Nebraska Medicare Supplement New Business Rate Filing Guidelines
January 2nd, 2024 Version

The Division is posting these guidelines to assist carriers submitting Medicare Supplement new business rate filings in Nebraska.

1. **Base Period Experience**
   Complete quantitative support should be provided for the development of the Base Period Experience as described below.

   Medicare Supplement experience used to develop Base Claim Costs within the rate filing must be in accordance with the following hierarchy:
   1. The carrier utilizes their own fully credible Nebraska experience on similar plans.
   2. The carrier utilizes their own partially credible Nebraska experience and their own National experience on similar plans.
   3. The carrier utilizes their own partially credible Nebraska experience and a parent/affiliated company's National experience on similar plans.
   4. The carrier has no Nebraska experience but utilizes their own National experience on similar plans.
   5. The carrier has no Nebraska experience but utilizes a parent/affiliated company's Nebraska and/or National experience on similar plans.
   6. The carrier has no Nebraska or National experience of their own or for any parent/affiliated company must use a publicly available Medicare database, an outside actuarial database, or public rate filings from competitors.

   The statistical credibility of the underlying data used must be defined, and detailed support blending Nebraska and National data must be provided.

   Collateral data is defined as any data used to support the carrier's partially credible data. The use of such data must be justified based upon the hierarchy described above.

   Detailed supporting data from all models or proprietary databases must also be provided. Simply indicating the use of an outside model or proprietary database to set starting claim costs is not acceptable, and the rate filing may be rejected for incomplete support.

   <u>Base Period Summary</u>
   Base Claims Costs used for rate setting should be included for each data source used and for each year of experience by Plan and in Total, and should be summarized to include the following elements:

   - Member Months of enrollment
   - Total (Fully) Incurred Claims: Split by Actual Incurred Claims and Estimated IBNR Claims
   - Total (Fully) Incurred Claims PMPM
   - Cost Sharing Data should be split by Cost Share component (Part A deductible, Part B deductible, etc..) if used to calculate total Cost Share by Plan

2. **Adjustments to Base Period Experience**
   The following adjustments should be used to calculate a Starting Projected Claims PMPM

   <u>Population adjustments</u>
   - Geographic differences between states or between regions within a state
   - Benefit plan and cost sharing differences

- Demographic differences (Age mix, Gender Mix)
- Morbidity differences
- Underwriting mix difference

Projections to Future Rating Periods
- Trend factors
- Time from Base Period Experience to first year of future rating period

3. Durational Loss Ratio Calculations for Each Plan

A sample spreadsheet calculation that should be provided has been made available in the Excel Sheet Titled: "Durational Loss Ratio Exhibit for Medicare Supplement, Jan 2nd, 2024.xls".

Durational Loss Ratio Methods
- Exhibits for each Plan should use one of two methods:
  - Member Cohort – the Durational LR projection is based on starting members in year 1.
  - Premium Cohort - the Durational LR projection is based on starting premium in year 1.
- Initial Claims Per Member Per Year (PMPY), shown in Column (8) of the sample spreadsheet, should be consistent with Starting Projected Claim PMPM from Section 2.

4. Retention Table Illustration for each Plan

For each Plan the company should provide an illustration of expected retention levels as outlined below. More detailed breakouts may be provided if necessary.

Retention Table Elements (as a % of Premium)

Retention table elements should be provided for Year 1, Year 2 and Lifetime Levels.
- Administrative Expenses %
- Compensation %
  - The Commission schedules, for 1st year policies (new business), 2nd – 6th year renewal commissions, 7+ years renewal commissions.
  - All Cash Bonus schedules for 1st year policies (new business); and if any exist for renewal commissions.
  - All Other Incentive schedules for any form of Compensation paid, by policy year.
- Marketing & Advertising %
- Profit Margin %
- Taxes, assessments %
- Other %
- Total Retention %: Total Retention % over a policies' lifetime should equal (1-Lifetime Target Loss Ratio %)

Total Compensation Levels for Each Plan:

The company should demonstrate that the expected total compensation including commissions will meet the requirements contained in the NAIC Model Regulation 651, and the NAIC Medicare Supplement Compliance Manual. Total compensation must comply with the following:
- First-year compensation must not be greater than twice the renewal compensation (years 2 through 6). The dollar level of first-year compensation should be no more than twice the dollar level of second-year compensation and shall not vary based on the rating methodology selected by the policyholder.
- Duration years two through six must be level. Renewal compensation for years two through six may be a constant dollar amount that does not vary based on the rating methodology or may be defined as a constant percentage of the issue-age premium.
- Compensation rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.
- The compensation rate calculation for replacement situations must clearly be stated.

5. **Provide Support for All Assumptions and Rating Factor Development:**
   The carrier should provide actuarial support for all assumptions applied in rate setting, including the development of the claim trend. This should include providing historical claim trend data showing adjustments in trend data for demographics, morbidity, and other factors. The four most recent years of monthly claim experience used to evaluate historical trends should be provided, if available. The carrier should indicate any prospective unit cost or utilization adjustments made to the data to arrive at the final claim trend.

6. **Rate Manual:**
   A rate manual must be provided. The rate manual must include all rate tables, rating factors and formulas used to calculate the rate for any policyholder. Complete rating factor tables should be provided for each factor applied to base rate tables in determining rates including:
   - Age factors
   - Area factors, including what zip code or county definition of an area.
   - Modal factors
   - Tobacco/Smoking factors
   - Gender factors
   - Family Status (Married/Single)
   - Underwriting Class
   - Change in Rating Methodology

7. **Underwriting Manual:**
   The Underwriting (UW) manual must be provided in new business rate filings, and in any subsequent renewal rate filing where modifications are made. Criteria for applying any UW adjustment, such as tables supporting height/weight rating factors or criteria to disapprove an applicant, must be included.

8. **Protections Against Inadequate Rates:**
   As indicated in the NAIC Medicare Supplement Compliance Manual "Rates should be adequate to provide for the benefits in accordance with the rating methodology used and reasonable assumptions regarding claim costs by duration. Rates based strictly on early duration favorable experience would generally not be considered adequate".

   Rates are considered "adequate" if applying future annual trend factors as the annual rate increases will not result in an underwriting loss over the lifetime of the policy. That is, large rate increases above trend should not be required in the future to keep the Lifetime Loss Ratio below a level where underwriting losses would occur.

9. **Future Rate Filings and Target Loss Ratios:**
   The premium trend illustrated in the Durational Loss Ratio shall be applied as an increase to the following year rates in the first renewal rate filing, and in subsequent year rate filings, in the absence of credible experience being available in the early years of the plan.

   When credible experience is not available at the first renewal, a company may NOT simply state that they are ignoring their original pricing projection calculation's expected claim and premium trends and taking a 0% rate increase. This also holds for all subsequent renewal year rate filings until the block of business can be transitioned to an experience rated basis. In the initial new business rate filing the certifying actuary MUST include in their actuarial certification a statement that the claim and premium trends are expected to continue into future years, and that the company will continue to increase rates appropriately for trend in subsequent years. Failure to apply cost trends in future year rate filings may result in the NE DOI disallowing rate increases larger than trend in later years. Only the NE DOI rate filing reviewer can allow an adjustment to the claim and premium trends stated in the new business rate filing. The filing actuary may request a review, but the NE DOI reviewer's decision will be binding on future year rate increases.

   Note that any future rate change request must be based on the same lifetime loss ratio standard as originally submitted, unless there has been a material change in assumptions used to price the product. Changes to the

lifetime loss ratio must include adequate support and cannot be implemented until requested and approved. Future filings must also include the actual and expected benefit ratios, and the ratio of actual to expected for both the experience and rating periods.