



Illinois Department of Insurance

JB PRITZKER
Governor

ANN GILLESPIE
Acting Director

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

FROM: Ann Gillespie, Acting Director *ARG*

DATE: May 2, 2025

RE: COMPANY BULLETIN 2025-07 - Illinois Filing Requirements for Individual and Small Group Health Plans, On and Off-marketplace (On and Off-exchange) and Stand-alone Dental Plans

The Department of Insurance (The Department) is issuing this Bulletin 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 Affordable Care Act (ACA) Marketplace (Off-Exchange) in the individual and small group markets for Plan Year 2026. 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 Centers for Medicare & Medicaid Services (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	6/4/2025
	Get Covered Illinois (GCI) sends QHP Certification Agreements to Issuers	6/4/2025
	Public Posting of the proposed rates	6/11/2025
	Illinois DOI Initial SERFF Binder Data Transfer Deadline	6/11/2025
	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	6/13/2025
	CMS reviews initial QHP Applications and releases results for issuers and states to review	6/12/2025 – 7/11/2025
	Issuers return signed QHP Certification Agreements to GCI	7/15/2025
	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	7/16/2025

CMS reviews Rates Table Template data and resubmitted QHP Application data, and releases results in the Plan Management (PM) Community for issuers and states to review	7/17/2025 – 8/8/2025
Issuers, Exchange administrators, and CMS preview the 2025 QHP quality rating information	8/2025-9/2025
GCI Countersigns and Executes Carrier Agreements	8/1/2025-8/31/25
Issuer Plan Confirmation/Crosswalk Deadline: Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates.	8/6/2025 – 8/20/2025
Illinois DOI Final SERFF Binder Data Transfer Deadline: Deadline for issuers to submit changes to their QHP Applications	8/4/2025
Illinois DOI Plan Confirmation Deadline: Recommendations: State completes final plan confirmation	9/4/2025 – 9/11/2025
Limited data correction window	9/12/2025– 9/13/2025
GCI releases certification notices to issuers	9/30/2025-10/1/2025
Anticipated public display of QHP quality rating information	11/1/2025
Open Enrollment Begins	11/1/2025

* [CMS Deadlines](#) will apply in the event Illinois is not approved to operate a State-based Marketplace.

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 13 deadline. There are no fees for QHP issuers associated with accessing and using the IDSS.

Issuers are advised to consult federal regulations, the [2026 Letter to Issuers](#) released January 15, 2025, and state law in conjunction with this Bulletin to ensure full compliance. Helpful documents can be found on the Department's [ACA Issuer Homepage](#).

1. Illinois is in the process of transitioning to a State-based Marketplace and awaiting final approval from CMS in order to operate as a full State-based Marketplace for Plan Year 2026. We are issuing this guidance with the expectation that we will receive this approval, likely in early August of 2025. However, there is a possibility that this approval is not granted. If this occurs, issuers should then follow the timeline and guidance of CMS outlined in the [PY2026 QHP Data Submission and Certification Timeline Bulletin](#).
2. 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.
3. 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.
4. 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.
5. Visit the [CMS QHP Certification Website](#) and complete the QHP Application checklist.
 6. 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.
 7. For Plan Year 2026 plans, Illinois requires the crosswalk template to be uploaded to the binders. Any revised crosswalk submitted to CMS in PM Community, must also be submitted to the state binder in System for Electronic Rate and Form Filing (SERFF).
 8. Submit all **checklists, templates and supporting documentation** in SERFF.
 9. 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.
 10. Associate all relevant filings in the SERFF binder including, but not limited to, form, rate, external review, and network adequacy filings.
 11. The Department requires full updated network adequacy filings to be submitted. Please note, all network plans other than most excepted benefits 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 Marketplaces on the Federal Platform, the Department will enforce those standards as the operator of the Illinois State-based Marketplace. Per the 2026 Letter to Issuers, the appointment wait time standards in the [2025 Letter to Issuers](#) remain in effect for both medical QHPs and SADPs. **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 for medical plans and Table 3.3 for SADPs 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 #14 below.
 12. 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.
 13. 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.
 14. Issuers who are not able to comply with the network adequacy standards for time and distance, provider ratio, and appointment wait times are required to complete the [Network Adequacy Exception Form](#) (now available in PDF or Excel) 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 must still identify and disclose such deficiencies.
 15. 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.

16. 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.
17. 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.
18. Every plan listed on the Plans & Benefits Template that the Issuer intends to market as a High Deductible Health Plan (HDHP) or for use with a 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.
19. If approved as a State-based Marketplace for PY 2026, the Department will not require issuers to offer standardized plans or impose a limit on the number of non-standardized plans an issuer may offer. Because Illinois will operate as a State-Based Exchange on the Federal Platform (SBM-FP) in PY 2026 until conditional approval is granted by CMS, issuers must submit standardized plans with the initial PY 2026 QHP application by Illinois’ initial application deadline of 6/4/2025, in accordance with CMS guidance. These plans must adhere to all federal and state QHP certification requirements. Issuers will be given an opportunity to withdraw these plans from QHP certification consideration if conditional approval is granted to Get Covered Illinois. If any medical QHP is withdrawn, the issuer still must comply with the flat-dollar copay prescription drug offering requirements in 215 ILCS 134/45.3, and as a result the issuer will be required to submit an updated compliance spreadsheet for that statute. If Get Covered Illinois does not receive conditional approval, it will not certify non-standardized plans in excess of the number allowed by 45 C.F.R. 156.202. In preparation, any issuer that chooses to initially file non-standardized plans in excess of that number should give preliminary notice to the Department identifying the non-standardized plans the issuer intends not to proceed to certification for an SBM-FP. The issuer may change its selection of excess non-standardized plans to withdraw if any denial of conditional approval actually occurs.
20. **NEW for PY 2026:** All issuers on the SBM-FP will be required to complete the [Formulary Compliance Template](#) to assist in the evaluation of Illinois specific requirements for prescriptions drugs. The checklist must accompany the medical plan’s binder submission under the Supporting Documentation tab in SERFF.
21. **PENDING LEGISLATION THAT MAY IMPACT COVERAGE REQUIREMENTS IN PY 2026:**
The Department strongly encourages plans to monitor all pending legislation, including but not limited to the following pending bills with effective dates prior to January 1, 2027, to ensure compliance for coverage:

[HB 1085](#) - MH/SUD coverage & reimbursement expansion

[SB 1480](#) - Crisis response services reform

[HB2464](#) - Prohibits intensive neonatology balance billing

[HB3605](#) - Requires coverage for cancer screenings without cost-sharing

NOTE: Maximum Annual Limitation on Cost Sharing for Plan Year 2026

	Individual Coverage	Family Coverage
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Health Plans	\$10,150	\$20,300
SADPs	\$450	\$900

Exhibit 1:

2026 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:

CMS and the National Association for Insurance Commissioners (NAIC) have established a system connection between the 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. For the rate filing in SERFF, the URRT, Part II Written Justification (if required), federal Actuarial Memorandum, and redacted federal Actuarial Memorandum should only be included on the URRT Tab (not on other tabs).

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=dc62c787e0658801e981c296b1bdf52>

1. The Department will allow carriers to modify their individual and small group rate filings through **July 11, 2025** 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 of ACA program changes and Medicaid eligibility changes on the Plan Year 2026 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. Actuarial memorandums must include a description of the state mandates included in the rate filing and the pricing impact of each mandate.
6. Actuarial Value (AV) screenshots should be included in the rate filing and a summary of the AV calculator output should be provided in Excel.
7. Carriers offering QHPs in the individual market are required by 215 ILCS 5/355(c-5) to apply a cost-sharing reduction defunding factor for on-exchange Silver plans within the range of 1.26 to 1.33. The factor for other plans should be 1.00. **NOTE:** This guidance is subject to change depending on federal law.
8. Carriers offering QHPs in the individual market are required by 215 ILCS 5/355(c-5) to apply induced demand factors based on the formula: $(\text{Plan Actuarial Value})^2 - (\text{Plan Actuarial Value}) + 1.24$. Please use the pricing AV for the base plan including (or adjusted for) the CSR load. The induced demand factor should be consistent between the index rate and the plan-adjusted index rate.
9. Carriers offering QHPs in the individual market must submit 2 sets of rates for Plan Year 2026 to account for the uncertainty around whether the enhanced Advance Premium Tax Credits (APTCs) will be extended into 2026. The default set of rates in the SERFF rate filing must assume that the enhanced APTCs expire at the end of 2025. The other set of documents which assume that the enhanced APTCs are extended in full in 2026 should be submitted in the Supporting Documentation tab of SERFF. Please add a section called “Alternate Rates” and load all documents in that section. The documents, at a minimum, should include a revised URRT, a revised Rate Table Template, and a revised actuarial memorandum. The actuarial memoranda should clearly describe the differences in assumptions between the two sets of rates.
10. 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.

Public Posting of Initial Rate Filings:

As a result of [Public Act 103-0106](#), the 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 rate filing summary templates must include all information described in 50 Ill. Adm. Code 2026.50(e). An Excel template titled “Plan Year 2026 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 and other public portions of the rate filing 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.

Aside from the summary templates, which are not eligible for redaction, if the QHP issuer deems any rate filing information to be proprietary, privileged, or confidential such that disclosure of the information would cause

competitive harm to the issuer, the QHP issuer must file both 1) an unredacted version and 2) a version with the deemed confidential information redacted that is separately marked for public access in SERFF. Additionally, to qualify for ongoing exemption from production under Section 7(1)(g) of the Freedom of Information Act [5 ILCS 140], proprietary, privileged, or confidential information must be furnished to the Department with the explicit claim that the disclosure of the information would cause competitive harm to the issuer. The issuer must furnish that claim in a letter separate from the substantive rate filing documents but within the same SERFF filing.

The posting of the rate filings to the Department’s website will start a 30-day public comment period where comments may be submitted to the Department of Insurance. The comments received will then be posted to the Department’s website.

The deadlines for small group quarterly rate filings are:

<u>Effective Date</u>	<u>Due Date</u>
April 1, 2026	November 17, 2025
July 1, 2026	February 16, 2026
October 1, 2026	May 19, 2026

Small group quarterly rate filings will also be posted on the DOI website for public comment.

Exhibit 2:

2026 Health Plans Filing Requirements – Rates

	Required Submission via SERFF		
Federal Required Templates	On-Exchange	Off-Exchange	Location
QHP Rating Module Documents Rates Table 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 2026.