of the transaction may not be justified. As discussed above, these risks include lower payment rates to hospitals and doctors, higher bad debt loads for providers, and the potential of an availability and affordability crisis in certain parts of the insurance market that will aggravate the bad debt problem faced by providers in the future. In addition, providers – and all Kansans – face the risk of delegating the management of the Kansas Plan to a large organization whose future is no more certain than that of the Kansas Plan itself. In the event the new owner encounters extraordinary difficulties, a scenario that has confronted other insurance companies, repairing the situation will be much more difficult for the Kansas Insurance Commissioner or Kansas Legislature.

In prior similar transactions, four major arguments have been propounded to justify the transaction. The first is that scale economies will result from consolidation. The evidence presented above suggests otherwise. In fact, in the health insurance industry, it is difficult to show that becoming bigger results in continuous efficiency gains. Certain organic aspects of the health insurance industry, as well as the experience of at least one of the largest carriers, suggest that economies of scale may be self-limiting; because of the distribution, marketing, claims handling and provider relations aspects of the health insurance

process, it is difficult to consolidate functions with any certainty that administrative costs will decline on a per unit basis. Indeed, as noted above, administrative costs appear to increase, not decrease, with size.

There are specific organic problems that obtain in the health insurance industry that are not typical of other aspects of insurance or other successfully consolidated industries. The first is that all health care, and hence all health insurance, is "local" in its production and servicing. Certain unique aspects of the Kansas health care market are not to be found in other states. The wisdom of the Blue Cross franchise arrangement recognizes local market characteristics as a critical distinction in the health insurance industry. A second organic problem is embedded in the information technology that is critical to claims payment. It is nearly impossible to bring the claims systems from any two health insurance companies together to operate on a common platform. Many companies have tried it and all but a few have failed. The first challenge to common data management is presented by the unique character of health insurance contracts from place to place. The built-up innumerable idiosyncrasies of payment rules from one company to the next often is insurmountable when a common data platform is attempted. In addition, the means and methods of medical management as related to claims processing can vary so enormously between carriers as to require a total overhaul of the culture of the acquired company, a culture that is key to the company's continued success in its local market area. History tells us that most consolidating companies eventually give up on the hope

of efficiencies by consolidating information technology, one of the most important areas where economies of scale should be realized. Finally, because health insurance companies are much more labor intensive than any other line of insurance, span of control and communications issues commonly emerge as the most difficult of all barriers to realizing any true economies.

Many of the problems described here are thought to characterize the problems faced by Aetna, the largest consolidator of health companies. Aetna, which has had trouble demonstrating its ability to achieve economies of scale among its many acquisitions, has not been able to develop a common data or claims platform. Moreover, it has not been able to develop a common market strategy among its acquisitions. Earlier this year the company announced that over a 24 month period it intends to reduce covered lives by 3.9 million, a 20 percent reduction! During the same period it will lay off 11,000 employees.

A second justification for sale is that competition from yet larger, already consolidated companies inevitably will become so intense as to imperil the survival of the local company. Nothing in the current market environment suggests that this is the case or is likely to become the case in the immediate future of Kansas Blue Cross Blue Shield. The Kansas Blue Plan enjoys one of the best reputations in the nation for efficiency and consumer service. It also enjoys enormous market share that has continued to grow. There are no other Blue plan competitors likely to enter the market, as the rules of the Blue Cross

Blue Shield Association prohibit Blue plans from doing business as a Blue plan in another plan's territory. As mentioned, no competitor has the necessary understanding of the unique market conditions in Kansas to rival that of the Kansas Plan. Its underwriting, claims payment and provider relations, all of which have been notably successful, provide a shield against many competitive threats, especially from a non-Blue carrier. Thus, the immediate competitive threat from large companies is unlikely. As a strategic objective, a number of the biggest for-profit plans have chosen not to expand their market reach as health plans and are busy diversifying into other lines.

The third reason commonly advanced to justify conversion or sale is the need for capital to compete effectively in the future, including the need to invest rather significant sums in information technology. Conversion advocates assert that it is imperative that companies join together and convert to for-profit form, in order to access cheaper capital in public equity markets. This argument must be carefully examined from two perspectives. First, without a credible demonstration that competition for business is increasing at such a rate that the Plan must spend enormous amounts of capital in order to hold its market share, the argument is specious. Further, the Kansas Plan has significant reserves and has sufficient capital to see itself through any short-term challenge, whether external, *e.g.*, a competitive threat by a large carrier that might commit to a strategy of short-term predatory pricing, or, internal, *e.g.*, a claims-related shock such as an unexpected short term rise in the inflation trend factor. Second, there is no

evidence that carriers that have become more successful at managing data through improved information technology have in fact achieved any more market success than others. In many ways, the pursuit of the most advanced technology solution is an endless process; it is unlikely that any amount of spending will distinguish one competitor from another or will yield any certainty of higher earnings in the future.

Finally, it has been argued that conversion and/or sale of non-profit Blue plans is necessary to provide management with the compensation and incentives required to attract and hold talent. There are many well-managed Blue plans that, by charter and contemporary declarations, are committed to remaining non-profit organizations. These plans have sound reserves, are making substantial profits and are strong competitors in their market areas. Their managements are well paid. In such plans we see a continuation of the historic committment to non-profit entrepreneurship. The managements of such plans see themselves as engaged in special service roles in their communities.

Absent a convincing economic rationale for conversion to a for-profit entity – in the Kansas case through a sale to an already existing for-profit company – the hospitals and physicians of Kansas are rightly concerned that such a decision is fraught with danger. Experiences in prior conversions teach that providers will face aggressive downward pressure on payment rates, that payment cycles may be lengthened thus adding to their costs of doing business, and that premiums

will rise, causing fewer people to be covered. Without a detailed explanation of the benefits that conversion will bring to the Kansas community to offset these risks, the transaction should be presumed to be without sufficient public interest.

Change in Ethos of Kansas Blue Plan and the Risk to Providers. The Kansas health care economy has been characterized from its first as a non-profit world populated by charitable institutions. The State's hospitals formed the Kansas Blue Plan as a non-profit entity. Likewise, the State's physicians formed a community service company to provide insurance against the cost of doctors' bills, also as a charitable organization. The values that have characterized the State's hospitals was the same charitable, community-oriented service ethos that was infused into Kansas Blue Cross. Notwithstanding the Legislature's having long ago removed the Plan's obligation to act in a "benevolent and charitable" manner, the Plan has continued to act as a community-focused and friendly player. It is the largest single force in the State's health care economy. It enjoys enormous market penetration; it has behaved as the State's insurer of last resort; it has served both the federal Medicare beneficiary population and the State's Medicaid population as the intermediary for government. The Plan has achieved remarkably high levels of service, and enjoys an unusually high regard among providers as compared to Blue plans in other states.

Yet, the intended transaction suggests that this success cannot continue. There is an unspoken proposition in the reasoning advanced to support the sale,

namely, that the founders and previous managers of Blue Cross could not see that the organizational form that they chose eventually would prove incompetent to meet the future. The argument suggests that the non-profit model in health insurance can no longer survive. A similar viewpoint was very much accepted twenty years ago regarding the ability of the non-profit form to carry hospitals into the future. Indeed, many Wall Street experts pronounced without qualification that by the beginning of the 1990s, there would be four or five investor-owned "mega-firms" that would control all the hospitals in the U.S. That future never emerged, in part because those who tried to operate hospitals from a distant corporate site found that local conditions were critical to the successful delivery of health care and that there were few economies of scale to be gleaned by consolidation. Likewise, less than a decade ago, Wall Street was convinced that all physicians would be "owned" by four or five giant physician practice management companies. This industrial transformation appeared to the financial community as inevitable. Enormous amounts of venture capital were lost trying to make this reality happen. In fact, the economics of medical practice were unyielding – the old rules would not give way to the vision of investors who knew that bigger was better.

For the most part, people who make health care work in Kansas operate with old-fashioned values. Hospitals have a deeply embedded ethos of serving their particular communities. The State's physicians continue to minister to their patients much as they did years ago. Although the technology in their offices

certainly looks profoundly different, and they treat as routine many diseases and conditions that would have killed or maimed just a generation ago, Kansas doctors still operate in individually owned offices or group practices, not in corporate settings. The ethos of community service, in charitable hospital settings, is important to the operation of the Kansas system. What is at stake in the conversion of the Kansas Blue Plan is the imposition of a new set of values about insurance and the financing of care.

The founders of the State's Blue Cross and Blue Shield plans were not naïve. They were business people who understood the importance of a non-profit organization to deal with a private market for a near-public good. They also understood that in health care the laws of the market did not always work and that, in some instances, unchecked market forces would produce results that were unacceptable to a compassionate community. These founders were social entrepreneurs. Most of the hospital trustees who were critical in forming the State's Blue Plan were successful private sector business leaders, people who had made their careers in the market system. When they contemplated the delivery of health care, however, their view was that a non-profit alternative was appropriate and necessary. Today, it is appropriate to have the same concerns about markets that do not work to make health care available to all citizens. The ethos that characterized the Kansas Blue Plan shouldn't be lightly dismissed. Providers are appropriately concerned that the intrusion of the pressure for shareholder returns, without any clear evidence that the for-profit form that the

Blue Plan seeks will benefit the citizens of Kansas, may be a very bad bargain and one that is, in the end, transitory. A stable, mixed system of insurance has served Kansas and its providers well. It should not be abandoned without an abundance of evidence that the good that will come to the health system will outweigh the risks to the State's providers and its citizens.

Respectfully submitted,

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