Health Care Reform Coordinating Council

Created by Executive Order 01.01.2010.07

Comprehensive Evaluation of the Federal Health Reform and Foundation for Implementation in Maryland

An Interim Report

July [], 2010

DRAFT

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Executive Summary

[to be completed following decisions made at the July 1 meeting of the HCRCC]

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Background

Overview of Reform

The Patient Protection and Affordable Care Act (PPACA) sets the stage for transformation of health care in Maryland and the rest of the United States. For the first time, access to affordable coverage will be within reach for every citizen.

For the first time, Americans who already have insurance will be able to count on it when they become ill—no more annual caps, lifetime limits, or insurance carrier decisions to rescind individuals' existing policies. For the first time, purchasing insurance will be easier and more transparent, due to the creation of a new marketplace known as an exchange where both individuals and small employers will have the opportunity to comparison shop among different policies offered by different insurance carriers. For the first time, all low-income childless adults will have access to comprehensive coverage through Medicaid. For the first time, discrimination against individuals with pre-existing conditions will be prohibited—a person's poor health status will not be considered when pricing an insurance policy. For the first time, many small businesses and Americans with modest incomes will be eligible to receive substantial tax credits to assist them in the purchase of health insurance. In short, no longer will restrictive eligibility rules, modest income, or poor health status pose an insurmountable barrier to obtaining coverage, and no longer will people wonder about the reliability of the insurance they possess.

PPACA contains many other transformative features that will reshape public health and the health care delivery system, payment methods, long-term care and access to community-based supportive services, and the quality of care delivered across products, programs, and populations. Summarized below, the primary components of PPACA's coverage provisions are closely intertwined, with most becoming effective in January 2014:

- *Medicaid Expansion*: All non-elderly U.S. citizens at or below 133 percent of the federal poverty level (FPL) will be eligible for Medicaid.
- *Health Insurance Exchange*: Individuals and small businesses will be able to purchase insurance through an exchange. Non-elderly citizens above 133 percent of the FPL who lack access to employer-sponsored insurance will be able to purchase coverage through the new health insurance exchange. The exchange will offer a comprehensive array of products that range from basic insurance to more expensive policies with more expansive benefits.
- *Federal Subsidies*: Individuals between 133 and 400 percent of the FPL will receive a federal subsidy on a sliding scale to buy their coverage through the exchange.
- *Small Employers*: Small employer groups will also be able to buy coverage through the exchange, and many will be eligible for federal subsidies to assist in the purchase of coverage.
- *Insurance Market Reforms*: The insurance market will operate under new rules, with guaranteed issue of coverage, no annual or lifetime caps, and no exclusions based on pre-existing conditions. Adjusted community rating rules will be utilized for both individual

and small group purchasers. This means that health care premiums will be based on the average experience of a broad range of individuals, making the cost of premiums higher for some individuals and lower for others.

- *Individual Insurance Mandate*: In order to ensure that premiums are affordable, PPACA requires all individuals to secure coverage or pay a penalty. Under health reform, insurance market rules will change so that individuals with poor health status can now access health insurance. The individual mandate guards against the impact on health care premiums if individuals wait to buy insurance until they need health care. By encouraging personal responsibility and the participation in the insured pool of both relatively healthy and more vulnerable people, this requirement will spread the risks and costs of insurance across all individuals, and promote affordability.
- *Large Employer Responsibility*: PPACA also promotes large group employer-sponsored insurance by requiring that large employers offer coverage or pay a fine.
- *Medicare*: Medicare will continue to be protected as a strong and stable insurance program for the elderly.

Making all of this work to realize the full potential of reform poses significant challenges. We must ensure coordination of access to coverage. We must expand and maintain a robust health care workforce with provider capacity sufficient enough to serve the population and meet increasing demands. The exchange must be well-designed, with both governance rules and a structure that are suited to competition, choice, flexibility, and adaptability as the health insurance market evolves. We must also ensure that the cost of insurance is kept within a reasonable and affordable rate of growth over time. All of these goals are achievable. In order to achieve them, we will need a coordinated and sustained effort across all levels of government and the private sector. The Health Care Reform Coordinating Council (HCRCC) is focused on leading this effort to make health reform in Maryland a success.

Role of Coordinating Council

PPACA was signed into law by President Obama on March 23, 2010. The next day, Governor O'Malley signed Executive Order 01.01.02010.07, creating the HCRCC[1] to coordinate Maryland's response to PPACA. The objective is to ensure that the state implements federal reform thoughtfully and thoroughly, with careful deliberation and collaboration across agencies and branches of government, and with meaningful participation of the health care community and other private sector stakeholders.

The significance and breadth of health reform in Maryland is reflected in the composition of the HCRCC. Led by Lt. Governor Anthony Brown and Secretary John Colmers of the Maryland Department of Health and Mental Hygiene (DHMH), the twelve-member HCRCC includes leadership from all of Maryland's executive health agencies, budget and management, and the

[1] The Executive Order is Appendix [] to this report.

Governor's office; chairs and leading members of the health committees in both the Senate and House; and the Attorney General.

The Executive Order created the HCRCC as the primary body in Maryland that is charged with coordinating the activity of state government in implementing PPACA. The HCRCC is directed to identify and make a series of recommendations on the issues and decisions that are critical to the successful implementation of health reform in Maryland. To fulfill this mandate, the Council must submit both this interim report and a final report by January 1, 2011. This first report includes a presentation of the key milestones and a timeline for reform; the critical decisions that will require recommendations in the final report; a financial model for an ongoing estimate of the state's projected costs and savings through 2020; and a section-by-section summary of PPACA.

The HCRCC's mission is to implement health reform effectively to improve access, quality, and affordability of health care for all Marylanders. Thus, its focus includes the people seeking insurance, the companies offering coverage and the producers/third party administrators facilitating its purchase, the providers delivering services, and the businesses securing insurance on behalf of their employees. The HCRCC must also seek to build capacity in the workforce, protect the state's safety net, and represent the interests of public and private stakeholders who are essential to the state's long-term health. As such, the HCRCC recognizes the need to be transparent and inclusive in its work, and it welcomes assistance and input from all stakeholders.

In all of this work, the HCRCC will factor into its recommendations the cost to the state in selecting among various options. While cost is not the only factor, it is an important one, and the members of the HCRCC are cognizant of their obligations to the state and its residents. Moreover, the HCRCC will be attentive to the fact that reform is not easy. In some instances, it is important for individuals and organizations to embrace change, and embrace the opportunity that reform brings. Still, the HCRCC is aware that individual and organizational change is complicated, and may be resisted for quite legitimate reasons. The HCRCC will conduct its work open to all viewpoints on the pace and nature of change that should be encouraged within health reform.

Opportunity for Reform Implementation in Maryland

Health care reform presents an historic opportunity in Maryland. Health reform has the potential to improve public health, reduce racial and ethnic health disparities, improve access to behavioral health and promote parity, and improve Maryland's overall health care delivery system.

To ensure that this window of opportunity is not wasted, implementation cannot focus simply on those tasks minimally necessary to comply with the new federal law. Rather, the efforts must embrace the full possibility of what reform can bring to Maryland. Policy makers must examine and think creatively about how the federal law can best be harnessed both to preserve what has worked well for its residents and to redesign and rebuild what has not. Recommendations should resist being bound by historic regulatory frameworks and should instead consider new paradigms for those components of our health care delivery system that have fallen short.

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To achieve these goals, the HCRCC has adopted as an operating principle[2] that its recommendations be guided by the critical objectives of promoting positive health outcomes; expanding access; improving quality, equity, and administrative efficiency; fostering workforce development; and containing the rate of growth in public and private sector health financing. Thus, our approach to implementation must:

- Develop a consumer-centric approach to coverage, enrollment and eligibility determinations, with movement among and across the commercial and public insurance markets as seamless as possible
- Use the tools provided by reform to improve quality and contain costs
- Think broadly and creatively about strategies to promote access to affordable coverage and mitigate risk selection
- Prepare and expand the health care workforce to meet new demands

It will not be easy to realize the full potential of health reform. With significant technical and operational challenges ahead of us, it will be daunting to bring together and balance the wide range of perspectives and interests at stake. Yet with the help of all its public and private sector partners, the state is poised to achieve historic reforms that will create a vastly better health system for future generations, and we must work together to do so.

Foundation for Reform Implementation in Maryland

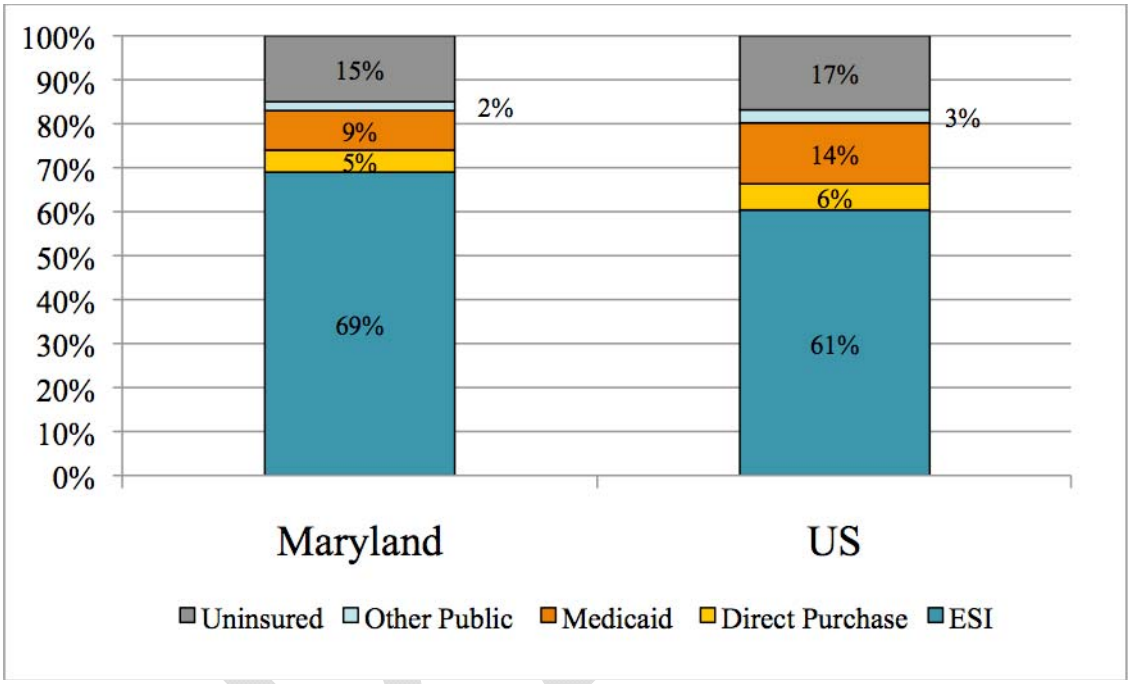
Federal health reform leaves numerous implementation decisions to states. Accordingly, Maryland policy makers have the flexibility and obligation to consider the state's unique health care landscape and regulatory environment when evaluating choices about how to implement reform in a way that best serves Marylanders. In doing so, they are not starting from scratch. Rather, current reform efforts will build on a long and unique history of coverage expansion and financing and delivery system innovations in Maryland. For example, in recent years, Maryland has extended coverage to 200,000 or more Marylanders by expanding Medicaid eligibility for adults with low income, helping small employers offer coverage, creating a high-risk pool for individuals unable to secure insurance because of their health conditions, and improving access to commercial insurance for young adults. In some areas, federal reforms present a logical extension of these and other current policy initiatives, while in other cases, federal mandates may require rethinking the existing efforts. In any event, policy makers will need to determine how best to implement federal reform in the context of Maryland's unique health care and regulatory environment.

Status of Coverage and the Uninsured in Maryland: Maryland is a relatively wealthy state with a higher percentage of individuals covered through their employers than the national average; only four states have higher rates of employer-sponsored coverage. A little over half (58 percent) of all private sector employers in Maryland offer health insurance—slightly higher than the national average. Offered rates vary significantly by firm size, however, with less than 40 percent of firms

[2] Appendix X contains a complete list of the Health Care Reform Coordinating Council's Operating Principles.

with fewer than 10 employees offering insurance, down from prior years. With respect to overall rates of coverage, 700,000 people in the state remain uninsured. Representing 15 percent of non-elderly Marylanders, the state's uninsured rate is in the mid-range, slightly lower than the national average of 17 percent.

Chart X. Health Insurance Coverage of Non-Elderly, 2006-2007



Source: MHCC, Health Insurance Coverage in Maryland through 2007, January 2009.

Maryland's Insurance Market: Federal reform makes a number of changes to the ways in which states regulate their health insurance markets. These changes, however, will affect only about one-third of the commercial health insurance market that is actually subject to state regulation. The remaining two-thirds is covered by large self-insured plans exempt from state regulation by the federal law known as the Employee Retirement Income Security Act of 1974 (ERISA).

Maryland's regulated health insurance sector is divided into the small and non-group markets, both of which are highly concentrated and dominated by one carrier. Although seven insurance carriers operate in the non-group market, CareFirst has over 80 percent of the market. Similarly, eight insurance carriers offer coverage in the small group market, but CareFirst accounts for over 75 percent of that market.[3]

Maryland's Small Group Market Reforms: In 1993, Maryland sought to improve small employers' access to insurance by enacting certain reforms to the small group market, which is

[3] Maryland Insurance Administration, 2009 Health Benefit Plan Report, Market Share by Earned Premium

composed of employer groups of 2 to 50. It created a minimum level of coverage, the Comprehensive Standard Health Benefit Plan (CSHBP), which requires all insurance carriers to offer the same benefits to all small employers. It also established standardized cost sharing for different products. The Maryland Health Care Commission (MHCC) may annually update and modify the CSHBP so that the average cost does not exceed 10 percent of Maryland's average annual wage. Employers can add benefits by purchasing riders but may not reduce benefits. The vast majority of small employers choose to purchase riders, which results in a wide variety of cost-sharing arrangements across employer-sponsored plans, despite the uniformity of the basic CSHBP rules.

Other key characteristics of Maryland's small group market are that all plans must be offered on a guaranteed issue and guaranteed renewal basis and are subject to modified community rating. Modified community rating limits the factors insurance carriers may consider when they price insurance policies, and thus reduces variation in how much small businesses pay for health insurance. This provision makes it possible for a small employer with a sick employee, or a group or sick employees, to nevertheless purchase insurance, because insurance carriers cannot price policies based on a given small employer's history of health care costs. Since 2009, though, insurance carriers have been allowed to impose limited and pre-existing limitations or exclusions for individuals who are new to the small group market, or who had previously been uninsured. As of July 2010, insurance carriers are also able to adjust premiums based on health status for new small businesses purchasing coverage.

Premium Assistance for Small Businesses: In 2007, Maryland created the Maryland Health Insurance Partnership to help very small, low-wage businesses offer health insurance to their employees. For qualifying businesses who have not previously offered insurance, the Maryland Partnership will pay half the cost of health insurance. As of 2010, the Partnership had enrolled 250 businesses or about 1,200 individuals—below the initial projection in part because of the country's economic downturn. The federal reform's small business tax credit shares many features of the Partnership but will be available to more small employers, including those currently offering insurance and those with more than 10 employees.

Maryland's Non-Group Market: Maryland's non-group market is very different from the small group market and covers about 160,000 individuals. This is a smaller percentage of the insured population than the individual market comprises in most other states. Unlike in the small group market, insurance carriers are allowed to medically underwrite products sold in the individual market, i.e., base the price on a person's health status, or exclude sick people altogether. Thus, applicants may be charged higher premiums based on age or health status, have limitations placed on their coverage, or be denied coverage in the individual market. These underwriting practices serve to keep premium rates down in this market, especially for younger, healthier individuals. Moreover, a relatively large number of high-deductible plans with skinny benefit designs are permitted to, and do, exist in the individual market (as compared to the group market). These benefit designs also help to keep premiums down in this market. Finally, although a number of coverage mandates apply in the non-group market, insurance carriers are not required to offer any standard plan like the CSHPB.

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Maryland's High-Risk Pool: For individuals denied coverage in the non-group market on the basis of health status, Maryland has operated a high-risk pool since 2003. It is called the Maryland Health Insurance Program (MHIP). Through MHIP, individuals can access coverage even if they are "uninsurable" (unable to secure coverage based on health status) in the individual market. Administered on behalf of MHIP by CareFirst, and now the sixth largest high-risk pool in the country (out of 34 nationwide), MHIP enrolls over 18,000 individuals and is about 10 percent of Maryland's individual commercial market.

MHIP enrollees typically pay a higher premium to purchase insurance through MHIP than the "average" premium in the individual market (which is medically underwritten, as described above). The higher premium in MHIP partially reflects the fact that the composition of the MHIP risk pool is sicker than the pool of generally healthier people able to obtain individual coverage in the standard individual market. Since 2005, MHIP also has offered an "MHIP Plus" plan. MHIP Plus provides subsidies to low and moderate income individuals to enable them to buy coverage through MHIP. Eligibility for subsidies in MHIP Plus is available to people up to 300 percent of the FPL. MHIP receives the money to provide these subsidies through an assessment that is applied to all hospital rates in the state. The hospital assessment generated approximately $114 million to MHIP in the most recent year; this constitutes about 62 percent of MHIP's overall funding.

Market Implications for Reform: These characteristics of Maryland's small and non-group markets and high-risk pool have potential implications for federal reform. Effective January 2014, insurance carriers that sell products within the exchange will be required to enroll all individuals seeking coverage in at least a basic benefit package, without application of underwriting rules. MHIP will be phased out, as a state-run high-risk pool no longer is needed. Depending on how Maryland chooses to implement other components of reform, therefore, these changes in current non-group underwriting practices and the elimination of the high risk pool may increase premiums for the younger and healthier individuals presently covered in the individual market. Policy makers must assess strategies to address this potential disruption.

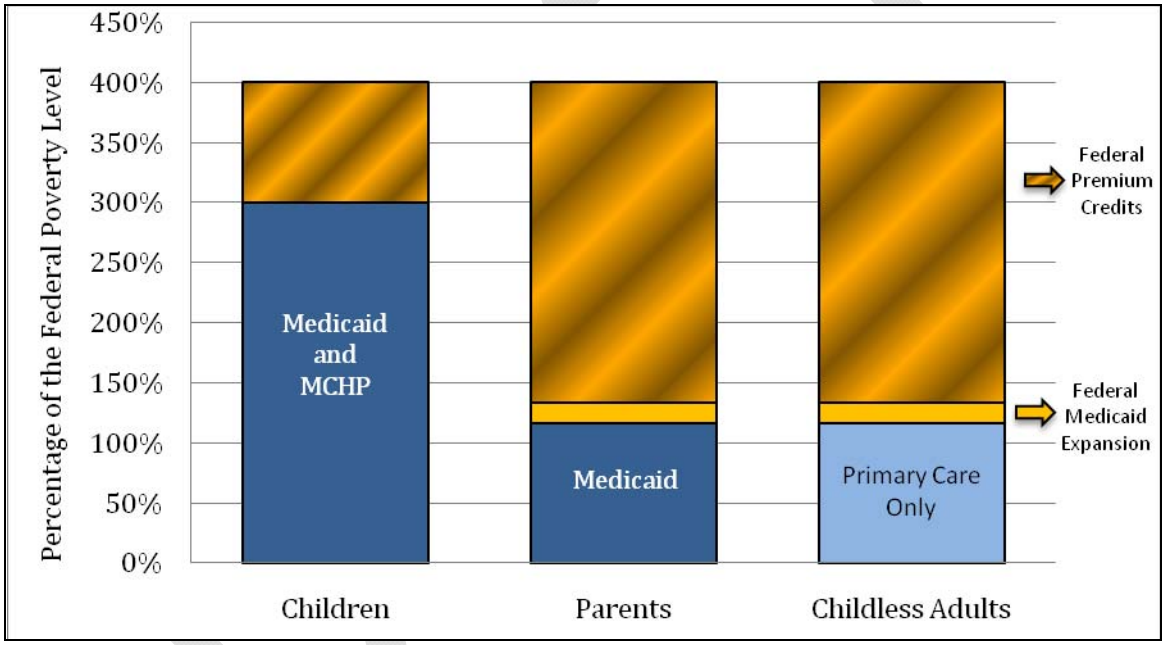
Coverage for Young Adults: In 2008, Maryland became one of several states to help young adults maintain health insurance. The new law expanded the definition of dependents to include adults up to age 25, allowing young adults to remain on their parents' insurance policies as dependents. Federal reform expands the definition of dependents by one year, to age 26.

Public Coverage—Medicaid, Maryland Children's' Health Insurance Program, and Primary Adult Care: No later than January 2014, federal reform requires states to expand coverage to more adults with low income. This will end the categorical nature of Medicaid. Historically, Medicaid coverage has been limited to specific categories of people, such as children, pregnant women, parents of minor or dependent children (below certain poverty levels), individuals with permanent disabilities, and the elderly. In 2007, Maryland began its own effort to implement a phased-in expansion of Medicaid coverage to all low-income adults. First, it extended eligibility to parents with income up to 116 percent of the FPL. This expanded coverage to over 65,000 adults in two years, and moved Maryland from one of the most restrictive eligibility states to one of 17 states that provide Medicaid coverage to low-income parents above 100 percent of the FPL ($18,000 for a family of three). Second, Maryland began a phased-in expansion of coverage to

low-income childless adults to be implemented over several years. This was accomplished by progressively adding benefits to the existing Primary Adult Care (PAC) program. The new coverage levels for adults required under federal health care reform (i.e., coverage up to 133% of the poverty level) are similar to those targeted by a full phase-in of the state's 2007 expansion.

From the outset of the states' Children's Health Insurance Program (CHIP) in 1997, Maryland has been a leader in coverage levels for children. Maryland's program, MCHP, provides comprehensive health insurance coverage to children in families with incomes up to 300 percent of the FPL (or $55,000 for a family of three). Maryland is one of only five states with comprehensive coverage at this level. In recent years, a few states have expanded CHIP eligibility to all income levels, essentially allowing higher-income families to buy into the program at full cost. Federal reform will require states to maintain their current coverage levels for children for which they will receive enhanced matching funds.

Public Coverage Today and 2014



Maryland's Rate Setting System: In addition to many health insurance coverage initiatives, Maryland has a unique system for financing hospital uncompensated care. The hospital rate setting system finances over $1 billion in uncompensated care annually to Maryland hospitals, spreading the cost of the uninsured among all payers. The rate setting system has also been used to finance policies that reduce the amount of uncompensated care, including Maryland's high-risk pool and recent Medicaid expansions.

Maryland's Safety Net Programs: A number of programs and initiatives also provide a safety net of coverage for the state's uninsured and underinsured. Maryland has 16 Federally Qualified Health Centers (FQHCs) with over 60 sites. Health reform provides significant new funding for FQHCs, although Maryland has not been competitive historically in obtaining funding for FQHCs because of its relative wealth. In some jurisdictions, local health departments provide

direct care services. Networks of other programs also contribute to the safety net, including Maryland's public mental health system, substance abuse treatment services provided through local jurisdictions, the Breast and Cervical Cancer Program, and the Kidney Disease Program.

Fiscal Implications of Health Care Reform in Maryland

Federal reform and states' implementation of its mandates will have an enormous fiscal impact on health care costs and savings in both the public and private sectors. Any current and future projections about relative costs and savings necessarily will be fluid and dependent on the various choices and decisions states make in implementing reform, and how various components of the delivery system—from the insurance markets to providers and consumers—respond to the reforms as they evolve. The goal of a financial model, therefore, is to be dynamic in order to make projections that can be adapted and updated as data become available, and as conditions and factors change over time.

With that caveat, estimates of the savings Maryland can expect from health reform between fiscal year (FY) 2010 and FY 2020 range from $[]-$[], with a midpoint estimate of $[] in savings.[4] Underlying this estimate are several components, some of which will increase the state's costs and others projected to generate substantial savings. Overall costs will increase in areas such as Medicaid because of the mandated expansion, state employee/retiree health insurance because of new consumer protections in the insurance market, and various state administrative and implementation infrastructure costs, including development of new eligibility systems and an exchange to ensure seamless access to coverage. On the positive side, the state anticipates substantial savings in other areas, such as CHIP coverage for children where the federal government will bear a greater share of the cost, termination of the state's MHIP subsidies once the exchange is operational, and the reduction in funding for safety net programs once the number of uninsured Marylanders declines.

Health reform will affect many other state-funded programs and funding streams. The full details underlying the financial model are found in Appendix X, along with a detailed description of the data sources and methods utilized to generate the projections. It is important to keep in mind the following cautionary notes:

- The model itself is a living tool that will be updated as actual data emerge to refine the assumptions and replace projections with actual financials. It must be understood as a dynamic tool, not as a static and fixed guarantee.
- While health reform is expected to generate substantial savings to Maryland over the next ten years, in the initial years, costs will likely be above the baseline as the state prepares for 2014 by building the infrastructure and making the investments necessary to launch the exchange, implement Medicaid expansion, and offer new protections to employees and retirees on whose behalf the state purchases insurance.

[4] The detailed Financial Model is found as Appendix [] to this report.

The full model, with a detailed and annotated summary of the data sources and methods utilized in its development, is provided in the appendices.

Workgroups, Critical Decisions, Process for Recommendations

[To be added based on feedback from July 1 HCRCC Meeting]

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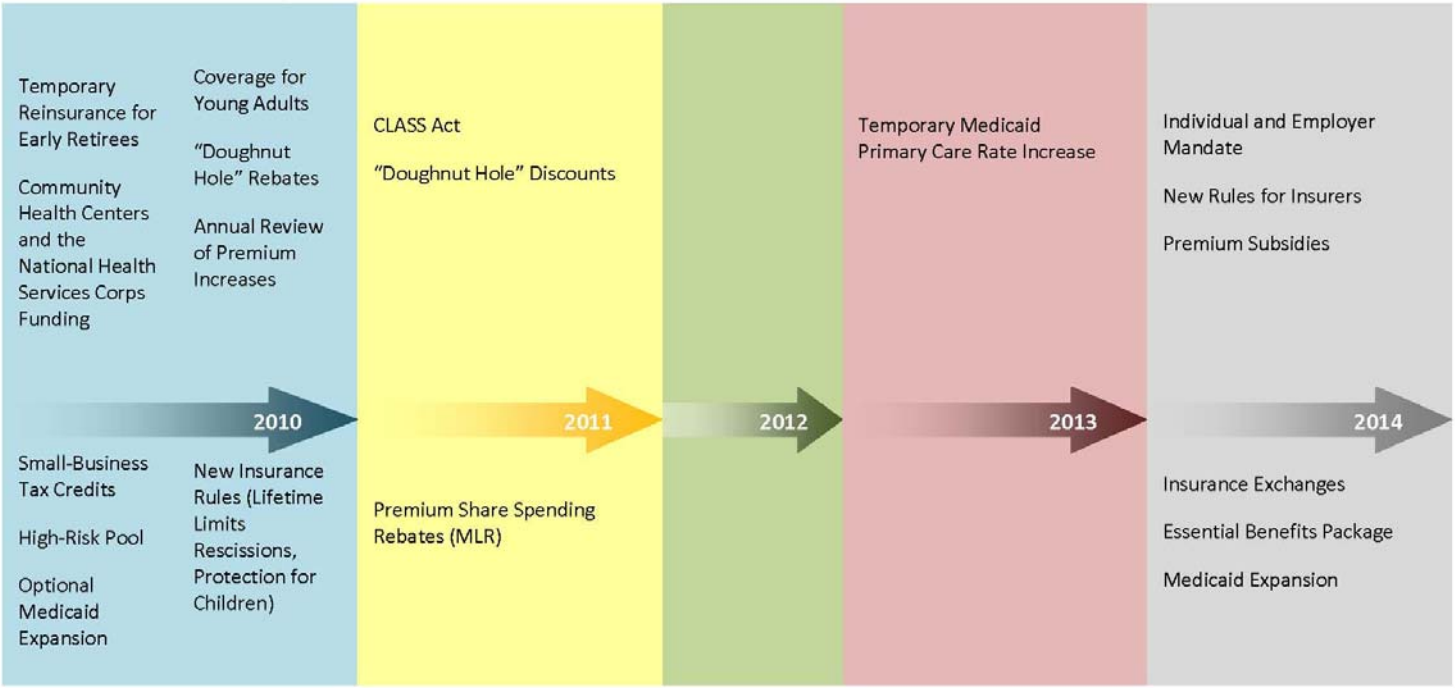
Timeline for Implementation of Key Activities

The major elements of health care reform become effective in 2014. However, a number of provisions become effective sooner, and many changes require implementation activities to begin immediately. Successful implementation requires Maryland to focus on the long-term transformative opportunities of reform, not just the many provisions that require immediate attention.

A comprehensive timeline of Maryland health reform implementation issues, highlighting areas that potentially require state action, is shown in Appendix [XX].

From Maryland's perspective, the establishment of a new federal high-risk pool to operate alongside the MHIP program is one of the most immediate implementation activities. The federal government is issuing guidance on several insurance market changes; Maryland's role is largely to conform to these federal mandates and to conduct oversight to ensure that the new rules are enforced. There are optional initiatives, grants, and demonstration projects that become available immediately. However, the major provisions that require significant implementation activity by the states will become effective in 2014, including the establishment of exchanges, expansion of Medicaid, and premium credits.

Effective Dates for Major Health Reform Initiative



The planning and implementation activities required to successfully implement major components of the reform need to begin immediately. As illustrated by the timelines in Table X, infrastructure and systems changes will be significant. Sufficient implementation timeframes are essential to meet even the basic requirements of reform. Workgroup recommendations and policy decisions will affect this initial timeline. A more comprehensive timeline of overall health reform implementation, highlighting areas that potentially require state action, is shown in Appendix XX.

Major State Activities: Implementation Timeline

	2010		2011		2012	2013	2014
Exchange and Insurance Market Changes	General Direction and Goals	Initial Statutory Changes (Conforming changes to Insurance)	Plan	Statutory Changes	Implementation Activities (Staff, IT, Navigators, Plan Contracting)		Start-Up
Seamless Entry to Coverage	General Direction	Budget for Planning Statutory Changes	Implementation Activities (IT, Web Portal, Training, Outreach)				Begin Enrollment
Education and Outreach	Plan	Information on Immediate Changes; How to Participate in Planning; Future Changes		Plan Campaign (input on strategies, test approaches)	Launch Outreach Campaign		
Workforce	General Direction	Statutory Changes (if needed)	Implement, On-Going Strategy Development	Statutory Changes (if needed)	On-Going Implementation, Monitoring and Refining Strategy		
Safety Net	General Direction	Plan (based on information about benefit design and other implementation decisions)		Statutory Changes (if needed)	Implementation Activities		Begin New Strategies
Benefit Design	General Direction	Review and Respond to Federal Guidance/Planning		Statutory Changes (if needed)	Implementation Activities		Benefit Changes Effective

Appendix A. Executive Order

[to be inserted]

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Appendix B. Council Members

The Honorable Anthony G. Brown
Lieutenant Governor, State of Maryland
Co-Chair

John M. Colmers
Secretary, Maryland Department of Health & Mental Hygiene
Co-Chair

Carolyn Quattrocki, Deputy Legislative Officer
Governor's Designee

T. Eloise Foster
Secretary, Department of Budget and Management

Beth Sammis
Acting Commissioner, Maryland Insurance Administration

Douglas F. Gansler
Maryland Attorney General

Marilyn Moon
Chair, Maryland Health Care Commission

Donald A. Young, M.D.
Chair, Health Services Cost Review Commission

The Honorable Edward J. Kasemeyer
Member, Maryland Senate

The Honorable Thomas "Mac" Middleton
Member, Maryland Senate

The Honorable Peter Hammen
Member, Maryland House of Delegates

The Honorable James W. Hubbard
Member, Maryland House of Delegates

Staff:

Chuck Milligan, JD, MPH
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Other Appendices

Note: the following Appendices are in development and will be included in final Interim Report

Meeting Agendas

Affected State Law and Regulation Spreadsheet

Comprehensive Timeline when Decisions Need to be Made

Financial Model: Detailed Spreadsheet and Documentation of Data Sources and Methods

Potential Grants and Funding Opportunities Spreadsheet

Summary of Public Comments Received

Glossary of Terms

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