Center for American Progress

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September 2014

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August 2014

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Introduction and summary

Over the past few years, the growth in health care costs has slowed dramatically. But because the reasons for this are unclear, it is likely that additional policies will be needed to keep growth down. Without action, health care spending will continue to crowd out other vital spending in household and government budgets.

Given the current political gridlock, it is unlikely that the federal government will take the lead on reforms to control health care costs system-wide. States must therefore play a leadership role, with the federal government empowering and incentivizing them to act. We propose that the federal government should implement a model that gives states the option to become "Accountable Care States"—meaning that they are accountable for health care costs, the quality of care, and access to care—with sizable financial rewards for keeping overall costs low. This model would control costs across the system rather than shift costs from public programs to the private sector or to consumers.

The Accountable Care States model offers the potential for substantial savings in health care spending. If only about half of the states—those that expanded their Medicaid programs in 2014, for example—opt to become Accountable Care States, the potential savings in total health care spending would exceed $1.7 trillion over the first 10 years of implementation. Of that amount, the federal government would save more than $350 billion. The financial incentives for states to participate and succeed would also be powerful: 21 states would earn more than $1 billion, 33 states would earn more than $500 million, and 44 states would earn more than $200 million. By 2025, the average savings for an individual with private health insurance would exceed $1,000 and grow over time.

Why do we need more health care cost control?

National health care spending per capita—after adjusting for inflation—has grown less than 2 percent per year since 2007, and rates over the past few years are the lowest on record.[1] While total health care spending accelerated in late 2013 and early 2014, it is unclear to what extent the acceleration simply reflects an increase in the number of insured people or whether costs per insured person are also accelerating. There remains considerable debate about the factors that have caused the slowdown and whether it will continue.

There is no doubt that the Great Recession was an important factor. As a result of job losses, enrollment in private health insurance has declined by more than 9 million people since 2007.[2] States with budget shortfalls reduced Medicaid payments and benefits substantially.[3] With lower incomes, enrollees in private insurance had less money to spend on health care.[4]

Several studies use historical data to determine the relationship between economic growth and health care spending growth. These studies estimate that the economic downturn explains anywhere from 37 percent to more than two-thirds of the slowdown in health care spending.[5] However, this methodology has serious limitations: It is highly sensitive to assumptions about the timing of the effect of economic growth on health care spending growth. Another recent study compares private health care spending in geographic areas where the severity of the recent economic downturn varied, estimating that the downturn explains about 70 percent of the slowdown in private health care spending.[6]

Still, most experts believe that the economy is not the only factor at work for two reasons. First, the slowdown began before the Great Recession. Second, the economic downturn cannot explain the slowdown in Medicare spending. Because the vast majority of Medicare beneficiaries have supplemental coverage for cost-sharing, financial losses did not reduce their use of health care.[7]

In addition to the economy, another important factor is the long-term trend of rising cost-sharing—or out-of-pocket costs paid by consumers such as deductibles, copayments, and coinsurance—that discourage the use of health care. Since 2006, the number of workers who have a deductible has risen sharply, the average deductible amount has nearly doubled, and 20 percent of covered workers are now enrolled in high-deductible plans.[8] Coinsurance for hospital admissions and copayments for physician visits have also risen sharply.[9] According to one analysis, rising cost-sharing explains 20 percent of the slowdown in health care spending, although other experts have concluded that this factor is even more important.[10]

The use of new technologies—which historically drove cost growth—has also moderated. For many surgical procedures involving medical devices, as well as imaging with MRIs and CT scans, rates of use declined during the late 2000s.[11] Additionally, because a large number of high-volume, high-cost drugs lost patent protection, cheaper generic drugs account for an increasing share of prescriptions.[12] However, some experts who are surveying the technology pipeline predict that a surge in new surgical procedures, medical devices, and specialty drugs is on the horizon.[13]

The Affordable Care Act, or ACA, also contributed to the slowdown. The law reduced Medicare payments to medical providers and Medicare Advantage plans. Moreover, there is evidence that reductions in Medicare payments had a spillover effect on private insurance.[14] Because the law reduced Medicare payments to hospitals with high readmissions, the readmission rate has dropped from 19 percent to about 17.5 percent, avoiding 130,000 readmissions.[15] Reducing these preventable readmissions, as well as hospital-acquired conditions, lowers costs while improving the quality of care.

Perhaps most importantly, it is possible that the Affordable Care Act created an expectation of cost-control reforms that changed medical providers' behavior. In other words, providers may have become more cost-efficient in anticipation of reforms to the payment and delivery system. As evidence of this effect, providers have sharply curtailed their investment in technologies and facilities that could drive up costs.[16] To the extent that this effect is real, providers may revert to business as usual unless anticipated reforms soon become reality.

Several of these factors had a one-time effect on the level of health care spending and cannot be expected to continue to moderate the growth of spending over the long term. For example, cost-sharing in private insurance cannot increase indefinitely, and the rate of generic substitution for brand-name drugs cannot go much higher. Moreover, some factors that have slowed cost growth—such as rising cost-sharing—may have the undesirable side effect of reducing access to necessary care.

Analysts generally project that cost growth will increase over the next few decades but at a slower rate than before the slowdown. Growth in health care spending per capita is still projected to exceed growth in the economy by 1.15 percentage points to 1.6 percentage points.[17] Even if the Great Recession and its aftermath explain less than half of the slowdown, once the economy improves—and the effect of rising cost-sharing maxes out—cost growth can be expected to rise appreciably.

Even at a slower rate of cost growth, the projected trend is unsustainable for two reasons. First, cost growth that exceeds wage growth will dampen real income, as it has in the past.[18] Second, cost growth that exceeds economic growth will eventually require much higher taxes or deep reductions in other government spending, crowding out vital investments in education and infrastructure. Under the Congressional Budget Office's long-term projections, the following will occur by 2035, even if costs per capita grow no faster than the economy:[19]

- Medicare spending as a share of the economy will increase 30 percent.

- Total federal health care spending as a share of the economy will increase 37 percent.

Because our aging population accounts for 39 percent of projected growth in federal health care spending, costs per beneficiary would need to grow more slowly than the economy to stabilize this spending as a share of the economy.[20]

Importantly, growth trends and causes vary by payer. While growth in private spending is strongly associated with economic growth, increased Medicare spending is not.[21] For private spending, the slowdown was driven by the Great Recession and rising cost-sharing—one-time or undesirable effects that did not benefit consumers. Policymakers must therefore address this component of national health care spending.

For Medicare spending, the slowdown had more promising effects but remains unexplained. To the extent that medical providers changed their behavior in anticipation of reforms to the payment and delivery system, policymakers must continue to send strong signals to providers that these reforms will take root. While payment and delivery system reform in Medicare and Medicaid would have a spillover effect on private insurance,[22] policymakers must focus on ways to amplify this effect. Reforms that focus on one payer alone will not send strong and consistent signals to providers.

State innovation models

Because health care issues have become so polarized, it is unlikely that the federal government will lead reforms to control system-wide costs. Many Republicans propose reforms that aim to reduce costs by reducing the amount of insurance coverage. At the same time, many Democrats do not recognize the need for greater cost control beyond the Affordable Care Act's reforms.

States, however, are well-suited to play a leadership role on cost control for two reasons. First, they have a wide variety of tools and policy levers at their disposal to control costs and improve the quality of care. (see "State cost-control tools" text box) Second, because health care delivery varies locally, states can tailor models to their unique needs.

State cost-control tools

State health care programs and regulations can affect health care spending by influencing the supply of services, the demand for services, the behavior of medical providers and consumers, the bargaining power of purchasers, or the degree of market competition. Here are some of the areas in which states can control health care costs:

- Medicaid and Children's Health Insurance programs
- State employee plans
- State-run health insurance exchanges
- Premium rate review
- Provider network adequacy regulations
- Provider regulations
- Regulation of the supply of medical facilities
- Scope of practice laws
- Physician licensing
- Medical malpractice laws
- Price and quality transparency initiatives
- Administrative requirements
- Contractual rules between health plans and medical providers
- State antitrust laws
- Public health programs

Several states are already taking the lead in adopting innovative reforms, as the following case studies illustrate.

Arkansas

Under the Arkansas Health Care Payment Improvement Initiative, multiple payers provide the same payment incentives based on an episode of care, or a bundle of services, rather than treating each service separately.[23] The variety of payers that are participating include Medicaid, private insurers, and some self-insured employers, such as Wal-Mart. Currently, there are 12 episodes of care in the program, including upper respiratory infection, total hip and knee replacement, congestive heart failure, and attention deficit hyperactivity disorder, or ADHD. The goal is to implement episodes for up to 40 percent of spending over the next few years.[24]

Medical providers are still paid a fee for each service. Payers designate a Principal Accountable Provider, or PAP, that is the main decision maker for most care and can coordinate other providers during an episode. Payers track quality and costs across all episodes during a time period. If the PAP keeps the average cost below a target and meets quality standards, then it can keep a share of the savings. But if the average cost exceeds the target, then the PAP must pay back a share of the excess costs.

Arkansas is also implementing patient-centered, primary care medical homes for public and private payers. Medical homes receive extra monthly payments to coordinate care for patients. If a medical home keeps costs below its own historical trend and below a target—and meets quality standards—then it can keep a share of the savings. The majority of Arkansans will have access to a medical home by 2016.[25]

Based on current projections, Arkansas will save about $560 million for Medicaid, $310 million for Medicare, and $365 million for private insurers over three years.[26]

Maryland

The Centers for Medicare & Medicaid Services, or CMS, approved Maryland's reform to its all-payer system for hospitals in January. Under this system, an independent agency sets payment rates for both public and private payers.[27] The recent reform limits the growth in total hospital spending per capita to the long-term trend in state economic growth per capita.

To meet this goal, hospitals will face financial consequences if they provide an excessive volume of services. Maryland has also set aggressive targets for improvements in hospital readmissions, quality measures, and hospital-acquired conditions. Hospitals will be at risk of losing increasing amounts of revenue if they do not make progress toward these targets.

In future years, Maryland intends to propose an approach to limit the growth in total health care spending per capita.[28]

Massachusetts

Massachusetts enacted legislation to control health care costs in 2012.[29] The reform set a global target that limits the growth in total health care spending to growth in the state economy and is adjusted to remove fluctuations due to business cycles. A new commission enforces this target: Medical providers with excessive cost growth must file and implement a performance improvement plan and could be fined up to $500,000 for failure to comply.

The state Medicaid program, the state employee health insurance program, and other state-funded programs must transition to new payment models. The state Medicaid program must use new payment models, such as payments for a bundle of services, for at least 80 percent of beneficiaries by July 2015.[30] In the private insurance market, insurers must offer tiered network plans that reduce cost-sharing for enrollees who choose high-value medical providers.

Medical providers must report regularly on financial performance, market share, cost trends, and quality measures. The new commission will conduct a "Cost and Market Impact Review" of changes in the health care industry, such as consolidations or mergers, that could increase costs or reduce quality or access. The commission can refer these changes to the attorney general for further investigation.

Massachusetts is also a national model of health care price transparency.[31] Its reform requires insurers to provide consumers with binding estimates of their out-of-pocket costs for specific procedures. In addition, medical providers must disclose price information to patients and a public website will provide data on the relative costs of different providers.

Oregon

Oregon has committed to reduce the growth in Medicaid spending per capita by 2 percentage points relative to the national growth rate by the end of 2014, while maintaining quality and access.[32] If the state does not meet the cost growth target or if quality or access significantly decline, then the federal government will reduce some of the extra funding that it has agreed to provide.

Under the reform, the state Medicaid program makes fixed payments to Coordinated Care Organizations, or CCOs—community-based organizations governed by medical providers and consumers—to provide medical, behavioral, dental, and other services to beneficiaries. These payments are set to grow at a fixed rate of 2 percentage points below the national growth rate. The state withholds a portion of the payments so that it can make some additional payments to CCOs with high performance on quality and access.

Preliminary data from 2011 to 2013 indicate that CCOs reduced emergency department visits by 13 percent, as well as hospital admissions for congestive heart failure, chronic obstructive pulmonary disease, and adult asthma.[33]

In the future, Oregon has committed to expanding the CCO model to Medicare, state employee health plans, and health insurance exchange plans.[34]

Medicare's State Innovation Models Initiative

The Affordable Care Act created the Center for Medicare & Medicaid Innovation, or CMMI, to test and expand payment reforms.[35] One of CMMI's initiatives is the State Innovation Models, or SIM, Initiative, which provides grants to states for payment reforms that are adopted by multiple payers.[36] Currently, six states are testing reforms, including Arkansas and Oregon. The largest grant is $45 million over three and a half years or about $13 million per year.[37] In May, CMMI announced a second round of grants, which could range from $20 million to $100 million over four years or $5 million to $20 million per year.[38]

The SIM Initiative is promising, but faces four limitations. First, the financial rewards for states are not strong enough. With little federal money at stake, states do not have enough incentive or leverage to exert pressure on stakeholders; several states report that medical providers and private payers resist even participating in reform

discussions.[39] Second, the initiative focuses on payment reform, but states have many other policy levers. (see "State cost-control tools" text box) Third, the federal government provides start-up grants but does not reward results or provide direct incentives to reduce federal health care spending. Fourth, the participation of Medicare—the single largest payer—in this initiative has been minimal.

The effectiveness of the SIM Initiative will therefore be limited. A bolder approach has the potential to spark state innovations, as exemplified in the case studies above, across the country.

The Accountable Care States model

The federal government should empower and incentivize states to take the lead in implementing innovative cost-control models. The federal government should allow states to become "Accountable Care States" that are accountable for the growth in health care costs, as well as the quality of care. Under this model, Accountable Care States would share federal savings, prevent cost-shifting to consumers, implement payment reforms, ease administrative burdens, and track data on costs and quality of care.

Share federal savings

Accountable Care States would agree to limit the growth in total health care spending per capita—including spending by both public and private payers—to a target linked to the state's economic growth per capita. To remove fluctuations in economic growth due to business cycles, the target would be linked to economic growth over the long term or what growth would be assuming full employment, known as "potential economic growth." If states successfully meet this cost target, then they would receive a share of the federal government's savings on payments through Medicare, Medicaid, Affordable Care Act subsidies, and other federal health care programs.

To be eligible for these shared savings, Accountable Care States must also meet targets for the quality of care and access to care. In addition, states must have a balanced, broad-based approach, reducing the growth rate for public spending and private spending by at least 1 percentage point each. Rather than solely focusing on public programs—or shifting substantial costs from public programs to private insurance—states should adopt reforms that reduce costs across the system.

Accountable Care States would have to meet one of two cost targets. If states limit health care spending to economic growth plus 0.5 percentage points, then they would be eligible to keep 25 percent of the federal savings. If states limit health care

spending even further to the rate of economic growth, then they would be eligible to keep 50 percent of the federal savings. In addition, if states agree in advance to return any of their excess federal spending to the federal government, then their share of any federal savings would increase by 25 percentage points. For this purpose, excess federal spending would be the amount that exceeds economic growth plus 1 percentage point. By accepting greater accountability for excess cost growth, states would have the potential to earn greater rewards.

Accountable Care States would have two options for receiving their share of the federal savings. They could receive the savings in the year after the savings accrue, or they could receive the savings projected over three years upfront. But under the latter option, states would have to pay back this frontloaded savings if they do not meet their targets.

The federal government would measure the federal savings each year by comparing a state's actual growth rate in federal spending per enrollee to one of these baselines:

- The state's growth rate in federal spending per enrollee over the past five years, adjusted to remove fluctuations due to business cycles

- A blend of the state's growth rate and the national growth rate

States with growth rates that are already below the national growth rate would benefit from the blended baseline.

The federal savings would be adjusted to exclude savings that result from medical providers' participation in Medicare demonstrations or from Medicare incentive payments. Growth rates would also be adjusted to account for spending growth due to factors unrelated to cost-control reforms, such as the expansion of coverage under the Affordable Care Act, including a Medicaid expansion; demographic changes; natural disasters; or regional disease outbreaks. The Government Accountability Office, or GAO, would certify measurements of savings and adjustments.

Prevent cost-shifting to consumers

As a general rule, Accountable Care States would not be able to credit any savings toward their targets that result from policies that simply shift costs to consumers. The Affordable Care Act established essential health benefits, minimum coverage levels, and limits on out-of-pocket costs—all of which curb increases in consumers'

out-of-pocket costs.[40] In addition, states would be limited in their ability to meet their targets by shifting spending from payers to consumers because total health care spending would include out-of-pocket spending by consumers.

However, Accountable Care States would be able to count savings from tiered or limited provider networks. While plans with limited networks exclude high-cost medical providers, plans with tiered networks reduce cost-sharing for enrollees who choose high-value providers. To ensure that consumers retain meaningful access to providers, states would not be credited with such savings unless the networks meet minimum standards for adequate health care access. States would also be able to count savings from increasing cost-sharing for low-value services—such as emergency department visits for non-emergencies and brand-name drugs when generic drugs are available—consistent with consumer protections under Medicaid.

Implement payment reform across payers

To be eligible for shared savings, Accountable Care States must transition to new payment models that are coordinated across public and private payers. As an alternative to paying a fee for each service—which encourages medical providers to increase the number of services—these new payment models pay a fixed amount for care coordination through primary care medical homes; for a bundle of services, known as bundled payments; or to an Accountable Care Organization for all of the care a patient needs.

Accountable Care States would need to phase in new payment models so that an increasing percentage of payments by all payers are made using these new models:

- Year 2: 20 percent
- Year 3: 30 percent
- Year 4: 40 percent
- Year 5: 50 percent

As the single largest payer, the participation of Medicare is key to health system transformation. For medical providers to change how they operate, a large portion of their revenue must be affected. Alignment across payers can also help counteract the market power of providers.

Accountable Care States would be encouraged to propose models that include Medicare, much like how states take the lead on demonstration programs to integrate care for dual eligible populations.[41] Medicare would be required to participate in the following state payment models:

- Models that CMS has approved for the state's Medicaid program, to the degree feasible. In Arkansas, for instance, Medicare would be required to use the same bundles as the state Medicaid program.

- Models that have been tested and proven to reduce costs and improve the quality of care, as judged by the CMS Office of the Actuary. For instance, states could implement the Acute Care Episode program's bundled payments for cardiac and orthopedic procedures across payers.

- Models that CMMI is currently testing for some providers, unless results show that the models reduce the quality of care.

- Models that implement some form of all-payer rate setting, under which payment rates to providers would be the same or more similar for all payers, that does not increase Medicare spending when combined with other reforms.

Ease administrative costs and burdens

States often lack administrative capacity to design and implement major reforms. To defray administrative and implementation costs, Accountable Care States would receive either an enhanced Federal Matching Assistance Percentage under Medicaid or funding from CMMI.

The federal government would standardize and streamline a process for states that are interested in becoming Accountable Care States. CMS would create a new Office of Accountable Care States to review and approve a single application for waivers to Medicaid, payment and delivery system reforms to Medicare, and changes to state-run health insurance exchanges. This office would be similar in function to the Medicare-Medicaid Coordination Office created under the Affordable Care Act to coordinate Medicare and Medicaid demonstrations and simplify processes.[42] In addition, CMS would publish Accountable Care State templates with standard conditions such as those discussed above to remove any guesswork or inconsistencies from the process.

Track cost and quality data

Accountable Care States would need to track cost and quality data to measure their performance against targets. These data would also inform the public and policymakers about the drivers of health care costs and shine a spotlight on payers and medical providers that need to improve.

To be eligible for shared savings, Accountable Care States must establish all-payer claims databases—combining data from Medicare, Medicaid, and private payers—within two years. The databases would include data on utilization of services and payments by provider and payer but not personal information. The federal government would provide Medicare and Medicaid data and the state's health insurance exchange—whether federal or state-run—would provide data from exchange plans. The federal government would provide start-up funding for the databases.

Within two years, each Accountable Care State would also need to standardize quality measures and reporting requirements across its payers. Currently, medical providers face an assortment of quality measures, which results in an administrative burden and inconsistent signals and incentives.

Potential health care savings

The Accountable Care States model has the potential to yield substantial health care savings to states, the federal government, businesses, and households. We estimated the impact of this model primarily using Congressional Budget Office, or CBO, data on projected health care spending. (see "Methodology" text box) Our estimates are highly conservative because we assume a modest take-up rate among states.

If only about half of the states—for example, those that expanded their Medicaid programs in 2014—opt to become Accountable Care States, the potential savings in total health care spending would exceed $1.7 trillion over the first 10 years of implementation. Of that amount, the federal government would save more than $350 billion. This amount of federal savings would be net of shared savings payments that the federal government would make to participating states.

These shared savings payments would be substantial, creating powerful incentives for states to participate and succeed. Table 1 displays each state's potential share of federal savings. Over the first 10 years of implementation, 21 states would earn

more than $1 billion, 33 states would earn more than $500 million, and 44 states would earn more than $200 million. Because these amounts would be in addition to savings in state Medicaid spending, the potential financial gain to states would be much larger.

TABLE 1

Potential state shares of federal savings, 2018–2027

State	Savings (millions of dollars)	State	Savings (millions of dollars)
Alabama	$840	Montana	$180
Alaska	$160	Nebraska	$340
Arizona	$1,050	Nevada	$430
Arkansas	$500	New Hampshire	$260
California	$5,910	New Jersey	$1,620
Colorado	$790	New Mexico	$370
Connecticut	$780	New York	$4,160
Delaware	$190	North Carolina	$1,720
District of Columbia	$240	North Dakota	$140
Florida	$3,610	Ohio	$2,280
Georgia	$1,550	Oklahoma	$640
Hawaii	$230	Oregon	$710
Idaho	$240	Pennsylvania	$2,580
Illinois	$2,160	Rhode Island	$230
Indiana	$1,230	South Carolina	$810
Iowa	$530	South Dakota	$150
Kansas	$500	Tennessee	$1,200
Kentucky	$820	Texas	$4,050
Louisiana	$850	Utah	$430
Maine	$300	Vermont	$110
Maryland	$1,070	Virginia	$1,250
Massachusetts	$1,600	Washington	$1,160
Michigan	$1,820	West Virginia	$380
Minnesota	$1,030	Wisconsin	$1,090
Mississippi	$550	Wyoming	$80
Missouri	$1,200	**Total**	**$56,120**

Source: Authors' calculations based on data from the Congressional Budget Office and Centers for Medicare & Medicaid Services. See "Methodology" text box for details.

Consumers would also reap savings from lower premiums and out-of-pocket costs. By 2025, the average savings for an individual with private health insurance would exceed $1,000 and grow over time.

Methodology

To estimate the impact of the Accountable Care States model, we assumed that the model would not be fully implemented in half of the states until 2018. We also assumed that participating states would choose to maximize their shared savings with a cost target equal to the growth in gross domestic product, or GDP.

To construct a baseline of federal health care spending, we used CBO projections of Medicare spending, Medicaid spending, and Affordable Care Act subsidies through 2024, extending the trends through 2027.[43] To estimate the national savings in federal health care spending, we used CBO estimates of the amount by which the growth rate for each program exceeds GDP growth, known as "excess cost growth."[44]

Because CBO does not project private health care spending, we used private spending data from the National Health Expenditure Accounts, or NHEA, maintained by the Office of the Actuary at CMS, isolating data on premiums and out-of-pocket costs.[45] National savings in private health care spending is the difference between the NHEA projection and what private spending would be if it grew at the rate of the Accountable Care States cost target instead. This savings estimate, divided by the NHEA projection of the number of enrollees in private health insurance,[46] is the average savings for an individual with private insurance.

To derive the savings for each state, we allocated national savings to states based on each state's portion of national health care spending, as measured by the NHEA.[47] To apportion Medicaid savings between the federal government and a state, we applied the Affordable Care Act's enhanced matching rate to Medicaid spending resulting from the ACA and the state's regular Federal Matching Assistance Percentage, or FMAP, to the rest of Medicaid spending.[48]

Conclusion

Many powerful stakeholders have a vested interest in driving up the cost of health care. The incentives for policymakers to take action must be strong—so strong that inaction is almost not an option. Only states have the policy levers and the political will to lead reform, and only the federal government can provide strong enough incentives. The Accountable Care States model—which combines these state and federal elements—therefore represents our best hope for sustainable health care spending in the coming years.

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Acknowledgements

The Center for American Progress thanks the Peter G. Peterson Foundation for their support of our health policy programs and of this report. The views and opinions expressed in this report are those of Center for American Progress and the authors and do not necessarily reflect the position of the Peter G. Peterson Foundation. The Center for American Progress produces independent research and policy ideas driven by solutions that we believe will create a more equitable and just world.

Endnotes

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