Illinois Department of Insurance

JB PRITZKER
Governor

DANA POPISH SEVERINGHAUS
Director

COMPANY BULLETIN

TO: All Companies Writing Accident and Health Insurance and Manage Care Plans in Illinois

FROM: Dana Popish Severinghaus, Director dps

DATE: May 3, 2023

RE: COMPANY BULLETIN 2023-05 - ILLINOIS FILING REQUIREMENTS FOR INDIVIDUAL AND SMALL GROUP HEALTH PLANS, ON AND OFF-MARKETPLACE (ON AND OFF-EXCHANGE) AND STAND-ALONE DENTAL PLANS

The purpose of this Bulletin is to provide instructions to Issuers seeking certification or recertification of individual and small group plans and Stand-alone Dental Plans (SADP) offered on the Individual and Small Business Health Options Program (SHOP) Marketplace. This Bulletin also applies to those plans offered off the ACA Marketplace (Off-Exchange) in the individual and small group markets for Plan Year 2024. Student health plans are required to meet the standards for individual QHP plans with the exception of filing dates and rating rules. Student Health plans must follow the specific rating and eligibility rules as outlined by CMS for such plans.

Note: The issuer deadlines apply to ALL individual and small group health plans, and dental plans offered on and off the Marketplace.		
Activity		Dates
Plan and Rate Application and Review Process	**Deadline for Issuers to Submit Plan Data and Rate Filings to Illinois Through SERFF**	**5/24/2023**
	Illinois DOI First SERFF Data Transfer Deadline.	6/14/2023
	CMS Reviews Initial Qualified Health Plan (QHP) Applications	6/15/2023 – 7/14/2023
	Illinois DOI Second SERFF Transfer Deadline	7/19/2023
	CMS reviews Rates Table Template data and resubmitted QHP Application data, and releases results in the PM Community for issuers and states to review	7/20/2023 – 8/11/2023
	Issuer Plan Confirmation/Crosswalk Deadline: Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates in the PM Community*	8/9/2023 – 8/23/2023
	Illinois DOI **Final** SERFF Data Transfer Deadline. Deadline for issuers to submit changes to their QHP	8/16/2023

	Applications and to submit marketing URL data in the HIOS Supplemental Submission Module (SSM)	
	CMS reviews QHP Applications and releases results for issuers and states to review	8/17/2023 – 9/11/2023
	CMS sends QHP Certification Agreements to issuers	9/12/2023
	Illinois DOI Completes CMS Final Plan Recommendations	9/12/2023 – 9/20/2023
	QHP Agreement Signing Deadline: Issuers return signed QHP Certification Agreements to CMS	9/12/2023– 9/20/2023
QHP Agreement/ Final Correction	Limited Data Corrections Window (Outreach to Issuers with CMS or Illinois DOI Identified Data Errors; Issuers Submit Corrections; CMS Reviews and Finalizes Data for Open Enrollment)	9/14/2023– 9/15/2023
	Machine-Readable/URL Deadline: Deadline for issuers' machine-readable data to be posted and marketing URLs to be live and active	9/20/2023
	CMS Releases Certification Notices to Issuers and States	10/3/2023 – 10/4/2023
	Anticipated public display of QHP quality rating information	11/1/2023
Open Enrollment Begins		**11/1/2023**

*Any revised crosswalk submitted to CMS in PM Community, must also be submitted to the state binder in SERFF.

Issuers are advised to consult federal regulations, 2024 Letter to Issuers released May 1, 2023 and state law in conjunction with this Bulletin to ensure full compliance. Helpful documents can be found on the Illinois Department of Insurance's ACA Issuer Homepage.

1. All form filings must be submitted in the format of a complete insurance policy. The Department will not accept matrix insert page filings, riders, amendments, variable language, or brackets within individual (including ACA compliant student health plans) and small group filings. Approved filing will only be reopened upon request from CMS. NOTE: Summary of Benefits and Coverage may contain bracketed information per the federal template, and the cover page may include brackets for policyholder name, policy number, product name, effective date of policy and other identifying data.
2. Issuers are prohibited from utilizing misleading plan marketing names on all forms and/or corresponding templates. Specifically, issuers are prohibited from using misleading dollar amount references in plan marketing names and templates. All plan marketing name information should be validated to ensure accuracy and consistency across the plan or plan variation marketing name, Plans & Benefits Template, HealthCare.gov plan selection information, and other applicable QHP certification materials.
3. Visit the CMS QHP Certification Website and complete the QHP Application checklist.
4. **NEW for PY 2024:** Issuers are reminded to obtain access to and use the new HIOS module, Marketplace Plan Management System ("MPMS"). Issuers that previously submitted QHP Application data in the Issuer, Benefits & Service Area, Rating, and Supplemental Submission Modules within HIOS will instead submit these data in the new HIOS MPMS Module to create QHP Applications, submit templates and supporting documents, validate templates, and access some QHP Application review results.
5. For 2024 plans, Illinois will require the crosswalk template to be uploaded to the binders.
6. Submit all checklists, templates and supporting documentation in SERFF.
7. Provide a red-lined version identifying the variations in plan benefit design from the plans submitted for the previous plan year for each form filing submitted for recertification. Red-lined versions must be submitted under the supporting documentation tab in the form filing in SERFF.
8. Associate all relevant filings in the SERFF binder including, but not limited to, form, rate, external review, and network adequacy filings.

9. The Department requires full updated Network Adequacy filings to be submitted. Please note, all network plans other than limited-scope dental, vision, and LHSO plans are subject to standards and filing requirements pursuant to 215 ILCS 124/ as well as 50 Ill. Adm. Code 4540 Network Adequacy and Transparency, which became effective March 28, 2023.
10. Network Adequacy County Facilities Collection Template - This excel document must be accurately completed for each applicable network(s) that the plan intends to service. Data collected will identify specific contracted Acute Inpatient Hospital and Inpatient or Residential Behavioral Health Facility information for each respective county the plan intends to service. This document must accompany the Network Adequacy filing. Visit the Accident & Health Checklists section of the Department's website to access and complete the template.
11. Service Area Exemption: Issuers that fail to offer coverage to an entire rating area must obtain an exception from the Department. (See QHP Service Area Exception Form) The Issuer must provide service area maps to show compliance with the service area requirement.
12. Issuers who are not able to comply with the network adequacy standards for time and distance and provider ratio are required to complete the Network Adequacy Exception Form with specific details pertaining to the known deficiency for the Department's review and consideration. Note: Pursuant 215 ILCS 124/10(g) no exceptions may be granted for the requirements set forth in 215 ILCS 124/10(d-5), but issuers should still identify deficiencies.
13. Remit the fee of $3,000.00 for certification of each new QHP plan and $1,500.00 for recertification for each existing QHP plan via EFT in SERFF binder filings at the time of binder submission.
14. For Plans that will be discontinued or modified, Issuers must submit the appropriate letters or notifications pursuant to 215 ILCS 97/60 no later than July 1, 2023.
15. Issuers offering individual and small group off-exchange only plans must submit an off-exchange only binder submission with all off-exchange only plans following the requirements outlined in this bulletin.
16. Every plan listed on the Plans & Benefits Template that the Issuer intends to market as an HDHP or for use with an HSA must have "HSA-Eligible" checked on the template. No plan with a flat-dollar copayment structure for the entire prescription drug benefit as described in 215 ILCS 134/45.3 may be marketed as an HDHP or have the "HSA-Eligible" field checked on the template. Pursuant to the Final Notice of Benefit and Payment Parameters for 2024, standardized plan options do not include HSA-eligible HDHPs.
17. **NEW for PY 2024:** a QHP Issuer on the Federally-facilitated Exchange is limited to four non-standardized plan options per product network type, metal level (excluding catastrophic), and inclusion of dental and/or vision coverage, in any service area. The Issuer must offer at least one standardized plan option at every product network type, metal level (except non-expanded bronze), and throughout every service area that it also offers a non-standardized option, including the income-based CSR variations for silver plans.
18. **PENDING LEGISLATION THAT MAY IMPACT COVERAGE REQUIREMENTS IN PY24:** The Department strongly encourages plans to monitor the following pieces pending legislation to ensure compliance for coverage effective on or after January 1, 2024:

    SB 1344: Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed in the State on or after (rather than only after) January 1, 2024 shall provide coverage for all abortifacients, hormonal therapy medication, human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis drugs approved by the United States Food and Drug Administration, and follow-up services related to that coverage. Effective immediately.

    HB2089: Removes provisions added by Public Act 94-677, which has been held unconstitutional. In provisions concerning coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions, removes language that provides that a request for expedited

external review must be initiated within 24 hours following the adverse determination notification by the insurer, and failure to request an expedited external review within 24 hours shall preclude a covered person or a covered person's authorized representative from requesting an expedited external review. Makes other changes. Amends the Small Employer Health Insurance Rating Act. Provides that the provisions shall not apply to any health benefit plan for a small employer that is delivered, issued, renewed, or continued in the State on or after January 1, 2022, unless specified federal law is repealed. Amends the Health Maintenance Organization Act. Provides that health maintenance organizations shall be subject to specified provisions of the Illinois Insurance Code mandating coverage for certain services. Amends the Managed Care Reform and Patient Rights Act. Changes the definition of "health care plan" to include specified not-for-profit voluntary health services plans. Effective July 1, 2023

Issuers may be required to attach other checklists and/or supporting documentation and templates, as indicated by the ACA Individual and Small Group Checklists.

Maximum Annual Limitation on Cost Sharing for Plan Year 2024

	Individual Coverage	Family Coverage
Health Plans	$9,450	$18,900
SADPs	$400	$800

Exhibit 1:
2024 Health Plans Filing Requirements – Form and Binder

	Required Submission Via SERFF		
Federal Required Templates	On/Off-Exchange	Off-Exchange	Location
All Applicable templates/documents listed on the CMS Certification Checklist	Yes	Yes	Binder
Illinois Required Documents			
ACA Individual, Small Group, and Catastrophic Checklist	Yes	Yes	Form filing
ACA Individual and Small Group SADP Checklist	Yes	Yes	Form filing
Network Adequacy and Transparency Checklist (not applicable to SADPs)	Yes	Yes	Network Adequacy Filing
Mental Health Parity Supporting Documentation Template (does not include SADP)	Yes	Yes	Form Filing
Proposed Enrollment Template	Yes	Yes	Binder
External Review Checklist (Not applicable to SADPs)	Yes	Yes	External Review Filing

QHP Rates Guidance:
New for the 2024 plan year, the Centers for Medicare & Medicaid Services (CMS) and the National Association for Insurance Commissioners (NAIC) have established a system connection between the System for Electronic Rates & Forms Filing (SERFF) and the Health Insurance Oversight System Unified Rate Review (HIOS URR) module.

All new filings created AFTER 3/25/22 should be submitted using the new SERFF to URR Transfer Process. This is done by using the new URRT Tab in SERFF.

If an issuer enters their rate submission incorrectly through HIOS instead of SERFF, CMS will deactivate that submission and notify the issuer that it must be entered through the SERFF Transfer Process.

Two tutorial videos are below:

- URRT tab/filing submission (17 minutes)
    - https://naic.webex.com/naic/ldr.php?RCID=8fdd279b684dd81e95f1ed6576bdee6d
- URRT Responses/Amendments (6 minutes)
    - https://naic.webex.com/naic/ldr.php?RCID=dc62c787e0658801e981c296b1bdfe52

1. The Department will allow carriers to modify their individual and small group rate filings through **July 7, 2023** to reflect updated assumptions related to risk adjustment. Other types of changes or changes after this date will be allowed at the discretion of the Department. All documents that change will need to be resubmitted in redline format to allow for a more efficient review.
2. Since July 1, 2019, it has been illegal in Illinois to sell tobacco products to individuals under 21 years of age. Accordingly, premium rates for consumers in this age group should not include a tobacco load.
3. Actuarial memorandums must break out separately the assumed impact(s) of the unwinding of the continuous enrollment provision which has applied to Medicaid since the Covid-19 public health emergency. on the Plan Year 2024 proposed rates, if any, and provide both quantitative and qualitative support for the assumed impact(s).
4. Actuarial memorandums must include the commission schedules and any recent or anticipated changes thereto.
5. Carriers offering QHPs in the individual market are encouraged (but not required) to load the expected costs of missing CSR payments from the federal government onto just their on-exchange Silver plans and to also offer off-exchange only Silver plans without this load. Actuarial memorandums must include the quantitative development of the CSR load(s) being applied in the development of the Plan Year 2024 proposed rates.

Induced Demand Guidance for the 2024 ACA Illinois Rate Filing Process:
One of the larger variations seen in the development of ACA rates in the Illinois market is the induced demand component that is attributed to plans. As such, the Illinois Department of Insurance is issuing guidance for the 2024 ACA Rate Filings. Below are the items that the Illinois Department of Insurance is asking carriers to provide with the development of the 2024 ACA Rates:

- Stand-alone Induced Demand Factors – The induced demand factors should be provided for each plan as a separate and stand-alone factor.
- Quantitative and Qualitative Support – Provide both quantitative support for the development of the induced demand factors as well as qualitative support to explain the process and the reasoning behind any quantitative assumptions. For any assumptions or calculations that are the result of internal/external models, carriers should be prepared to demonstrate and explain both the methodology and the results behind each model output. Additionally, carriers should provide support to demonstrate that the proposed induced demand factors do not reflect the impact of morbidity differences between the members expected to enroll in each plan or set of plans.
- Historical Induced Demand Factors – Provide a table listing the minimum, maximum and average (weighted by plan membership) induced demand factor by metal level for the most recent 4 years (2021, 2022, 2023 and 2024).

COVID-19 Guidance for the 2024 ACA Illinois Rate Filing Process:

- Historical Experience Adjustment – Actuarial memorandums must include a description of how the historical base experience base experience was adjusted in order to remove the effect(s) that COVID

may have had on the claims experience in that year. In providing its description, the carrier should make sure to include the adjustment that was applied to the historical base experience, as well as both quantitative and qualitative support for the adjustment.

- Prospective Adjustment - Actuarial memorandums must include the carrier's anticipated impact of COVID on the 2024 claims experience, if any, relative to if COVID did not exist. To the extent the anticipated effect of COVID on claims in aggregate for 2024 is different than 0.0% (i.e., no impact), carriers must break-out separately and provide quantitative support for each of the following items: COVID vaccine costs, COVID testing costs, COVID treatment costs, Other COVID-related costs (please include a description of what is included in Other if different from 0.0%).

Other Rate Adjustment Factors:

- Consolidated Appropriations Act, 2023 (CAA)
- Risk Adjustment Data Validation (RADV)

If any of the above "Other Rate Adjustment Factors" apply, please provide narrative and quantitative support detailing all assumptions as well as explain where the adjustment is applied.

Exhibit 2:

2024 Health Plans Filing Requirements – Rates

	Required Submission via SERFF		
Federal Required Templates	On-Exchange	Off-Exchange	Location
QHP Rating Module Documents • Rates Table Template • Business Rules Template	Yes	Yes	Rate filing & Binder
Unified Rate Review Template	Yes	Yes	Rate Filing & Binder
Illinois Required Documents			
Health Premium Rate checklist	Yes	Yes	Rate Filing & Binder
Proposed Enrollment Template	Yes	Yes	Rate Filing & Binder

Reminders:

- **The Department requires issuers to submit the applicable federal QHP templates for all off-exchange only non-QHP individual and small group filings via a separate off-exchange only Binder submission.**
- **Network adequacy testing extends to all ACA products, including both individual and small group, with federal requirements in place as of PY 2023.**