How Clover Health is Working to Achieve Health Equity

Fixing an unfair system and making it more sustainable for the government
The U.S. healthcare system is sick.

The scientific brilliance of the modern healthcare system belies its failings to provide equitable care to all Americans. This system favors the rich, yet struggles to meet the basic medical needs of many of our citizens. Sometimes, questions of access overlap with those of affordability, as insurance networks place financial constraints on their members that limit access to doctors patients most want to see. In many areas, specifically rural or lower-income communities, access is constrained because doctors are simply less available, or difficult to get to.

Exacerbating these failings is the fact that the patients least likely to get the best care already bear other major burdens: social, economic, or otherwise. Disproportionately, they are people of color, who have waged a generations-long battle against systemic racism. Over time, many have learned not to place much reliance on the healthcare system.

This paper highlights our commitment at Clover Health to delivering a business model which staunchly offers truly equitable access to healthcare for Medicare beneficiaries. To make reliable and top-quality care available to all, we realize that we need to challenge some basic assumptions about the out-moded ways insurance programs work today. Specifically, how they serve (or fail to serve) their most vulnerable members, including senior citizens, those battling chronic ailments, and people who face increased barriers to a healthy life by symptom of their socioeconomic realities.

When we discuss equity, we need to remember that this is more than just health equality, or simply the equal allocation of resources on a per capita basis. **Boosting health equity is about everyone being able to achieve their full health potential, regardless of socio-economic and demographic factors including race, gender, age, or income.** In other words, we need to invest more resources in underserved groups, on a per capita basis, in order to achieve equity.

Health equity needs to move from being a consideration to becoming a priority for insurers, starting with a deep understanding of the communities they serve. It’s clear that Black, Latinx and other people of color tend to face more barriers to care, increasing their rate of chronic illness and lowering their life expectancy.
That’s why at Clover we emphasize making comprehensive, affordable Medicare plans widely available in these communities. At present, 49 percent of our Medicare Advantage members who self-report their race or ethnicity identify as people of color while the industry average is 34 percent. In 2018 research showed that around two-thirds of all Medicare beneficiaries have two or more chronic conditions, a percentage which rises steeply once income is factored into the equation. Reflecting this, 72 percent of our members are diagnosed with at least two chronic diseases, and about 66 percent live in communities that fall within the top five deciles of what the government defines as areas with high socioeconomic deprivation. The higher the area deprivation index score for a particular neighborhood, the more likely its residents are to require additional support to address healthcare needs.

Recently, the National Committee for Quality Assurance (NCQA) informed us of preliminary evidence of Clover’s plan’s strong performance on a prototype of the Medicare Advantage (MA) Health Equity Summary Score (HESS), a newly developed measurement tool for identifying plans that do well at providing high-quality, equitable care to their members, including groups who are disproportionately affected by social risk factors. This is an issue being monitored by the CMS Office of Minority Health, which recently developed the Health Equity Summary Score (HESS). We believe this achievement demonstrates Clover’s success in ensuring high-quality care for those most in need.

Since Clover’s founding in 2014, our team members have shared a single vision:

**Do whatever we can to improve the quality of life for all Medicare beneficiaries, their families, and the doctors who care for them.**

We believe this can be achieved through offering great benefits that are affordable to everyone, on a wide, open network of doctors. Maintaining quality care over a wide network is possible by empowering small- and medium-sized practices with the clinical support technology that is typically available to well-financed health systems. Deploying technology to support small- and medium-sized practices helps to improve physician decision-making, reduce administrative burden, and thereby better enable physicians to improve the health of their patients. That’s why our technology platform, the Clover Assistant, is so vital to the success of our model.

We already have seen a positive impact from our approach, and as we continue to innovate and roll out our healthcare delivery model, we believe that we will keep people healthier and lower the economic cost of healthcare. Our intent is to reinvest savings back into the system to make our plans more and more affordable, your tax dollars more efficient, and the entire Medicare program more sustainable.
Currently, many insurers build their plans on narrow networks, particularly Health Maintenance Organizations (HMOs). While this model can help plans minimize costs through better coordinated care, it doesn’t address the biggest obstacles to health equity. Understanding these obstacles, then designing better plans, can remove inequities and improve health outcomes for all Americans.

Clover believes that better plan design requires three elements:

1. **Access**
   - Patients should be empowered to visit the doctor they trust, to receive culturally appropriate care.

2. **Affordability**
   - The goal must be to minimize the cost of care to the patient, starting by eliminating premiums and ensuring that co-pays are either minimal or non-existent.

3. **Benefits**
   - Plans should have benefits that directly address the social determinants of health.
Open Networks are Essential for Health Equity. 

So Why Do Narrow Networks Dominate?

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<tr>
<th>Open Network (PPO)</th>
<th>Closed Network (HMO)</th>
<th>In- and Out-of-Network Cost Sharing Parity</th>
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<td>With a Preferred Provider Organization or PPO plan, patients have a network of providers, but they aren’t restricted to seeing just those physicians. Most PPO plans do incentivize patients to seek care from a narrow network of preferred providers by covering a larger share of the cost when patients see an in-network clinician vs. an out-of-network one.</td>
<td>With an HMO plan, patients must stay within the plan’s network of providers (chosen by the insurer) to receive coverage.</td>
<td>With in- and out-of-network cost sharing parity, an insurer allows its members to pay the same amount to see a provider regardless if the provider is in-network, out-of-network or preferred. This removes financial barriers that restrict individuals from seeing the provider of their choice.</td>
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CAPTION: Clover members broken down by Area Deprivation Index (ADI), a Census-based measure that ranks neighborhoods by socioeconomic disadvantage based on data around income, education, home ownership, and household status. This chart shows that a disproportionate percentage of Clover’s members are part of the highest three deciles of ADI. While overall data show that 29% of Medicare beneficiaries in New Jersey fall into these three deciles, in the case of Clover, this figure is 43%. Conversely, while 30% of Medicare beneficiaries in New Jersey fall into the bottom three deciles, representing the lowest social challenges, this figure is only 16% for Clover.

For plans striving to be more equitable, we believe open networks with in- and out-of-network cost-sharing parity are essential because they allow patients to see the clinicians they prefer. This structure also better enables members to access care where it’s most convenient without having to pay hefty sums to consult an out-of-network provider.
Studies have shown people prefer doctors who practice in close proximity to their home or workplace, or who share their same race or ethnicity. On the surface, therefore, it seems unfortunate that narrow networks dominate the insurance landscape since they are more likely to force members to put their preferences aside when seeking care. However, we also know that physicians working in low-income communities struggle with administrative burdens, lower reimbursements and insufficient time for each patient. It’s important to note that the patients they serve tend to need more resources and support than patients in areas that register as being more affluent on the ADI scale.

This imposes still more constraints on physicians, which in turn increases the rate of burnout and attrition. Unfortunately, quality of care metrics perpetuate this dynamic. To perform well on quality metrics, physicians need to demonstrate implementation of evidence-based practices. The greater the degree to which socioeconomic factors limit the time providers can devote to addressing the complex medical and social issues that occur all too frequently in this population, the lower a provider’s quality score will be. For example, if a person can’t find transportation to the doctor, can’t afford to buy their medications, or doesn’t have access to fresh food, then the doctor is seen as failing to implement a care plan, and their financial reimbursements may suffer as a result. Lower reimbursements then force the physician to see more patients, giving them less time to properly document each interaction which compounds the negative effect on their quality scores.

We believe insurance plan providers often drop (or fail to include) doctors who work within disadvantaged communities due to poor performance on quality measures. Indeed, the greater the needs of a community and the higher the hurdles facing members requiring care, the more difficult it may be for a primary care physician (PCP) to qualify for inclusion in some insurance plans. That, in turn, has a negative impact on patients, who face an unpalatable choice of seeking out a new provider or paying out-of-pocket to keep seeing the physician they know and trust. And in certain markets, finding a preferred or HMO provider who is open to new patients can be a logistical challenge and time-consuming endeavor.

To succeed in leveling the playing field in healthcare and improving the lives of those eligible for Medicare, we must concentrate on building the widest, most open networks possible.

Clover’s PPO plan with in- and out-of-network cost sharing parity for physicians allows members to see any Medicare physician who is willing to accept them as a patient. We believe it’s in our members’ best interests to enable them to make the decision about which physician or provider to consult, particularly those that are culturally appropriate to the patient.

Why? Because when we present our members with this kind of choice, we believe they will visit their providers more. This, in turn, encourages members to work more closely with that PCP in addressing their health issues, and to engage more with the healthcare system as a whole. That ability to choose, we believe, plays a significant role in improving health outcomes, particularly for people of color. Research from the National Bureau of Economic Research shows that Black men who consulted Black doctors were more likely to trust them and to consent to preventive services like immunizations and cardiovascular screenings.
Clinicians find that building strong relationships with their patients and devoting more time to each is beneficial to them, leading to increased happiness and higher work satisfaction on the part of the healthcare provider. That translates to less physician burnout, which allows patients to continue to receive care from the clinicians that know them best. The more consistently patients see their PCP, the more opportunity there is for those providers to develop and oversee effective care plans which produce more cost-effective and higher-quality healthcare overall.

This is not an easy solution given there are often fewer PCPs serving in disadvantaged communities, where increased patient workload puts exceptional strain on practices and leads to physician burn out. Clover seeks to address this by providing technology, designed by doctors for doctors, to increase efficiency both with care management support for patients and faster administration and billing.

Naturally, when choosing a plan, most consumers prioritize cost consciousness when assessing premiums, or the amount they pay monthly. The majority of Clover’s plans have no premiums: the reason for this is our conviction that the more successful we are at reducing or eliminating any and all barriers to care, the more likely it is that members’ health will improve.

Copays are also important to consider when thinking about affordability. That’s why Clover’s PPO plans don’t require members to pay any share of the financial cost of primary care visits. The absence of a copay encourages members to visit their PCPs as often as they feel is necessary, enabling doctors to identify problems earlier and reduce suffering by helping patients avoid deferring care for financial reasons.

For a patient, adherence to their medication regimen is crucial to maintaining good health. Clover’s prescription formulary prioritizes providing a number of key medications for common chronic conditions at no additional cost to our members, while making others available at a very low cost. This is the most financially rational decision, since the more unwell patients become, the more “expensive” they are for a payor. Any patient unable to afford the cost of their statins or diabetes medication is likely to end up either in a physician’s office or hospital with problems that have become more complex and costly to resolve.

Importantly, we help doctors understand the cost of the medications they’re prescribing to their patient. This helps to ensure they don’t prescribe an expensive drug without being aware that a lower-cost, equally good (sometimes even better) alternative exists. If an expensive drug is absolutely necessary (i.e. if it’s the most effective treatment) our team of social workers helps members to identify and apply for any programs for which they may be eligible that will reduce members’ medication costs as much as possible, including Medicaid, pharmaceutical assistance programs, Low Income Subsidy (LIS), and other state programs.

The result? Based on 2020 data, Clover’s highest enrolled plan offers members average lifetime cost savings of 17 percent compared with our nearest competitor. Overall, Clover members save an average of 41 percent over the lifetime cost of membership in Original Medicare.
Create Plan Benefits that Tackle Social Determinants of Health

“About 80% of Clover members have an underlying health condition, and basic food access is vital to maintaining their physical and mental health. The inspiration for a grocery stipend stems from the countless empty fridges our nurses encounter when checking on our members in their homes. This benefit isn’t just about improving nutrition—we’re addressing food insecurity in its truest form; where people often have to make a hard choice between buying food, filling their prescriptions, or paying their utility bills.”

Vivek Garipallii, Chief Executive Officer, Clover Health

In 2018, Feeding America found that 5.3 million seniors, or about 7 percent of the population aged 65 or older suffered food insecurity, meaning that they didn’t know how they would feed themselves in the coming days.

To address this, one of the newest benefits available to eligible Clover members is a stipend of up to $800 a year to purchase over-the-counter medications or groceries, as needed. They can also use this stipend to cover delivery costs. Therefore anyone who is homebound, or struggles with mobility issues or lacks access to transportation, doesn’t have to worry about how they will obtain the items they need.

To be eligible for this benefit, CMS requires Clover members to meet certain criteria, such as being diagnosed with an underlying health condition including cancer, chronic kidney disease, or hypertension. Based on the health profiles of our membership, we believe that about 80 percent of Clover members will be eligible.

Introducing this new benefit is simply the first step. We know that having enough nutritious food to eat is vital to both mental and physical health, and we will continue to look for opportunities to break down the barriers that keep too many older Americans under-nourished or food insecure.
CHAPTER 2

Healthcare technology should focus on care, not billing.

Clover’s aim is to provide physicians with timely access to the most recent, relevant and actionable information about their patients. With our technology, we believe we can enable personalized care delivery, lower the cost of care, and offer great benefits to all Medicare beneficiaries.

The Clover Assistant: Designed by Physicians, for Physicians

The Clover Assistant is a platform that gathers large amounts of data, then uses machine learning, decision rules, and evidence-based guidelines to develop and deliver clinical insights directly to physicians and other providers at the point of care.

The goal of this unique tool is to help every doctor, physician’s assistant, nurse and other professional be more effective and efficient in the way they deliver care. Providing them with instant access to the most meaningful, personal clinical data of every member they treat is crucial. Of course, we know it can be too easy to distract or overwhelm busy health professionals with irrelevant or unhelpful data, so Clover maintains a rigorous focus on a specific patient’s individual health needs during each interaction. This, we believe, enhances the doctor-patient relationship and produces better clinical results for all patients.

Working closely with clinical staff and panels of doctors, Clover’s product team focuses on the kind of information that doctors find valuable when they’re talking to each patient. It’s the Clover Assistant’s ability to gather and sort through a tremendous amount of data, gather insights, and then present it to the doctor in a simple and personalized view that makes it so helpful to physicians.
In 2021, it should be ‘table stakes’ to present doctors with personalized information on each patient. Unfortunately, that’s not the case. Throughout much of the country, clinicians don’t have access to the real-time information they need, nor do they have the time to chase it down and sift through it themselves. The problem is most acute for doctors in independent practices. According to a 2018 survey conducted by the Physicians Foundation, 80 percent of physicians across all specialties reported working at full capacity or being overextended.

Providing a doctor with information personalized to that patient is more efficient and saves a lot of research time on their behalf. This is also useful in helping them tailor the care journey for the patient. For example, a significant number of our members may require a statin to prevent or manage vascular disease, but the similarity between each patient ends there. The level of intensity (or dosage) recommendations can vary significantly, based on an individual’s overall health and the specifics of their vascular condition. The Clover Assistant may begin by prompting a physician to consider prescribing a statin, but may also recommend a specific statin preparation on that patient’s plan formulary and the dose intensity that is most appropriate to that individual’s clinical profile.

Our goal is to give clinicians the information that empowers them to make the right decision for the right patient at the right time. Every piece of information the Clover Assistant provides to a doctor requires the latter to use their clinical judgment. Crucially, Clover will never reward doctors for agreeing with Clover Assistant recommendations or penalize them if they disagree. Providing these suggestions without further financial incentives creates efficient workflows, and overall, supports higher quality of appropriate care.
How the Clover Assistant Becomes More Effective Over Time

The Clover Assistant is designed to marry the computational power of machine learning—synthesizing massive volumes of data to create insights—with the clinical knowledge and skills of the doctor.

Effective machine learning requires a feedback loop to constantly improve its own process and methodology, as every suggestion and resulting action is fed back into the system. The result? Better-informed and more accurate suggestions in the future.

As with all technology built on a feedback loop (Google’s translation engine is an example), the more the product is used, the more helpful it becomes as a tool. Whenever doctors use the Clover Assistant, their interactions with it tell us what clinical interventions have the greatest impact on the overall health of individual patients. By incorporating that input through true bidirectional communication between the doctor and Clover, the Clover Assistant can further improve the recommendations it gives over time.

Each month, the Clover Assistant provides machine learning-driven insights to 15,000 individual patient care plans, and guides physicians through 2,500 prescriptions. The constant flow of clinical information these doctors and their teams provide generates feedback that helps us continue to improve Clover Assistant features for all doctors on our platform.

Technology Can Fill Care Gaps

In addition to bringing our advanced technology to clinicians, we are also putting it into the hands of patients. The healthcare system hasn’t evolved in a way to make it as simple as it needs to be for the most frail members or most elderly members of our society to obtain the care they need. The result is that it’s not unusual for homebound individuals to fall between the cracks of our healthcare system.

That is why we deliver pre-programmed, internet-enabled tablets to the homes of members who lack access to a video-enabled device, allowing them to have a virtual visit with a clinician at the touch of a button. This program, called Video on Wheels, gives our members who lack hardware or internet connectivity, or the physical ability to leave their home, access to a doctor or nurse practitioner. As of the autumn of 2021, we are conducting more than 500 Video on Wheels visits each month.

The COVID-19 pandemic highlighted that a number of our members, especially those living in areas of high deprivation, did not have access to a smartphone, tablet or personal computer. Even among those who did, a significant proportion didn’t have an affordable and reliable internet service. As a result, these individuals were unable to take full advantage of the benefits of telemedicine which increasingly became a way for physicians and other care providers to keep tabs on their patients during lock downs. Telemedicine has remained a significant component of care delivery for many vulnerable or homebound individuals during the pandemic recovery.
The success of our Video on Wheels program demonstrates the impact the technology gap has on underserved communities and the importance of allocating additional resources to provide truly equitable care.

**Caption:** Clover members participating in our 2021 Video on Wheels program broken down by Area Deprivation Index (ADI). The chart shows that a vast majority of Video on Wheels participants live in high ADI neighborhoods, with about 57% being residents of communities that fall into the top three deciles of the ADI scale. Only about 8% of Clover members enrolled in our Video on Wheels program live in communities that fall within the lowest three ADI deciles, which represent the lowest social challenges.
In healthcare, the most critical relationship is the one that exists between physician and patient. But insurers rarely play a supportive role; in fact, insurers operating on narrow networks often disrupt this relationship, separating patients from their preferred doctors.

When Clover set out to create plans that would have a transformative impact on the lives of our members, we put strong, productive patient-physician relationships at the center of our thinking.

Clover’s approach to fostering those relationships is...

- Giving members the freedom to consult with the physicians they trust.
- Providing physicians with the data they need to deliver personalized care.
Data-Driven & Personalized Care

On average, PCPs spend just 18 minutes with each patient, and see 20 patients a day. According to a report by Annals of Internal Medicine, doctors in outpatient settings spent approximately 27 percent of their day seeing patients, but had to devote 49 percent of each day to administrative tasks.

Think of the Clover Assistant as being a real-time GPS for physicians. Just as a GPS can flag traffic jams and suggest alternate routes for drivers, the Clover Assistant guides a provider through the process of developing and managing a patient’s care plan. When a physician uses the Clover Assistant during a patient visit, it flags new clinical guideline-concordant interventions and may prompt the doctor to inquire about symptoms that would indicate co-morbidities or other conditions. It spells out critical information that involves this specific patient. Have they been able to obtain needed preventive screenings or specialist appointments? Have they filled their prescriptions? Have they taken their medicine as directed?

At Clover, we believe good medical care is a combination of art and science. This means that we never attempt to substitute a physician’s judgment with our own. Rather, we provide value by giving busy practitioners access to clinical information that is directly relevant to the patient they are treating and that might otherwise take considerable effort for them to obtain. Providing them with the Clover Assistant prompts them to think about issues that they might not otherwise discuss with their patients. Or it might free up time to focus on a shared plan of care and help reinforce the patient-provider relationship, or simply and efficiently move on to the next patient.

Easing the Administrative Burden

The time PCPs are required to spend maintaining their practice is time they’re not able to spend with patients. This is particularly true in lower-income areas. It’s in everyone’s interest for doctors to concentrate on helping their patients rather than focus on paperwork, pursue reimbursement, and negotiate contracts. By definition, those able to devote more time and thought to patient care will see that reflected in improved health outcomes, lower costs and better financial health. Minimizing a physician’s need to troubleshoot issues with insurers also improves the patients’ experience of care.
We believe our technology-first approach is having a real and measurable impact. For example, Medicare Fee-For-Service data in 2019 (the most current year for which these numbers are available) showed that our members had 197 in-patient hospital admissions per 1,000 enrollees, compared with 252 admissions per 1,000 enrollees in the Original Medicare benchmark. Our members also visited the emergency room less frequently: in 2019, only 465 out of every 1,000 members turned to an emergency room for care. That figure compares with 600 emergency-room visits per 1,000 beneficiaries in Original Medicare. The bottom line? Clover members had 22 percent fewer hospital visits and 23 percent visits to the ER, on average, during 2019.

The reimbursement structure built into the Medicare program makes it particularly crucial for Clover to provide as much support as possible to physicians and providers working in lower-income communities. Medicare and Medicaid pay significantly less than do commercial insurance companies for the same services, which means the socio-economic breakdown of the communities a physician serves shapes the financial stability of their practice, as well as that community’s healthcare facilities. If a practice treats a high percentage of patients receiving Medicare or Medicaid, then physicians are driven to increase the number of patients they see in order to preserve the viability of their practice. The result is that these physicians have less time to devote to each individual. An even worse outcome is that such economic realities can discourage providers from treating patients on Medicare and Medicaid or those without any health insurance coverage, further reducing access to care.

Clover pays a flat fee of $200 to any PCP for any Clover patient visit, as long as the doctor uses the Clover Assistant. That’s about double the Medicare rate a PCP receives for an office visit. The two key benefits of this strategy are providing additional monetary resources to independent physicians, as well as the technology they need to deliver personalized data-driven primary care.

This $200 flat-fee payment mitigates the pressure on providers to ration the time they spend with their patients and encourages them to allocate their time and attention based on each patient’s needs. When this reimbursement approach is paired with the Clover Assistant, we believe that the caliber of care increases, a better relationship is forged, and the patient’s overall experience of care and health improves.
In many practices, physicians view insurance companies as an adversary. This is understandable, given that these physicians too often must battle to obtain reimbursement for the services they have provided, or approval for the specialist treatments and medications they deem necessary.

Clover’s commitment is to become a partner with physicians in improving the health and wellbeing of patients. We listen intently to providers and acknowledge that it is they who are face to face with the social and economic factors that very often determine whether or not patients receive the care they need in a timely fashion.

Another approach we have taken is the creation of Clover Home Care, our home-based primary and collaborative care service. We designed this program to better identify and care for Clover’s most medically complex, frail and homebound members. Unlike many other such value-based programs, Clover Home Care closely collaborates with patients’ pre-existing PCPs to provide an extra layer of support in the home that improves patient well-being and health outcomes.

To measure this program’s success, Clover calculates the extent to which a range of member health outcomes has improved, including a reduction in hospitalizations and stays in a skilled nursing facility. Importantly, the majority of Clover’s historic financial return from Clover Home Care has been a result of better health outcomes improvement leading to lower costs. From the inception of the program, members enrolled in Clover Home Care have seen a 17 percent reduction in hospitalizations compared with a control group of members with similar health profiles. Their overall medical expenses fell by an average of $325 per member per month compared to the control group.
If we’re to reach our goal of improving the health of everyone in the communities we serve, we know we need to go beyond the physician’s office and assist patients in overcoming obstacles that prevent them from seeking care or following medical recommendations.

**Barriers to Appropriate Screenings**

Physicians often urge their patients to begin colorectal cancer screening at 45 or 50 years of age, and to receive regular colonoscopies until the age of 75. It’s worth noting that early-stage colorectal cancer can be asymptomatic in its early stages. That makes proactive screenings particularly crucial, since by the time a patient notices something is wrong, the cancer may be at a later stage and require more aggressive intervention.

The Clover Assistant will prompt a PCP to discuss a routine screening with a patient, but in a manner that flags different ways in which that screening can be conducted. Specifically, when a member is reluctant to schedule a colonoscopy (or doesn’t show up for an appointment), the Clover Assistant will prompt physicians to suggest a FIT test as an alternative. This is a much simpler process, requiring the patient to mail a stool sample to the lab rather than undergo the more invasive colonoscopy. True, it’s not as comprehensive, but higher acceptance rates mean it can be a very effective tool to encourage earlier interventions on potential problems. Through the Clover Assistant, doctors can immediately request a FIT test kit be mailed to their patient. Clover then follows up directly with that member to ensure receipt of the test kit and then surfaces the results to the doctor through the Clover Assistant.
Barriers to the Right Medications

A 2021 report from AARP’s Public Policy Institute calculates that “the total retail prescription drug costs for the typical older American who takes four to five prescription drugs per month would be $31,000 per year—more than the $29,650 average annual income for Medicare beneficiaries.” In 2021, retail prices of some of the most commonly used brand-name prescription drugs increased at twice the rate of overall inflation, potentially putting the medications out of the financial reach of many U.S. seniors.

Our members often have little discretionary income to cushion them from the impact of prices going up. That’s why Clover works proactively to identify and help patients for whom cost is an obstacle. For instance, we’ll help enroll our members in programs, such as state pharmaceutical assistance programs or Medicaid, that help cut the cost of medications. We don’t simply point them in the direction they need to go; we help them along the path to get the support they need, assisting them in filling out and submitting necessary paperwork.

The Clover Assistant also enables physicians to extend the prescription length for chronic medications to reduce the cost patients must cover in co-payments. Doctors have used this Clover Assistant feature some 28,900 times as of mid-2021, making medications more affordable for 12,000 members and saving them an average of $150 per year.

As well as helping members afford their medications, Clover encourages providers to assist members who would like to obtain mail order delivery of their medications. Simply not having medication on hand is one of the most significant reasons that someone fails to adhere to their medication regimen. Clearly, finding a reliable way to ensure our members receive medications promptly means they are more likely to take them. Our partner, CVS Caremark, can deliver members a 90-day or even a 100-day supply of prescribed medications by mail. This means that patients don’t have to plan time-consuming treks to a pharmacy for refills of medications that may be on different schedules. The data show this to be an effective driver of medication adherence; members receiving 100-day prescriptions are 10 percent more likely to take their medications than those on 30-day prescriptions, and members getting mail order medications are 9 percent more likely.

Caption: The Clover Assistant prompts physicians, when clinically appropriate, to extend members’ fill lengths for Tier 1 and 2 prescription drugs from the standard 30 days to 90 or 100 days. Needing to refill a drug three or four times a year is much easier, and less expensive, than 12 times a year, which is the requirement for a standard 30-day fill, and makes it more likely that individuals will avoid periods without any medications on hand.
Successful strategies for improving health equity in urban or suburban areas do not translate to rural areas, where access and affordability issues are further exacerbated by the geographic distances between patients and healthcare providers. Unfortunately, it isn’t possible to simply replicate the strategies we’ve found to be successful in urban areas for our rural communities. Meanwhile, policy responses have been limited, meaning that care levels continue to fall further behind what is available to residents of urban communities. Data from the CDC indicates that the 46 million-plus Americans living in rural areas are more likely to die from five leading causes—heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke—than their urban counterparts.

Our clinical leaders have met with individual physicians, nurse care managers, hospital and clinic administrators, and quality improvement leaders in rural communities to unearth the following problems:

- **Proximity to care.** Access to high-quality specialists is particularly hard in rural areas with travel time and distance being the biggest issues. If you’re a homebound senior with mobility issues, driving 60 or 70 miles (each way) to consult a rheumatologist isn’t feasible.

- **Home-based care is possible, but inefficient.** “Windshield time” chews up hours that care teams could otherwise devote to patients. It can take many hours each day to travel between patients, which reduces the time they can spend delivering care.

- **Lack of support.** Many rural stalwarts cherish their independence. Too often, however, as they age, this risks leading to social isolation, precisely at the stage when human interaction is vital to solve someone’s care needs. We all need others to motivate us some of the time, but in rural settings, those individuals whom a person trusts most and who help influence their health for the better—family, friends, neighbors, a pastor—may be miles away.

Clover’s clinical leaders continue to examine, research and discuss ways to introduce solutions that are distinctive to these rural challenges, and are currently exploring a number of routes in which we may invest in the future, including:

- **Better telehealth solutions that include specialists and remote monitoring.** Bringing specialists into the telehealth environment, in particular, requires more preparation in advance of each meeting. Our research here will also develop care protocols and information management to ensure more attention to logistics.

- **Solving home care.** Bringing complex care to the home, while inefficient, is absolutely necessary. There is currently no clear option to address this need other than to devote more resources in each market in the shape of higher reimbursements to support growth of services.

- **Building community.** We’ll devote research to better understand how to connect patients with potential local “carers,” and train and incentivize members of the community to help provide that care.
CONCLUSION

The mission to improve lives

Too many Americans, especially older adults, struggle with issues that limit their ability to lead healthy and fulfilling lives. While the roles played by chance and genetics mean we can’t prevent or completely cure most conditions, physicians and other healthcare providers today can draw on a vast and ever-expanding database of research and expertise to help their patients. At Clover Health, our goal is to ensure that all our members – and ultimately, a growing proportion of Americans – have access to this kind of thoughtful care and support.

We know that to succeed in this mission, we must demolish the barriers to care that historically have blocked too many older Americans from reaping the benefits of medical advances in chronic disease prevention and management. We believe the evidence suggests that the lowest-income communities, and some communities of color, tend to benefit most from our technology and our innovative approach to delivering care. These are the groups who are disproportionately affected by the dramatic inflation in health care costs, from health plan premiums through to prescription prices.

We are not simply another health insurer offering potential customers another suite of Medicare plans. That isn’t enough to succeed as a sustainable and ethical business, nor will it address inequity in the current healthcare system. Fulfilling our mission requires us to focus on transforming the nature of the role of an insurer. It demands us to place innovation, creativity and empathy at the heart of our business model. In turn, this approach can improve lives while lowering costs for the whole healthcare system.
The Clover Assistant is at the center of our efforts to help members stay healthy. It provides insights to physicians that empower them to deliver personalized data-driven care. We believe we now have evidence that blending technology with the ‘human touch’ in this manner can improve both medical outcomes and quality of life. Clover members enrolled in our complex care program have fewer hospital stays and emergency room visits than do similar situated cohorts in Medicare; their care teams work to prevent the kind of complications that often result in costly and debilitating hospital stays for older Americans.

We believe that it is possible to deliver lower cost plans without compromising access or quality, and while addressing questions of health equity.

Our approach is a better recipe for profitability and a more ethical strategy than the historic approach of targeting affluent communities whose members are less likely to struggle to obtain the care they need. Indeed a recent study has indicated that the Medicare Advantage plans thought to be the highest performing have the greatest disparities in outcomes for patients from racial and ethnic minority groups, as well as for patients with lower education levels.

We believe the information that we have received from the NCQA on our Health Equity Summary Score (HESS) reaffirms our conviction that this holistic and technology-centered approach is the right way to address the inequities and inefficiencies in the U.S. healthcare system. As described above, per the HESS analysis, Clover’s PPO plans perform well at providing high-quality, equitable care to its members, including groups who are disproportionately affected by social risk factors.

We know that we face a tremendous challenge in trying to reshape U.S. healthcare, all of us at Clover, individually and collectively, pledge to continue to improve our approach to health equity issues.