trilliant health

THE HEALTH ECONOMY SUMMIT

October 2024

Executive Session Takeaways

THE Summit

The Health Economy (THE) Summit program has been crafted to foster meaningful discussions and data-driven debate with the goal of challenging the status quo of the health economy.

THE Summit 2024 brought together key executives across the health economy to discuss and debate:

- What the data reveals about the key dynamics shaping healthcare supply, demand and yield; and,
- The implications of emerging trends and necessary strategies from different stakeholder vantage points.

Underlying the discussion was the concept of "value" in healthcare, which most health economy stakeholders have a different definition for. For individuals, value often relates to personal health outcomes and quality of life. Employers typically understand value as ensuring their healthcare investments yield significant return on the investment in employee productivity. Conversely, provider organizations see value as quality multiplied by price, focusing on enhancing care quality while managing revenue streams. Regardless of the different vantage points, every health economy stakeholder can – and must – deliver more value for money to their customer.

The following executive summary presents the key insights and takeaways from each session across the three-day event, including presenter remarks and participant dialogue, representing diverse perspectives from an array of healthcare stakeholders.

CO-CHAIRS

Sandeep Acharya
Co-Founder & CEO
Octave

Diane Hammon
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2024 Trends Shaping the Health Economy: Value Optimization

Sanjula Jain, Ph.D., Chief Research Officer, Trilliant Health

The health economy creates more data than any other part of the economy, but the industry has been challenged to distill and analyze the data in a way that provides meaningful information for decision makers. In this session, Jain debuted the *2024 Trends Shaping the Health Economy Report*, which features eight data-driven secular trends shaping the $4.5T health economy. The original research findings featured in this annual series are gleaned from proprietary Trilliant Health datasets and analytic models that measure various dimensions of demand, supply and yield across the health economy.

Key Takeaways

Value for money will be the defining trend of the U.S. health economy over the next decade. This construct is at odds with the still-predominant fee-for-service reimbursement system on which U.S. health economy stakeholders rely, which is merely transactional in nature. The very few stakeholders who understand value for money do not have a shared definition of what it is or how to measure it. While every health economy stakeholder may have a different definition of value, each of them must face an inexorable reality: The U.S. healthcare system is what game theorists call a "negative-sum game," and the rules of that game are immutable.

2024 Trends Shaping The Health Economy

1	The Current Healthcare System Does Not Promote Health and Is Disproportionately Expensive
2	Healthcare Utilization Patterns Suggest Health Status Will Continue To Decline
3	Government Innovation and Regulation Are Failing To Produce Value
4	The Value of Technological Advancements Is Uncertain
5	Supply Constraints Are Correlated With Inadequate Yield
6	Forced Consumerism Due to Cost Shifting Has Fostered Fragmentation Without Corresponding Value
7	Lower-Cost Care Settings Can Offer Better Value
8	Employers Are Better Equipped To Demand Value for Money

CONCLUSION: Health economy stakeholders who focus on value optimization will have a competitive advantage.

Disrupting Traditional Health Benefits

Tony Miller, Founder and CEO | Managing Partner, Harbor Health | Lemhi Ventures

Tony Miller co-founded and was CEO of Definity Health, a national leader in consumer-driven health benefit programs, through its acquisition by UnitedHealth Group. In 2006, Tony founded Lemhi Ventures and led the formation and development of Lemhi portfolio companies. After that, Tony founded and was CEO of Bind Benefits, where they pioneered personalized health plans, creating a new category of health insurance. Currently, Tony is CEO of Harbor Health, a multi-specialty health system based in Austin, TX where he is pursuing his vision of connecting quality care to a cutting-edge payment mechanism.

Key Takeaways

In this session, Miller discussed a shift from traditional health insurance models to more consumer-driven, condition-focused and incentive-aligned approaches that challenge the "status quo" in U.S. healthcare financing and delivery. He discussed his past ventures in healthcare and how "his next strike gets him closer to his next home run."

Healthcare Financing and Pricing

- The U.S. healthcare system suffers from pricing inefficiencies, with Medicare's historical pricing strategies lacking negotiation, resulting in inflated costs. The RVU-based payment structure also disproportionately favors specialists over primary care providers.
- The AMA and the focus on RVUs have resulted in a scenario where "primary care is dead," because PCPs and physicians in general are not "condition-oriented."
- The annual funding cycle for healthcare promotes short-term thinking and inefficiency – "disease does not recognize the calendar year." HSAs have largely failed to address broader healthcare financing issues, with only $116B in consumer HSAs compared to trillions in spending.

Consumer and Employer Roles

- Employer-sponsored insurance is a "tax accident" rather than a purposeful strategy for healthcare financing. Shifting towards consumer-driven financing could allow individuals to select and pay for condition-specific coverage as needed, increasing transparency and personal engagement in healthcare decisions.
- A credit and debit model in healthcare could leverage consumer assets, similar to how companies like Airbnb utilize latent consumer resources, to build sustainable funding as people age.
- Behavioral economics shows that individuals aren't strictly rational decision-makers. Thus, effective healthcare design must incorporate clear incentives. With the right incentive structures, consumers can make informed choices that improve outcomes, emphasizing transparency in costs and benefits.

Insurance and Risk Management

- The current insurance model, with its "first in, first out" approach, is criticized for being simplistic and poorly suited to diverse consumer needs.
- Despite favoring short-tailed risk, insurance companies should focus on long-tailed risk, increasingly encouraging consumers towards more cost-effective healthcare utilization.
- Organizing care around conditions, rather than service categories, would improve both efficiency and patient outcomes. The Triple Aim's goals of enhancing patient experience, improving population health and reducing costs set the bar too low; healthcare should be designed with the ambition to eradicate disease.

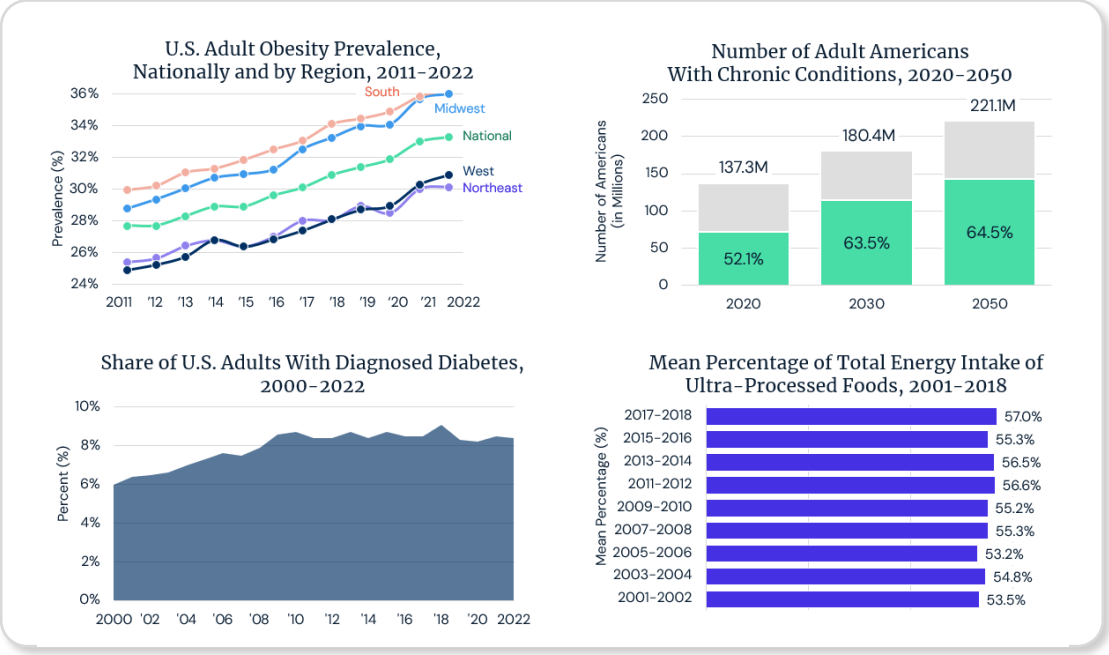
Key Takeaways

In reflection of the panel discussion with Tony Miller, participants reacted with observations and related experiences about a shift from traditional models to more consumer-driven, condition-focused and incentive-aligned approaches that challenge the “status quo” in U.S. healthcare financing and delivery.

- The U.S. healthcare system primarily incentivizes care for the sick rather than preventive measures, sustaining high spending, particularly in unpredictable areas like oncology. Incremental changes are insufficient and thus a revolutionary approach is necessary for meaningful transformation.
- There is skepticism about whether patients can realistically anticipate and prepare for future healthcare costs, given the system's complexity and unpredictability of complex diseases. The for-profit structure has yet to create an effective healthcare system despite decades of free-market operations.
- Wellness tools, such as step counters, are typically utilized by those who need them the least, raising questions about their efficacy across diverse populations.
- The assertion that "primary care is dead" sparked surprise, with some asserting that primary care remains critical, acknowledging that primary care looks different for each patient and variation in provider behavior emphasizes the need to optimize utilization.
- Socialized risk is already a reality through programs like Medicaid and Medicare, yet many patients still face financial ruin due to medical expenses. This raises concerns about the adequacy of existing safety nets and the urgent need to address rural health disparities.
- Employers vary widely in their healthcare needs and definitions of value, making a one-size-fits-all approach to employer-sponsored insurance inadequate. The concept of "commercial" buyers is misleading, as it encompasses diverse entities with different objectives.
- Effective risk stratification is essential for prioritizing care based on urgency and addressing inefficiencies. AI could help allocate limited resources more effectively, ensuring that patients receive timely care.
- Participants raised concerns about condition-based budgeting, especially for unpredictable or high-cost cases like rare pediatric conditions and oncology. Shifting entirely to consumer-driven models may overlook the needs of those lacking resources or understanding to manage their health expenses effectively.
- As costly breakthrough drugs and therapies emerge, the healthcare system must adapt to accommodate these advancements, potentially reshaping financing and delivery models. A more tailored approach to healthcare is crucial to ensure that no population is left behind, recognizing the unique and varied needs across the country.

Trend 1: The Current Healthcare System Does Not Promote Health and Is Disproportionately Expensive

The U.S. spends $4.5T on healthcare, nearly 2X more per person than peer countries, but has worse physical and mental health outcomes. Spending is expected to continue to increase, with categories like hospital and prescription drug spending projected to grow by more than 70% by 2032. This is indicative of poor value, waste and inefficiency.



Key Takeaways

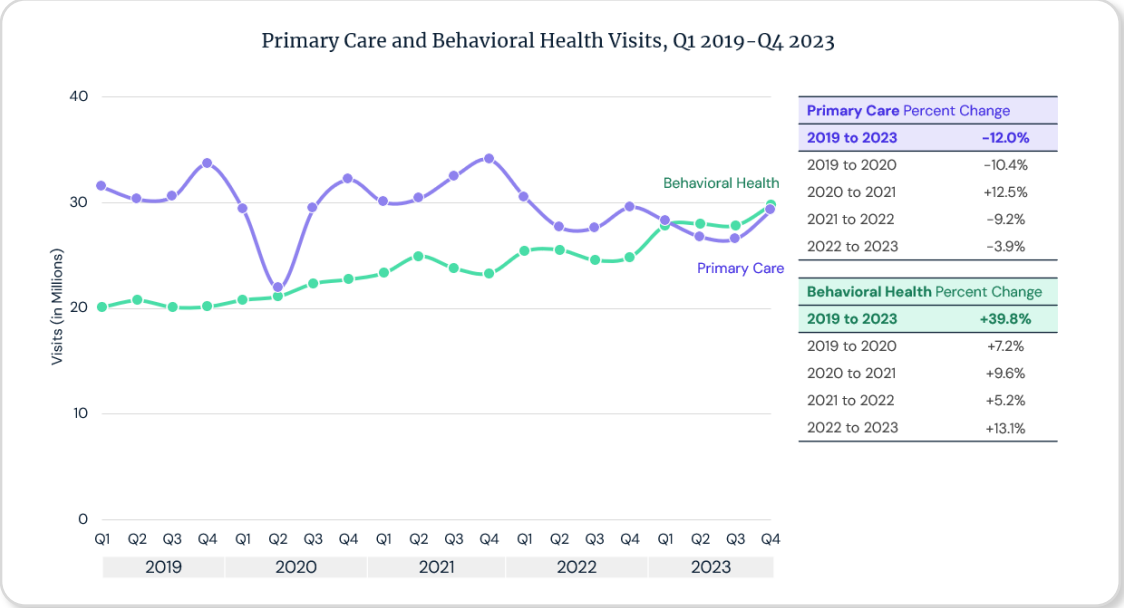
- Comparisons to Canada's two-tier system were made, where although some patients rely on public funding, they still have options to pay for faster, private care. This sparked a conversation on whether the U.S. should adopt a similar model.
- The prevalence of GoFundMe campaigns for healthcare needs indicates a systemic failure to provide adequate financial protections, prompting discussions on how the U.S. might better safeguard patients against catastrophic medical costs.
- While employers typically prioritize improved health outcomes and better patient experiences, aligning these priorities with diverse business needs and financial constraints is difficult.

Go-Forward Considerations

- How can we leverage data transparency to expose inefficiencies and guide better resource allocation across the health economy?
- What lessons can be learned from other industries or countries that have optimized cost and value in healthcare?
- Are we ready for a healthcare system that is similar to that of the NHS?
- What will be the catalyst for systemic change? Will it be legal pressures on employers facing lawsuits over the cost of health benefits? American consumers demanding transparency and more value?

Trend 2: Healthcare Utilization Patterns Suggest Health Status Will Continue To Decline

Compared to 2019, healthcare utilization in 2023 decreased across most care settings, including home health, primary care, inpatient care, emergency department and hospital outpatient. In contrast, care volumes for non-hospital outpatient, urgent care and behavioral health have increased during this time period. The concurrent reduction in preventive care and increase in behavioral health demand, paired with constrained provider supply, will likely result in greater morbidity and mortality.



Primary Care Percent Change	
2019 to 2023	**-12.0%**
2019 to 2020	-10.4%
2020 to 2021	+12.5%
2021 to 2022	-9.2%
2022 to 2023	-3.9%

Behavioral Health Percent Change	
2019 to 2023	**+39.8%**
2019 to 2020	+7.2%
2020 to 2021	+9.6%
2021 to 2022	+5.2%
2022 to 2023	+13.1%

Key Takeaways

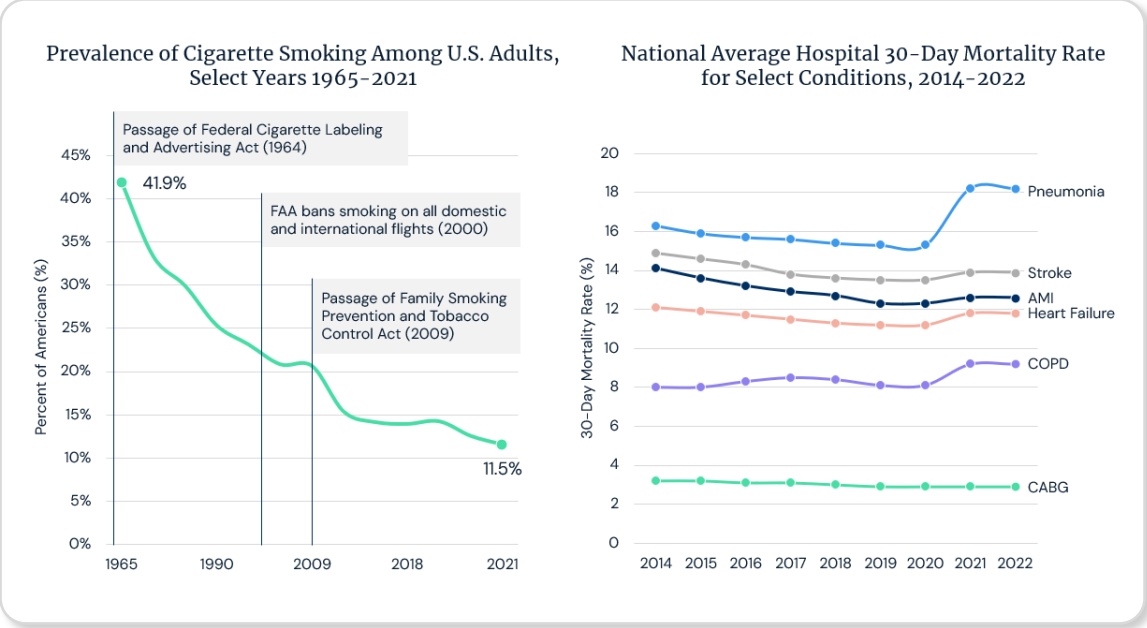
- The variability in wait times for essential services such as MRIs highlights the lack of standardization in U.S. healthcare. While some patients can receive MRIs within days, others may wait 10 to 20 weeks.
- There is need for more effective prospective risk assessments to help manage financial stability and avoid unforeseen costs that can significantly impact healthcare systems.
- The example of cardiac rehab programs was highlighted as an effective yet underutilized intervention. While the benefits of cardiac rehab are well-documented, adoption remains low, suggesting that even proven programs struggle with uptake due to behavioral, systemic and regulatory barriers.

Go-Forward Considerations

- What are the underlying drivers of the increasing demand for behavioral health services, and how can we better meet that demand?
- With declining primary care utilization and an increase in patients trusting non-traditional sources for health information, how can providers ensure patients receive informed and proactive care?
- Can the payer business model, which in the past has relied on a healthy and young population to control risk and costs, survive an increasingly sicker population?

Trend 3: Government Innovation and Regulation Are Failing To Produce Value

Since the 1980s, the Federal government has launched various initiatives to balance affordability, quality and consumer choice. Recently, efforts have included mandating price transparency, launching numerous value-based care models and renewing focus on market-based competition. While there is a lack of a clear relationship between market concentration and hospital quality, it remains important to understand the wide variation in market concentration that exists across the country.



Key Takeaways

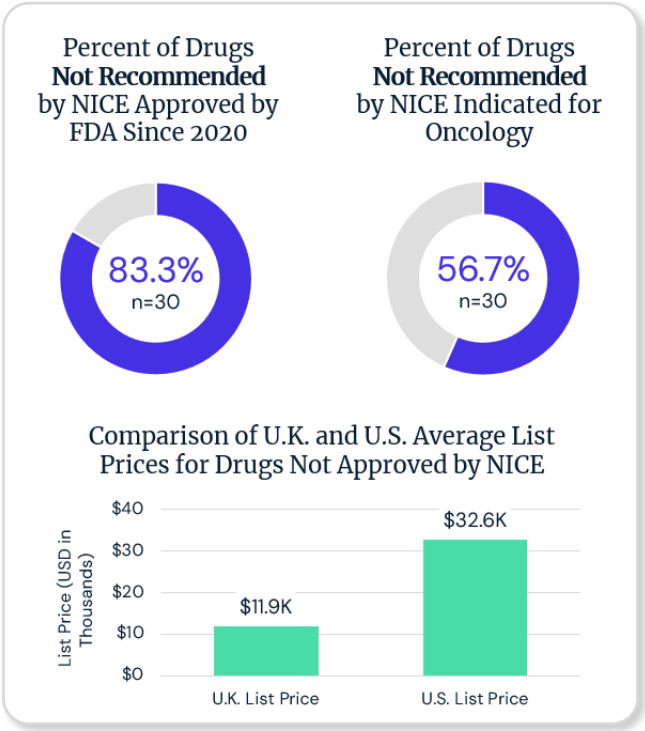
- While some attendees voiced mistrust in government-led healthcare changes, others noted that government programs like Medicare and the VA enjoy high patient satisfaction due to their reliability and consistent quality of care. Some participants argued for increased government involvement to address systemic issues, while others expressed concern over the government's ability to implement meaningful changes to reimbursement and care delivery effectively.
- There was discussion around the complexity of public health interventions, especially in tackling ingrained behaviors like smoking. Despite clear evidence of harm, people often continue unhealthy behaviors because they find life challenging, underscoring the limitations of education and awareness alone, in contrast with government regulation targeted to other health outcomes (e.g., mortality).
- Participants emphasized the role of broader determinants, such as ZIP Codes, in predicting health outcomes, which could inform more targeted government public health strategies.

Go-Forward Considerations

- Is the amount of money traditional providers are spending on quality reporting and quality initiatives worth it? What is necessary vs waste?
- What reforms are most urgently needed at the federal and state levels to unlock greater value from the U.S. healthcare system?
- In what ways can employers leverage government innovation and regulatory changes to better manage their healthcare costs?

Trend 4: The Value of Technological Advancements Is Uncertain

Does a new clinical intervention lead to a net increase or decrease in value? As new therapies come to market, it is critical to holistically weigh the potential benefits and harms and to understand their downstream impact on the use of additional services and/or drugs. As emerging evidence is incorporated into clinical guidelines, it is likely that some high-margin surgical procedures will be replaced by less invasive interventions or pharmacologic interventions, which will disrupt current trends in care utilization. For this reason, it is important to identify existing services which may be impacted by novel treatment paradigms.



Key Takeaways

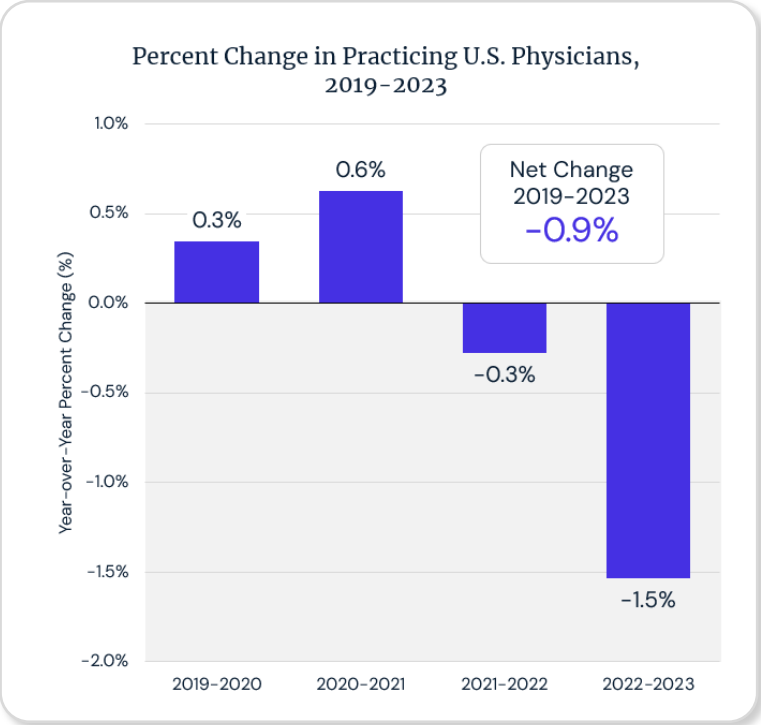
- There was particular interest in AI's potential for risk stratification, relieving administrative burden and improving triage, which could lead to better resource allocation. However, systemic challenges remain, as current applications often fall short of driving substantial change in their current form.
- AI holds the potential to increase efficiency and make a difference in every healthcare organization as its current form is akin to a "college intern," but will be at a "PhD level" within a matter of years.
- There was consensus that the U.S. could benefit from a cost-effectiveness framework like NICE, but it would need to be adapted to American market dynamics and societal needs.
- Discussions around drug pricing highlighted the challenge of balancing high research costs with affordability. While some participants noted the economic penalty for certain treatments in outpatient settings, others called for reforms like eliminating drug rebates and exploring high-risk pools for costly gene therapies.
- Although digital health innovation is promising, execution remains problematic. Participants pointed out that many healthcare organizations lack the expertise to fully leverage virtual health, and there is excessive fragmentation in digital solutions – "we need to invest the digital health dollars more judiciously." Many health systems have solid virtual strategies but lack the financial resources or staff to have any meaningful execution of those strategies.

Go-Forward Considerations

- Are providers prepared for the potential volume declines and corresponding revenue losses associated with replacement therapies? Are drug manufacturers prepared for growth in demand for their therapies?
- The healthcare industry is adopting more technological solutions, but the value of these innovations remains in question. Are we on the right track, or are we just inflating costs?

Trend 5: Supply Constraints Are Correlated With Inadequate Yield

Competition is intensifying for a smaller number of physicians, evidenced by the widening gaps in primary care physicians, medical specialists and surgeons. This is further exacerbated by the growing employment of physicians by non-physician corporate entities rather than hospitals or independent practices. The inadequate supply of providers will undoubtedly contribute to the already-worsening health status of Americans.



Key Takeaways

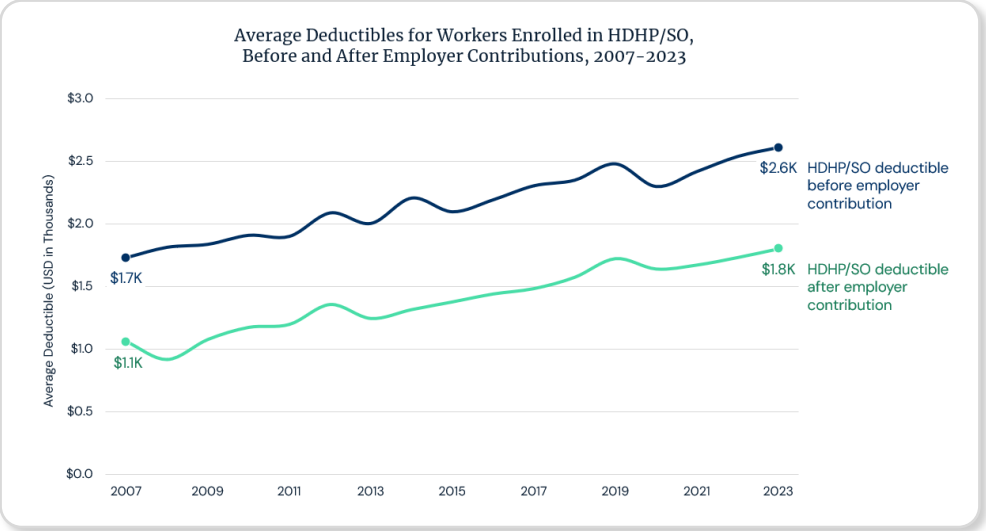
- Nurse practitioners and physician assistants play a crucial role in expanding healthcare access and alleviating supply constraints. However, their utilization varies significantly by region, with some area more resistant to independent practice of allied health due to regulatory barriers (e.g., OH vs. FL).
- There is a growing emphasis on team-based care, especially for primary care and complex care (e.g., oncology). While advanced practice providers (APPs) are generally accepted in primary care, some populations, such as seniors, show less trust in APPs compared to physicians.
- Given the constrained physician supply, every provider should be working at top of license (i.e., nobody should be treating patients for which they are overqualified). In many cases, "being a specialized APP is often a better position to treat complex patients than generalist physicians."
- The declining interest in primary care among younger providers is attributed to financial barriers and limited autonomy. Suggestions for improving recruitment include subsidizing medical education costs, removing state-specific licensure barriers and providing incentives for self-employment in primary care.
- The RVU model drives productivity but often emphasizes high-cost services with economic benefit rather than patient-centered care. There is a call to reform RVUs to incentivize high-value services and address the significant salary disparities between primary care and specialized fields.
- There is a notable difference in burnout levels between employed and independent PCPs. Some argue that bringing autonomy back to PCPs and moving primary care out of hospital systems could help address burnout and improve patient care.

Go-Forward Considerations

- What strategies can health systems use to retain and attract healthcare professionals amidst growing workforce shortages?

Trend 6: Forced Consumerism Due to Cost Shifting Has Fostered Fragmentation Without Corresponding Value

Although High Deductible Health Plans (HDHPs) were introduced to reduce employee spending on healthcare, deductibles for these plans have increased by more than 50% between 2007 and 2023, and 57% of Americans spend at least one-tenth of their monthly budget on healthcare. As more non-traditional direct-to-consumer products and providers come to market and patients increasingly rely on non-physician sources of health information, patient trust in the healthcare system continues to decline. Across the U.S. population, there is variation in how, when and where people consume healthcare. Understanding this heterogeneity is key to designing effective care delivery models, products and policies.



Key Takeaways

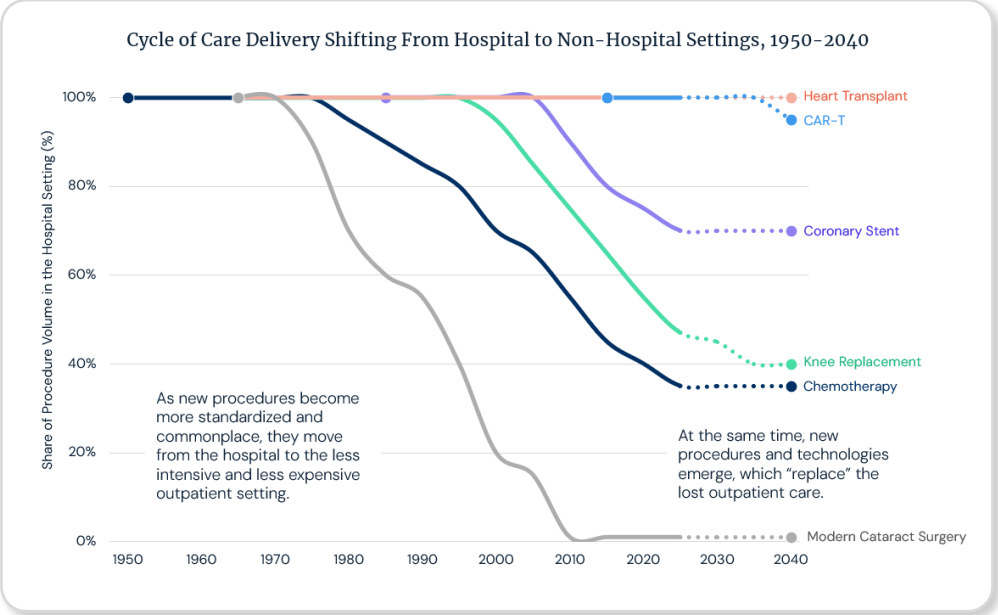
- While PCPs are still trusted, the nature of trust is evolving – "I don't think people trust PCPs less, rather they trust other things more." For younger generations, the desire for a continuous relationship with a specific provider may be less pronounced, especially for low-acuity care that doesn't require personalized attention. Preferences for trust may also be influenced by political views and attitudes towards institutions, and less about generation and more about acuity level (e.g., primary care vs. oncology patient).
- Fragmented care can lead to duplication, unnecessary services and challenges in maintaining consistent quality. However, some argue that advances in technology and data-driven approaches could offset potential declines in quality, even as care becomes more segmented.
- Patient perceptions of quality often revolve around convenience and immediacy rather than clinical outcomes. This may lead to loyalty towards systems that meet these preferences, even if clinical measures of quality suggest otherwise.
- The growth of specialized point solutions and care navigators has led to further fragmentation, "care navigators have their own care navigators." While navigators are intended to streamline patient care, the proliferation of navigation roles has itself become fragmented, with various navigators addressing condition or service-line-specific use cases.

Go-Forward Considerations

- In what ways can technology help consumers make better healthcare decisions without further fragmenting their care?

Trend 7: Lower-Cost Care Settings Can Offer Better Value

New treatment paradigms often originate in the hospital setting. However, over time, technological advancements and innovation can facilitate more optimized delivery outside of the hospital setting, costing less and providing the same amount of quality.



Key Takeaways

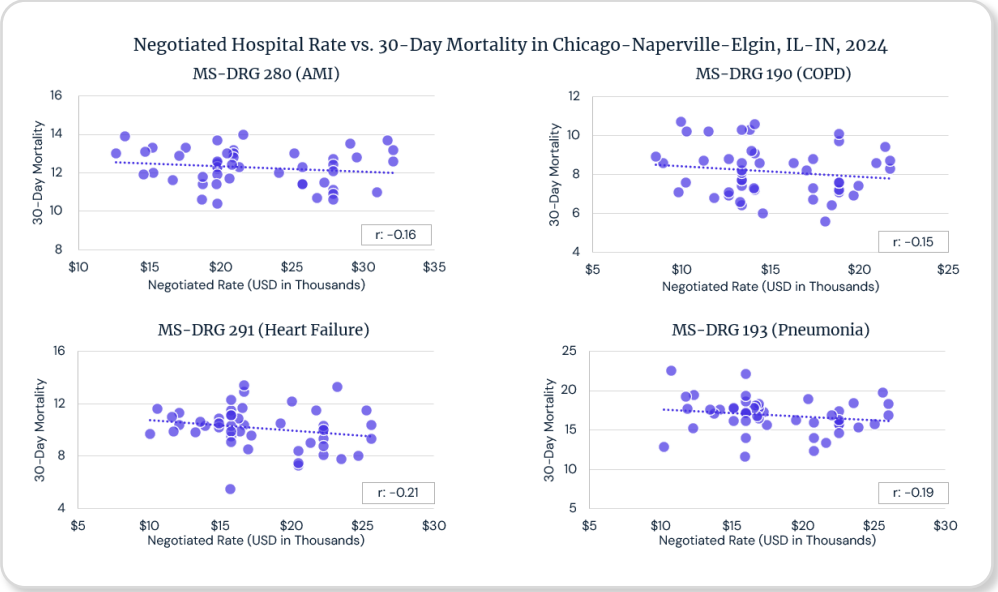
- There's consensus that site-neutral payment reform is inevitable. However, the gradual removal of procedures from the IPO list would have significant financial implications for many hospitals, potentially leading to insolvency if not managed carefully, highlighting the importance of being proactive vs. reactive with IP and OP surgical strategies.
- Employers are increasingly focused on shifting services to OP settings to control costs, but they face challenges due to limited internal resources. The shift requires both large national and local employers to drive change within health systems in their markets, in order to ensure market-level cost pressures and facilitate leverage for the employers in the "middle" of national and local employers. Concerns were raised over potentially moving too much surgical care into OP settings.
- There is skepticism about the future of the 340B program and PBMs, as both face scrutiny and potential reform. Changes here could significantly impact the financial sustainability of academic medical centers that rely on 340B revenue to support broader missions.
- RPM is gaining traction in various settings, including post-surgery and behavioral health. However, scaling these programs remains a challenge due to staffing shortages and the need for expanded infrastructure.

Go-Forward Considerations

- What factors should be considered when deciding which services are most appropriate for lower-cost settings like urgent care or outpatient clinics?
- How can employers and health plans work together to promote the use of lower-cost care settings?
- What barriers exist to expanding access to lower-cost care settings, and how can they be addressed?

Trend 8: Employers Are Better Equipped To Demand Value for Money

Employers have historically been relatively passive in managing healthcare costs. However, mandated price transparency requirements both enable and compel employers to demand value for money. The health plan price transparency data reveals an indefensible amount of variation, with the same services varying by tens of thousands of dollars within the same market. Notably, higher prices are not associated with higher quality. To reduce wasteful spending and increase value in healthcare delivery, it is imperative to identify and address unwarranted variation in the prices of healthcare services across services and markets.



Key Takeaways

- Employers vary widely in how they define and seek value in healthcare, challenging the idea of a singular "commercial" buyer. Instead, the employer market is fragmented, with thousands of purchasers, each with different priorities. Participants noted the critical role of improving outcomes and patient experiences as metrics of value, yet recognized that aligning these across diverse employer needs is challenging.
- Health systems frequently use certain services and service lines as loss leaders, where the cost of care exceeds reimbursement. This sparked a discussion on the need for a value framework that addresses both short-term costs and the sustainability of essential services.
- The conversation also touched on how some companies are already reducing costs – like one DTC provider with dermatology products and services – illustrating the possibility of offering quality care at lower prices. This led to reflections on whether more industries could adopt similar approaches to provide value without unsustainable price increases.

Go-Forward Considerations

- How will transparency in the price of medical services translate into transparency for other segments of the health economy (i.e., life sciences, device manufacturers)? Are these industries prepared to deliver value for employers?

Fireside Chat with Charlie Cook of Cook Political Report

Charlie Cook, Cook Political Report
Jarrett Lewis, Partner, Public Opinion Strategies

Charlie Cook is widely regarded as one of the nation's leading authorities on U.S. elections and political trends. He founded the independent, nonpartisan Cook Political Report in 1984, serving as Editor and Publisher for 37 years. Covering and analyzing U.S. elections and domestic political trends, The New York Times once referred to Cook Political Report as "a newsletter that both parties regard as authoritative" while CBS News' Bob Schieffer called it "the bible of the political community."

Key Takeaways

In this panel, Cook analyzed the 2024 election landscape, exploring voter dynamics, party strategies and the evolving role of polling and persuasion in a highly polarized environment. He offered insights into how key factors may influence the outcome of the Presidential Election in November.

- Cook likens the candidates' positions to a poker game, where Harris has a weak hand played well, while Trump has a strong hand poorly played, emphasizing the impact of candidate performance on electoral outcomes.
- Kamala Harris has exceeded expectations significantly, surprising many with her strong performance following less-than-ideal debate and campaigning performance as VP.
- The current election cycle has created a sense of relief for some, akin to a "drowning person being thrown a life ring," highlighting the urgency and emotional stakes involved.
- This election is expected to be turnout-driven, as both parties have mastered mobilization but have largely abandoned efforts at persuasion. A small percentage of undecided voters (4-6%) remain, who are dissatisfied with both Harris and Trump.
- For many voters, party loyalty is strongly tied to identity, with core supporters voting with their party most of the time. Independents, however, are less engaged with issues and more focused on practical concerns like financial stability.
- The accuracy of national voter polling has been in question, particularly following recent underestimations of Trump support. Uncertainty persists about the current polls' reliability.
- The expected surge in Democratic turnout post-Dobbs was underwhelming, as evidenced by fewer votes for Democrats in the 2022 midterms than the previous midterms.
- On Election Night and in the days following, key races in Virginia and North Carolina could provide insights into broader electoral trends.
- The political landscape has been fundamentally altered since Trump "rode down that escalator in 2015 to announce his candidacy," with a continued sense of unpredictability and instability.
- In a scenario where Trump is victorious, it was because Trump capitalized on voter dissatisfaction with Biden's handling of the economy and border security. Despite his missteps, the dissatisfaction with the Biden Administration's performance supported this win.
- In a scenario where Harris is victorious, it was because she overcame the odds by executing a disciplined campaign that capitalized on Trump's inability to stay focused. Her surprising improvement in public performance since Biden's exit helped her to defy expectations and secure enough support to win.

Go-Forward Strategies: Value Maximization ≠ Value Optimization

Health economy stakeholders who shift their focus from value maximization for themselves to value optimization for their customers will gain a significant competitive advantage. To do so, stakeholders must focus on becoming more productive by getting more output out of every unit of input rather than by raising prices. The future of the health economy belongs to those who prioritize optimizing value for their customers by considering price, quality, safety and convenience. By adopting specialized, efficient and consumer-centered care models, stakeholders can achieve a sustainable competitive advantage.

What Learnings and "Big Ideas" are We Taking Back to Our Organizations To Deliver More Value to Customers?

- Increase investments and use of AI.
- Don't run at ten different strategic objectives. Instead, invest resources and time and "run" at one objective that you really know can make an impact.
- Translate a higher level of acuity into ASCs and figure out the most efficient ways to shift more acute surgeries to outpatient settings.
- Protecting quality and outcomes while trying to increase efficiency. We can't rely on patients and we can't rely on communication. Convenience is the outcome for consumers, and we have to be aware of that.
- Re-evaluating past approaches that were unsuccessful (i.e., "failures), while assessing current strategies for opportunities to improve.
- Enter into a cycle of being more proactive with strategy development, rather than always being reactive to regulatory or systemic change.
- Provide more upstream patient education.

Memorable Quotes From "The Salon"

- *"Disease does not recognize the calendar year."*
- *"Working in healthcare is like working with a team of goalies. I think we need some forwards."*
- *"We are in the sick people business and are incentivized to treat sick people, that's just what the reality is. Everyone is chasing reimbursement, and we would need a massive paradigm shift to change that."*
- *"A one size fits all does not fit the U.S. healthcare system. We can't leave people behind."*
- *"Nothing is static and even the best data is constantly changing."*
- *"The number one issue is being able to navigate the healthcare system and find the right provider at the right time when they actually need it."*
- *"The ones who succeeded weren't necessarily the people who had the best idea, but rather the ones who were able to navigate the system."*
- *"Technology is permanently on the care team."*
- *"You have to give the most and cost less to win."*
- *"Nothing proves healthcare is local more than the five boroughs of NYC."*