TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2026
HEALTH INSURANCE RATE REVIEW~~PREMIUM INCREASE JUSTIFICATION AND REPORTING~~

Section

AUTHORITY: Implementing Section 355 of the Illinois Insurance Code [215 ILCS 5], Section 28 of the Dental Service Plan Act [215 ILCS 110], Section 4-12 of the Health Maintenance Organization Act [215 ILCS 125], Section 3006 of the Limited Health Service Organization Act [215 ILCS 3006], and Section 13 of the Voluntary Health Services Plans Act [215 ILCS 165], and authorized by Section 401 of the Illinois Insurance Code; 42 U.S.C. 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Adopted at 38 Ill. Reg. 2213, effective January 2, 2014; amended at 48 Ill. Reg. _____, effective _____.

Section 2026.5 Purpose ~~and Scope~~

~~a)~~ ~~Purpose~~
This Part describes the Director's authority and timelines to review, approve, modify, or disapprove rate filings pursuant to Section 355 of the ~~Illinois Insurance~~ Code.

~~b)~~ ~~Scope~~
~~This Part establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Director. This Part further establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this Part.~~

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.10 Definitions

"Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act (42 U.S.C.~~USC~~ 18001 et seq.).

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the ~~Illinois~~ Department ~~of Insurance~~.

"CMMS" means the Centers for Medicare and Medicaid Services.

"Excepted benefits" has the meaning ascribed in 42 U.S.C. 300gg-91(c).

"Federal medical loss ratio standard~~Medical Loss Ratio Standard~~" means the applicable medical loss ratio standard for the State and market segment involved, determined under subpart B of 45 CFR 158.

"Grandfathered health plan" has the meaning ascribed in 45 CFR 147.140 (Dec. 15, 2020) (no later editions or amendments).

"Health insurance coverage~~Insurance Coverage~~" has the meaning ascribed in 42 U.S.C. 300gg-91(b)(1) ~~given that term in PHS Act section 2791(b)(1)~~.

"Health insurance issuer~~Insurance Issuer~~" has the meaning ascribed in 42 U.S.C. 300gg-91(b)(2) ~~given that term in PHS Act section 2791(b)(2)~~.

"Inadequate rate" means a rate:

that is insufficient to sustain projected losses and expenses to which the rate applies; and

the continued use of which endangers the solvency of a health insurance issuer *using that rate*. (Section 355(a) of the Code)

"Individual market~~Market~~" has the meaning ascribed in 42 U.S.C. 300gg-91(e)(1)(A)~~given in PHS Act section 2791(e)(1)(A)~~. Coverage that would be regulated as individual market coverage under that definition~~, as defined in PHS~~

~~Act section 2791(e)(1)(A)~~, if it were not sold through an association, is subject to rate review as individual market coverage.

~~"PHS Act" means the Public Health Service Act (42 USC 201 et seq.).~~

"Plain language" or "plain writing" *has the meaning provided* for "plain writing" *in the federal Plain Writing Act of 2010* (Pub. Law 111-274) *and subsequent guidance documents, including the "Federal Plain Language Guidelines"* published by the Plain Language Action and Information Network with support from the United States General Services Administration, 1800 F Street, NW, Washington, DC 20405 (rev. 1, May 2011) (no later editions or amendments), available online at: https://www.plainlanguage.gov/media/FederalPLGuidelines.pdf. (Section 355(a) of the Code)

"Product" has the meaning ascribed in 45 CFR 144.103 (May 6, 2022) (no later editions or amendments)~~means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state~~.

"Rate increase~~Increase~~" means any increase of the premium rates for a specific product ~~offered in the individual or small group market~~.

~~"Rate Increase Subject to Review" means a rate increase that meets the criteria set forth in Section 2026.30.~~

"Secretary" means the Secretary of the United States Department of Health and Human Services.

"Short-term, limited-duration health insurance coverage" has the meaning ascribed in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act.

"Small group market~~Group Market~~" has the meaning ascribed in 42 U.S.C. 300gg-91(e)(5)~~PHS Act section 2791(e)(5); provided, however, that for the purpose of this definition, "50" employees applies in place of "100" employees in the definition of "small employer" in section 2791(e)(4)~~. ~~"~~Coverage~~"~~ that would be regulated as small group market coverage under that definition,~~(as defined in section 2791(e)(5))~~ if it were not sold through an association, is subject to rate review as small group market coverage.

"Student health insurance coverage" has the meaning ascribed in 45 CFR 147.145 (March 8, 2016) (no later editions or amendments).

"*Unreasonable rate increase*~~Rate Increase~~" *means a rate increase that the Director determines* ~~under Section 2026.40~~ *to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205* (May 23, 2011) (no later editions or amendments). (Section 355(a) of the Code)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.20 Applicability

~~a) In General~~

The requirements of this Part apply to health insurance issuers offering health insurance coverage that is subject to Section 355 of the Code~~in the individual market and small group market, as defined in 45 CFR 154.103~~.

~~b) Exceptions~~

~~The requirements of this Part do not apply to grandfathered health plan coverage as defined in 45 CFR 147.140 or to excepted benefits as described in PHS Act section 2791(c).~~

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.30 Rates~~Rate Increases~~ Subject to Review or Prior Approval

a) All rates and classifications of risks in the individual or small group market, other than for grandfathered health plans, excepted benefits, student health insurance coverage, or short-term, limited-duration health insurance coverage,~~A rate increase filed~~ on or after January 1, 2014, or effective on or after January 1, 2014 and taking effect no later than December 31, 2025, are~~is~~ subject to review under applicable law and Department rules, including, but not limited to, Part 916, as well as:

1) the public posting and public comment period described in Section 355(d) and (e) of the Code; and

2) review for unreasonable rate increases through the implementation under Section 355 of the Code of an Effective Rate Review Program described in 45 CFR 154.301 (April 17, 2018) (no later editions or amendments) if~~,~~ ~~as required by 45 CFR 154.200~~:

A~~a~~) the~~The~~ rate represents a rate increase of~~is~~ 10 percent or more and applies~~applicable~~ to a 12-month period as calculated under subsection (a)(2)(B)~~(b)~~.

B~~b~~) a~~A~~ rate increase meets or exceeds the applicable threshold set forth in subsection (a)(2)(A) if the average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold.

C~~c~~) if~~If~~ a rate increase that does not otherwise meet or exceed the threshold under subsection (a)(2)(B)~~(b)~~ meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review. The review shall include a review of the aggregate rate increases during the applicable 12-month period.

b) All rates and classifications of risks effective on or after January 1, 2026 in the individual and small group markets, other than for grandfathered health plans, excepted benefits, student health insurance coverage, or short-term, limited-duration health insurance coverage, are subject to the Director's prior approval under the State's implementation of an Effective Rate Review Program described in 45 CFR 154.301 and State standards for inadequate rates.

c) All rates and classifications of risks not described in subsections (a) or (b) must be filed for the Director's review under applicable law and Department rules, including, but not limited to, Part 916. The rates and classifications of risks are not subject to the Director's prior approval unless specifically provided by applicable law.

d) For all rates described in subsection (a) or (b), and to the extent applicable to rate filings described in subsection (c):

1) a rate sheet must be filed as a separate document that includes either all finally proposed rates or all finally proposed base rates and all factors used to calculate the final rates, which must be marked for public access in SERFF; and

2) the maximum, overall, and minimum rate changes, overall rate impact, written premium for the program, written premium change for the program, and number of affected policyholders must be specified in SERFF and marked for public access.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.40 Unreasonable Rate Increases

a) When the Director reviews a rate increase for any rate described in Section 2026.30(a)(2) or (b), the Director~~he or she~~ will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase, as required and defined by 45 CFR 154.205.

b) The rate increase is an excessive rate increase if the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage (see 45 CFR 154.205(b)). In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, the Director will consider:

1) Whether the rate increase results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under federal law;

2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

c) The rate increase is an unjustified rate increase (as defined in 45 CFR 154.205(c)) if the health insurance issuer provides data or documentation to the Director in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

d) The rate increase is an unfairly discriminatory rate increase (as defined in 45 CFR 154.205(d)) if the increase results in premium differences between insureds within similar risk categories that do not reasonably correspond to differences in expected costs or otherwise are not permissible under applicable State law.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.50 Submission of Rate Filing Justification

a) For all rates described in Section 2026.30(a) and (b)~~If any product is subject to a rate increase~~, a health insurance issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products, to the Director on a form and in a manner prescribed by the Secretary in 45 CFR

154.215(a) (April 17, 2018) (no later editions or amendments) and as further provided in this Section.

b) The Rate Filing Justification must consist of the following Parts (as required in 45 CFR 154.205(b) and pursuant to Section 355 of the Code):

1) Unified rate review template (Part I), as described in subsection (d).

2) Written description justifying the rate increase (Part II), as described in subsection (e).

3) Rating filing documentation (Part III), as described in subsection (f).

c) Circumstances for Required Parts

1) For all rate increases regardless of the amount, a~~A~~ health insurance issuer must complete and submit Parts I and III of the Rate Filing Justification described in subsections (b)(1) and (b)(3) to the Director as required by 45 CFR 154.215(c). If the health insurance issuer deems any information contained in either Part I or III to be proprietary, privileged, or confidential such that disclosure of the information would cause competitive harm to the issuer, the health insurance issuer must file both an unredacted version and 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 health insurance issuer. The health insurance issuer must furnish that claim in a letter separate from but contemporaneously with the Part I and III documents. This subsection supersedes any conflicting provisions of 50 Ill. Adm. Code 4521.60.

2) For all rates regardless of any increase, decrease, or continuation~~If a rate increase is subject to review~~, the health insurance issuer must ~~also~~ complete and submit to the Director Part II of the Rate Filing Justification described in subsection (b)(2) that is marked for public access in SERFF. This subsection supersedes any conflicting provisions of 50 Ill. Adm. Code 4521.60.

3) Without expanding the scope of information for which a health insurance issuer may obtain protection under Section 7(1)(g) of the Freedom of

Information Act, the following information must not be redacted and will not be deemed confidential, proprietary, or privileged by the Department:

A) any portion of Part II of the Rate Filing Justification described in subsection (e);

B) the rate sheets and other rate, premium, and policyholder information described in Section 2026.30(d); and

C) any information described in subsections (c)(3)(A) or (c)(3)(B) that appears elsewhere in the rate filing.

d) Content of unified rate review template (Part I): The unified rate review template must include the following, as determined appropriate by the Director and in accordance with 45 CFR 154.215(d):

1) Historical and projected claims experience.

2) Trend projections related to utilization, and service or unit cost.

3) Any claims assumptions related to benefit changes.

4) Allocation of the overall rate increase to claims and non-claims costs.

5) Per enrollee per month allocation of current and projected premium.

6) Three year history of rate increases for the product associated with the rate increase.

e) Content of written description justifying the rate increase (Part II): The written description of the rate increase must include a simple and brief narrative in plain writing describing the data and assumptions that were used to develop the rate increase and must include the following as required by 45 CFR 154.215(e) and Section 355(d) of the Code. The entirety of this document will be included in the posting of the rate filing to the Department's public website under Section 355(d):

1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary; ~~and~~

2) Brief description of the overall experience of the policy, including historical and projected claim and administrative expenses, ~~and~~ loss ratios, number of historical and projected covered lives, and assumed medical

trends. In addition to general medical trends and other trend information the issuer deems relevant for the justification, the description of assumed medical trends must address the impact of hospital and generic, brand, and specialty drug cost trends on the proposed premium rates; and

3) Notification of the public comment period described in Section 355(e) of the Code.

f) Content of rate filing documentation (Part III) as required by 45 CFR 154.215(f): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient to conduct an examination satisfying the requirements of 45 CFR 154.301(a)(3) and (4) and to determine whether the rate increase is an unreasonable increase.

g) If the level of detail provided by the issuer for the information under subsections (d) and (f) does not provide sufficient basis for the Director to determine whether the rate increase is an unreasonable rate increase, the Director will request the additional information necessary to make a determination, as allowed by 45 CFR 154.215(g).

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.60 Determination of an Unreasonable Rate Increase or Inadequate Rate

a) When~~As required by 45 CFR 154.225(a), when~~ the Director receives a Rate Filing Justification for a rate ~~increase~~ subject to review under Section 2026.30(a)(2) or (b) and the Director reviews the rate ~~increase~~, the Director will make a timely determination whether:

1) for any rate increase subject to review under Section 2026.30(a)(2) or prior approval under Section 2026.30(b), the rate increase is an unreasonable rate increase, and submit that decision to CMMS within 5 business days following the final determination as required by 45 CFR 154.210(b)(2) (May 23, 2011) (no later editions or amendments); and

2) for rates described in Section 2026.30(b), the rate is inadequate.

b) If the Director determines that the rate increase is unreasonable or the rate is inadequate, then:

1) For rate increases described in Section 2026.30(a)(2) that the Director determines to be unreasonable, CMMS will provide the Director's final

determination and brief explanation to the health insurance issuer within 5~~five~~ business days following CMMS' receipt of the final determination as described in 45 CFR 154.225(c) (February 27, 2013) (no later editions or amendments).

2) For rates described in Section 2026.30(b), the Director will notify the health insurance issuer of the decision to disapprove or modify the rate as an unreasonable rate increase or inadequate rate within 60 days after the close of the public comment period described in Section 355(e) of the Code. If the Director does not notify the health insurance issuer within 60 days, the rates will automatically be deemed approved.

c) The Director's rate review process includes an examination of the following as required by 45 CFR 154.301(a)(3) for unreasonable rate increases, which the Director also will apply to the review for inadequate rates:

1) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions;

2) The health insurance issuer's data related to past projections and actual experience;

3) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act (42 U.S.C. 18061 and 18063); and

4) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the ACA.

d) As required by 45 CFR 154.301(a)(4) for unreasonable rate increases, the examination must take into consideration the following factors, to the extent applicable to the filing under review, which the Director also will apply to the review for inadequate rates:

1) The impact of medical trend changes by major service categories;

2) The impact of utilization changes by major service categories;

3) The impact of cost-sharing changes by major service categories, including actuarial values;

4) The impact of benefit changes, including essential health benefits and non-essential health benefits;

5) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under 42 U.S.C. 300gg ~~PHS Act section 2701~~;

6) The impact of any overestimate or underestimate of medical trends for prior year periods related to the rate increase;

7) The impact of changes in reserve needs;

8) The impact of changes in administrative costs related to programs that improve health care quality;

9) The impact of changes in other administrative costs;

10) The impact of changes in applicable taxes, licensing or regulatory fees;

11) Medical loss ratio;

12) The health insurance issuer's capital and surplus;

13) The impacts of geographic factors and variations;

14) The impact of changes within a single risk pool to all products or plans within the risk pool; and

15) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the ACA (42 U.S.C. 18061 and 18063).

e) For rates described in Section 2026.30(a)(2) and (b), the Director will take into account information contained in public comments submitted under Section 355(e) of the Code, along with the actuarial justifications submitted by the health insurance issuer, for the purpose of determining whether the rate is an unreasonable rate increase or an inadequate rate as defined in this Part, including the examination described in subsections (c) and (d) of this Section.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 2026.70 Public Comment

All rate filings and summaries in the individual or small group markets that will be effective on or after January 1, 2025, other than grandfathered health plans, excepted benefits, student health insurance coverage, or short-term, limited-duration health insurance coverage, will be posted to the Department's website within 5 business days after the rate filing deadline set by the Department in annual guidance as described in Section 355(d) of the Code and will be open to a 30-day public comment period under Section 355(e) of the Code even if the rates are not subject to review for an unreasonable rate increase or inadequate rates. Information not subject to public disclosure when the health insurance issuer meets the criteria in Section 7(1)(g) of the Freedom of Information Act [5 ILCS 140], and health insurance issuer information deemed confidential under any other applicable law or regulation, will not be posted to the Department's public website. *The Department* will *post all of the comments received to the Department's website within 5 business days after the comment period ends.* (Section 355(e) of the Code)

(Source: Added at 48 Ill. Reg. _____, effective _____)

Section 2026.80 Prior Approval, Disapproval, or Modification of Rates

When the Director approves, disapproves, or modifies a rate described in Section 2026.30(b), the Director, within 60 days after the close of the public comment period, will *notify the health insurance issuer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision.* Any notice of modification or disapproval will state that the *health insurance issuer whose rate has been modified or disapproved may request a hearing within 10 days after* the Department issues the notice to the health insurance issuer. (Section 355(f) of the Code) Hearings will be conducted in accordance with Part 2402, and costs of the hearing may be assessed against the health insurance issuer under Section 408(5) of the Code and 50 Ill. Adm. Code 2402.270.

(Source: Added at 48 Ill. Reg. _____, effective _____)

Section 2026.90 Material Changes to the Director's Decision After Approving Rates

If, following the issuance of a decision but before the effective date of the premium rates approved by the decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates described in Section 2026.30(b), *the Director may consider supplemental facts or data reasonably related to the event.* (Section 355(g) of the Code) The Director will issue a new decision rescinding the prior decision and notifying the health insurance issuer of the disapproval or modification of rates in accordance with Section 2026.80. After approval has been expressly given or automatically deemed by law, the Director will not disapprove or modify rates based solely on analysis or reconsideration of information already submitted to the Director by the health insurance issuer or in public comments before the approval decision was finalized.

(Source: Added at 48 Ill. Reg. _____, effective _____)

Section 2026.100 Review of Rates Not Subject to the Effective Rate Review Program

The Director's review of any rate or classification of risks described in Section 2026.30(c) is subject to Section 355(i) of the Code in addition to any other law or rule applicable to the type of coverage.

(Source: Added at 48 Ill. Reg. _____, effective _____)