Illinois Department of Insurance

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Governor

ANN GILLESPIE
Director

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

FROM: Ann Gillespie, Director ~~ARG~~

DATE: May 01, 2026 **(REVISED: June 02, 2026)**

RE: COMPANY BULLETIN 2026-06 - Illinois Filing Requirements for Individual and Small Group Health Plans, On and Off-marketplace (On and Off-exchange) and Stand-alone Dental Plans

Please note, items in red below have been amended as of the revised published date of this Company Bulletin.

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 2027. 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 New Issuer to Declare Intent to be On-Exchange**	**5/15/2026**
	Deadline for Issuers to submit QHP/NQHP Applications to Illinois DOI, including Plan ID Crosswalk data	**6/3/2026**
	Public Posting of the proposed rates	**6/10/2026**
	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]	6/15/2026
	~~Deadline for issuers to submit their QHP Application Rates Table Templates to CMS~~	~~7/15/2026~~
	~~CMS reviews Rates Table Template data and releases results in the Plan Management (PM) Community for issuers and states to Review~~	~~7/16/2026 – 8/7/2026~~
	Deadline for issuers to submit changes to their QHP Applications	8/4/2026
	Plan Preview and Data Correction Window	8/15/2026-9/15/2026
	Get Covered Illinois (GCI) releases certification notices to issuers	9/16/2026
	Anonymous Shopping Opens	**10/13/2026**
	Anticipated public display of QHP quality rating information	10/13/2026

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Open Enrollment Begins	11/1/2026*

[1] Each QHP issuer must submit and plan-lock its QRS clinical measure data by May 29 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 15 deadline. There are no fees for QHP issuers associated with accessing and using the IDSS.
*The Department intends to propose a rule change to start Open Enrollment on 10/15 and the Department will provide an updated notification if that change is adopted.

Issuers are advised to consult federal regulations, the 2027 Final Letter to Issuers released May 28, 2026, 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. 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. 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.
5. For Plan Year 2027 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).
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. Do not include symbols, such as the trademark symbol, in any plan names.
10. Please note, regardless of any federal flexibility, Get Covered Illinois does not find the following plans to be in the interest of qualified individuals or qualified employers in this State under 50 Ill. Adm. Code 4500.40(d)(2) and will not certify them:
    - Catastrophic plans with terms longer than one year;
    - Non-network QHPs or SADPs;

- **REVISED:** Plans, including Bronze plans, with a Maximum Out of Pocket Limitation that exceeds $12,000 for an individual or $24,000 for a family.

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. Issuers with planned provider terminations set to take place on or before 1/1/2027 should not include those providers within their PY27 Network Filing. For example, if a termination of a network agreement will take place 9/1/2026, the issuer should not include those providers within the PY27 filing unless the parties have formally executed a renewal of a subsequent contract into PY27. Per the 2027 Final 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. QHP Service Area Exception: Issuers that fail to offer coverage to an entire county 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 QHP 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 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. Issuers are reminded that as a result of H.R. 1 Section 71307, Section 223(c)(2) of the Internal Revenue Code was amended to expand the definition of "high deductible health plan" to include all individual market qualified health plans available through an Exchange at the catastrophic or bronze level of coverage, which grants such plans "HSA-Eligible" status. As clarified by Q&A #6 of IRS Notice 2026-5, this status applies to individual market catastrophic or bronze plans offered off-Exchange that are identical to an individual catastrophic or bronze plan offered through the Exchange, and it even applies to

"plans sold exclusively off-Exchange without a CSR reduction load that are otherwise identical to plans sold on-Exchange with a cost sharing reduction load" (emphasis added). However, this provision **does not** apply to any other plans that are exclusively sold off-Exchange or that are not sold in the individual market. Other than an individual market QHP available through an Exchange at the catastrophic or bronze level of coverage, 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."

19. All issuers on the SBM are 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.Claim Cost Distributions for Carriers Participating in the Individual ACA: The Department is considering the potential of a reinsurance program for the Individual ACA market through a Section 1332 Waiver. As part of the PY2027 rate filing submission, carriers participating in the Individual ACA market are asked to provide a member level total allowed cost (carrier paid and member paid prior to risk adjustment and any other claim offsets) distribution for calendar year 2024 and 2025. Please bucket the total allowed claim costs into $1,000 increments, for example $0-$999, $1,000-$1,999, etc. Provide the count of members in each bucket as well as the total allowed cost in each bucket. Please also provide a count of members with $0 claims for each year.
20. **PENDING LEGISLATION THAT MAY IMPACT COVERAGE REQUIREMENTS IN PY 2027:** The Department strongly encourages plans to monitor all pending legislation, including but not limited to the following pending bills with effective dates prior to or on January 1, 2027, to ensure compliance for coverage:

    HB 3454 would amend Section 356z.33 of the Illinois Insurance Code to substitute the term "epinephrine injector" with "epinephrine delivery system" and would incorporate a new definition from the Epinephrine Delivery System Act.

    HB 4464 would prohibit DOI-regulated plans - including stand-alone dental plans (SADPs) - from requiring dental providers to only accept electronic payments (including virtual cards).

    SB 2838 would place further oversight on DOI-regulated hearing benefit plans and audiology benefit managers and enact protections for audiology providers.

    ~~SB 3688 would prohibit DOI-regulated plans from requiring prior authorization or step therapy for menopause therapies.~~

    ~~SB 3707 would give DOI greater oversight of vision benefit managers and vision benefit plan issuers, create eye care provider reimbursement parity, and implement consumer protections.~~

    SB 3815 would prohibit DOI-regulated plans from denying coverage to an individual or employer due to a failure to pay premiums under a prior policy or contract. Allows plans to continue collecting past-due premiums. Note: this proposal would be effective immediately.

NOTE: Maximum Annual Limitation on Cost Sharing for Plan Year 2027 for IL

	Individual Coverage	Family Coverage
Health Plans	$12,000	$24,000

SADPs	$450	$900

Exhibit 1:

2027 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=dc62c787e0658801e981c296b1bdfe52

1. The Department will allow carriers to modify their individual and small group rate filings through **July 10, 2026** 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 include the commission schedules and any recent or anticipated changes thereto.
4. Actuarial memorandums must include a description of the state mandates included in the rate filing and the pricing impact of each mandate.
5. Actuarial Value (AV) screenshots should be included in the rate filing and a summary of the AV calculator output should be provided in Excel.
6. 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.
7. 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: (Plan Actuarial Value) ^ 2 - (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.
8. 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 2027 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:

Effective Date	Due Date
April 1, 2027	November 17, 2026
July 1, 2027	February 16, 2027
October 1, 2027	May 19, 2027

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

Exhibit 2:

2027 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

Illinois Health Rate Filing Web Portal:

The Department is sunsetting the Illinois Health Rate Filing Web Portal. Therefore, effective immediately, carriers are no longer required to submit rates to the Illinois Health Rate Filing Web Portal.

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 2027.