Illinois Department of Insurance

JB PRITZKER
Governor

ANN GILLESPIE
Acting Director

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

FROM: Ann Gillespie, Acting Director

DATE: May 14, 2024

RE: COMPANY BULLETIN 2024-11 - 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 2025. Student health plans are required to meet the standards for individual Qualified Health Plans ("QHP") 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 stand-alone dental plans offered On and Off the Marketplace.		
Activity		Dates
Plan and Rate Application and Review Process	**Deadline for Issuers to submit QHP/NQHP Applications to Illinois DOI, including Plan ID Crosswalk data**	6/5/2024
	Illinois DOI Initial SERFF Binder Data Transfer Deadline	6/12/2024
	QHP issuer submits the validated Quality Rating System (QRS) clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS)[1]	6/14/2024
	CMS reviews initial QHP Applications and releases results for issuers and states to review	6/13/2024 – 7/12/2024
	Illinois DOI Secondary SERFF Binder Transfer Deadline: Deadline for issuers to submit their QHP Application Rates Table Templates to CMS; optional deadline for issuers to submit corrected QHP Application data to CMS	7/17/2024
	CMS reviews Rates Table Template data and resubmitted QHP Application data, and releases results in the PM Community for issuers and states to review	7/18/2024 – 8/9/2024
	Issuers, Exchange administrators, and CMS preview the 2024 QHP quality rating information	Aug./Sep. 2024

Springfield Office
320 W. Washington Street
Springfield, Illinois 62767
(217) 782-4515

Chicago Office
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
(312) 814-2420

	Issuer Plan Confirmation/Crosswalk Deadline: Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates.	8/7/2024 – 8/21/2024
	Illinois DOI Final SERFF Binder Data Transfer Deadline: Deadline for issuers to submit changes to their QHP Applications	8/14/2024
	CMS reviews QHP Applications and releases results for issuers and states to review	8/15/2024 – 9/9/2024
	CMS sends QHP Certification Agreements to issuers	9/10/2024
	QHP Agreement Signing Deadline: Issuers return signed QHP Certification Agreements to CMS	9/10/2024 – 9/18/2024
	Illinois DOI Plan Confirmation Deadline: Recommendations: State completes final plan confirmation	9/10/2024 – 9/18/2024
	Limited data correction window	9/12/2022– 9/13/2024
	Machine-Readable/URL Deadline: Deadline for issuers' machine-readable data to be posted and marketing URLs to be live and active	9/18/2024
	CMS Releases Certification Notices to Issuers and States	10/1/2024 – 10/2/2024
	Anticipated public display of QHP quality rating information	11/1/2024
Open Enrollment Begins		**11/1/2024**

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

[1] Each QHP issuer must submit and plan-lock its QRS clinical measure data by May 31 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 14 deadline. There are no fees for QHP issuers associated with accessing and using the IDSS.

Issuers are advised to consult federal regulations, 2025 Letter to Issuer released April 10, 2024, 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 filings will only be reopened upon request from CMS. **NOTE:** Summary of Benefits and Coverage (SBC) 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 reminded to review all cost-sharing, benefit explanations, limitations and exceptions, listed within the SBC, Plan Summary documents and Plan and Benefits Template to ensure all data is displayed in a consistent and accurate manner to mitigate avoidable plan display inaccuracies and consumer confusion that may result in Special Enrollment Periods.
3. Issuers are prohibited from utilizing misleading plan marketing names on all forms and/or corresponding templates. Specifically, issuers are discouraged from using specific benefit and 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.
4. Visit the CMS QHP Certification Website and complete the QHP Application checklist.
5. Issuers are reminded to use the 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.

6. For Plan Year 2025 plans, Illinois requires the crosswalk template to be uploaded to the binders.
7. Submit all **checklists, templates and supporting documentation** in SERFF.
8. 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.
9. Associate all relevant filings in the SERFF binder including, but not limited to, form, rate, external review, and network adequacy filings.
10. The Department requires full updated Network Adequacy filings to be submitted. Please note, all network plans other than most excepted benefits or any short-term, limited-duration health insurance coverage are subject to standards and filing requirements pursuant to 215 ILCS 124/et seq. as well as 50 Ill. Adm. Code 4540. To the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans in State-based Exchanges on the Federal Platform, the Department will enforce those standards as the operator of the Illinois Health Benefits Exchange. **NOTE:** As a reminder to issuers with network plans, while the Department adopted the federal time and distance standards established in Tables 3.1 and 3.2 of the 2023 Letter to Issuers; the Department did not adopt the federal enrollee accessibility threshold of 90 percent. As previously indicated, issuers who are unable to meet 100 percent accessibility will be required to complete the Network Adequacy Exception Form (as allowed). See item #13 below.
11. 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.
12. 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.
13. 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 to 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 and disclose such deficiencies.
14. 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.
15. For plans that will be terminated, discontinued, or modified, Issuers must submit the appropriate notifications pursuant to 215 ILCS 97/30(C) and 215 ILCS 97/50(C). The issuer must also have provided advance notice to the Department pursuant 215 ILCS 97/60.
16. 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.
17. Every plan listed on the Plans & Benefits Template that the Issuer intends to market as an High Deductible Health Plan ("HDHP") or for use with an Health Savings Account ("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 2025, standardized plan options do not include HSA-eligible HDHPs.
18. **NEW for PY 2025:** QHP Issuers on the Federally-facilitated Exchange or State-Based Exchange on the Federal Platform are limited to two 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 (excluding catastrophic plans), and throughout every service area that it also offers a non-standardized option, including the income-based CSR variations for silver plans.

19. **PENDING LEGISLATION THAT MAY IMPACT COVERAGE REQUIREMENTS IN PLAN YEAR 25:** The Department strongly encourages plans to monitor all pending legislation, including but not limited to the following pending bills with effective dates on or after January 1, 2025, to ensure compliance for coverage:

    HB 5395: Healthcare Protection Act

    HB 5493: Administrative Bill

    SB3130: State-based Marketplace Omnibus

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

NOTE: Maximum Annual Limitation on Cost Sharing for Plan Year 2025

	Individual Coverage	Family Coverage
Health Plans	$9,200	$18,400
SADPs	$425	$850

Exhibit 1:
2025 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 (**Including 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:
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 12, 2024** 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 2025 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 2025 proposed rates.

Public Posting of Initial Rate Filing Summaries:
NEW FOR PY 2025: As a result of Public Act 103-0106, a summary of initial rate filings received by the Department will be publicly posted on the Department's website within 5 business days of the rate filing deadline. Pursuant to the recently amended 50 Ill. Adm. Code 2026.50(c)(2), regardless of any increase, decrease, or continuation in rates, submitted templates must include all information described in 50 Ill. Adm. Code 2026.50(e). An Excel template titled "Plan Year 2025 Public Rate Filing Summary.xlsx" accompanies this Bulletin and is to be completed by issuers summarizing the rate filing. Please only complete the shaded areas of the Rate Filing Summary template. All shaded areas are required to be completed except for "Any Other Relevant Comments (optional)".

The rate filing summary templates will be posted to the Department's website to fulfill this statutory requirement. If an issuer intends to offer both individual and small group coverage, a separate template for each should be submitted as part of the supporting documentation in each filing.

The posting of the rate filing summaries to the Department's website will start a 30-day public comment period where comments may be submitted to the DOI.HealthRateReview@illinois.gov email address. The comments received will then be posted to the Department's website.

Induced Demand Guidance for the 2025 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

2025 ACA Rate Filings. Below are the items that the Illinois Department of Insurance is asking carriers to provide with the development of the 2025 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 plan years (2022, 2023, 2024 and 2025).

If any other rate adjustment factors apply, please provide narrative and quantitative support detailing all assumptions as well as explain where the adjustment is applied.

Health Insurance Coverage, Affordability, and Cost Transparency Annual Report:
Issuers are notified that Public Act 103-0106 recently was passed which added 20 ILCS 1405-50 (shown in an Appendix to this Company Bulletin) to the Department of Insurance Law. The first Health Insurance Coverage, Affordability, and Cost Transparency Annual report is not due until May 1, 2026, so data collection will mostly be done in calendar year 2025. However, in preparation for gathering data for the report, issuers are asked to provide the following information in their PY2025 individual and small group actuarial memoranda:

- The issuer's definitions of "major service category."
- A complete description of the issuer's current and planned "health care quality improvement initiatives."
- A narrative description of the issues faced by the issuer with respect to provider availability by geographic location.
- A narrative description of the trends seen in out-of-pocket costs for consumers. If issuers are not currently monitoring these trends, be advised that, next year, the Department will be asking issuers to quantify these trends.

Any suggestions that an issuer has for making the report more informative or useful when the Department begins requesting data for it are welcome.

Exhibit 2:
2025 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 2025.

Appendix:

20 ILCS 1405-50

Sec. 1405-50. Health insurance coverage, affordability, and cost transparency annual report.

(a) On or before May 1, 2026, and each May 1 thereafter, the Department of Insurance shall report to the Governor and the General Assembly on health insurance coverage, affordability, and cost trends, including:

(1) medical cost trends by major service category, including prescription drugs;

(2) utilization patterns of services by major service categories;

(3) impact of benefit changes, including essential health benefits and non-essential health benefits;

(4) enrollment trends;

(5) demographic shifts;

(6) geographic factors and variations, including changes in provider availability;

(7) health care quality improvement initiatives;

(8) inflation and other factors impacting this State's economic condition;

(9) the availability of financial assistance and tax credits to pay for health insurance coverage for individuals and small businesses;

(10) trends in out-of-pocket costs for consumers; and

(11) factors contributing to costs that are not otherwise specified in paragraphs (1) through (10) of this subsection.

(b) This report shall not attribute any information or trend to a specific company and shall not disclose any information otherwise considered confidential or proprietary.

(Source: P.A. 103-106, eff. 1-1-24.)