Strategic Business, Financial and Regulatory Analysis of the Health Insurance Industry

Health Plan Weekly

August 17, 2020
VOLUME 30 | NUMBER 33

Sky-High 2Q Profits Train Spotlight on Health Insurers

With health care claims costs reaching ultra-low levels amid lockdowns, canceled elective procedures and consumers' fear of contracting the novel coronavirus at clinical sites, publicly traded health insurers saw their margins swell significantly in the second quarter of 2020. At the same time, insurers were quick to point out during their earnings conference calls that they have collectively provided billions of dollars' worth of financial relief to consumers and providers and expect utilization to rebound in the second half of the year.

However, the health insurance industry still found its way into the crosshairs of the House Energy & Commerce Committee, which revealed on Aug. 6 that it will investigate insurers' business practices "following reports that many of the companies are recording record profit margins during the COVID-19 pandemic."

"Although the Affordable Care Act requires many health insurance companies to limit their profit margins and issue rebates to consumers, I believe insurers should be doing more to help enrollees and providers immediately," Committee Chairman Frank Pallone (D-N.J.) said in a statement. In an Aug. 13 release, the committee revealed that it sent letters to Anthem, Inc., Cigna Corp., CVS Health Corp., Humana Inc. and UnitedHealth Group as part of its inquiry.

continued on p. 4

COVID-19 Crisis Spurs Increased Interest in Home Care

As visits to hospitals and outpatient clinics have become sources of anxiety for patients worried about exposure to the novel coronavirus, plans and providers alike have begun to make major investments in home care. Experts say that the shift away from clinical settings and back into the home could make a major dent in the cost of care.

According to a July white paper prepared by KMPG, the home health space has optimal conditions for growth: "more patients, including recovering COVID-19 patients, are choosing home care to avoid crowded hospitals," while "technological improvements allow for better home-care services, which are also more frequently reimbursed."

Shifting primary care to a home visit model has obvious appeal with COVID-19 still posing a threat in public spaces. Along those lines, Humana Inc. announced a $100 million investment in home primary care startup Heal Inc. on July 27. Heal CEO Nick Desai tells AIS Health his company will aid Humana's long-term strategy to reduce the cost of care and improve quality.

Heal's model places patients with a consistent primary care physician who makes house calls. The doctors are dispatched and routed using an app and driven to visits with a medical assistant, and they input notes and update care plans into an electronic health record (EHR) between visits. According Desai, the company's

Published by AIS Health, Washington, DC. An independent publication not affiliated with insurers, vendors, manufacturers or associations.

physicians typically see 10 or fewer patients per day and spend 30 minutes to an hour with each.

"Our doctors are paid on a salary basis, so they don't worry about the billing," Desai explains. "They have incentives and bonuses for delivering quality, but never for seeing more patients. We're fundamentally economically aligned around the delivery of value, not volume. So if a doctor sees six patients in a day instead of 10, but that doctor closes all the care gaps, that doctor creates cost savings that we monetize in part in a risk-based contracting arrangement. The real bread and butter of our business is aligning incentives between us and our payers."

Desai says that alignment can have tangible benefits.

"If a patient doesn't have a [primary care provider] or [the PCP] is too far away, they go to the emergency room," Desai explains. "We know that 80% of emergency room visits are for non-emergency purposes. We can remove those — in fact, we remove unnecessary trips to the ER by 71%. Every single trip increases the quality of care, because we're treating the patient in primary care, being more comprehensive than the triage-based approach in the emergency room, and it also saves a significant amount of money."

Ashraf Shehata, KPMG national sector leader for health care and life sciences, says that in other developed countries, house calls didn't fall out of favor in the same way that they did in the United States. In the Netherlands, for example, the whole health care system is based on a primary care model, and Shehata says the country has an exemplary house call primary care program for seniors.

Shehata adds that home health needn't be limited to the traditional house call.

"If we really think about home health as one of the options for care transitions on the post-acute side, it is pretty viable," Shehata tells AIS Health. "Years ago, we did some work with a Medicare Advantage carrier and a Medicaid risk carrier, and we actually reviewed the cases with their care management team. We identified probably 30-50% of those cases who went to a more traditional post-acute care setting could have been a viable option for home health care."

Where payers will find significant appeal in home care, Shehata says, is in reducing the duration and number of inpatient visits along the lines of Desai's emergency room visit reduction pitch. However, Shehata says plans need to take a proactive role in reducing time spent in the hospital, and suggests that health systems' care management programs can serve as an example.

"The best people I've noticed around coordinating home care services and other social services are hospital social workers," Shehata observes. "They really do an amazing job when they've hit the maximum number of covered inpatient days. Suddenly, amazing things happen. They find amazing resources, they find things nobody can find. Imagine that kind of creativity and knowledge of the network and system — they could move that up front, and payers can become better at that."

Home Care Could Be Tough to Scale

Shehata says that building home care capacity will give plans more flexibility to meet patients on their own terms and could improve outcomes in a post-acute context. Still, he suggests that there are substantial barriers to scaling up home care to that level. For example, there are regulatory standards, including special certifications, for licensed home care providers. He also notes lagging EHR interoperability impedes the flow of information between home care providers and other parts of the health care system.

COVID-19 has thrown a bright light on existing incentives for hospi-

Health Plan Weekly (ISSN: 2576-4365) is published 52 times a year by AIS Health, 2101 L Street, NW, Suite 300, Washington, D.C. 20037, 800-521-4323, www.AISHealth.com.

Subscriptions to ***HPW*** include free electronic delivery and access to all content online at www.AISHealth.com. To renew your annual subscription, please order online at www.AISHealth.com. For subscriptions for five or more users, contact sales@aishealth.com.

Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

tal systems to reduce inpatient stays. In the spring, concerned about likely strains on their intensive care units, Utah-based integrated health system Intermountain Healthcare launched a pilot program to move post-acute patients and low-acuity emergency patients to home care.

The pilot, which presently is operating out of one hospital and cares for less than 10 patients at any given time, diverts certain patients who have arrived in the hospital's ER to their home after triage. Patients must be within 20 miles of the originating hospital.

A home care nurse arrives with gear including diagnostic and remote monitoring equipment along with a tablet that connects the patient with a virtual care team including a doctor, nurse and any necessary specialists. The home care nurse helps the patient get situated and performs regular check-ups. A rotation of nurses is on call for emergencies and other in-person, incidental care, and Intermountain is in discussions with emergency medical technicians to scale up response teams.

Intermountain Touts Promising Pilot

Nick Bassett, vice president for population health services at Intermountain subsidiary Castell, says the pilot is tied to health system's longer-term value-based care strategy. He adds that the pilot has shown promising savings.

Intermountain executives looked at both the variable and fixed costs associated with providing care in a hospital, Bassett explains. "Then we essentially compared that to the variable and fixed costs associated with providing this in the home. The bottom line is somewhere between 20-30% lower costs for these patients [when they're cared for at home]."

Bassett says the savings mainly come from reducing the physical plant and staffing costs of a hospital stay.

"You're able to extend your physician further in that case, if they're simply moving from call to call as opposed to going room to room or floor to floor; there's some gained efficiencies there. You don't have a building, a cafeteria, you don't have housekeeping. So you've got a lot of things that you don't have to support like you would in a regular hospital."

New Payment Model Is in the Works

According to Bassett, Intermountain's payer partners have expressed interest in the program when it reaches scale, starting with SelectHealth, its insurance subsidiary. He says the pilot has required Intermountain to use existing billing practices, but there is now enough data to develop best practices and a new payment model.

"We essentially leaned on as many existing processes as we could," Bassett says. "We're working through, initially with our own health plan SelectHealth, what that modified billing arrangement will look like, and how to really help the risk-bearing entity realize the savings we're talking about. Speaking from a national perspective, as we look at what other national payers and other similar programs have done, I would say definitely there is interest from payers in looking at and helping accelerate models like this."

Bassett cites recent moves by UnitedHealthcare, along with Humana's home care investments, as examples of a growing interest in home care.

"The big, national payers are being approached by groups that are doing this," Basset says. "I think we'll see more and more of this becoming a standard of care."

Read more about the Heal-Humana deal at https://huma.na/30R3mft and the KPMG white paper at https://bit.ly/2FmuUB8. Contact Bassett via Holly Nelson at holly.nelson2@imail.org, Desai via Meredith Luerssen at mluerssen@5wpr.com, and Shehata via Bill Borden at wborden@kpmg.com. ✧

by Peter Johnson

With Risk Corridors Suits Settled, CSR Cases Heat Up

Fresh off winning a Supreme Court case concerning billions of dollars' worth of payments from the Affordable Care Act risk corridors program, health insurers that operate in the ACA exchanges are racking up lower-court victories and filing new lawsuits over halted cost-sharing reduction (CSR) payment funding.

In mid-July, the U.S. Court of Federal Claims ordered the federal government to pay L.A. Care Health Plan more than $16.7 million in CSR payments that it withheld in 2019. Combined with a summary judgment made last year in L.A. Care's favor regarding 2017 and 2018 payments, federal courts have ruled that the insurer is owed a total of $35.4 million. Even more recently, Humana Inc. on Aug. 10 filed a complaint in federal claims court arguing that it is owed just under $2 million in CSR payments for 2017.

CSRs are one of two major forms of subsidies available to ACA exchange plan enrollees who qualify based on income. The other type of subsidies — advance premium tax credits — reduce enrollees' monthly premium rates, while CSRs help them pay out-of-pocket health care expenses such as copays.

In 2016, a Republican-controlled House of Representatives won a court case challenging CSRs, having argued that insurers were being reimbursed for the subsidies without proper appropriation from Congress. Seizing on that ruling, the Trump administration stopped reimbursing insurers for CSRs in late 2017 — but those companies were still statutorily obligated to provide the subsidies to ACA exchange enrollees. Starting with the 2018 plan year, health insurers worked with state regulators to load the cost of providing CSRs onto their silver-level plans, a practice known as "silver loading" that shielded enrollees from added costs since premium subsidies rise in tandem with silver-plan rates.

Insurers also filed lawsuits in response to the halting of CSR payments, arguing that the ACA expressly promised them reimbursement as part of their agreement to sell health plans on the exchanges. Not only are such suits seeking payments from 2017 — when insurers weren't able to recoup their losses — but also for subsequent years when silver-loading effectively reimbursed insurers.

Insurers Prevail in Lower Courts

"My understanding is that every case that has been dealt with at the lower court level, the insurance companies won," says Katie Keith, a health care attorney and research professor at Georgetown University's Center on Health Insurance Reforms. Four consolidated CSR cases are now at the Court of Appeals for the Federal Circuit, and a host of other lawsuits brought by insurers — including Molina Healthcare, Inc., Harvard Pilgrim Health Care and various Blue Cross Blue Shield plans — have been stayed pending the outcome of the appeal, Keith wrote in a July 21 Health Affairs blog post.

Meanwhile, insurers including Anthem, Inc., Cigna Corp. — and now also Humana — filed new CSR complaints after the Supreme Court's April 27 ruling *(HPW 5/4/20, p. 1)* in favor of insurers' consolidated risk corridors case, *Maine Community Health Options v. United States*. Other insurers have amended their risk corridors complaints to add claims for unpaid CSRs. In an interview with AIS Health, Keith points out that the risk corridors and CSR cases are similar because they concern "whether payments can be made without an explicit appropriation." However, there is an extra layer of complexity with CSRs since insurers found a way to recoup their losses.

Could SCOTUS Step In?

The Court of Appeals for the Federal Circuit held arguments in January for the consolidated CSR cases, and since then there have been two rounds of supplemental briefings — concerning the question of whether insurers that silver-loaded should still receive damages, and how the risk corridors ruling affects CSR claims.

When the federal circuit court renders its decision, whichever side loses has the option of petitioning for a review by the full panel of circuit court judges. As for whether the CSR cases will go the way of risk corridors litigation and reach the highest court in the land, Keith observes that it's not yet clear. "It could absolutely end up in front of the Supreme Court; I think we'll know a little bit more, though, once we get the fed circuit opinion," she says.

View the Humana complaint at https://bit.ly/33PTUed and the L.A. Care judgment at https://bit.ly/3fQHTHG. Contact Keith at kmk82@georgetown.edu. ✧

by Leslie Small

Insurers Face Heat

continued from p. 1

America's Health Insurance Plans (AHIP) swiftly hit back, outlining in an Aug. 7 blog post all the steps that insurers have taken to respond to the COVID-19 crisis, such as offering premium grace periods and discounts to members, giving direct financial assistance to providers and community organizations, expanding access to telehealth, launching new mental health services, and eliminating cost sharing for COVID-19 testing and treatment before they were required to by Congress' pandemic relief legislation.

AHIP Warns Care Costs Will Rise

What's more, "the second half of the year could see a lot more care, and higher costs, than the first half of 2020," AHIP President and CEO Matt Eyles wrote. "However, if these costs never materialize and remain below certain levels, American consumers, businesses, and taxpayers are protected by provisions in federal and state laws that require health insurance providers to deliver premium rebates and put money back into their pockets."

Experts say that although it is indeed bad optics for insurers to record robust second-quarter profits while the nation reels from the pandemic and a compressed economy, the industry is wise to proceed as though its current windfall won't last.

"There's no question health insurers' medical costs have plummeted due largely to factors related to COVID-19. However, most insurers have taken aggressive steps to greatly reduce or eliminate member costs for testing of and treatment for COVID-19. Most are also reaching out to members to encourage them to continue treatment for chronic conditions,

keep up to date on health screenings and preventive care, and take advantage of telemedicine services," Joe Paduda, principal of Health Strategy Associates LLC, tells AIS Health.

"Fact is, we have no idea of the long-term health impact of COVID-19," Paduda adds. "There is increasing evidence of long-term implications including lung damage, cardiac issues, kidney and liver dysfunction and persistent blood clotting problems. A prudent insurer must ensure it has adequate reserves to cover treatment for these conditions — as well as pay for costs associated with the pent-up demand for services."

Insurers during their recent second-quarter earnings calls generally reported that they were seeing health care utilization return to normal or near-nor-

Experts Predict Robust Health Care Agenda After Election

Avalere Health experts who spoke during an Aug. 11 webinar predicted an "active legislative environment" for health care regardless of which party emerges victorious from the coming election. The selection of Sen. Kamala Harris (D-Calif.) as former vice president Joe Biden's running mate probably won't change that or move Biden's health care agenda further left.

During the webinar, which was recorded before Harris was announced as the presumptive Democratic vice presidential nominee, Avalere founder Dan Mendelson predicted the next president and Congress will confront three major health issues: the COVID-19 pandemic, expanding health insurance coverage and reducing racial disparities in health care access and delivery.

In an interview after Harris' selection, Mendelson tells AIS Health that he expects the California senator will not press for substantial changes to Biden's health care agenda, even though she staked out positions further to the left during the Democratic primary. Mendelson says Harris' stance on Medicare for All was more a reactive campaign stance than a position motivated by deep conviction.

"My perspective is her views are really very consistent with his when it comes to health care," Mendelson says. "She is a relatively centrist Democrat on health care issues, and I think will essentially fit in well with a lot of the thinking that is going on in the campaign. Biden has set down certain markers — he's not doing Medicare for All. He's going to do an expansion of Medicare down to age 60 in some form or fashion. There's going to be some form of a public option. He's very clearly outlined the parameters of what his policy is going to be. That limits the potential for any divergence."

In the interview, Mendelson continued to emphasize his earlier points about COVID-19 response and fighting racial injustice.

"When you look at the polling data, what Americans really want is strong, federal policy around COVID-19 to get us out of the pandemic and get the economy back in a way that's safe. And then, Americans also want there to be strong policy around health disparities," Mendelson says. "And [Harris] has actually positioned herself very aggressively on the disparities issue, which I think will be a nice add to the campaign."

Though Biden has outlined an ambitious agenda, Avalere principal Matt Kazan, a former health policy aide to Senate Democrats, says that the makeup of Congress will dictate what Biden is able to do if elected.

Kazan explained that even if Democrats gain a majority in the Senate and consolidate their hold on the House, they will have to earn 60 votes to pass substantial health care reforms — unless they do away with the filibuster. Otherwise, he points out that new legislation will have to pass via the budget reconciliation process, a complicated and arcane procedure that can only be used for policies that are directly related to the budget and taxation.

Kazan and Mendelson agree that action on drug pricing is likely whether Biden or President Donald Trump wins the election. The Trump administration has made drug pricing a signature health care issue, and announced executive orders in recent weeks intended to lower prescription drug costs *(HPW 8/3/20, p. 1)*. Yet even if the Trump administration does continue, "I don't believe complete repeal of the ACA is a political possibility," Mendelson said during the webinar.

Watch the webinar at https://bit.ly/31PQnd3 and contact Mendelson at dmendelson@avalere.com.

by Peter Johnson

mal levels starting in June — even as some parts of the country continue to struggle with coronavirus outbreaks. For that reason, companies including Anthem, Centene Corp., Cigna, Humana and UnitedHealth all maintained their full-year earnings projections despite their very strong second-quarter financial performances (see infographic, p. 8).

> **It's a curious thing about health insurance, that there are very few other industries where we say, 'Gee, if somebody has a good quarter, that's really unethical and that's a push for wholesale, fundamental change.'**

Still, some Wall Street analysts expressed a degree of skepticism. Stephen Tanal of Leerink SVB, for example, wrote in an Aug. 5 investor note that Humana's second-quarter financial results suggest that its 2020 earnings guidance is "extremely conservative" and could be "tough to achieve." And during UnitedHealth's July 15 call, Citi analyst Ralph Giacobbe questioned executives about why they believe health care utilization will rebound in the second half despite COVID-19 surges *(HPW 7/20/20, p. 3)*. "We would expect the infection rates to ebb and flow based on geography, but we don't expect to see sort of a broad-based shutdown," UnitedHealthcare CEO Dirk McMahon replied at the time.

Major publicly traded insurers are not the only ones to report utilization levels returning to normal. Blue Cross Blue Shield of Michigan said in an Aug. 10 press release that after "declines that briefly reduced claims by one-half year over year in April, health care claims submissions to Blue Cross and Blue Care Network have steadily risen by an average of five to seven percent per week and are currently running at or above historical levels." Market segments where claims are above historical levels include inpatient hospital admissions, specialty prescription drugs and behavioral health, the insurer added.

Under the Affordable Care Act's medical loss ratio (MLR) provisions, large-group employer health plans must spend at least 85% of their premium dollars on health care and quality improvement — and rebate customers if they spend less than that. For the individual and small-group markets, the MLR threshold is 80%. Recognizing that some plans' MLRs will dip below 80%, CMS is temporarily allowing ACA exchange insurers to prepay to enrollees all or part of their estimated MLR rebate for the 2019 reporting year. Many states also have provisions in their Medicaid managed care contracts to claw back excess profits from MCOs, insurer executives have pointed out during recent earnings calls.

In addition to all those requirements, claims-cost savings that accrue in the self-insured market are by definition returned to employers, points out Jon Kingsdale, an associate professor at Boston University School of Public Health and a former executive at Tufts Health Plan. A similar effect applies to cases when insurers have risk-sharing arrangements with providers, as those organizations get to share in any earned savings.

In summary, "yes, there's a case that can be made that health plans ought to give back some of the 'excess profits' that they lucked into in the second quarter of 2020, but there's a

MCO Stock Performance, July 2020

	Closing Stock Price on 7/31/2020	July Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$172.69	(10.6%)	(15.7%)	$18.50
UnitedHealth Group	$302.78	11.0%	3.5%	$16.49
Anthem, Inc.	$273.80	3.4%	(9.0%)	$22.44
Commercial Mean		**1.2%**	**(7.1%)**	
MEDICARE				
Humana Inc.	$392.45	16.8%	8.0%	$18.65
Medicare Mean		**16.8%**	**8.0%**	
MEDICAID				
Centene Corp.	$65.25	4.2%	5.4%	$4.83
Molina Healthcare, Inc.	$184.70	49.3%	38.5%	$12.00
Medicaid Mean		**26.8%**	**22.0%**	
Industry Mean		**12.3%**	**5.1%**	

*Estimates are based on analysts' consensus estimates for full-year 2020.

SOURCE: Bank of America Merrill Lynch.

fair amount of caveat around really how much there is that they won't have to give back anyway — either to self-insured employers or to rate-payers under MLR or to providers under risk arrangements," he says.

"The other issue, frankly, is actuarial projections for next year are all over the map," Kingsdale adds. "Actuaries hate uncertainty, and for them it's way better to price on a pessimistic scenario than on an optimistic one." A Wakely Consulting report commissioned by AHIP estimates that COVID-19 treatment costs could range anywhere from $30 billion to $547 billion for 2020-2021.

In an Aug. 7 note to investors about the House committee investigation of insurers, Giacobbe pointed out that "while MCOs have posted big 2Q upside due to broader under-utilization of healthcare," they uniformly expect higher costs in the second half of the year and have provided billions of dollars in support to customers. "Nevertheless, we anticipate more headlines emerging not just around…COVID, but other policy and general healthcare coverage debate as the election draws near, [which] could cause some volatility for the MCO group in the [near term]," he wrote.

Asked whether high insurer profits in the throes of a pandemic will strengthen calls to abolish private insurers — through a system like Medicare for All — Kingsdale observes: "It's a curious thing about health insurance, that there are very few other industries where we say, 'Gee, if somebody has a good quarter, that's really unethical and that's a push for wholesale, fundamental change.'"

However, it's also clear amid the current crisis that the ACA hasn't completely solved the country's coverage access problems, Kingsdale says. In fact, the Kaiser Family Foundation has estimated that as of May 2, nearly 27 million people could lose employer-sponsored insurance and become uninsured following a job loss.

"The huge economic dislocation from our mishandling of the pandemic in the United States has underscored some of the many failings of our existing health care financing system," Kingsdale concludes.

View th E&C release at https://bit.ly/3arjyad and Eyles' post at https://bit.ly/3iHPdr7. Contact Paduda at jpaduda@healthstrategyassoc.com and Kingsdale at jon131@bu.edu. ✧

by Leslie Small

News Briefs

✦ ***Molina Healthcare Inc. and two of its subsidiaries have been accused of providing subpar care and overbilling the government for children's behavioral health services by $20 million, Axios reported on Aug. 13.*** A recently unsealed lawsuit obtained by the news outlet — which was first filed in 2018 — alleges that Molina billed for some care as though it was provided by a professional even when it wasn't, failed to give some providers proper training, provided care for some children who weren't eligible to receive it and fired an employee who complained about such practices. Axios' article noted that Molina did not respond to a request for comment. Visit https://bit.ly/2PSrqIB to learn more.

✦ ***New Mexico Health Connections, a consumer operated and oriented plan (CO-OP) that offered health plans on the state's individual insurance exchange, will shut down on Jan. 1, 2021, according to an Aug. 10 press release.*** "With continued high claims costs and limited opportunities for new investment, it has become clear that the amount of growth required to provide quality care at reasonable rates will be unlikely in the next plan year," said Marlene Baca, the CO-OP's president and CEO. New Mexico Health Connections previously filed a lawsuit challenging the formula used to calculate payments in the Affordable Care Act risk adjustment program, arguing it disadvantages smaller and newer health plans. New Mexico Health Connections is the latest in a long string of CO-OPs that have folded amid challenging market conditions on the ACA exchanges. Read more at https://bit.ly/343Tyk2.

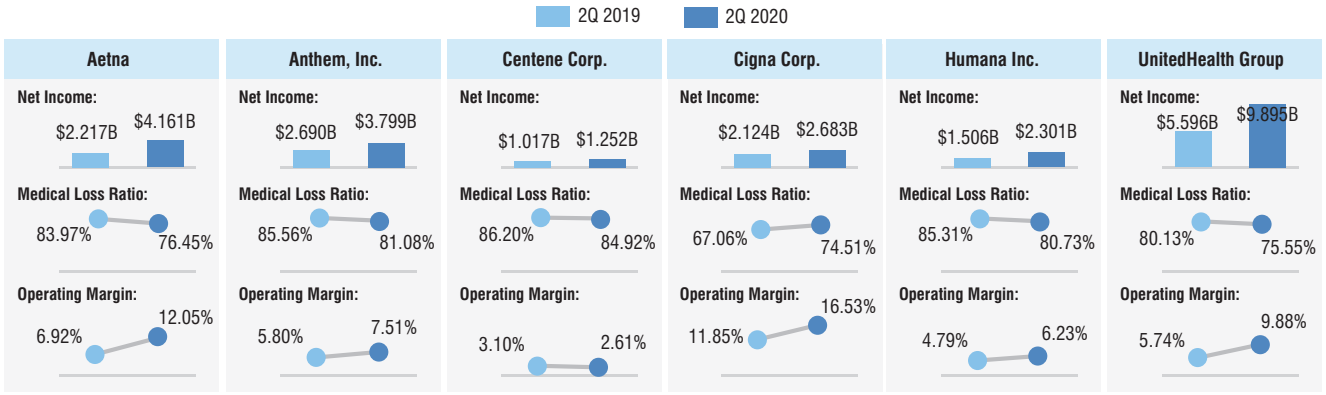
✦ ***Between 2016 and 2018, the share of primary care physicians affiliated with vertically integrated health systems increased from 38% to 49%, according to a study published in the August issue of Health Affairs.*** Researchers noted that "for-profit and church-operated systems had the largest increases in system size, driven in part by a large number of system mergers and acquisitions." As of 2018, more than half of U.S. physicians and 72% of hospitals were affiliated with one of 637 health systems. Find the study at https://bit.ly/3anB2Vh.

Major Insurers Get Financial Boost From COVID-19

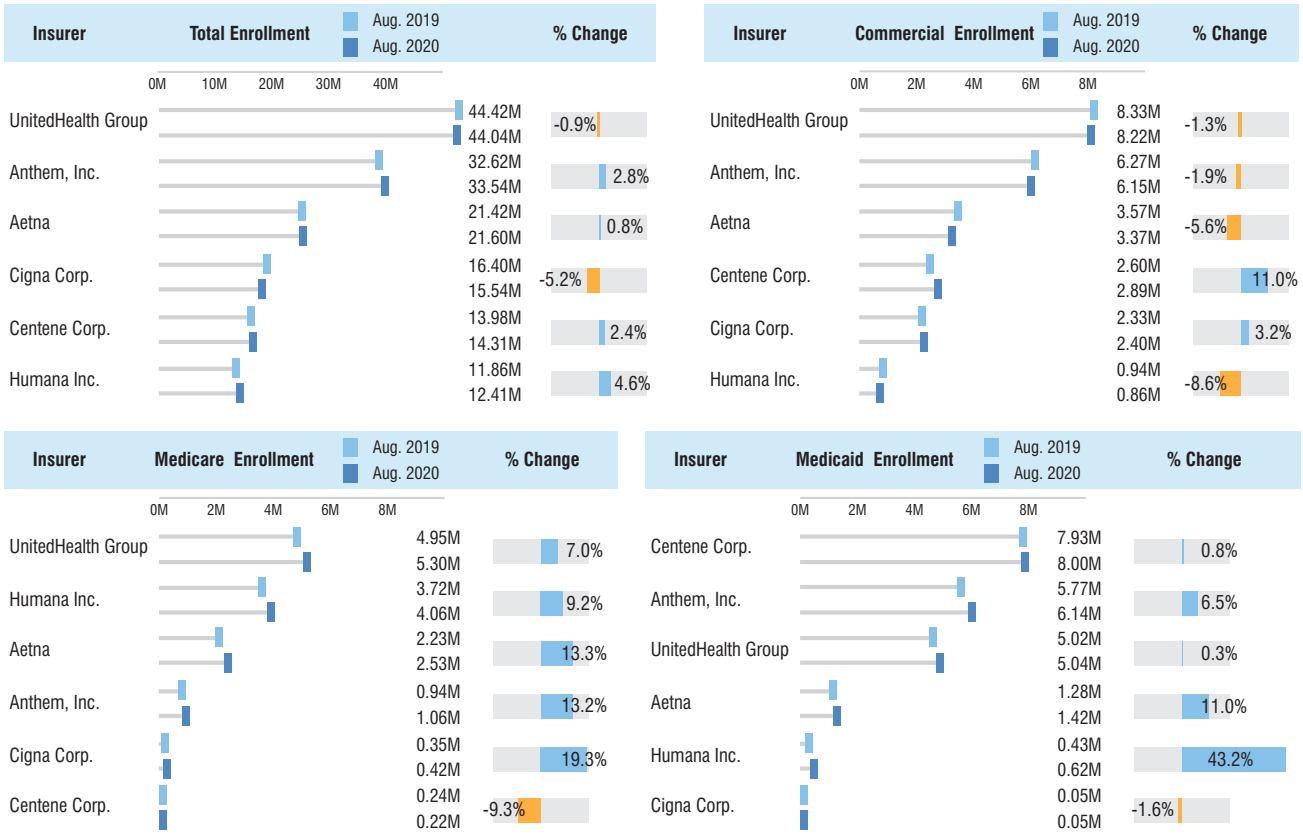
by Jinghong Chen

Publicly traded health insurers had unusually strong financial performances during the second quarter of 2020, mainly driven by a reduction in health care utilization due to the coronavirus pandemic. Six leading health insurers — CVS Health Corp.'s Aetna, Anthem, Inc., Centene Corp., Cigna Corp., Humana Inc. and UnitedHealth Group — all saw net income growth compared with the second quarter of last year. Among them, four insurers' commercial membership decreased, while all but Cigna's Medicaid enrollment grew year over year in the quarter.

Key Financial Data for Leading Health Insurers, as of 2Q 2019 & 2020



Membership of Key Leading Health Insurers, as of August 2019 & 2020



SOURCES: AIS's Directory of Health Plans, as of August 2019 and 2020. "Key Financial Data for Leading Health Plans, Second Quarter 2019." Visit https://bit.ly/2XVbQ3i.