

**TESTIMONY OF ANDREW TOY,
SAN FRANCISCO, CALIFORNIA
BEFORE WAYS AND MEANS COMMITTEE
US HOUSE OF REPRESENTATIVES
DATE: TUESDAY, MAY 8, 2018**

Chairman Roskam, Ranking Member Levin, and distinguished Members of the Committee:

Thank you for providing Clover Health the opportunity to testify before the Committee and to provide our views on the Current Status of and Quality in the Medicare Advantage (“MA”) Program.

I am Andrew Toy, the Chief Technology Officer of Clover Health (“Clover”). At Clover, I am responsible for overseeing engineering, data science, product, IT and security, and driving the vision for how technology and analytics can improve the lives of Clover's MA beneficiaries. Prior to Clover, I coordinated Google’s enterprise activities for the Android team and ran machine learning, enterprise search and analytics for the Google Cloud G-Suite team. Before that, I was the CEO and co-founder of Divide, a company focused on creating a split between work and personal data on mobile devices, which was acquired by Google in 2014. I received my B.S. and M.S. in Computer Science from Stanford University, where I also served as an associate lecturer in computer science.

I joined Clover earlier this year to help advance the way Medicare beneficiaries are cared for. Clover does this by capturing and analyzing data to identify at-risk beneficiaries and to proactively intervene with services to improve health outcomes, fill care gaps, and reduce avoidable costs. Our business model is designed to rapidly generate new care delivery approaches and test their real-world effectiveness. In 2013, Clover began offering MA plans in New Jersey and has grown to over 30,000 enrollees. In 2018, the company expanded plan coverage to Georgia, Philadelphia, and Texas, with further expansion planned for 2019.

We appreciate that the Committee wants to hear about Clover's experiences as an emerging healthcare start-up focused exclusively on MA. Congressional leaders, together with the Centers for Medicare and Medicaid Services ("CMS"), have designed and overseen a MA program that offers beneficiaries the value of complex care coordination and management and high quality standards. My testimony is focused on four areas: (1) using data and technology to deliver high quality care to Medicare beneficiaries, (2) addressing barriers to MA growth, thereby encouraging robust competition in MA, (3) facilitating innovation and better health outcomes by allowing plan flexibility, and (4) supporting a continued focus on the individual right to health data.

I. Applying Data and Technology in Medicare Advantage

Innovation and health improvement begins when we are able to understand factors that drive beneficiary engagement and that promote the management of their chronic conditions so that we can proactively address preventable episodes of care. In other health organizations, researchers and clinicians are constantly reviewing and assessing whether a clinical program is working, or whether a medication adherence intervention results in an actual adherence uptick. The health insurance industry should be no different -- insurers should evaluate approaches to managing care and integrate successful preventive outcomes in their operations. However, the health insurance model is often reliant on managing costs through pricing and utilization controls such as benefit design rather than disease prevention.

As a new entrant to the health insurer market, Clover believes that the MA program -- and the application of data and technology -- can uniquely deliver on the promise of improved health outcomes for and value to Medicare beneficiaries. Clover's business model is built around rapid learning and iteration, and is focused on determining what actually works in a highly complex industry. We apply our learnings for the benefit of our membership and we employ a large team of data and research scientists to aid us in evaluating these questions.

Clover looks at data differently than others in the healthcare space. Health data can take different forms: claims data from hospital and provider visits, electronic health records with detailed provider notes, prescription fill history, or personalized genomic data. Clover's data platform has the ability to compile data from these varied sources and structure this information to provide a more comprehensive health profile of our beneficiaries. With this enhanced view of our beneficiaries, Clover can apply our machine learning capabilities that enable us to examine data for key insights, such as predicting whether a beneficiary is at risk for a medical condition or disease state.

Structuring and examining the health data of our beneficiaries is only useful if we're able to impact health outcomes. Clover is developing intervention protocols to address risks and to help manage and improve outcomes. For example, Clover has developed home care protocols for chronically ill patients, a program that allows at-risk beneficiaries to be seen in their homes by physicians. This ensures they are cared for and reduces friction for at-risk beneficiaries to be transported to, and seen at, provider offices or hospitals, thus preventing hospitalizations and increasing beneficiary satisfaction. We are launching another program where Clover will offer gene-informed medication management for in-home primary care members to reduce adverse drug interactions. For Medicare beneficiaries, a large number of hospital admissions are due to adverse drug events. To reduce these risks, Clover will perform pharmacogenomic testing to personalize each member's drug regimen at no cost to our enrollees. We believe the result of these three capabilities - compiling data, monitoring, and proactive interventions - is improved beneficiary health outcomes.

As Clover learns more about beneficiary behaviors and outcomes, we hope there will be opportunities for MA plans to partner with the Committee and with CMS to develop new models that will improve outcomes and contribute to high quality care programs. Any learnings produced by these programs would, of course, be shared back with CMS in order to benefit the overall Medicare population. We believe that our model will ultimately deliver meaningful data and evidence that can have a critical impact on understanding successful beneficiary interventions. Using this rich data, CMS and

health plans could develop scalable, dynamic and personalized programs for beneficiaries that achieve successful outcomes, while limiting those which only provide pecuniary gain.

II. Increasing Medicare Advantage Competition and Lowering Barriers to Entry By Addressing Network Adequacy

Even with the growth of MA plans over the last decade, there are still significant opportunities for further expansion and growth. The Congressional Budget Office estimates that Medicare Advantage enrollment will rise from 33 to 41 percent of all Medicare beneficiaries by 2027.¹ Yet according to a recent Commonwealth Fund study, there is little or no competition in MA insurance markets in 97 percent of U.S. counties.² The report also found that, of the 100 counties with the greatest number of Medicare beneficiaries, 81 lacked significant competition. Indeed, market competition is often the best way to motivate providers, hospitals, and health plans to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers.

As a new MA plan looking towards expansion, Clover has a unique perspective on barriers to entering the MA market and factors that inhibit market competition. Unlike many tech start-ups or incumbent health plans, we're not able to provide our product in all 50 states and territories overnight. At a minimum, entry into a MA market requires us to obtain state licenses (often not an issue) and to satisfy network adequacy requirements. Addressing the second factor, permitting flexibility to CMS' existing network adequacy regime will encourage greater competition, and new entrants, in MA markets across the country. CMS' requirements that plans maintain an adequate network of providers, specialists, and hospitals may impede competition and growth,

¹ Congressional Budget Office, "Medicare – Congressional Budget Office's January 2017 Baseline," January 24, 2017. Available at:

<https://www.cbo.gov/sites/default/files/recurringdata/51302-2017-01-medicare.pdf>.

² Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist," The Commonwealth Fund (Aug. 2015),

<http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist>

particularly in areas where providers and hospitals systems have consolidated their market share. MA plans are required to have enough providers in their network to ensure that beneficiaries can access care within specific “time and distance” standards. These time and distance rules vary substantially by specialty and county based on the number of beneficiaries and type of region. Satisfying adequacy standards may measure access in HMO and closed network models, but such standards are not a consequential measure of access in open Preferred Provider Organization (“PPO”) plans. Clover offers MA PPO products in our service areas, meaning that our beneficiaries can see any provider who accepts Original Medicare. Our beneficiaries have expansive options; they have the benefit of utilizing Clover’s hospital and provider network, or they can select another provider in Original Medicare. Consequently, beneficiaries experience broad access to care in Clover’s PPO plan, regardless of whether providers choose to contract with Clover. Rather than relying on outdated time and distance standards, we urge the Committee to consider beneficiary access and choice when evaluating network adequacy.

Congressional leaders, together with CMS, may consider developing a “standardized” health system contract for providers who refuse to contract with MA plans based on unreasonable financial demands. Hospital consolidation has given significant power to health systems to prevent MA plans from entering certain markets. Indeed, the Federal Trade Commission (“FTC”) and the States have challenged some potentially harmful hospital mergers that could threaten competition and harm consumers. Hospital systems with exclusive control in a geographic area will often require exorbitant pricing to contract and become “in-network,” which often results in increased MA premiums and out-of-pocket costs to consumers. We would propose a construct wherein, with regard to a health system that participates in Original Medicare but is unwilling to sign a payor agreement with a MA plan at 100% of the fee-for-service Medicare rate (keeping in mind these rates are already adjusted based on geography and economic factors), the MA plan should have the option of: a) deeming the health system out-of-network, or b) defaulting to a “standardized” Original Medicare

designated contract with such system and having the system be deemed in-network for purposes of network adequacy determinations.

Another approach to foster increased competition would be to establish network adequacy standards for MA plans as they enter new markets. For example, CMS could allow a 3-year “pilot” period in which a MA plan could enter a new market and make all reasonable efforts to develop a network that complies with the network adequacy standards. The plan would be subject to increased marketing transparency developed to ensure that beneficiaries are fully aware of any specific network limitations. During this time, assuming that the MA plan establishes a viable network that could attract beneficiaries, the MA plan would be able to show value to consumers and physicians in the geography, and thus, enable membership and network growth. This approach would lower the barriers for new market entrants for the purpose of increasing competition among MA plans.

III. Recent Policy Changes Supports Innovation

Clover shares the commitment by the Committee and CMS to transform the healthcare delivery system and the Medicare program. The 2018 Balance Budget Act, combined with CMS’ Final Rule affecting Part C and D Plans (“Final Rule”)³, moves the MA program forward and allows plans more flexibility to administer, and innovate on, the benefit offerings.

First, Clover welcomes the additional flexibility that MA plans now have to define the supplemental benefits offered to beneficiaries. As healthcare evolves to incorporate data on social and environmental determinants of health, health plans can evaluate whether benefits in transportation, nutrition, and housing can favorably impact health. Clover can combine these factors with our existing clinical information, and through our data analytics, potentially predict those beneficiaries that would be at greater risk for adverse events and generally worse health outcomes. Incorporating benefits to address

³ 73 Fed. Reg. 16440, “Medicare Program; Contract year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the Pace Program,” Centers for Medicare and Medicaid Services (Apr. 16, 2018).

these determinants could serve to further decrease healthcare costs and improve quality of care.

Second, we support CMS' expansion of telehealth coverage under Medicare Advantage. We believe the wider telehealth availability will increase beneficiary access and quality of care, and reduce costs using technology that has long been readily available. We understand CMS will continue to monitor telephonic and virtual delivery of services -- such as in virtual coaching on weight management in the Medicare Diabetes Prevention Program. Clover encourages CMS to thoughtfully embrace high value, low risk interventions delivered through innovative forums and modalities that increase beneficiary satisfaction.

Third, CMS continues to evaluate the risk adjustment model (1) at the direction of the 21st Century Cures Act, and (2) to address transparency, flexibility, program simplification, and innovation. The Medicare Advantage risk adjustment program was created, among other reasons, as a method of adjusting bidding by and payments to health plans to reflect the additional costs of providing care to beneficiaries with more complex disease states and conditions. We applaud CMS' recent changes to the risk adjustment model, incorporating meaningful chronic conditions like mental health, substance abuse disorder, and chronic kidney disease. Additionally, the Committee should consider changes that would link health plan interventions or actions to the risk adjustment data. As MA plans (and their vendors) become more successful at gathering information and identifying diagnosis codes for purposes of risk adjustment, we encourage additional requirements by CMS to ensure such data will be used to advance beneficiary health and outcomes. At Clover, we have designed our data platform so that, when we document risk adjustment diagnoses, we better understand our beneficiaries, and we then apply that better understanding to deliver more customized care for them.

Finally, we appreciate CMS' continued focus on Medicare quality standards and recent efforts in the Final Rule to reassess the methodology for the Part C and D Star Rating system. The Star Rating remains a critical tool for beneficiaries to evaluate and

compare MA plans. Clover supports the existing Star Rating program and encourages the Committee and CMS to consider additional adjustments to the methodology that rewards plans with better health outcomes and with broad provider access and choice.

IV. Empowering Patients with Access to Personal Health Records

Turning to privacy policy, Clover applauds the recent focus and efforts to empower beneficiaries with control of their health care information. Creating a beneficiary-centered model -- whereby beneficiaries have full access to their personal health care data -- will allow them to make informed decisions about their health. In this patient-centric model, the health data should move with the patient. We support regulations and legislation that allows the patient to own, direct, and disclose their health data to whomever they choose, such as to a new provider, health plan, or health app.

To that end, Clover is interested in working with the Committee on drafting a simple and meaningful individual consent and notification process for access to health information across federal entities. Today, health plans must obtain multiple consent forms and notifications to share data. This process requires plans to offer CMS forms, HIPAA authorizations, and appropriate FTC notifications. Foundational consenting documents should be simple, clear, and concise, enabling our beneficiaries to understand their rights to privacy and allow them to take personal charge of their health care data.

Thank you again for providing Clover Health with the opportunity to testify before Congress and provide our views.

It has been an honor to be here with you today. If you have any questions, I will be happy to answer.