

**STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES**

Bulletin 2026-14-INS

In the matter of:

**2027 Form and Rate Filing
Requirements for Medical Plans**

**Issued and entered
this 21st day of April 2026
by Anita G. Fox
Director**

SECTION 1: CERTIFICATION AND RECERTIFICATION FILING REQUIREMENTS FOR MEDICAL PLANS ON- AND OFF-MARKETPLACE

General Information

DIFS will continue to perform Plan Management Functions for Plan Year 2027 (PY27). Plan Management functions are part of DIFS' regulatory role for products offered on- and off-Marketplace. Issuers will work directly with DIFS to submit all Qualified Health Plan (QHP) application data in accordance with federal and state guidelines. SERFF will be used by issuers to transmit information to DIFS, and DIFS will use SERFF to transmit information to the Centers for Medicare & Medicaid Services (CMS).

Many of the same guidelines apply to issuers filing plans offered off-Marketplace and these items are referenced in this Bulletin.

Issuers are required by CMS to be registered for the [CCIIO Plan Management Community](#) and the [Marketplace Plan Management System \(MPMS\)](#).

New Information

One Set of Plan Year 2027 Individual Market Rates

Bulletin 2025-15-INS, in part, permitted two sets of rates to be filed in the individual market for Plan Year 2026 to reflect the possibility that Congress would appropriate funds to make Cost Sharing Reduction (CSR) payments to issuers. While legislation is still possible to restore CSR payments, DIFS will only require one set of rates assuming such payments are not appropriated. See Section 4 for further guidance.

Issuer-Initiated Changes to Rates

DIFS will permit issuer-initiated changes to initially filed rates until July 13, 2026. Except for changes to correct an error, issuer-initiated changes to rates will only be allowed at the Market Adjusted Index Rate level and only to reflect new information that could not reasonably have been known at the time rates were originally filed (e.g., emerging claims, reinsurance, or risk adjustment experience). Changes to plan or consumer-level rating factors (e.g., benefit, expenses, network, area, etc.) will only be accepted if such changes result from DIFS' review. The Actuarial Memorandum must clearly document each assumption that was changed, justification for the change, the corresponding impact on rates, and assurance that the information was not known when the initial rates were filed. DIFS will maintain Filing and Binder confidentiality through July 15, 2026.

New Plans and Recertification of QHPs

For PY27, DIFS' process for certification and recertification of a QHP is consistent with the process used in prior plan years. Issuers submitting previously approved plans for recertification will be required to submit much of the same information as for prior plan years. Issuers submitting plans for certification for the first time should review the pertinent federal and state guidance. **The omission of any federal or state requirement from this Bulletin should not be construed to mean that compliance with those requirements is not necessary.** For additional guidance, issuers should refer to the PY27 Draft Letter to Issuers ([Letter](#)) and PY27 Draft Notice of Benefit and Payment Parameters ([Notice](#)).

For PY27, DIFS is not permitting plans that do not use a network (non-network plans), as described in the Notice.

PY27 SUBMISSION TIMELINES

DIFS has established the following submission dates for Michigan issuers to file their proposed Forms, Rates, and Binders for PY27 for small group and individual markets:

Small Group

Small group issuers submit **Forms, Rates, and Binders** for all on- and off- Marketplace plans in SERFF by May 13, 2026. Rate filing justification Parts I, II, and III will be submitted in the Form/Rate filing in the URR Tab. See Exhibits 1 and 2 for the list of required templates and documents.

Individual

Individual issuers submit **Forms, Rates, and Binders** for all on- and off- Marketplace plans in SERFF by May 27, 2026. Rate filing justification Parts I, II, and III will be submitted in the Form/Rate filing in the URR Tab. See Exhibits 1 and 2 for the list of required templates and documents.

Timeline for Medical Submissions

	Activity	Small Group Dates	Individual Dates
Medical Application Submission and Review Process	Filing Deadline – Forms & Rates and Binder	5/13/26	5/27/26
	2 nd Rate Filing Deadline	7/13/26	7/13/26
	DIFS' 1 st transfer of plan data to CMS; Transparency in Coverage and Plan ID Crosswalk	6/10/26	
	Templates submission deadline		
	CMS reviews and posts initial QHP application results in MPMS	6/11/26 to 7/10/26	
	DIFS' 2 nd transfer of plan data to CMS	7/15/26	
Final Review	DIFS' final transfer of plan data to CMS	8/12/26	
	CMS reviews and posts final QHP application results in MPMS	8/13/26 to 9/8/26	
QHP Agreement/ Final Certification	CMS sends Certification Notices	9/8/26	
	Limited data correction window and last date to withdraw plans	9/10/26 to 9/11/26	
	CMS posts QHP agreements; Issuers send signed agreements; States confirm final plan recommendations.	9/29/26 to 9/30/26	
	Open Enrollment Begins	11/1/26	

PY27 Filing Requirements and Templates

A complete submission includes the SERFF Form/Rate filing and Binder, with all required validated templates and associated items, as outlined in Exhibit 1. Issuers are required to utilize the Validation Workspace in the [MPMS](#) and [QHP Application Tools](#), including the Data Integrity Tool, for the initial and all subsequent template submissions. Errors must be corrected prior to submission.

All template revisions made during DIFS' review must be uploaded to the same locations as originally filed, i.e., filing, Binder, or both. See Exhibit 1.

Note: Only one Business Rules Template and Transparency in Coverage Template needs to be completed. Each template should include both individual and small group plans and be

submitted in the SERFF Binder. Off-Marketplace only submissions do not require the Transparency Coverage Template.

PY27 Quality Improvement Strategy Filing Requirement

The Quality Improvement Strategy (QIS) standards include requiring issuers to address their efforts to reduce healthcare disparities in addition to the previous requirement to report on a QIS that includes at least one topic area defined in section 1311(g) of the Affordable Care Act.

Issuers should consult the [QHP Certification Application Materials](#) for instructions on how to meet the QIS requirements for the PY27 QHP Application Period. Issuers must complete and submit a QIS Implementation Plan and Progress Report Form in the Supporting Documentation tab in Binder.

The deadline for submitting this form in the small group market is May 13, 2026, and the deadline for the individual market is May 27, 2026.

PY27 Checklist Requirements

[Checklists](#) that must be completed and filed as shown in Exhibit 1 are:

- Checklist for Individual and Small Group Medical Plans– Forms [\(FIS 2307\)](#); and
- Checklist for Individual and Small Group Medical Plans–Rates [\(FIS 2306\)](#)

New for PY27, Checklist for Individual and Small Group Medical Plans– Network Adequacy [\(FIS 2313\)](#) is for informational purposes only to assist issuers with comprehensive and accurate binder submissions relative to network adequacy.

Revisions to Previously Approved QHPs: Red-Lined Versions

Issuers revising previously approved QHP forms must provide red-lined versions, as well as clean versions. The red-lined and clean versions must both be filed in the Forms Schedule tab of the SERFF Form/Rate filing under the same document number. **Note:** Forms not being revised must still be submitted.

File Naming

Certain items in the Supporting Documentation tab of the Form/Rate filing and/or Binder must adhere to a standard naming convention as follows: IssuerName_MIFormDescription_Version#. The purpose of adherence to a standard naming convention is to have the ability to track new versions as they are updated. It is important to start with Version 1 and use the same issuer name and form description in the file name each time. In addition, all review tools must be run each time a template is revised.

Items that are required to have a standard naming convention are:

- DIFS Medical Forms Checklist;
- DIFS Medical Rates Checklist;
- Rates Table Template;
- Actuarial Memorandum;
- URRT;
- MI Uniform Modification Justification Form;
- Michigan Network Adequacy Template
- Justifications and Attestations;
- Summary of Benefits and Coverage;
- Schedule of Benefits; and
- Any document that is amended from its original version that is not automatically versioned through SERFF.

Transitional Plans

Pursuant to prior CMS guidance, [Order 2026-11-M](#) extends the transitional policy so long as policies do not remain in force beyond December 31, 2027. Issuers with active transitional programs should develop a process to end these policies and advise insureds of their options for coverage.

SERFF Filings

All federal and Michigan-specific templates must be filed in Excel formats. Do not submit templates in PDF format. Additionally, **do not** submit templates in the Supporting Documentation tab of the Binder, except for the Plan ID Crosswalk, URRT and Michigan Network Adequacy templates.

Under Section 234 of the Michigan Insurance Code, MCL 500.234, the Director has the discretion to designate certain records to be nonpublic. Accordingly, issuers have the option to mark their filings as confidential when submitting. Upon submission, DIFS will maintain Filing and Binder confidentiality through July 15, 2026.

Guaranteed Renewability

All individual and small group plans offered on- and off-Marketplace must comply with federal and state law regarding guaranteed renewability, including all applicable federal regulations and guidance, and DIFS [Bulletin 2011-17-INS](#).

Plan Withdrawal

Plans may be withdrawn in accordance with the process published in the [PY27 Letter](#). The final opportunity to withdraw plans will be during the plan confirmation process. Issuers opting to withdraw must submit the following in both the SERFF Form/Rate filing and Binder:

1. A completed CMS Plan Withdrawal form for plans offered either on-Marketplace or on- and off Marketplace **or** a list of plans to be withdrawn for those offered off-Marketplace only.
2. A letter to the DIFS Director outlining the issuer's intent and how it will comply with both state and federal guaranteed renewability and availability requirements.
3. A copy of the proposed letter that will be sent to enrollees/consumers outlining the issuer's intent and detailing **all** options available to the enrollee/consumer, including seeking coverage from a different issuer. This letter must not be sent to enrollees/consumers until approved by DIFS.

Note: Pursuant to MCL 500.2213b(6)-(7), once an issuer withdraws from a nongroup or group market completely, there is a 5-year waiting period during which that issuer may not issue health coverage in the market from which it withdrew.

Uniform Modification and Plan ID Crosswalk

DIFS requires that the Michigan Uniform Modification Justification Form ([FIS 2316](#)) and Plan ID Crosswalk Template be submitted as shown in Exhibit 1. The Plan ID Crosswalk template must be submitted in the MPMS and in the Binder under Supporting Documentation. For state authorization requests, please send an email to FrancisS2@michigan.gov. State Authorizations will be sent by email in response to the requestor and will also be placed in the Binder as a Note to Filer. The deadline for this submission is June 10, 2026. DIFS will provide authorizations to issuers after its initial review of the Crosswalk ID template and satisfaction of any subsequent objections. Please submit only the authorization provided by DIFS to MPMS.

Licensure and Good Standing

DIFS will review the licensure status of all issuers filing plans on- and/or off- Marketplace.

Annual Limit on Cost-Sharing

The PY27 Maximum Out-of-Pocket (MOOP) for individuals is \$12,000 for self-only coverage and \$24,000 for other than self-only coverage for non-CSR plans, subject to flexibility permitted under the Notice and CMS guidance. See [CMS Bulletin](#) issued January 29, 2026.

Changes to Cost-Sharing

After the initial transfer to CMS, changes made to copay amounts and coinsurance percentages cannot be made without DIFS' approval.

Service Area

Issuers must inform DIFS of any service area data change through the SERFF binder and include all templates and supporting documentation impacted.

After DIFS' final transfer deadline, service area data may only be changed with DIFS' approval and CMS Certification of a Data Change Request (DCR), even if the change is directed by DIFS or CMS. Submission of the DCR to CMS is through the cases tab of the Plan Management Community and must include an explanation and justification for the change(s), evidence of state approval, and the Change Analysis Report. Issuers generate the Change Analysis Report in the Plan Validation Workspace of the MPMS Module.

Service area data changes include:

1. Revising Service Area Template to:
 - a. change any service area name or ID
 - b. add or remove a service area
 - c. add or remove one or more counties to a service area
 - d. change a county from full to partial
 - e. change a county from partial to full
 - f. adding or removing a zip code(s) associated with a partial county
2. Revising the Plans and Benefits Template (PBT) to:
 - a. change a Service Area ID
 - b. add or remove a Service Area ID
3. Any change to the list of counties associated with a particular plan

Any service area data change must be reflected on the Michigan Network Adequacy Template ([FIS 2385](#)).

For more information, see [CMS' QHP Information and Guidance](#) for Service Area and Data Change Windows.

Network Adequacy

The [Michigan Network Adequacy Guidance](#) reflects network sufficiency requirements and standards. See also Checklist for Individual and Small Group Medical Plans – Network Adequacy ([FIS 2313](#)), CMS [Letter](#) and [Notice](#), and [QHP Certification Information and Guidance](#).

Essential Community Providers

Adhere to CMS's standards and directions for submitting Essential Community Provider (ECP) data. See CMS' web page [QHP Certification Application Materials](#) for Application Instructions, ECPs, Program Attestations, and Frequently Asked Questions.

Patient Safety Standards

CMS' Patient Safety Standards are unchanged from PY26. The federal State Partnership Exchange Issuer Attestation Response Form verifying compliance with the Patient Safety Standards in accordance with 45 CFR 156 must be submitted in Supporting Documentation of Binder.

SECTION 2: CONTRACT REQUIREMENTS (APPLICABLE TO ALL PLANS)

Readability

Submitted forms must comply with the following readability standards found under MCL 500.2236(3) and MCL 500.2212a(5):

1. Each form entered in the SERFF Form Schedule tab shall include the form's readability score.
2. The readability score must be based on the Microsoft Word Flesch Reading Ease test and have a score of 45 or higher. Forms with a Microsoft Word Flesch Reading Ease score lower than 45 will not be approved by DIFS.
3. Health care policies, contracts, and certificates of coverage with more than 3,000 words printed on not more than three pages, or more than three pages of text regardless of the number of words, shall contain a table of contents. (This requirement does not apply to riders or endorsements.)
4. Be printed in a font size not less than 10 point.

Internal Formal Grievance and External Review Procedures

QHPs offered by commercial issuers must offer a formal grievance procedure pursuant to MCL 500.2213 and adhere to the external review process under the Patient's Right to Independent Review Act (PRIRA), PA 251 of 2000 (MCL 550.1901 to 550.1929). These procedures must be part of the policy and submitted for approval with the medical filing. If the issuer has DIFS-approved grievance and external review procedures, these must be filed in the Supporting Documentation tab of the SERFF Form/Rate filing.

Complaint and Grievance Policy and Procedures must include information on [DIFS' Health Care Appeals – Request for External Review \(FIS 0018\)](#) and contact information for DIFS including fax number, email address, and mailing address.

Actuarial Value (AV) Requirements

All individual and small group plans offered on- and off-Marketplace must be assigned to one of the approved "metal level" AV tiers or be classified as a catastrophic plan. Determinations of AV must conform to 45 CFR 156.140(c), 45 CFR 156.200(b), and 45 CFR 156.400.

De Minimis Ranges

In its PY27 Notice, CMS proposes simplifying the allowable variations in the AV for a health plan (de minimis ranges) to the following:

- +5/-2 percentage points for expanded bronze plans
- +2/-0 percentage points for individual market silver QHPs
- +1/-0 percentage points for income-based silver CSR plan variations
- +2/-2 percentage points for all other plans

Issuers should expect the de minimis ranges to be consistent with the proposed rule but nevertheless must comply with the final rules for PY 27.

Actuarial Value Calculator

On February 25, 2026, CMS issued the Final 2027 Actuarial Value (AV) Calculator [Methodology](#). Issuers are expected to utilize the Final 2027 AV [Calculator](#).

Unique Plan Design

For plans with a unique plan design, in addition to the requirements set forth by CMS, please submit the following in the Binder under Supporting Documentation:

- The AVC screenshots for all plans, including silver CSR plan variants, labeled with the applicable HIOS Plan ID(s).
- The numeric development of each blended copay or coinsurance amount used under 156.135(b)(2).
- Adjustments, and their development, used under alternative method 156.135(b)(3).

As a reminder, the Issuer AV on the Plans and Benefits Template must match the AVC screenshots.

Religious Employer Exemption

DIFS will allow issuers who qualify for contraceptive coverage exemptions under federal rules to include additional language describing the administration of these benefits. The purpose of the additional language will be to clarify for employees that:

1. The employer will not contract, arrange, or pay for contraceptive benefits for employees.
2. The issuer will instead provide contraceptive benefits for employees (including notification to employee).
3. The costs for these benefits are not included in the program paid for the healthcare coverage.

ESSENTIAL HEALTH BENEFITS (EHB)

EHB Benchmark Plan

Issuers must use [Michigan's 2022 EHB benchmark plan](#) and review the benchmark to ensure their plans on- and off-Marketplace conform to it.

Mental Health Parity and Addiction Equity Act (MHPAEA)

All individual and small group plans must comply with the federal MHPAEA and applicable federal and state regulations.

Issuers should carefully review the final rule implementing the MHPAEA, issued on November 13, 2013, and generally applicable to plan and policy years on or after July 1, 2014. Issuers should review the final

rule to determine whether a particular plan is subject to the MHPAEA and is compliant with that statute and regulations.

Issuers should also consider State of Michigan regulations that became effective April 2, 2025, under MCL 500.3406hh.

Pursuant to the Consolidated Appropriations Act, 2021, all issuers must complete a Non-Quantitative Treatment Limitations (NQTL) comparative analysis to make available to state authorities upon request. DIFS requires submission of the NQTL analysis in the Supporting Documentation tab of the Form/Rate filing.

Coordination of Benefits

The coverage documents must include detailed information on the coordination of benefits, as required by MCL 550.253. Simply stating compliance with the Michigan Coordination of Benefits Act is not sufficient.

Actuarially Equivalent Substitutions of EHB

Actuarially equivalent substitutions of EHB are not permitted in Michigan.

Anti-Discrimination in EHB

DIFS will review policy and certificate forms for compliance with all provisions of federal and state antidiscrimination law, including but not limited to, section 1557 of the Affordable Care Act, 42 USC 18116, MCL 500.2027, and Bulletin 2023-07-BT/CF/CU/INS.

Issuers are encouraged to review in its entirety the final rule on Nondiscrimination in Health Programs and Activities, which is set forth at 45 CFR Part 92 (final rule).

Rehabilitative and Habilitative Services; Autism Spectrum Disorder

All plans must cover at least 30 visits for speech therapy, plus a combined 30 visits for physical and occupational therapy for rehabilitative services. Plans must also cover at least the same number of visits for habilitative services. However, for treatment of autism spectrum disorder specifically, plans may not limit the number of visits for any mandated type of treatment, including speech therapy, physical therapy, and occupational therapy.

SECTION 3: CONTRACT REQUIREMENTS (APPLICABLE TO ON-MARKETPLACE PLANS ONLY)

Data Corrections After the Final Application Submission Deadline

Issuers must request data correction changes and receive explicit direction and approval from CMS and DIFS.

- After DIFS' final transfer deadline, service area data may only be changed with DIFS' approval and CMS Certification of a Data Change Request (DCR), even if the change is directed by DIFS or CMS. Submission of the DCR to CMS is through the cases tab of

the Plan Management Community and must include an explanation and justification for the change(s), evidence of state approval, and the Change Analysis Report. Issuers generate the Change Analysis Report in the Plan Validation Workspace of the MPMS Module.

- Post-Certification Assessment(s) received from CMS require issuers to communicate to DIFS how errors or corrections were addressed.

Once Binders are closed, DIFS will only reopen for issuers to make data changes approved by CMS. Issuers must provide DIFS with evidence of CMS' approval for each data change.

Accreditation

45 CFR 155.1045 establishes the timeline by which issuers offering plans on- Marketplace must be accredited by NCQA, URAC, or AAAHC. An issuer's accreditation status will be available to consumers at the Marketplace website. Please include Accrediting Information in the SERFF Binder in the Company and Contact tab.

Summary of Benefits and Coverage and Schedule of Benefits

DIFS requires use of the 2021 form of Summary of Benefits and Coverage (SBC) as posted by CCIO on February 3, 2020. This form applies to individual and small group on-Marketplace plans. [The materials are available here](#). Each plan must have its own unique SBC, with the associated URL link, submitted via the MPMS Module.

For PY27, DIFS requires issuers file the required SBCs in the forms tab of the Form/Rate filing. The SBC and the Schedule of Benefits must include the Plan ID from the Plans and Benefits Template in the name. Each SBC must then be associated with the Plan to which it applies in the Binder. The requirements for unique SBCs and URL link filings remain the same as in PY23.

SECTION 4: RATING REQUIREMENTS (APPLICABLE TO ALL PLANS)

DIFS will not accept more than one filing per market (individual or small group). Issuers that offer both PPO/EPO and HMO/POS must submit both filings in the same Form/Rate filing.

Per 45 CFR 154.200, the Part II Justification remains at 15% and is applicable by plan, not the overall rate change.

Treatment of Enhanced Premium Tax Credit

Advanced premium tax credits in the individual market were temporarily expanded under the American Rescue Plan Act (ARPA) in 2021 and extended through plan year 2025 under the Inflation Reduction Act (IRA). Unless Congress acts, these enhanced credits will not be available in PY27. Issuers should submit rates assuming the enhanced subsidies will not be

available for PY27. Should legislation be enacted extending the subsidies prior to filing, issuers should reflect the availability of enhanced subsidies in their rates. Should legislation be enacted after filing, DIFS will determine, in consultation with CMS, whether it is appropriate or feasible for issuers to submit new rates to reflect the change. To aid DIFS in the determination of the impact, issuers should provide in their Actuarial Memorandum the rate change associated with the expiration of the enhanced subsidies and the potential impact should the subsidies be restored, as well as the associated methodology used to determine the rate change and potential impact.

Required Cost-Sharing Variations for Individual Market Plans Only

45 CFR 156.420 requires several cost-sharing plan variations for issuers offering coverage in the individual market on-Marketplace. Issuers must submit for approval the three plan variations for each silver plan offered, and the zero and limited cost-sharing variations for each plan at the platinum, gold, silver, bronze, and expanded bronze metal levels.

In August 2020, the Court of Appeals for the Federal Circuit concluded that issuers are entitled to unpaid CSRs, with the expectation that the unpaid CSRs will be offset in some manner for issuers' CSR premium loading. The decision could lead to CSR payments being restored by either Congress or HHS, but neither has taken action to date.

Consistent with prior DIFS guidance, DIFS requires issuers to submit rates assuming no CSR payments will be made (CSR load) for PY27, with the CSR load determined in accordance with 45 CFR 156.80(d)(2)(i). If CSR payments are restored by either Congress or HHS prior to the finalization of rates, DIFS may require companies to update their rates to remove the CSR provision. These rates apply only to on-Marketplace silver plan premiums.

The actuarial memorandum should disclose the amount of CSR load included in the silver plan rates and a detailed description of the methodology for determining the load. The CSR load should reflect reasonably anticipated CSR costs, using the expected cost sharing and distribution of enrollees across the silver plan variants. Issuers that develop CSR loads at the plan level should clearly identify the CSR loads for each plan and provide the member distributions and expected unfunded subsidies that support each plan's CSR load. If historic ACA incurred/paid claims were used to develop the Cost-Sharing Design factor, the impact of CSR subsidies in the experience period is already included and will need to be removed before applying the CSR Defunding Adjustment. Otherwise, the impact of CSR subsidies would be double counted in the projection period.

Rating Factors

Rates may vary based only on the following factors:

- Rating area
- Age (within a ratio of 3:1 for adults)
- Tobacco use (within a ratio of 1.5:1)

Additional Michigan Rating Factor Determinations

Michigan has made the following determinations related to the allowable rating factors, applicable to all individual and small group plans:

Age Rating

Michigan plans must adhere to the 3:1 ratio and federal default age curve for both individual and small group markets. The federal default age curve, applicable for plan years beginning on or after January 1, 2018, is detailed in the CMS Insurance Standards Bulletin: [Guidance Regarding Age Curves and State Reporting, Dec. 16, 2016](#).

Tobacco Ratio

Issuers will not be required to use a tobacco ratio less than 1.5:1. Issuers will be allowed to vary their tobacco ratio based on age, if the ratio does not exceed 1.5:1 for any specific age.

Standard Family Tier

Michigan will not allow the use of a standard family tier.

Per-Member Rating

Michigan requires per-member rating in the small group market. Issuers wishing to offer small employers the option to be billed on an equivalent composite premium basis must comply with the requirements set forth at 45 CFR 147.102(c)(3), including the development of separate composite premiums for individuals age 21 and older and individuals under age 21.

Geographic Rating

Michigan will continue using the previously defined 16 geographic rating areas for both the individual and small group market. [The 16 defined geographic areas, within each of the 83 counties in Michigan, labeled A through P, can be found here](#).

Merging of Markets

Pursuant to 45 CFR 156.80, Michigan requires issuers to maintain separate risk pools for the individual and small group markets.

SECTION 5: WELLNESS PLANS

General Guidelines

A wellness program may be offered with any plan provided it:

- Meets the requirements of 45 CFR 146 and 147,
- Is filed as part of the plan and approved by DIFS, and
- Is not contingent on COVID-19 vaccination status

Small Group Plans that Rate for Tobacco Use

Issuers must include a health-contingent wellness plan in the small group market if they are rating for tobacco use. The plan must provide for a reduction or elimination of the tobacco rating if the insured participates in a tobacco cessation program. The plan must also meet the requirements stated in the General Guidelines above. The plan materials must describe the conditions and benefits of the wellness plan; simply stating that a wellness plan is offered is not sufficient.

Any questions regarding this bulletin should be directed to:

Department of Insurance and Financial Services
Office of Insurance Rates and Forms
530 W. Allegan Street – 7th Floor
Lansing, Michigan 48933
Toll Free: (877) 999-6442

/s/

Anita G. Fox
Director



**Exhibit 1 – Templates & Supporting documents
PY27 Medical Plans Filing Requirements**

Federal Required Templates	Requires Submission via SERFF		SERFF Location:
	On- and On-/Off-Marketplace	Off-Marketplace	
Network Adequacy	Yes	No	Binder only
Plans and Benefits	Yes	Yes	Binder only
Service Area	Yes	Yes	Binder only
Network ID	Yes	Yes	Binder only
Prescription Drug	Yes	Yes	Binder only
Rates Table	Yes	Yes	Form/Rate Filing & Binder
Business Rules – One per Issuer, include both Individual and Small Group on the same template	Yes	Yes	Binder only
Plan ID Crosswalk (Individual only; Supporting Documentation tab)	Yes	No	Binder only
Transparency in Coverage – One per Issuer, include both Individual and Small Group on the same template (not required for off-Marketplace only)	Yes	No	Binder only
Filing Deadlines	Small Group 5/13/2026		
	Individual 5/27/2026		

Michigan Required Supporting Documentation	Requires Submission via SERFF		SERFF Location:
	On- and On-/Off-Marketplace	Off-Marketplace	
Service Area Partial County Supplemental Response Justification, as applicable.	Yes	Yes	Binder only
Michigan Network Adequacy Template (FIS 2385) (Supporting Documentation tab)	Yes	Yes	Binder only
Network Attestation	Yes	Yes	Binder only
Network Coverage Attestation	Yes	Yes	Binder only
Appointment Wait Time Attestation	Yes	No	Binder only
Network Submission Summary	Yes	Yes	Binder only
Checklist for Individual and Small Group Medical Plans – Forms	Yes	Yes	Form/Rate Filing & Binder
MI Uniform Modification Justification Form	Yes	Yes	Form/Rate Filing & Binder
Network Adequacy Justification, as applicable	Yes	Yes	Binder only
Filing Deadlines	Small Group 5/13/2026		
	Individual 5/27/2026		

NOTE: All required templates must be completed and, if applicable, validated before uploading to SERFF. Use of Validation Workspace in MPMS and PY27 QHP Application Review Tools including the Data Integrity Tool is required for the initial template submission and any subsequent submission. All file revisions must be uploaded to the same locations as originally filed (i.e., Form/Rate Filing, Binder, or BOTH).



**Exhibit 2 – RATES and AV
PY27 Medical Plans Filing Requirements**

Federal Required Templates	Requires Submission Via SERFF		SERFF Location
	On- and On-/Off- Marketplace	Off-Marketplace	
Part I: Unified Rate Review (URRT)	Yes	Yes	Form/Rate Filing URRT Tab & Binder
Part II: Written Description Justifying the Rate Increase*	Yes, for plans that exceed the federal rate review threshold	Yes, for plans that exceed the federal rate review threshold	Form/Rate Filing URRT Tab
Part III: Actuarial Memorandum	Yes	Yes	Form/Rate Filing URRT Tab & Binder
Rates Table	Yes	Yes	Form/Rate Filing & Binder
Unique Plan Design—Supporting Documentation and Justification**	Yes – as applicable under 45 CFR 156.135(b)	Yes – as applicable under 45 CFR 156.135(b)	Form/Rate Filing & Binder
Screenshots of the AVC***	Yes – for all plans with a unique plan design	Yes – for all plans with a unique plan design	Form/Rate Filing & Binder
Michigan Supplemental Health Care Exhibit	Yes	Yes	Form/Rate Filing & Binder
Checklist for Individual and Small Group Medical Plans-Rates	Yes	Yes	Form/Rate Filing & Binder
Filing Deadlines	Small Group 5/13/2026		
	Individual 5/27/2026		

*Subject to final CMS notification

**All blended cost sharing amounts and/or adjustments and the development allowed under 45 CFR 156.135(b)(2) and/or 45 CFR 156.135(b)(3) must be submitted with the Unique Plan Design- Supporting Documentation and Justification form.

***Screenshots of the AVC must be provided for all plans with a unique plan design including CSR variants for On-Marketplace Silver plans.