Health Update

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10 Megatrends Shaping Healthcare’s Next 10 Years

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10 Megatrends Shaping Healthcare’s Next 10 Years

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EDITOR’S NOTE: Looking at the regulatory, technological, medical and market changes converging to re-invent healthcare, the thought leaders at Manatt identified 10 megatrends that will impact how industry leaders need to manage their organizations in the decade ahead. The article below summarizes the top-ten forces that are re-shaping the healthcare landscape—and re-defining how all the players, from payers to providers to life sciences companies, must adapt to drive growth. To download the full paper on healthcare industry megatrends, click here.

The American healthcare system is undergoing massive change. From transformational policies to disruptive technologies to groundbreaking medical advances, powerful forces are coming together to re-create the healthcare environment. To guide their organizations through a new market landscape, industry leaders need to understand and prepare for 10 critical megatrends that will shape the next 10 years in healthcare. An informed and effective strategy demands considering the ramifications of these game-changing developments—and ensuring organizations are ready to seize the opportunities and overcome the hurdles of a radically different healthcare model.

Megatrend #1: Consumers Take Charge

Diego Miralles, MD, Head of Janssen Healthcare Innovation, points out that “Empowering and trusting consumers with their own information could unleash huge efficiencies in healthcare.” As patients have both more information about health issues and better tools for monitoring their own behaviors and health status, they are gaining more control over their care. Consider that in the U.S., alone more than 75% of healthcare costs result from chronic diseases—many of which are preventable with the right behaviors—and the importance of consumers taking charge of their own health is clear. Sub-trends supporting “consumers in charge” include:

The birth of Insurance Marketplaces, resulting in the “Insured Consumer.” Healthcare Marketplaces will result in new shoppers comparing plans and prices. At the same time, high-deductible and cost-sharing plans will lead to a new awareness of care costs—and new options, such as limited provider networks, for lowering expenses.

The “information everywhere” phenomenon, leading to the “Engaged Consumer.” Transparency is the word of the decade. From the prices of drugs and hospitals to the clinical facts about conditions to the scoop on doctors and treatments shared on social media, any information we want will be readily available.

The explosion in self-care, creating the “Responsible Consumer.” Consumers will be increasingly responsible for managing their own health. As a result, we'll see fast growth in home-based self-care, as well as self-monitoring technologies. Initiatives such as “pay for performance” and “patient-centered medical home” will further spur…
Megatrend #2: More with Less: From Volume to Value

Doing more with less is an overarching theme of our revamped healthcare system. Across the board, stakeholders will need to support higher quality, better outcomes and greater patient satisfaction—all while reducing costs. “Value” will be a central focus, as we seek to improve the results we achieve for every dollar we spend. Six “sub-trends” will support the megatrend of delivering the best performance with the least expense:

- **The demise of fee for service.** As we move from a volume-based to a value-based system, payers—whether private insurers or states—will transition to more innovative payment mechanisms, including bundling agreements, risk sharing and capitation arrangements.

- **A changing care delivery environment.** The focus on cost effectiveness will drive the growth of integrated delivery systems, such as ACOs (Accountable Care Organizations). In addition, it will lead to reforms in medical education and medical malpractice.

- **A reduction in physician incomes.** Primary care will once more be primary, as referral systems are improved, specialty use becomes more targeted and specialty services are re-priced. Lower physician incomes also will result in rising hospital employment, generating more practice acquisitions.

- **The emergence of risk-based healthcare.** Providers and suppliers will need to become risk-sharing organizations, while consumers will have to accept more cost sharing, particularly for specialty products.

- **The expanding role of non-physician providers.** With a shortage of 45,000 primary care physicians predicted by 2025, non-physician providers, such as physician assistants, nurse practitioners and pharmacists, will step in to fill the gap. Models will move to expanded team-based care, including lower-cost providers playing larger clinical roles.

- **The increased importance of quality metrics.** Reimbursement will be based on quality metrics, with sophisticated tools weeding out providers falling below quality and efficiency standards.

Megatrend #3: Healthcare Everywhere

Driven by the rise of new technologies, experts anticipate that, over the next decade, as much as 50% of healthcare will move from hospitals and clinics to homes and communities. From smartphones to social media to sensors, new tools are empowering consumers with more information and control over their healthcare decisions—and physicians with more options for where and how they treat their patients. Sub-trends driving the “healthcare everywhere” phenomenon are:

- **The rise of ubiquitous connectivity.** From interoperable electronic health records to cloud-based computing and data storage, continuous innovation from private sector startups will keep us connected and informed, everywhere we go.

- **The power of smartphones.** Smartphone technology has put health information—and applications—into everyone’s hands. With what Eric Dishman of Intel Corporation calls “the medicalization of consumer devices,” smartphones are monitoring vital signs, measuring calories and helping consumer manage their own health in every possible setting.

- **The new right care, right place, right time approach.** Care delivery will transition from acute care settings to local clinics and retail environments. A new system of care will mean treatment by the lowest-cost providers, including pharmacists, nurse practitioners and physician assistants.

Megatrend #4: Mega Health Systems

Experts are predicting that 20% of the nation’s hospitals will seek to merge in the next five to seven years, driven by increasing pressures to lower costs, increase efficiency and improve quality. Hospitals say that mergers allow them to focus more resources on care, technology and the self-care trends.
patient services. Others argue they lead to decreased competition and higher prices. A study last year from the Robert Wood Johnson Foundation shows that hospitals merging in already consolidated markets can send prices soaring by more than 20%. Sub-trends behind the rise of the mega health system include:

- **The consolidation of healthcare.** Mergers and acquisitions across and within stakeholder groups—including payers, hospitals and health systems, pharmaceutical suppliers and other healthcare entities—will create mega-healthcare entities managed by mega-sized organizations. As mega-systems grow in market power, the day of the independent practitioners and stand-alone hospital will come to an end.

- **The “take off” of systems re-engineering.** Clinical systems will embrace population health, with a tidal wave of provider-sponsored health plans, payer/provider joint ventures and direct contracts with employers and employer coalitions. Proactive medical models will mean reaching out to patients not meeting clinical guidelines, focusing on prevention and supporting patient-centered care and self-management. Advanced analytics and predictive modeling will help identify and treat high-risk populations. Provider compensation will increasingly be tied to performance.

- **The optimization of information technology.** Paper will be abandoned, as providers seek to meet federal standards. As they integrate new electronic tools, providers will struggle to realize their full value and protect themselves from the risks of poor implementation.

- **The growth of a multi-billion dollar HIT and services industry for risk management.** Lack of expertise in population health management will give birth to a multi-billion dollar HIT and services industry that will provide an infrastructure of care coordination and analytics.

- **The increase in limited networks.** Marketplaces will move toward narrow networks to contain costs, testing consumer acceptance of limited options.

- **The vulnerable will present key challenges.** In an environment where the ability to change will determine success—and the funds to support that change are essential to implementation—the safety net of not-for-profit healthcare, as well as small, community hospitals, will struggle to remain intact. The declining role of these providers will leave gaps in both charity care and rural access.

**Megatrend #5: The Centrality of States as Payers, Public Health Agents and Innovators**

States will play an increasingly important role as payers, public health agents and innovators. According to the National Academy of State Health Policy, “Much of the failure or success of federal health reform will depend on the ability of states to implement its key provisions.” Key sub-trends include:

- **The transformation of Medicaid into a proactive provider.** An aging population, federal and state budget deficits and the potential addition of 16 million lives to cover are among the trends coming together to drive major Medicaid reform.

- **The convergence of Medicaid, Medicare, Marketplaces and other private insurance.** Expanding Medicaid enrollment, increasing reliance on Medicare, growing numbers of dual eligibles and the emerging Marketplaces are leading to a closer alignment between public and private insurance.

- **The coming together of medical care, behavioral care, public health interventions and social determinants of health.** Healthcare stakeholders at every level are seeing the importance of taking an integrated approach to medical, behavioral, public health and social issues.

- **Extending managed care to high-cost beneficiaries.** The aged, blind and disabled will move into managed care plans and be included in integrated care initiatives. This will demand a shift in how we deliver care to populations with functional vs. medical needs. It also will drive new partnerships between acute and long-term care (LTC) providers, traditional and non-traditional providers and LTC providers and plans.

- **Increasing public health intervention and emerging rapid virus dissemination.** Public health officials are increasingly committed to
Megatrend #6: Value through Data

According to IBM, healthcare organizations are leveraging big data technology to get more complete patient insights, supporting care coordination and outcomes-based reimbursement models, population health management, and patient engagement and outreach. Successfully harnessing big data helps achieve three critical objectives for healthcare transformation—build sustainable healthcare systems, collaborate to improve care and outcomes, and increase access to healthcare. Important sub-trends include:

- **The dynamic use of information to improve decision making.** Creating and analyzing huge data sets will support quality improvement and planning processes...more effective population health management...and greater opportunities for innovation.

- **The increase in data-driven discovery, evaluation and innovation for drugs and medical devices.** Integrating and modeling clinical, molecular and demographic data sets will drive research and development for pharmaceutical and medical device companies...create new linkages between pharmaceutical companies, medical device manufacturers and providers with clinical data...identify safety concerns...and assess cost effectiveness.

- **The facilitation of clinical trials with big data.** Data-driven patient enrollment will facilitate and accelerate clinical research trials and results.

Megatrend #7: Predict, Prevent, Personalize

Traditional medicine focuses on the symptoms of a patient’s illness. In contrast, personalized medicine directly examines and analyzes the genetic basis of a disease and stratifies the total population into subsets, each with common but unique disease characteristics. According to Bio-Medicine, the benefits of this approach are accuracy, efficacy, safety and speed.

Over the past decade, biomedical research has founded a series of new, predictive sciences that share the suffix -omics (i.e., genomics, cytomics, proteomics). These are opening new approaches to drug development, as well as the potential for significantly more effective diagnosis, therapeutics and patient care. Major sub-trends include:

- **The transformational impact of genomics, epigenetics and predictive diagnostics.** Genomics may change the face of healthcare through personalized medicine, genetic manipulation and predictive diagnostics. As genome mapping becomes more prevalent, it will raise awareness around the importance of nutrition, lifestyle and preventive medicine. It also will cause new concerns about privacy issues—and new questions around how the statistical risk of a condition affects a person’s treatment and coverage.

- **The power of artificial intelligence-based clinical support.** Evidence-based clinical support will be embedded in smart applications, become part of the clinical workflow and be incorporated into consumer self-management.

- **The shift toward personalized medicine.** The next few years will bring continued development of cybernetics (i.e., artificial vision), cloning and regenerative medicine,

- **The continued emergence of evidence-based clinical support.** Evidence-based clinical support will be built into the care delivery workflow, standardizing and supporting the provider decision process. New systems will ensure the timely integration of innovative drugs and procedures into clinical decision support tools.

Megatrend #8: Employers Recalibrate

In early July, the Obama administration decided to postpone until 2015 the ACA’s mandate that employers with 50 or more employees provide a minimum level of coverage or face potential penalties. Experts believe that the delay will have negligible effects as most employers offer coverage today and will continue to do so. As the mandate goes into effect, however, employers will face changes both in the ways they provide coverage and the administrative burden of complying with the reporting requirements of the new regulations. The sub-trends to watch...
Megatrend #9: The New Aging

Today, 13% of the U.S. population—40 million people—are 65 or older. By 2030, the over-65 segment will soar to 72 million or 19% of the total population. The 85+ population will be 6.6 million by 2020. Over the next 20 years, 74 million baby boomers will retire. All of these stats point to a healthcare system that will need to cope with a dramatically growing group of older Americans—and find innovative ways to deal with the medical and functional needs of an aging population. Major sub-trends are:

- The new aging modalities and the increasing prevalence of chronic diseases. From self-care to connected care to monitoring devices, the focus will be on helping people stay in their homes longer. In addition, it will be more important than ever both to manage chronic disease and to integrate behavioral health methods to promote better choices.

- The skyrocketing demand for caregivers. The need for family caregivers will increase, along with the impact on their health and well-being.

- The new Medicare. State and federal governments will need to think outside the box. The shift to managed care will continue, along with the need to focus on behavioral health initiatives and transition to care management models.

- The preparations for end of life. The expansion of palliative, hospice and related services will lead to new approaches for helping people face the end of their lives with dignity.

Megatrend #10: Healthcare Goes Global

From patent and IP issues to access hurdles to pricing complexities, pharmaceutical companies will face an array of challenges as they seek to bring their products to emerging markets. While large populations and a growing middle class in many emerging countries pose new opportunities, they come with the need to understand different regulatory, cultural and payment structures.

In addition, while we are used to people from other countries coming to the U.S. for treatment, new trends in medical tourism have many Americans traveling abroad for less costly care. Globalization is opening up new options but also presenting new risks. Critical sub-trends include:

- Complex market access issues. Many emerging markets have complex access issues and regulatory structures. The pharmaceutical industry will need to create clear strategies for selecting the most productive markets for their product lines and achieving access in those target countries. They also will face pressure to make branded products available and affordable in low-income nations, if generics are not yet an option.

- The expanding middle-income opportunity. Countries, such as Brazil, have an expanding middle class willing to pay cash for specialty products, making them attractive markets for pharmaceutical manufacturers. Some of these markets also are starting to see pharmacy benefit management emerge.

- The globalization of delivery. With globalization, many Americans may seek to save money by getting tested, diagnosed and cared for through medical tourism—or remotely via telemedicine. The top-five categories for medical tourism are cosmetic surgery, dentistry, cardiovascular, orthopedics and cancer.

Conclusions

From health reform to scientific advances to technological innovation,...
President Obama has announced that health insurance issuers will be permitted to renew health insurance policies in 2014 that do not comply with certain provisions of the Affordable Care Act (ACA) that will be in effect in 2014. The transitional policy is an attempt to resolve growing complaints from policyholders who would not have been able to renew their current policies for 2014, because those policies are not ACA compliant. This transitional policy means that fewer people will have the full patient protections of the ACA in 2014, and the risk pool for Exchange enrollees may not be as healthy as it would otherwise have been.

Details of the Transitional Relief

Following the president’s announcement, the federal Centers for Medicare & Medicaid Services (CMS) sent a letter to state insurance commissioners explaining that, for individual or small group health insurance policies in effect on October 1, 2013, a health insurance issuer can choose to renew the policy for one year, starting before October 1, 2014, even if the policy does not comply with key ACA reforms, such as community rating, the prohibition on excluding preexisting conditions, or the requirements to cover essential health benefits, provide minimum actuarial value and limit cost sharing. If an issuer chooses to renew policies that are not ACA-compliant, the issuer must explain to enrollees what provisions of the ACA the policy is not complying with and their option to purchase a potentially subsidized ACA-compliant policy through an Exchange.

State insurance commissioners are not required to implement this transitional relief. States could continue to require that policies renewed in 2014 comply with the ACA requirements. As of November 20, 15 states have announced they will adopt it and 10 have said they will not. In states that choose to permit the fix, allowing non-compliant policies to be renewed in 2014, issuers could still choose not to offer non-compliant policies.

CMS says it will re-evaluate next year whether to extend this transitional relief beyond October 1, 2014. The National Association of Insurance Commissioners and America’s Health Insurance Plans have released statements expressing concern with the transitional policy.

EDITOR’S NOTE: Manatt has created a state-by-state chart of state decisions and insurer reactions, including key details and links. For more information, please contact Patricia Boozang at pboozang@manatt.com.

Implications and Open Questions

CMS’s action will likely have a greater impact on the individual market than the small group market, because the individual market is impacted more significantly by the ACA. Under existing federal law, small group products are sold on a guaranteed issue basis, and there are limits on pre-existing condition exclusions. Nevertheless, some of the potential impacts described below in the individual market could also impact the small group market.

1. Risk Pool. Because the individual market is medically underwritten today (i.e. high-risk members can be excluded or charged more), the existing individual market is healthier on average than the existing uninsured population. A key strategy in the ACA to reduce insurance costs is pooling together the risks of the healthy and sick. Presumably, the only people who will decide to renew their policies under this transitional relief are those who are getting a better deal currently than they would under the ACA, although it is unclear how many people fit in this population. These individuals will likely be healthier than the average population. Therefore, permitting them to renew their current policies--and stay out of the 2014 community-rated risk pool—means the remaining individual market risk pool will likely be less healthy and more expensive than issuers had anticipated.

Issuers have already set their rates for 2014. They may want to revisit those rates, however, in light of the transitional relief. This transitional
relief could decrease profits and increase losses for issuers in 2014. CMS has announced that it will consider adjusting the temporary risk corridor program to address this problem. The risk corridor program permits CMS to compensate issuers that participate in Exchanges if they incur higher than expected losses. Such an adjustment would increase costs to the federal government and would not completely compensate issuers. The risk corridor program only compensates issuers for a fraction of their losses and only compensates those who participate in Exchangees, whereas the skewed risk pool will affect every issuer in the individual market. Finally, it is possible that this relief will not significantly alter the Exchange risk pool in states that were already permitting issuers to renew individual market policies in late 2013, permitting policyholders to maintain 2013 rates for most of 2014.

2. Patient Protections. Individuals who choose to renew their existing non-compliant policies will not receive the full benefit of the ACA patient protections. The most important benefit these individuals will miss may be the lack of coverage of the complete essential health benefits package and the plan’s ability to exclude coverage of pre-existing conditions. But patients who choose to renew these policies must be notified of these deficiencies.

The ACA establishes a category of grandfathered policies that were in place on March 23, 2010, and do not need to comply with the 2014 market reforms. The transitional policy does not change the definition of grandfathered plans. Because these non-compliant renewals are not grandfathered policies (as the term was used in the ACA), these policies will still be required to eliminate annual dollar limits on most benefits and have a minimum medical loss ratio.

3. Rate and Form Filing. Health insurance issuers that permit renewals of non-complying 2013 policies in 2014 will want to adjust their rates to account for, at minimum, a year of medical inflation. Issuers and state regulators will need to work through this issue quickly, which will be challenging given the late date and the usual state insurance rate and form review processes.

4. Statutory Authority. CMS does not cite any particular statutory authority for its action and appears to believe it is acting within the executive branch’s inherent authority to determine the manner in which laws are enforced. There are some legal limits to using enforcement discretion to modify how laws are applied, but courts tend to permit time-limited enforcement policies such as this.

Conclusion

Many key details on the transitional policy, as well as the responses of both states and issuers, are still emerging. Manatt will monitor the situation closely and keep you updated on current developments.

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How Has the Exchange Concept Evolved—and Where Should We Focus Next?

An Interview with Joel Ario, Managing Director, Manatt Health Solutions

EDITOR’S NOTE: Before joining Manatt, Joel Ario served as director of the Office of Health Insurance Exchanges at the U.S. Department of Health & Human Services, where he led HHS efforts to develop the regulatory framework for Exchanges. He has spent 30 years helping to shape and implement public policy, including two decades devoted to leading health insurance reform efforts at the state and federal levels. In a recent interview with “Health Insurance Marketplace News,” Joel shared his firsthand perspective on how the concept of Exchanges has evolved—and what he’d like to see next. Following are some key excerpts.

How Has the Concept of Exchanges Changed over Time—and What Has Changed Most?

Joel’s Response: I first learned about Exchanges in 2003 when a Republican legislator in Oregon called me to his office to discuss a pro-Exchange white paper by the Heritage Foundation. By the time Governor Romney and a Democratic legislature passed their reform in 2006, I was actively promoting the same ideas in Oregon and was thrilled when the idea of Exchange marketplaces became a defining feature of the Affordable Care Act. It was the opportunity of a lifetime when I was asked to lead the federal office of Exchanges in 2010. I would still be in that job were it not for the fact that my wife and three boys were not buying another move for Dad’s career. So after 13 months of commuting from Hershey PA to D.C., I came home to serve the cause in a bit more balanced way, though I have the good fortune of continuing to work with states and other key stakeholders as a managing director at Manatt Health Solutions.
The essential concept of Exchanges has not changed, and it will prevail. I am confident that most consumers will eventually purchase health insurance through public or private Exchanges—web-based Marketplaces where competition is fierce among sellers fighting for market share from consumers with the tools they need to compare choices and find the right products for their families. We won’t see the full power of the concept in 2014, but as the health insurance marketplace begins to resemble other web-based marketplaces, we will look back and wonder how we tolerated such an opaque market for so long. I don’t understand all the technologies, but I talk to a lot of entrepreneurs who are eager to reshape a three-trillion-dollar marketplace.

Exchange Marketplaces will come in a lot of flavors. The public Exchanges, which will dominate the individual market in 2014, will test all kinds of ideas—active purchasing vs. clearinghouse approaches, more vs. less standardization of products, etc. Private Exchanges, which already have a toehold in retiree and other niche markets, will grow their share of the group market. Some private models will look like the public Exchanges, with metal levels and risk adjustment. Other models will allow mega-employers to keep much of their current role in delivery system reform while experimenting with defined contribution roles. It won’t be too many years before most Americans will expect to be offered choices and accept the fact that some choices will cost them more than others.

The ACA promise of basic coverage for everyone, with no loopholes, is the foundation of reform, but it also is critical that we become more price-conscious. Increased cost sharing is not a new trend in the Marketplace, but Exchange Marketplaces will make the cost drivers in healthcare a lot more transparent and make it easier to find those that are delivering the best quality at the lowest price.

What Occupies a Typical Day?

Joel’s Response: My work with Manatt Health Solutions gives me a 360-degree view of the healthcare marketplace, since we have clients in every sector, from government to providers to payers. Having worked for both states and the federal government, I respect the federal role in establishing the rules of the road for the new marketplace, but I look to the states to be the real innovators, and I have done work for nearly half the states since joining Manatt. I also have worked for insurers, hospitals, employers and foundations and have gleaned some new perspectives that are not always shared with regulators. My favorite activity is still a robust off-the-record discussion on a tough implementation issue.

Where Should We Focus Next?

Joel’s Response: When I came to HHS in August 2010, I never dreamed that the partisanship would go on as long as it has. The opposition makes a tough job even harder, but the irony is that much of what the opposition is fighting—Exchange marketplaces that empower consumers, states stepping up rather than ceding control to the federal government—are bipartisan if not conservative ideas. The two political parties will always disagree about levels of subsidy and regulation, but I look forward to the day when the success story in Massachusetts is duplicated in California and across the country, and the stakeholders that I deal with are less distracted by politics and can focus their energies on making our health system work better.

Learn the True Impact of New Drug Compounding Legislation at a New Manatt Webinar, Regulating Compounding Pharmacies: What’s the Real Prescription for Change?

Click here to Listen Free on Demand—or Download a Copy of the Presentation.

For years, oversight of compounding pharmacies has been a patchwork of state regulation and federal oversight. Last year’s meningitis outbreak, caused by a tainted steroid prepared in a Massachusetts compounding pharmacy, put a spotlight on the public safety concerns driven by the enforcement gaps. Responsible approximately for 64 deaths, the outbreak sparked vigorous debate over how to resolve the issue—and whether the FDA should have more power over compounding pharmacies. In November, the Drug Quality and Security Act, clarifying the laws around compounding pharmacies, passed both the House and the Senate and has made its way to President Obama for signature.

What exactly does the new law mean for drug compounders, the pharmaceutical industry and the public? How does it split the
responsibilities of state boards of pharmacy and the FDA? And is it really the solution to ongoing safety issues? Find out at a new, free webinar from Manatt, Regulating Compounding Pharmacies: What's the Real Prescription for Change? During the program, you'll have the chance to:

- Track the history of compounding regulation, including the legislative actions and judicial decisions that created the patchwork approach to enforcement jurisdiction.
- Examine state spotlights, including the trends in enforcement jurisdiction that grew out of the meningitis outbreak.
- Analyze legislation, understanding the implications for stakeholders.
- Compare the new legislation with the key points FDA Commissioner Dr. Margaret Hamburg and other experts raised during Congressional testimony—and learn if, under the new law, the FDA would have the enforcement jurisdiction it needs to resolve public safety issues.

Click here to view Regulating Compounding Pharmacies and learn what the implications of the Compounding Quality Act will be for all the healthcare players. You can watch the webinar free, on demand, at your convenience.

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