HEALTHCARE INDUSTRY GROUP

Provider-Sponsored Health Plans: Bridge or Anchor?

A CFO/CEO Perspective on the Future of Vertically Integrated Health Systems

Executive Summary

Provider-sponsored health plans (PSHPs) were designed to hedge against declining fee-for-service margins, capture premium dollars, and accelerate the shift toward value-based care. The idea was compelling: If health systems could also act as payers, they could better control costs, keep patients within their networks, and reinvest surpluses into mission.

Today, this narrative is unraveling.

- **UCare**, Minnesota's second-largest Medicare Advantage (MA) carrier, lost $504 million in 2024 and announced a full MA exit by 2026.[1,2] More than $400 million in reserves remain tied up and unavailable for redeployment.
- **McLaren Health** continues to debate divestiture as its plan has weakened enterprise margins and drawn scrutiny from lenders.[6]
- **Centra Health** exited Medicare Advantage and outsourced commercial operations after sustained losses.[7,8]
- **Baylor Scott & White Health** (Texas) and **Sutter Health** (California) both scaled back PSHP ambitions after struggling to balance growth with capital demands.[9,10]

Meanwhile, only a handful of systems have achieved scale and capabilities. UPMC Health Plan has more than 4 million members, Priority Health has grown through acquisitions to more than 1.3 million members, and Intermountain's SelectHealth covers more than 1 million members.[11,12,13]

The central message for CFOs and CEOs: A PSHP is never neutral. It is either a bridge to integration, enterprise value, and resilience—or it is an anchor that drains liquidity, ties up reserves, raises borrowing costs, and undermines strategic focus.

Kaiser Permanente was deliberately excluded from this analysis. Its 80-year-old closed-panel model is an anomaly that cannot be replicated under today's market conditions.

PSHPs were conceived as strategic hedges; in practice, many are financial liabilities disguised as strategy.

Why Health Systems Sponsor Plans: Promise vs. Reality

The promise of PSHPs has always been rooted in diversification and control. As inpatient margins eroded under fee-for-service, boards and CFOs were drawn to the idea of capturing premium revenue and investing in population health.

But history has shown how difficult it is for systems to succeed in the payer business. Insurance is a fundamentally different competency: Actuarial science, risk adjustment, regulatory capital, distribution, and claims administration are not rooted in most hospital DNA.

- Health systems originally pursued PSHPs to capture premium revenue in order to hedge against shrinking inpatient margins.
- They also sought to integrate care delivery with financing, advancing population health capabilities.
- Another common rationale was to gain leverage with payers and employers by competing directly with them.
- Approximately 60 PSHPs exist nationally today, covering around 14 million lives.[12]
- Fewer than 15% of PSHPs formed since 2010 have reached sustainable profitability.[4]
- Many mid-size systems, including McLaren, and Centra, have been destabilized by plan losses.[3,4,7,6]
- Rating agencies increasingly cite PSHP performance in negative credit outlooks.[5,6]

Examples:

- **Henry Ford Health** joint-ventured its Medicaid business with CareSource to share risk and free up reserves.[14,15]
- **Baylor Scott & White** scaled back after realizing its commercial plan ambitions required more capital than anticipated.[10]
- **Sutter Health** reduced its insurance operations under financial strain.[9]

PSHPs were conceived as strategic hedges; in practice, many are financial liabilities disguised as strategy.

Performance Reality: Divergence at the Tails

The performance of provider-sponsored health plans has become increasingly polarized. At one end of the spectrum is a handful of systems that have achieved meaningful scale, developed payer-grade competencies, and have invested in infrastructure over decades. These "winners" have turned their plans into strategic assets that reinforce their provider enterprises. They use their plans to diversify revenue, integrate care delivery, and compete directly with national insurers. For these systems, the health plan serves as a **bridge**—a source of strategic advantage and enterprise stability.

At the other end of the spectrum is the majority of systems whose PSHPs are subscale, undercapitalized, and operationally deficient. These plans often lack actuarial rigor, suffer from poor quality performance, and cannot absorb rising medical and pharmacy costs. They become recurring drains on liquidity, contribute to negative credit outlooks, and force boards to consider retrenchment or exit. For these systems, the health plan is an **anchor**—dragging down financial results, trapping capital, and consuming leadership bandwidth.

The contrast between winners and strugglers is stark. Where UPMC, Priority, and SelectHealth demonstrate scale, discipline, and long-term commitment; UCare, McLaren, and Centra illustrate the fragility of plans without these attributes.

Performance Divergence

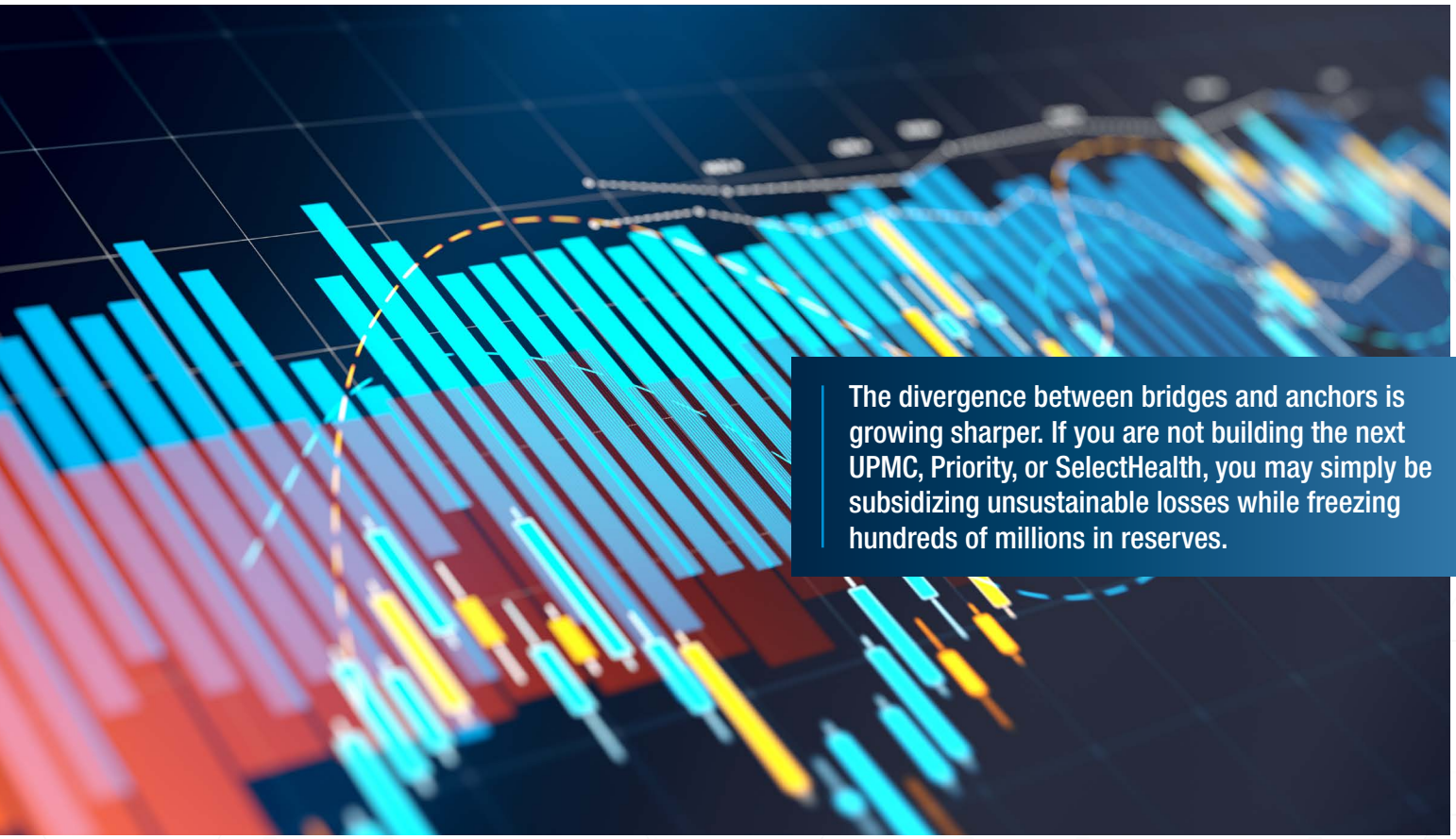
Sustained Performers (Bridges):

- **UPMC Health Plan** – More than 4 million members across Medicare Advantage, Medicaid, and Commercial. Consistently earns top-quartile Star ratings and leverages strong brand equity to compete with national insurers.
- **Priority Health** – More than 1.3 million members after acquiring Physicians Health Plan of Northern Indiana and expanding into Wisconsin.[11,12] Consolidation strategy improved scale and bargaining power.
- **Intermountain SelectHealth** – Surpassed 1 million members in 2023, benefiting from a closed regional market where Intermountain's delivery network dominates.[13]
- **Geisinger Health Plan** – Approximately 600,000 members, with long-standing Medicaid and MA competencies built over decades.

Chronic Strugglers (Anchors):

- **UCare** – Lost $504 million in 2024 and announced full MA exit by 2026;[1,2] more than $400 million in reserves tied up.
- **McLaren Health** – Plan deficits have weakened enterprise margins and have been noted in Fitch credit outlooks.[6]
- **Centra Health** – Exited Medicare Advantage in 2022 and outsourced commercial operations in 2023 to stop ongoing losses.[7,8]
- **Baylor Scott & White Health** – Scaled back its insurance strategy in 2022 due to capital pressures.[10]
- **Sutter Health** – Abandoned its commercial plan expansion in 2021 to refocus on core provider operations.[9]

The divergence between bridges and anchors is growing sharper. If you are not building the next UPMC, Priority, or SelectHealth, you may simply be subsidizing unsustainable losses while freezing hundreds of millions in reserves.



Six Pressure Points Squeezing PSHPs

The operating environment for provider-sponsored health plans has shifted from challenging to structurally unsustainable for many. What were once considered stable pillars—Medicare Advantage and Medicaid—are now volatile and margin-constrained.

Medicare Advantage, long viewed as a growth engine, is facing payment headwinds from CMS's risk adjustment changes, declining Star ratings, and expanded RADV audits. At the same time, medical and pharmacy trends are accelerating. GLP-1 drugs alone have increased Medicaid spending by more than 500% between 2019 and 2023, adding thousands of dollars per member annually in new costs with little near-term savings.[16,17]

Medicaid, another traditional anchor for PSHPs, is increasingly fragile. Post-pandemic redeterminations have forced more than 25 million individuals off Medicaid rolls since 2023, creating unprecedented churn and raising administrative costs by 15–20%.[18] Dual-eligible carve-ins and long-term services programs require payer-grade infrastructure that most PSHPs lack. The Big Beautiful Bill further compounds the risk by projecting $1 trillion in federal Medicaid funding cuts over the next decade, forcing states to tighten capitation rates and squeeze already thin plan margins.

Beyond these programmatic pressures, PSHPs continue to face scale disadvantages, trapped reserves under risk-based capital requirements, and a shortage of payer-grade actuarial and Stars expertise. Layered on top of this is the strategic identity conflict: Hospitals are built to maximize volume, while plans are built to minimize it. This fundamental misalignment creates governance paralysis that exacerbates financial losses.

For CFOs, each of these pressure points has a direct balance sheet implication—reduced margin, frozen reserves, higher borrowing costs, or regulatory sanctions. Together, they explain why so many PSHPs have become anchors instead of bridges.

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Six Pressure Points

Medicare Advantage margin compression

- CMS's Risk Adjustment v28 is reducing payments, particularly for higher-acuity populations.[14]
- Average MA Star ratings declined from 4.04 in 2024 to 3.92 in 2025, resulting in significant bonus revenue losses.[15,16]
- Expanded RADV audits are increasing the risk of multi-million-dollar clawbacks.[17]

Pharmacy and emerging therapies

- GLP-1 utilization in Medicaid grew by 400% from 2019 to 2023, with gross spending up 500%.[16,17]
- These drugs are adding $1,000–$2,000 in per-member annual costs, with little offset from avoided medical utilization.

Medicaid volatility and funding cuts

- Post-pandemic redeterminations have disenrolled more than 25 million individuals, destabilizing membership and raising administrative costs by 15–20%.[18]
- **The Big Beautiful Bill** projects approximately **$1 trillion in federal Medicaid funding reductions** over 10 years, forcing states to cut capitation rates.
- Dual-eligible carve-ins and managed long-term services programs require payer-grade infrastructure that most PSHPs lack.

Scale and capital constraints

- Plans with fewer than 100,000 members cannot spread fixed administrative costs effectively.
- RBC requirements at or above 200% ACL tie up hundreds of millions of dollars in statutory reserves, freezing liquidity that could otherwise support enterprise operations.[21]

Talent and competency gaps

- Most provider-sponsored plans lack experienced payer CFOs, actuaries, and Stars/RA experts.
- Oversight failures have already led to state corrective action plans, such as Contra Costa Health Plan in California.[22]

Strategic identity conflict

- Hospitals generate margin from volume, while health plans create margin by reducing utilization.
- This structural misalignment frequently paralyzes governance and undermines strategic coherence.

Each of these headwinds is quantifiable in dollars—margin erosion, trapped reserves, or higher debt costs. Taken together, they explain why most PSHPs are not just underperforming but are structurally unsustainable without radical change.

CFOs are especially vulnerable if their finance teams are not producing an integrated per-member-per-month (PMPM) analysis that spans both plan and provider.

Enterprise Economics: Seeing the Whole Elephant

One of the most persistent blind spots in evaluating provider-sponsored health plans is how their performance is reported to boards and CFOs. In many systems, the plan and the provider are measured in silos. Losses at the plan level are rationalized as hospital revenue inflows—a kind of "left pocket/right pocket" logic. On paper, the hospital sees an increase in utilization and revenue, even though the health plan is bleeding cash.

This siloed view is misleading and dangerous. It ignores the full enterprise effect: leakage to external providers, statutory reserves tied up under RBC requirements, and administrative overhead borne by the plan. Once those elements are included, the "neutral" picture often becomes a deeply negative one.

The trap is clear: What looks like a wash on a financial statement, can, in reality, mask significant enterprise deterioration. CFOs are especially vulnerable if their finance teams are not producing an integrated per-member-per-month (PMPM) analysis that spans both plan and provider. Without it, capital allocation decisions—whether to double down, partner, or exit—are being made with distorted information.

Illustrative Example (False Neutrality)

- Reported view: A PSHP posts a $100 million loss. The hospital division reports $100 million in offsetting revenue from plan-paid admissions. On paper, the net looks neutral.
- True enterprise view:
  - PSHP loss: –$100M
  - Hospital revenue from plan: +$100M
  - Leakage to external providers: –$40M
  - Reserves frozen under RBC requirements: –$50M
  - Net enterprise impact: –$90M[21]

This is not hypothetical. UCare provides a case study: Despite hospital revenues tied to the plan, the $504 million loss in 2024 combined with more than $400 million in locked reserves turned what looked neutral into a massive enterprise drain.[1,2]

- Siloed reporting obscures true enterprise economics, creating a "false neutrality" trap.
- Hospital inflows from plans are not free money; they often mask net enterprise losses once leakage and reserves are accounted for.
- RBC rules can lock up hundreds of millions in reserves, effectively reducing days cash on hand.[2,3]
- Without enterprise PMPM reporting, CFOs risk misallocating capital and misjudging viability.

If you are not looking at enterprise PMPM, you are not managing reality—you are subsidizing illusions. The real economics are almost always worse than the siloed reports suggest.

Strategic Options: From Illusion to Decision

Once the "false neutrality" illusion is stripped away, the decisions facing CFOs and CEOs become unavoidable. A PSHP is either strengthening enterprise value, or it is eroding it. There is no middle ground. The idea that a system can "wait and see" or tolerate small annual losses for the sake of strategy is a dangerous fallacy. Every year of delay compounds losses, freezes more reserves under RBC rules, and signals indecision to bondholders and rating agencies.[6,21]

For most systems, there are only five real pathways forward. Each option is not just strategic—it is financial. The differences between them are measured in capital requirements, reserves freed or frozen, and the impact on days cash on hand. CFOs must view these not as theoretical possibilities but as balance sheet moves.

Option 1: Double Down

- **Capital requirement:** Typically, $250–$500 million in technology modernization, payer-grade talent, and reserves.
- **Viability:** Requires at least 500,000 members across multiple lines of business to be sustainable.
- **Examples:** UPMC (>4 million members) and Priority (>1.3 million members with regional acquisitions).[11,12]
- **CFO implication:** For a small handful of systems, doubling down can transform the plan into a strategic asset. For most, the capital required far exceeds realistic capacity.

Option 2: Joint Venture or Outsource

- **Capital impact:** Can offload 30%–40% of administrative costs and free $100–$200 million in reserves.
- **Examples:** Henry Ford partnered with CareSource for a Medicaid joint venture; SSM Health delegated plan administration to Medica.[14,15]
- **CFO implication:** A pragmatic option for systems unwilling or unable to scale independently. Preserves brand and some leverage while mitigating financial drag.

Option 3: Consolidate for Scale

- **Capital impact:** Requires acquisition capital and integration resources but allows overhead and compliance costs to be spread across a larger membership base.
- **Examples:** Priority Health acquired Physicians Health Plan of Northern Indiana and expanded into Wisconsin, growing to >1.3 million members.[11,12]
- **CFO implication:** Can help cross the viability threshold, but integration is complex, and many markets lack willing partners.

Option 4: Exit

- **Capital impact:** Releases $200–$400 million in reserves, improves days cash on hand, and can reduce rating pressure by 50–100 basis points.
- **Examples:** UCare's MA exit in 2026; Centra's decision to divest Medicare Advantage and outsource Commercial.[2,7,8]
- **CFO implication:** The most immediate path to liquidity relief and ratings stability. Politically difficult, but often the financially responsible choice.

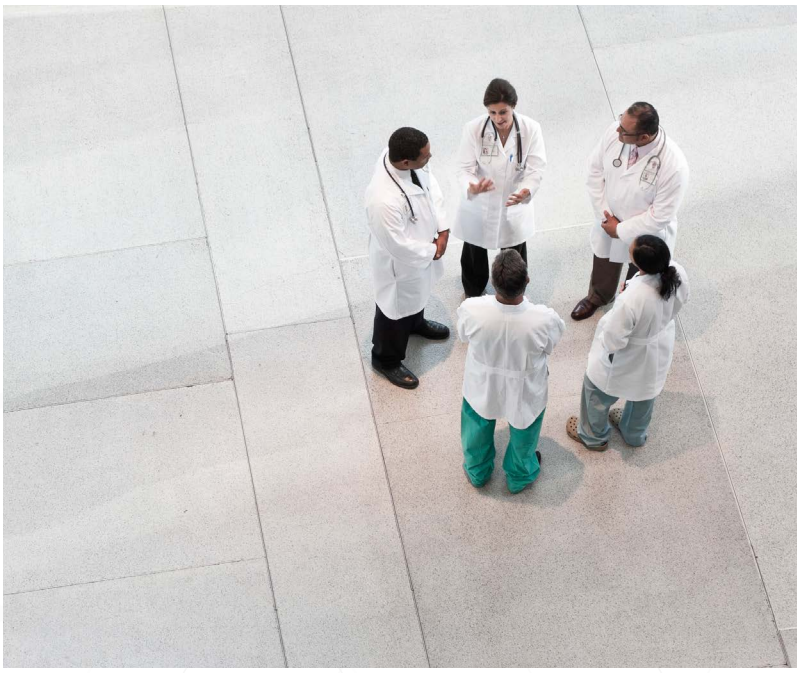
Option 5: Refocus Narrowly on ERISA Self-Insured Plans

- **Capital impact:** Eliminates most regulatory costs and avoids RBC requirements.
- **Examples:** Many mid-sized regional systems have retained only employee health plans as a platform for care management and quality infrastructure.
- **CFO implication:** Limited growth upside but removes enterprise-threatening risk while maintaining some capabilities in value-based care.

Considerations:

- Doubling down requires large-scale investment and is only viable for systems that already have 500,000 members.
- Joint ventures or outsourcing arrangements can mitigate risk and free reserves while preserving market presence.
- Consolidation can create scale but requires acquisition capital and exposes the system to integration risk.
- Exit provides immediate capital relief and ratings improvement but is often politically sensitive.
- ERISA-only focus allows retention of competencies without exposure to MA/Medicaid volatility.

Every option is a capital strategy. "Wait and see" is not neutral—it is active value destruction. The only real choice is whether to invest, partner, or exit, and the time horizon is measured in months, not decades.



Bridge vs. Anchor: A CFO Decision Tree

CFOs cannot afford to rely on anecdotes or strategic aspirations when evaluating a PSHP. The right test is brutally simple: Does the plan meet minimum thresholds of scale, capital adequacy, quality, leadership, and enterprise transparency? Each threshold is both an operational gate and a financial gate. A "No" answer is not neutral—it signals a measurable drag on liquidity, reserves, or ratings. When multiple gates fail, the plan should be treated as an Anchor until proven otherwise.

Gate 1: Scale

Test: Does your plan have at least 100,000 members in one line of business?

Financial consequence: If no, fixed administrative overhead (~$20–$30 million annually) overwhelms the plan's ability to generate positive margin.

Ratings consequence: Rating agencies view subscale plans as structural drags on the enterprise, given their inability to cover overhead.

Verdict: Failure = likely Anchor unless JV or consolidation pursued.

YES NO

Gate 2: Capital and Liquidity (RBC Ratio)

Test: Is your risk-based capital (RBC) ratio above 250% and trending upward?

Financial consequence: If no, statutory reserves are frozen, reducing available days cash on hand by 20–30 days for many systems. Liquidity cannot be redeployed to support hospital operations.[21]

Ratings consequence: Falling below 250% RBC moves the plan toward regulatory action level; Moody's and Fitch cite this as a direct credit concern.[6]

Verdict: Failure = frozen liquidity + ratings pressure = Anchor risk.

YES NO

Gate 3: Quality and Stars Performance

Test: Are your Medicare Advantage Star ratings at or above 3.5 and trending upward?

Financial consequence: If no, bonus revenue is lost. For a 500,000-member plan, this translates to $25–$50 million in annual margin impact.[15,16]

Ratings consequence: Persistent low Stars can attract CMS oversight, accelerate member attrition, and increase reputational risk.

Verdict: Failure = ongoing revenue erosion = Anchor risk.

YES NO

Gate 4: Payer-Grade Leadership

Test: Do you have payer-grade executives (CFO, actuary, Stars/RA leadership) in place?

Financial consequence: If no, oversight failures can trigger corrective action plans (CAPs), increase administrative costs, and expose the system to fines.[22]

Ratings consequence: Weak governance is cited by regulators and can translate into confidence erosion among investors.

Verdict: Failure = governance and compliance gaps = Anchor risk.

YES NO

Gate 5: Enterprise Economics (PMPM View)

Test: Can you produce a unified enterprise PMPM that integrates plan and provider economics?

Financial consequence: If no, plan losses appear offset by hospital inflows—masking net enterprise losses once leakage and reserves are included.[3,2] This creates distorted capital allocation decisions.

Ratings consequence: Inability to demonstrate enterprise economics raises questions about management credibility with rating agencies.

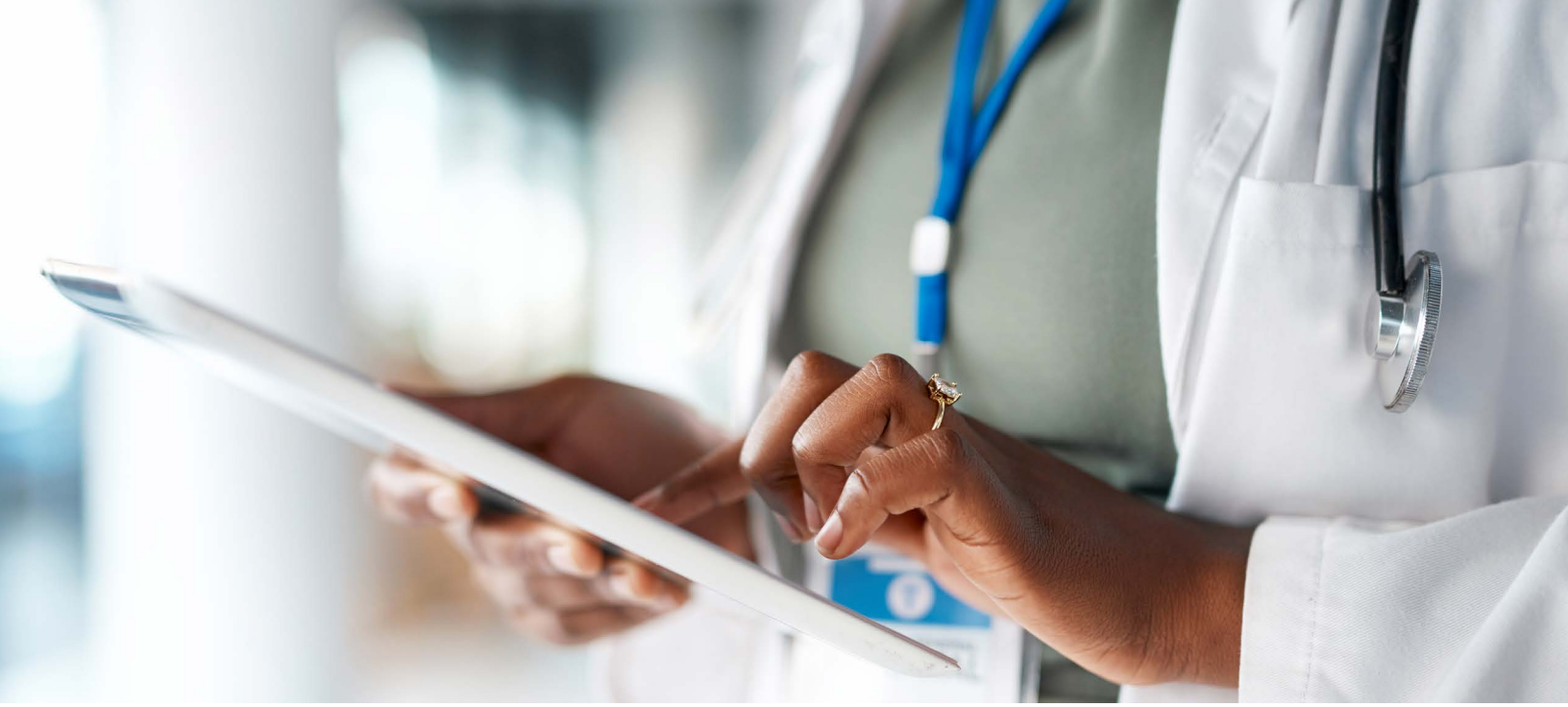
Verdict: Failure = misallocation of capital + credibility loss = Anchor risk.

YES NO

Interpretation

- **Five "Yes" answers = Bridge potential.** CFOs can justify continued sponsorship if capital is available and strategic fit is strong.
- **Three to four "Yes" answers = Unstable.** The plan is on the edge of viability; partnership, outsourcing, or consolidation should be considered within 12–24 months.
- **Two or fewer "Yes" answers = Almost certainly an Anchor.** The plan is destroying liquidity, tying up reserves, and undermining credit; urgent action is required.

This decision tree is not theoretical. Each "No" carries a dollar consequence and a ratings consequence. If you cannot clear at least three gates, your PSHP is not a strategic asset—it is an Anchor dragging your enterprise under water.



The evidence across markets, case studies, and regulatory trends is clear: Provider-sponsored health plans produce binary outcomes. For a small handful of systems with the necessary scale, capital, and payer-grade competencies, a PSHP can still serve as a bridge—strengthening enterprise economics, reinforcing the provider strategy, and enhancing long-term competitiveness. For the majority, however, PSHPs have become anchors that consume liquidity, tie up hundreds of millions in reserves, and undermine ratings and investor confidence.

The options available to CFOs are stark but straightforward. Section 5 highlighted five distinct strategic pathways: double down, joint venture or outsource, consolidate, exit, or refocus narrowly on ERISA self-insured coverage. Each is a capital strategy with direct implications for reserves, liquidity, and cost of debt. Section 6 then provided the diagnostic—a CFO decision tree that translates operational thresholds into financial consequences.

Taken together, these tools leave little room for ambiguity. CFOs now have both a framework to measure whether their PSHP is a bridge or an anchor, and a menu of options on which to act decisively. The real question is not whether to act but when—and the answer is sooner rather than later.

Waiting is the most expensive option. Every year of delay compounds losses, freezes more reserves under RBC rules, and erodes board, regulator, and investor confidence. "Incrementalism" signals indecision, which rating agencies increasingly punish.

- PSHP outcomes are binary: They are either bridges that create enterprise value or anchors that destroy it.
- The five strategic options are clear and capital-specific.
- The CFO decision tree provides a rigorous test of viability.
- Delay is not neutral—it is active value destruction.

The middle ground is gone. If your PSHP does not pass the decision tree and cannot be positioned within one of the viable strategic options, it is already an anchor. CFOs and CEOs must decide within 12–24 months: double down, partner, consolidate, or exit. If you cannot prove your PSHP is a bridge, assume it is an anchor—and act accordingly.

Appendix – Case Studies in PSHP Viability

Case 1: UCare

MINNESOTA/WISCONSIN

Context: UCare, Minnesota's second-largest Medicare Advantage (MA) carrier (~186,000 members), also operated Medicaid and ACA plans.

What Happened:

- Reported a $504M operating loss in 2024;[1]
- Announced a full exit from MA by 2026;[2]
- Laid off ~9% of workforce (~144 jobs).[1]

Financial/Strategic Impact:

- Reserves of >$400M locked up in statutory capital requirements;
- Exit will be one of the largest non-sale withdrawals in MA's 28-year history.[2]

Lessons Learned:

- Even well-established nonprofit PSHPs can be overwhelmed by RA v28, Stars volatility, and medical trend;
- For CFOs, MA participation without scale is a high-risk, high volatility bet.

Case 2: Henry Ford Health/Health Alliance Plan

MICHIGAN

Context: Henry Ford Health has owned Health Alliance Plan (HAP) for decades, historically active in commercial and Medicaid.

What Happened:

- Facing competitive Medicaid bids and rising costs, Henry Ford formed a Medicaid joint venture with CareSource;[14,15]
- Delegated infrastructure and shared risk while retaining brand affiliation.

Financial/Strategic Impact:

- JV arrangement freed capital reserves otherwise tied to Medicaid;
- Allowed HAP to stabilize without draining Henry Ford's balance sheet.

Lessons Learned:

- Joint ventures can mitigate capital drag while preserving market presence;
- CFOs should consider partnerships as alternatives to outright exits.

Case 3: Priority Health

MICHIGAN/REGIONAL EXPANSION

Context: Priority Health, affiliated with Corewell Health (formerly Spectrum), is one of the largest PSHPs in the US.

What Happened:

- Acquired Physicians Health Plan of Northern Indiana;[11]
- Took governance role in Group Health Cooperative of Eau Claire (Wisconsin);[12]
- Grew to ~1.3M members across multiple states.

Financial/Strategic Impact:

- Scale enables Priority to compete with Blues and nationals;
- Consolidation improved administrative efficiency and bargaining power.

Lessons Learned:

- Regional consolidation is one of the few viable paths to PSHP scale;
- CFOs should evaluate M&A opportunities to cross scale thresholds.

Case 4: Intermountain SelectHealth

UTAH/REGIONAL FOOTPRINT

Context: SelectHealth is Intermountain's integrated health plan, operating across Utah, Idaho, and Nevada.

What Happened:

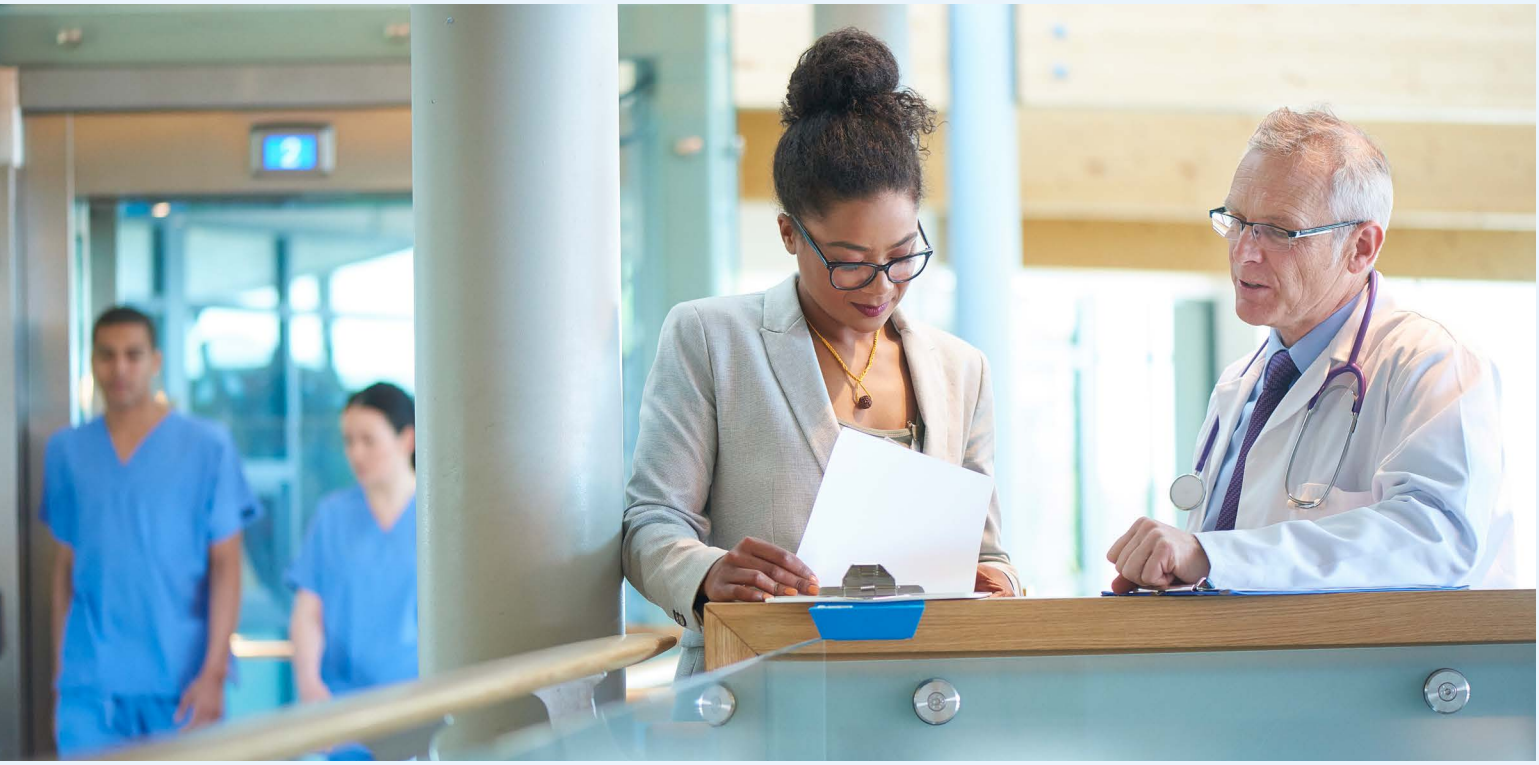
- Surpassed 1M members in 2023;[13]
- Operates within a relatively closed geographic market, leveraging Intermountain's network.

Financial/Strategic Impact:

- Integrated model supports alignment of incentives across financing and delivery;
- Provides stable contribution to enterprise results.

Lessons Learned:

- Closed-system geographies provide structural advantages;
- CFOs in open, competitive markets should not assume SelectHealth's model is replicable.



Case 5: Centra Health

VIRGINIA

Context: Centra operated small-scale MA and commercial plans.

What Happened:

- Exited Medicare Advantage in 2022;[7]
- Outsourced commercial operations in 2023.[8]

Financial/Strategic Impact:

- Released reserves tied up in small MA/commercial plans;
- Reduced system exposure to rating risk.

Lessons Learned:

- Exit can be value-preserving if executed decisively;
- CFOs should act early when scale thresholds cannot be met.

Case 6: Sutter Health

CALIFORNIA

Context: Sutter Health pursued a regional plan strategy with ambitions to grow commercial enrollment.

What Happened:

- Announced exit from select commercial plan offerings in 2021;[9]
- Refocused on provider operations.

Financial/Strategic Impact:

- Reduced capital burden;
- Allowed Sutter to stabilize operations during a period of financial strain.

Lessons Learned:

- Even large systems may need to retreat from insurance ambitions to preserve capital.

Case 7: Baylor Scott & White Health

TEXAS

Context: Baylor Scott & White (BSW) pursued a PSHP strategy to complement its provider footprint.

What Happened:

- Adjusted strategy in 2022, scaling back growth ambitions due to capital demands.[10]

Financial/Strategic Impact:

- Reduced risk exposure to underperforming commercial lines;
- Preserved reserves for provider-side investments.

Lessons Learned:

- Scaling PSHPs in competitive markets requires far more capital than most systems anticipate.

Appendix Takeaway

Across the cases, outcomes are binary:

- **Bridges:** UPMC, Priority, SelectHealth – scale, capital, payer DNA.
- **Anchors:** UCare, Centra, McLaren – losses, capital drag, rating pressure.
- **Middle paths:** Henry Ford/CareSource JV – partnerships as risk mitigation.

For CFOs: The real question is not "Should we own a plan?" but "Can we sustain scale, quality, reserves, and talent—or is this an anchor pulling us under?"

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