About SASB

The SASB Foundation was founded in 2011 as a not-for-profit, independent standards-setting organization. The SASB Foundation’s mission is to establish and maintain industry-specific standards that assist companies in disclosing financially material, decision-useful sustainability information to investors.

The SASB Foundation operates in a governance structure similar to the structure adopted by other internationally recognized bodies that set standards for disclosure to investors, including the Financial Accounting Standards Board (FASB) and the International Accounting Standards Board (IASB). This structure includes a board of directors (“the Foundation Board”) and a standards-setting board (“the Standards Board” or “the SASB”). The Standards Board develops, issues, and maintains the SASB standards. The Foundation Board oversees the strategy, finances and operations of the entire organization, and appoints the members of the Standards Board.

The Foundation Board is not involved in setting standards, but is responsible for overseeing the Standards Board’s compliance with the organization’s due process requirements. As set out in the SASB Rules of Procedure, the SASB’s standards-setting activities are transparent and follow careful due process, including extensive consultation with companies, investors, and relevant experts.

The SASB Foundation is funded by a range of sources, including contributions from philanthropies, companies, and individuals, as well as through the sale and licensing of publications, educational materials, and other products. The SASB Foundation receives no government financing and is not affiliated with any governmental body, the FASB, the IASB, or any other financial accounting standards-setting body.
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INTRODUCTION

Purpose of SASB Standards

The SASB’s use of the term “sustainability” refers to corporate activities that maintain or enhance the ability of the company to create value over the long term. Sustainability accounting reflects the governance and management of a company’s environmental and social impacts arising from production of goods and services, as well as its governance and management of the environmental and social capitals necessary to create long-term value. The SASB also refers to sustainability as “ESG” (environmental, social, and governance), though traditional corporate governance issues such as board composition are not included within the scope of the SASB’s standards-setting activities.

SASB standards are designed to identify a minimum set of sustainability issues most likely to impact the operating performance or financial condition of the typical company in an industry, regardless of location. SASB standards are designed to enable communications on corporate performance on industry-level sustainability issues in a cost-effective and decision-useful manner using existing disclosure and reporting mechanisms.

Businesses can use the SASB standards to better identify, manage, and communicate to investors sustainability information that is financially material. Use of the standards can benefit businesses by improving transparency, risk management, and performance. SASB standards can help investors by encouraging reporting that is comparable, consistent, and financially material, thereby enabling investors to make better investment and voting decisions.

Overview of SASB Standards

The SASB has developed a set of 77 industry-specific sustainability accounting standards (“SASB standards” or “industry standards”), categorized pursuant to SASB’s Sustainable Industry Classification System® (SICS®). Each SASB standard describes the industry that is the subject of the standard, including any assumptions about the predominant business model and industry segments that are included. SASB standards include:

1. Disclosure topics – A minimum set of industry-specific disclosure topics reasonably likely to constitute material information, and a brief description of how management or mismanagement of each topic may affect value creation.

2. Accounting metrics – A set of quantitative and/or qualitative accounting metrics intended to measure performance on each topic.

3. Technical protocols – Each accounting metric is accompanied by a technical protocol that provides guidance on definitions, scope, implementation, compilation, and presentation, all of which are intended to constitute suitable criteria for third-party assurance.

4. Activity metrics – A set of metrics that quantify the scale of a company’s business and are intended for use in conjunction with accounting metrics to normalize data and facilitate comparison.
Furthermore, the *SASB Standards Application Guidance* establishes guidance applicable to the use of all industry standards and is considered part of the standards. Unless otherwise specified in the technical protocols contained in the industry standards, the guidance in the SASB Standards Application Guidance applies to the definitions, scope, implementation, compilation, and presentation of the metrics in the industry standards.

The *SASB Conceptual Framework* sets out the basic concepts, principles, definitions, and objectives that guide the Standards Board in its approach to setting standards for sustainability accounting. The *SASB Rules of Procedure* is focused on the governance processes and practices for standards setting.

### Use of the Standards

SASB standards are intended for use in communications to investors regarding sustainability issues that are likely to impact corporate ability to create value over the long term. Use of SASB standards is voluntary. A company determines which standard(s) is relevant to the company, which disclosure topics are financially material to its business, and which associated metrics to report, taking relevant legal requirements into account. In general, a company would use the SASB standard specific to its primary industry as identified in **SICs®**. However, companies with substantial business in multiple **SICs®** industries can consider reporting on these additional SASB industry standards.

It is up to a company to determine the means by which it reports SASB information to investors. One benefit of using SASB standards may be achieving regulatory compliance in some markets. Other investor communications using SASB information could be sustainability reports, integrated reports, websites, or annual reports to shareholders. There is no guarantee that SASB standards address all financially material sustainability risks or opportunities unique to a company’s business model.

### Industry Description

The Managed Care industry offers health insurance products for individual, commercial, Medicare, and Medicaid members. Companies also provide administrative services and network access for self-funded insurance plans and manage pharmacy benefits. Enrollment in managed care has traditionally been correlated with employment rates, while revenues are driven by the inflation of medical costs. The Patient Protection and Affordable Care Act reduced the percentage of uninsured adults, and created additional demand for the industry’s plans. However, legislative uncertainty and a focus on reducing health care costs may create downward pricing pressure and continue to drive consolidation within the industry. In addition, a focus on patient outcomes and plan performance continue to shape the industry’s sustainability risks and opportunities.

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1 **Legal Note**: SASB standards are not intended to, and indeed cannot, replace any legal or regulatory requirements that may be applicable to a reporting entity’s operations.
### Table 1. Sustainability Disclosure Topics & Accounting Metrics

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² Note to HC-MC-230a.2 – Disclosure shall include a description of corrective actions implemented in response to data breaches.

³ Note to HC-MC-230a.3 – The entity shall briefly describe the nature, context, and any corrective actions taken as a result of the losses.
### Table 2. Activity Metrics

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Customer Privacy & Technology Standards

Topic Summary

Regulations, such as the Health Insurance Portability and Accountability Act (HIPAA) in the U.S., may require health insurance plans to comply with various requirements relating to the use, disclosure, storage, and transmission of patient health information. Companies in this industry are required to develop policies and technical safeguards to protect patient health information. A failure to comply with these evolving standards, which in the U.S. include provisions established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, can lead to significant civil and criminal penalties. These risks are intensified by an increase in cyberattacks that target managed care companies.

Accounting Metrics

HC-MC-230a.1. Description of policies and practices to secure customers’ protected health information (PHI) records and other personally identifiable information (PII)

1 The entity shall describe the nature, scope, and implementation of its policies and practices related to securing customer protected health information (PHI) records and other personally identifiable information (PII), with a specific focus on how it addresses the collection, usage, and retention of customers’ information, where:

1.1 PHI is defined by U.S. law in 45 CFR 160.103 and referenced in Section 13400 of Subtitle D ("Privacy") of the Health Information Technology for Economic and Clinical Health (HITECH) Act as information that is a subset of health information, including demographic information collected from an individual, that meets the following criteria: The information: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual or (ii) there is a reasonable basis to believe the information can be used to identify the individual.

1.1.1 Health information is defined as any information, whether oral or recorded in any form or medium, that (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, and (B) relates to the past, present, or future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

1.1.2 PHI includes information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

1.1.3 PHI excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act (20 U.S.C. 1232g), records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by a drug retailer in its role as employer.
1.2 PII is defined as any information about an individual that is maintained by an entity, including any information that can be used to distinguish or trace an individual's identity, such as name, Social Security number, date and place of birth, mother's maiden name, or biometric records and any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.  

2 The entity shall describe the information “lifecycle” (i.e., collection, use, retention, processing, disclosure, and destruction) and how information-handling practices at each stage may affect individuals’ privacy.  

2.1 With respect to data collection, the entity may describe which data or types of data are collected without consent of an individual, which require opt-in consent, and which require opt-out action from the individual.  

2.2 With respect to usage of data, the entity may describe which data or types of data are used by the entity internally and under what circumstance the entity shares, sells, rents, or otherwise distributes data or information to third parties.  

2.3 With respect to retention, the entity may describe which data or types of data it retains, the length of time of retention, and practices used to ensure that data is stored securely.  

3 The entity shall describe the systems it uses to ensure compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules and the HITECH Act, including policies and practices related to the collection, usage, storage, and disposal of PHI and PII.  

4 The entity shall describe its efforts to ensure compliance in the context of how it implements the following three categories of system security:  

4.1 Administrative safeguards, which are defined as documented, formal policies and procedures that are intended to manage the selection and execution of security measures to protect data and manage the conduct of personnel in relation to the protection of data  

4.2 Physical safeguards, which are defined as the protection of physical computer systems and the buildings holding such systems from natural and environmental hazards and inappropriate intrusion or removal  

4.3 Technical safeguards, which are defined as processes put in place to protect information, authenticate users, and control individual access to information  

5 Relevant practices to discuss include: internal monitoring practices; technology and security programs to prevent data breaches; training programs and protocols in place for employees who handle PHI or PII; and disposal methods for paper and electronic PHI records.  

6 The entity shall disclose if it employs heightened security measures to ensure the security of PHI, including a discussion of those additional measures.  

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The entity should not include in its disclosure any information that compromises the security of its systems or its enrollees’ PHI or PII.

HC-MC-230a.2. (1) Number of data breaches, (2) percentage involving (a) personally identifiable information (PII) only and (b) protected health information (PHI), (3) number of customers affected in each category, (a) PII only and (b) PHI

1 The entity shall calculate and disclose (1) the total number of data breaches identified during the reporting period.

1.1 Data breach is defined as the unauthorized movement or disclosure of sensitive information to a party, usually outside the organization, that is not authorized to have or see the information. This definition is derived from the U.S. National Initiative for Cybersecurity Careers and Studies (NICCS) glossary.

1.2 The scope of disclosure is limited to data breaches that resulted in a deviation from the entity’s expected outcomes for confidentiality and/or integrity.

2 The entity shall disclose (2) the percentage of data breaches in which customers’ (a) personally identifiable information (PII), but not protected health information (PHI), was subject to the data breach.

2.1 PII is defined as any information about an individual that is maintained by an entity, including: (1) any information that can be used to distinguish or trace an individual’s identity, such as name, Social Security Number (SSN), date and place of birth, mother’s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. This definition is derived from the U.S. Government Accountability Office’s Report to Congressional Requesters, Alternatives Exist for Enhancing Protection of Personally Identifiable Information.

2.2 PHI is defined in U.S. 45 CFR 160.103 and referenced in Section 13400 of Subtitle D (‘Privacy’) of the U.S. Health Information Technology for Economic and Clinical Health Act (HITECH Act) as information that is a subset of health information, including demographic information collected from an individual, that meets the following criteria: The information (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual or (ii) there is a reasonable basis to believe the information can be used to identify the individual.

2.2.1 Health information is defined as any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse and relates to the past, present, or future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
2.2.2 PHI includes information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

2.2.3 PHI excludes individually identifiable health information in education records covered by the U.S. Family Educational Rights and Privacy Act (20 U.S.C. 1232g), records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by a covered entity in its role as employer.

2.2.4 PHI is a subset of PII.

2.3 The scope of disclosure shall include incidents in which encrypted data were acquired with an encryption key that was also acquired, as well as if there is a reasonable belief that encrypted data could be readily converted to plaintext.

2.3.1 Encryption is defined as the process of transforming plaintext into ciphertext. This definition is derived from the NICCS glossary.

2.4 The scope of disclosure is limited to breaches in which customers were notified of the breach, either as required by law or voluntarily by the entity.

3 The entity shall disclose (2) the percentage of data breaches in which customers’ (b) PHI was subject to the data breach.

4 The entity shall disclose (3) the total number of unique customers who were affected by data breaches in which the customers’ (a) PII, but not PHI, was subject to the data breach.

5 The entity shall disclose (3) the total number of unique customers who were affected by data breaches in which the customers’ (b) PHI was subject to the data breach.

6 Accounts that the entity cannot verify as belonging to the same customer shall be disclosed separately.

7 The entity may delay disclosure if a law enforcement agency has determined that notification impedes a criminal investigation or until the law enforcement agency determines that such notification does not compromise the investigation.

Note to HC-MC-230a.2

1 The entity shall describe the corrective actions taken in response to data breaches, such as changes in operations, management, processes, products, business partners, training, or technology.

1.1 The U.S. SEC’s Commission Statement and Guidance on Public Company Cybersecurity Disclosures may provide further guidance on disclosures on the corrective actions taken in response to data breaches.

2 All disclosure shall be sufficient such that it is specific to the risks the entity faces, but disclosure itself will not compromise the entity's ability to maintain data privacy and security.
The entity may disclose its policy for disclosing data breaches to affected customers in a timely manner.

**HC-MC-230a.3. Total amount of monetary losses as a result of legal proceedings associated with data security and privacy**

1. The entity shall disclose the total amount of monetary losses it incurred during the reporting period as a result of legal proceedings associated with data security and privacy.

2. The legal proceedings shall include any adjudicative proceeding in which the entity was involved, whether before a court, a regulator, an arbitrator, or otherwise.

3. The losses shall include all monetary liabilities to the opposing party or to others (whether as the result of settlement or verdict after trial or otherwise), including fines and other monetary liabilities incurred during the reporting period as a result of civil actions (e.g., civil judgments or settlements), regulatory proceedings (e.g., penalties, disgorgement, or restitution), and criminal actions (e.g., criminal judgment, penalties, or restitution) brought by any entity (e.g., governmental, business, or individual).

4. The scope of monetary losses shall exclude legal and other fees and expenses incurred by the entity in its defense.

5. The scope of disclosure shall include, but is not limited to, legal proceedings associated with the enforcement of relevant industry regulations, such as:
   
   5.1 U.S. Health Insurance Portability and Accountability Act (HIPAA)
   
   5.2 U.S. Health Information Technology for Economic and Clinical Health (HITECH) Act

6. The scope of disclosure shall include, but is not limited to, legal proceedings associated with the enforcement of relevant industry regulations promulgated by regional, national, state, and local regulatory authorities, such as:
   
   6.1 U.S. Department of Health and Human Services (HHS)
   
   6.2 U.S. Office for Civil Rights

**Note to HC-MC-230a.3**

1. The entity shall briefly describe the nature (e.g., judgment or order issued after trial, settlement, guilty plea, deferred prosecution agreement, or non-prosecution agreement) and context (e.g., cyberattack or employee error) of all monetary losses as a result of legal proceedings.

2. The entity shall describe any corrective actions it has implemented as a result of the legal proceedings. This may include, but is not limited to, specific changes in operations, management, processes, products, business partners, training, or technology.
Access to Coverage

Topic Summary
Although the Patient Protection and Affordable Care Act in the U.S. reduced the number of uninsured, more than 10 percent of adults in the United States remain uninsured. The percentage of uninsured is significantly higher for people near or at the federal poverty level. Managed care companies can play a role in providing additional access by limiting plan costs and rate increases. Companies must also comply with regulations intended to control plan costs, including medical loss rations, while also ensuring coverage for all applicants regardless of health status, gender, or pre-existing conditions. Increased regulatory focus on health care costs and the need to comply with evolving regulations continue to present challenges for the industry.

Accounting Metrics

HC-MC-240a.1. Medical Loss Ratio (MLR)
1 The entity shall disclose its Medical Loss Ratio (MLR).

1.1 Medical Loss Ratio (MLR) is defined by the U.S. Department of Health and Human Services (HHS) in Title 45: Public Welfare Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements (45 CFR Part 158), Section § 158.221 Formula for calculating an issuer’s medical loss ratio.

2 The disclosure shall be subject to the aggregation of data requirements and credibility adjustment, as specified by HHS in 45 CFR Part 158.

3 The entity shall disclose MLR consolidated for all business lines and for each of the entity’s business segments according to its disaggregation of financial information, as outlined by US GAAP Topic 280 (Segment Reporting), including, but not limited to:

3.1 Small employer group

3.2 Large employer group

3.3 Individual retail

HC-MC-240a.2. Total amount of rebates accrued and paid due to non-compliance with the Patient Protection and Affordable Care Act for Medical Loss Ratio (MLR)
1 The entity shall disclose the total amount of rebates owed to policyholders as calculated by Title 45: Public Welfare Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements (U.S. 45 CFR Part 158), Section § 158.240 Rebating premium if the applicable medical loss ratio standard is not met.
1.1 Medical Loss Ratio (MLR) is defined by the U.S. Department of Health and Human Services (HHS) in Title 45: Public Welfare Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements (45 CFR Part 158).

2 The entity shall disclose the aggregate amount of all forms of rebate, whether it was in the form of a premium credit, lump-sum check, or reimbursement to credit card or bank account.

3 The entity shall disclose the rebate amount accrued for the reporting period as well as the amount paid during the reporting period for rebate liabilities from the previous reporting period.

4 The entity should discuss the reason for any differences between the amount paid during the reporting period and the amount accrued during the previous reporting period.

HC-MC-240a.3. Percentage of proposed rate increases receiving “not unreasonable” designation from Health and Human Services (HHS) review or state review

1 The entity shall disclose “not unreasonable” rate increase requests as a percentage of all rate increase requests made by the entity during the fiscal period.

2 The entity shall disclose only for requests for which review has been completed during the reporting period and conducted as per U.S. Title 45: Public Welfare Part 154 — Health Insurance Issuer Rate Increases: Disclosure and Review Requirements.

3 The entity may access the publicly available, searchable database of rate increase requests, which includes reviews conducted by the U.S. Department of Health and Human Services (HHS) and state designees.
Plan Performance

**Topic Summary**
Managed care companies manage performance in areas such as responsiveness, complaints, voluntary disenrollment, and customer service in order to maintain competitiveness. Under the Five-Star Quality Rating System for Medicare Advantage Plans in the U.S., performance on key metrics are factored into federal reimbursement rates and bonus payments for Medicare Advantage carriers. Disclosure on key indicators related to plan performance may allow shareholders to understand how managed care companies are able to protect corporate value.

**Accounting Metrics**

**HC-MC-250a.1. Average Medicare Advantage plan rating for each of the following plan types: (1) HMO, (2) local PPO, (3) regional PPO, (4) PFFS, and (5) SNP**

1. The entity shall disclose the average Overall Plan Rating for each of the following plan types that it offers:

   1.1 Health Maintenance Organization (HMO)

   1.2 Preferred Provider Organization (PPO)

   1.3 Private Fee-for-Service (PFFS)

   1.4 Special Needs Plans (SNP)

2. The entity shall include in the calculation all plans of each type receiving a Medicare Advantage plan rating.

3. The average rating shall be disclosed rounded to the nearest tenth (one place after the decimal point).

4. Plan ratings are publicly available on Medicare’s ”Medicare Plan Finder” website.

5. The entity may disclose the percentage of its plans, by type, that are “Five Star Plans” - those plans that receive the highest Medicare Advantage plan rating.

**HC-MC-250a.2. Enrollee retention rate by plan type, including: (1) HMO, (2) local PPO, (3) regional PPO, (4) PFFS, and (5) SNP**

1. The entity shall disclose its enrollee retention rate.

2. The enrollee retention rate is calculated as:
2.1 (Total number of enrollees at close of reporting period – total number of new enrollees added during the reporting period) / (total number of enrollees at the close of the previous reporting period – total number of enrollees involuntarily terminated during the reporting period – attrition of employees in employee sponsored plans), where:

2.1.1 Involuntarily terminated enrollees – those whose plans were terminated by the entity due to fraud or intentional misrepresentation of material facts – shall be excluded from the calculation.

2.1.2 Attrition of enrollees in employer sponsored group plans due to turnover (voluntary or involuntary) shall be excluded from the calculation.

3 The entity shall disclose retention rates by plan type, which may include:

3.1 Health Maintenance Organization (HMO)

3.2 Local Preferred Provider Organization (PPO)

3.3 Regional Preferred Provider Organization (PPO)

3.4 Private Fee-for-Service (PFFS)

3.5 Special Needs Plans (SNP)

HC-MC-250a.3. Percentage of claims denied that were appealed by customers and ultimately reversed

1 The entity shall disclose the percentage of claims it denied that enrollees appealed and for which the entity reversed its decision having determined the denial to be invalid.

2 The percentage of reversed claims shall be calculated as: the total number of claims that were denied and successfully appealed by enrollees during the reporting period divided by the number of claims that were denied and appealed by enrollees during the reporting period.

2.1 A successful appeal is one in which the entity reversed its decision, having determined the denial to be invalid.

2.2 The scope of disclosure of denied claims excludes claims that were denied for a billing error, appealed and resubmitted, and ultimately paid.

3 The entity shall not consider ongoing claims appeals—only those that were resolved during the reporting period.

4 The scope of disclosure includes both appeals of denials at preauthorization and denials at the time of payment.
4.1 Preauthorization denials occur when a determination is made that: (1) the consumer is not eligible to receive the requested service because, for example, the service is not covered under the individual's policy, or (2) the service is not appropriate, meaning that it is not medically necessary or is experimental or investigational.

5 For the purposes of this metric, if the appeal relates to denial of a portion of a claim, the entity shall consider it in the same manner as an appeal to an entire claim denial.

6 For the purposes of this metric, complaints, such as those with a state department of insurance which can also result in a reversal of denial, shall be considered in the same manner as an appeal. Complaints in this context shall only include those related to denial of coverage.

7 Multiple appeals to the same claim shall not be counted separately for calculations.

**HC-MC-250a.4. Plan enrollee grievance rate**

1 The entity shall disclose the plan enrollee grievance rate.

2 The entity shall calculate the grievance rate as: the number of grievances reported during the reporting period / (monthly average enrollees / 10,000), where:

2.1 Grievance is defined as any complaint or dispute, other than an entity determination, expressing dissatisfaction with the manner in which the entity or delegated entity provides health care services, regardless of whether any remedial action can be taken

2.2 An enrollee or his/her representative may make the complaint or dispute, either orally or in writing, to the entity

2.3 Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item

2.4 Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care

3 Monthly average enrollees is calculated as the total number of member months (one member being enrolled in an entity's plan for one month) / by 12 months.
Improved Outcomes

Topic Summary
Managed care companies can play a critical role in maintaining and improving the health of enrollees. In addition, legislation continues to emphasize improved outcomes through provisions, including those that require health plans to provide coverage for preventive services without cost to members. The development of the Five-Star Quality Rating System for Medicare Advantage Plans in the U.S., for example, further strengthens the relationship between enrollee health and value by linking reimbursement rates and bonus payments to performance in five domains, including specific outcome-based measures. Companies that are able to improve the health of enrollees may be better positioned to protect shareholder value.

Accounting Metrics

HC-MC-260a.1. Percentage of enrollees in wellness programs by type: (1) diet and nutrition, (2) exercise, (3) stress management, (4) mental health, (5) smoking or alcohol cessation, or (6) other

1 The entity shall disclose enrollee participation in wellness programs.

1.1 Wellness programs are defined as those that foster:

1.1.1 Primary prevention by promoting health-related behaviors (e.g., immunizations), healthy body mass index, or healthy lifestyle (e.g., exercise or smoking cessation)

1.1.2 Secondary prevention by promoting early-stage disease detection and management

2 The percentage of enrollees in wellness programs participation shall be calculated as the number of unique, individual enrollees participating in a wellness program divided by the monthly average number of enrollees.

2.1 The monthly average number of enrollees is calculated as the total number of member months (one member being enrolled in an entity's plan for one month) divided by 12 months.

3 The entity shall disclose the percentage of participation for each of the following types of wellness program:

3.1 Diet and nutrition

3.2 Exercise

3.3 Stress management

3.4 Mental health
3.5 Smoking or alcohol cessation

3.6 All other wellness programs

**HC-MC-260a.2. Total coverage for preventive health services with no cost sharing for the enrollees, total coverage for preventive health services requiring cost-sharing by the enrollee, percentage of enrollees receiving Initial Preventive Physical Examinations (IPEE) or Annual Wellness Visits (AWV)**

1 The entity shall disclose the total value of claims paid for preventative services covered under Section 2713 of the U.S. Patient Protection and Affordable Care Act (PPACA), including services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF).

2 The entity shall disclose the total value of claims paid for preventive services outside the scope of Section 2713 of the PPACA, and for which it may require cost-sharing from enrollees.

3 The entity shall additionally disclose the percentage of the total cost of these services that its coverage constituted as follows:

   3.1 The total cost of coverage for all medical expenses divided by the total cost of preventive services.

4 Services are considered preventive if they are:

   4.1 Coded with a Current Procedural Terminology (CPT®) code that contains the modifier “33,” denoting a preventive service

   4.2 Specifically identified as preventive

   4.3 Inherently preventive in nature

5 The entity shall not include in its calculation those services that are conducted in response to a symptom, even if it is the same service that can be administered as a preventive measure.

6 The entity shall disclose the percentage of enrollees receiving wellness screenings, as CPT® / HCPCS coded for Initial Preventive physical examination (G0402, G0403, G0404, G0450) or Annual Wellness Visit (G0438, G0439).

**Definitions**

Preventive services: Encounters with health services that are not for the treatment of illness or injury. These are often classified with an International Classification of Disease (ICD) Z code (in the ICD-10-CM) representing the diagnosis. The ICD diagnosis code is then accompanied by a Current Procedural Terminology (CPT®) code that represents the services performed.
HC-MC-260a.3. Number of customers receiving care from Accountable Care Organizations or enrolled in Patient-Centered Medical Home programs

1 The entity shall include in its calculation enrollees in Accountable Care Organizations (ACOs) that meet the eligibility requirements of, and participate in, Medicare's Shared Savings Program for Fee-For-Service beneficiaries.

1.1 ACOs are defined by the Centers for Medicare and Medicaid Services as a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization’s payment is tied to achieving health care quality goals and outcomes that result in cost savings.

2 The entity may also include enrollees in ACOs not participating in the Medicare program, provided that such ACOs include, at a minimum, the coordination of care from a variety of health care providers (including primary care physicians, specialists, and a hospital), and have the ability to administer payments, set benchmarks and measure outcome-based performance, and distribute shared savings.

3 The entity shall include in its calculation enrollees receiving care from Patient-Centered Medical Homes (PCMH) that meet the recognition and accreditation guidelines published by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA).

3.1 Patient-Centered Medical Home is defined as a reimbursement model founded on an outcome-based care delivery, “pay for coordination,” system in which payment is based on the coordination of services and comprehensive care that is coordinated through a physician (or physician assistant or registered nurse).
Climate Change Impacts on Human Health

**Topic Summary**
An increase in extreme weather events associated with climate change could have significant health impacts. These events, coupled with the potential spread of infectious diseases and food and water scarcity, are likely to present material implications for the Managed Care industry through an increase in encounters with the health care system. Companies that are able to address the risks posed by extreme weather events and potential changes in the incidence, morbidity, and mortality of illnesses and diseases may be better positioned to protect shareholder value.

**Accounting Metrics**

**HC-MC-450a.1. Discussion of the strategy to address the effects of climate change on business operations and how specific risks presented by changes in the geographic incidence, morbidity, and mortality of illnesses and diseases are incorporated into risk models**

1. The entity shall discuss its strategic business approach to addressing significant risks related to the effects of climate change, including, but not limited to, changes in the following aspects of illnesses and diseases:

   1.1 Geographic incidence

   1.2 Morbidity

   1.3 Mortality

2. Relevant disclosure may include, but is not limited to, discussion of the following:

   2.1 Increases in allergic responses, asthma rates, and heat-induced illness

   2.2 Migration of tropical diseases such as malaria, dengue fever, and other vector-borne tropical diseases to non-tropical regions

   2.3 Increases in waterborne diseases, such as cholera, due to increased natural disaster incidence

   2.4 Increased rates of human developmental diseases such as malnutrition due to decreased food availability

3. The entity shall discuss any projected impacts on revenue, costs, or plan affordability.

4. The entity may discuss how it incorporates the effects of climate change into its risk assessment and risk adjustment activities.