**Nebraska Medicare Supplement New Business Rate Filing Guidelines**
**June 27th, 2022 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 development of:

(1) The starting claim costs used for setting each plan's rates, and
(2) The base rates used in the rate manual for calculating each plan's rates.

The carrier should include a quantitative summary of the historical base experience used to develop the expected claim costs that rates are based on. This could include similar historical experience that the company has from other blocks of business, or experience from other sources such as a consultants health cost manual. In all cases the experience used to determine the starting expected claim costs must be provided and documented, regardless of what source the experience came from.

The hierarchy for supporting data to be included in the development of starting claim costs in the rate filing is the following:

i. The carrier utilizes their own fully credible Nebraska Medicare Supplement experience on similar plans.
ii. The carrier utilizes partially credible Nebraska experience, and also has similar National experience to use.
iii. The carrier has no Nebraska experience, but has their own similar National experience to utilize.
iv. The carrier has no Nebraska experience, but has a parent or affiliated company Nebraska and/or National experience on similar Medicare Supplement plans that can be utilized.
v. The carrier has no credible Nebraska or National experience of their own, or for any parent/affiliated company, therefore an outside actuarial database must be utilized.
vi. The carrier has no credible Nebraska or National experience of their own, or for any parent/affiliated company, therefore public rate filings from competitors are used.

The statistical credibility of the underlying base experience used must be addressed.
Collateral data used to support partially credible data must be provided, and the use of such data must be justified. Simply indicating that you used a proprietary database to set starting claim cost levels is not acceptable. All detailed support from any model used must be provided or your filing may be rejected for incompleteness. If you have affiliated company experience available on similar Medicare Supplement policies in Nebraska, or nationally, and you are not using it for rate setting, you must still provide the experience, and include a justification for not using this experience in rate setting.

Base period data for rate setting should include for each data source used, and for each year of experience, the following data elements:
* Member Months of enrollment;
* Total Incurred Claims, and Incurred claims pmpm;
* Estimated IBNR Claims that were included in the Total Incurred Claims above.

**2. Adjustments to Base Experience and Projection to Future Rating Period.**

New business rate filings must provide complete support for how the new rating period's starting claim costs were developed, including all trend factors and other projection factors and adjustments that are applied.

Adjustments should be included to account for differences between the base claims data and claims of the plans and population expected to be enrolled, such as:

* Benefit plan and cost sharing differences;
* Demographic differences (Age mix, Gender Mix);
* Geographic differences between states or between regions within a state;
* Population morbidity differences;
* Underwriting mix differences.

Starting Projected Claims: A complete projection calculation should be provided including all trend and projection factors used to project base experience to the first year of the future rating period.

This projection calculation requirement can be satisfied by providing a LT Loss Ratio spreadsheet with all formulas included showing how the first projected year was calculated from the historical experience, and showing how all future projected years are calculated.

**3a. Lifetime Loss Ratio Calculations for Each Plan:**

For each plan a Lifetime Loss Ratio table by calendar year should be provided demonstrating incurred claims, IBNR claims, expected lives enrolled for the year (or member months), annual lapse rate, earned premium, loss ratio for each calendar year period, with a summary line calculation for all years included at the bottom of the table. The first year of this LT LR calculation should reflect the projected claims from the projection calculation in (2) above.

The carrier should include a lifetime loss ratio demonstration for all plans combined. This should include the projected loss ratio in each policy year in the future accounting for expected enrollment by year.

The lifetime loss ratio calculations based on estimated total enrollment each year should be in addition to any durational loss ratio exhibits provided which are based on a starting cohort of members and loss ratios by duration. All LT LR calculations and should be submitted in both pdf and Excel spreadsheet format.

**3b. Retention Illustration for Each Plan:**

For each plan the company should provide an illustration of expected retention levels broken out by at least the following categories as a % of premium:

* Administrative Expenses %
* Commission %
* Marketing & Advertising %
* Profit Margin %
* Taxes, assessments %
* Other retention %
* Total Retention % (over a policies Lifetime this should equal 1 – Lifetime Target Loss Ratio % ).

More detailed breakouts may be provided.

The retention illustration should provide this breakout on each of the following bases:

* First Year Levels;
* Year-7 Levels (reflecting final renewal commission levels);
* Lifetime Levels (The average % over the Lifetime of the policy).

**3c. Commission Levels for Each Plan:**

The company should demonstrate that the expected commission levels will meet the requirements contained in the NAIC Model Regulation 651, and the NAIC Medicare Supplement Compliance Manual.
Commission rates must comply with the following:

* First-year commissions must not be greater than twice the renewal commissions (years 2 through 6).
The dollar level of first-year commissions should be no more than twice the dollar level of second-year commissions and shall not vary based on the rating methodology selected by the policyholder.

* Duration years 2 through 6 must be level.
Renewal commissions 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.

* Rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.

* Commission rate calculation for replacement situations must clearly be stated.

**4. 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.

**5. 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 area used
* Modal factors
* Tobacco/Smoking factors
* Gender factors
* Family Status (Married/Single)
* Underwriting Class
* Change in Rating Methodology

**6. 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.

**7. Provide Competitive Rate Comparisons:**

The carrier should provide any competitive rate comparisons that were performed to determine how proposed rates compare to rates for similar plans in the Nebraska market. A carriers competitive rate comparison may not be considered to be valid if it does not include a comparison against rates that were set by carriers whose rates have been developed from credible experience, and have demonstrated that their rates are not inadequate.

The Division may provide our own analysis of the proposed rates versus rates in the market that were set by carriers whose rates have been developed from credible experience, and have demonstrated that their rates are appropriate

(not excessive or inadequate). The Division will measure the proposed rates against low and high rates in the market from such credible plans to gauge where the low and high ends of viable rates are for various plans, ages, areas, tiers. These measures may be used to identify whether any proposed rates from issuers appear to be excessive or inadequate in comparison to viable market rates.

**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 to be "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 in order to keep the Lifetime Loss Ratio below a level where underwriting losses would occur.

**9. Future Rate Filing Target Loss Ratios:**
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.