# IDOI FINAL LETTER TO ISSUERS – PLAN YEAR 2027

This notice is for all issuers writing ACA individual and small group major medical plans and stand-alone dental plans (SADPs) for Plan Year 2027. All questions should be directed to compliance@idoi.IN.gov.

**Form Filing Requirements QHP/Non-QHP Consolidated Appropriations Act ("CAA")**
Indiana will not review CAA information in the form filings. CMS will review for compliance the following four provisions of the CAA:

- **42 USC §300gg-111(b)(1)**: Surprise Billing-Non-Emergency Services;
- **42 USC §300gg-112:** Surprise Billing-Air Ambulance;
- **42 USC §300gg-113**: Continuity of Care; *and*
- **PHS §2719A:** Emergency Services-Prohibition on Prior Authorization and Cost-Sharing Restrictions.

CMS requires health insurance issuers in Indiana to submit form filings for the following health insurance products in CMS Direct Enforcement module in SERFF:

- Individual plans;
- Group plans, including fully insured small group and large group plans;
- Student health insurance plans;
- Grandfathered plans; *and*
- Grandmothered plans.

CMS has outlined the requirements for how/where filings should be remitted. **May 15, 2026** is the federal deadline for filing forms for all products in the individual and small group major medical markets subject to ACA and CAA compliance review. ***Indiana requires filings to be submitted no later than 12:00 p.m. EST on May 14, 2026.*** CMS requires that forms for student health insurance products and products offered in the large group market are due 60 days prior to marketing.

**Timeline For Plan Year 2027**
Single risk pool form(s) individual and small group filings are due **no later than 12:00 p.m. EST on May 14, 2026**. Rate filings are due **no later than 12:00 p.m. on June 9, 2026**. Filings need to be made concurrent into **BOTH** HIOS and SERFF. Please note that there will be a gateway between SERFF and the Unified Rate Review (URR) module in HIOS. This applies only to information submitted on the URRT tab in SERFF. All other templates must appear in both databases, and any updates must be made at the same time.

Filings must include all required forms and rates. Refer to plan management instruction in SERFF. All updates to rates and forms from issuers are due **no later than 5:00 p.m. EST on August 5, 2026.** An attestation is required as part of your final changes that a thorough plan preview has been completed. The IDOI will complete its review of single risk pool filings by August 12, 2026.

SADP forms filings are due **no later than 12:00 p.m. EST on June 9, 2026.** Rate filings are due

**no later than 12:00 p.m. EST on June 9, 2026.** Filings need to be made concurrent into **BOTH** HIOS and SERFF. Filings must include all forms and rates and all applicable templates. Please refer to plan management instruction in SERFF. All updates to rates and forms from issuers are due **no later than 5:00 p.m. EST on August 5, 2026.** An attestation is required as part of your final changes that a thorough plan preview has been completed. The IDOI will complete its review of SADP filings by August 12, 2026.

| Item | Deadline |
| --- | --- |
| Individual and Small Group Form Filings | May 14, 2026 by 12:00 p.m. EST |
| SADP Form Filings | June 9, 2026 by 12:00 p.m. EST |
| Individual, Small Group, and SADP Rate Filings | June 9, 2026 by 12:00 p.m. EST |
| Updates to Rates and Forms | August 5, 2026 by 12:00 p.m. EST |

## SERFF Response Times and Data Change Requests

SERFF response times will be adjusted based on the date of the objection:

| Date of Objection | Response Time |
| --- | --- |
| On or before June 26, 2026 | 10 business days |
| June 29, 2026 – July 10, 2026 | 4 business days |
| July 13, 2026 – August 12, 2026 | 2 business days |

**ALL** data change requests must be provided to the IDOI two business days **PRIOR** to the due date of the submission. Change requests must be emailed to sshover@idoi.IN.gov and Compliance@idoi.IN.gov with the subject line "Data Change Request from Issuer XXXX HIOS ID XXXX."

## Essential Health Benefits 2027

Indiana will retain the current 2017 essential health benefit benchmark plan for the 2027 calendar year:

- Anthem BCBS Blue 5 Blue Access PPO Medical Option 6 Rx Option G
- Pediatric Oral (FEDVIP)
- Pediatric Vision (FEDVIP)

Substitutions between benefit categories are not permitted. Additional information may be obtained by visiting IDOI Reference Documents.

## Actuarial Value (AV) De Minimis Ranges

The AV De Minimis ranges remain unchanged for Plan Year 2027. Please refer to additional sections on Bronze/Catastrophic plans.

## CSR Loading

For Plan Year 2027, loading for CSRs will continue to be applied to all metal levels, for both on and off exchange plans. Please review the proposed Notice of Benefit and Payment Parameters for 2027 for additional information.

**<u>SERFF Plan Management Instructions</u>**

*<u>General Information</u>*

Binder submissions and form/rate filing submissions are required by Indiana for all ACA compliant non-grandfathered plans that are part of the single risk pool as well as SADPs. Additional information on submission requirements, including those for rate filing justifications, will be forthcoming in a separate email.

On the Rate Review Detail in SERFF, issuers should report the min, max, and weighted average for the annualized PMPM as premiums to cover one month of coverage. On the Rate/Rule Schedule, the “Overall % Rate Increase” field should be set equal to the “Submission Level Rate Increase %” value from the URRT.

- For the “Minimum % Change” field, please use the rate change for the plan with the smallest increase/largest decrease from the URRT.
- Likewise, please use the rate change for the plan with the largest increase from the URRT for the “Maximum % Change” field.

All companies should review the uniform modification rules under the ACA. SCIDs **should not be changed** when the uniform modification rules do not require it.

*<u>URRT and Supporting Documentation Tab</u>*

SERFF implemented updates that made the Part II Justification, Part III Memorandum, and Redacted Part III Memorandum accessible through the SERFF Filing Access Portal. However, for the URRT, only the XML version is available rather than the Excel worksheet. Because of this situation, please attach a copy of the URRT to the Supporting Documentation tab in addition to the URRT tab.

*<u>Actuarial Memorandum and Effective Rate Review Information</u>*

In prior years, the IDOI noticed that some issuers attached a separate actuarial memorandum to the Supporting Documentation tab to meet Indiana’s rate review requirements, while other issuers submit a separate section in their Part III Memorandum, the “Effective Rate Review Information” section included in the Part III instructions. Please provide the “Effective Rate Review Information” section in the Part III Memorandum for Plan Year 2027, rather than a separate actuarial memorandum.

For Plan Year 2027, IDOI requests detailed information to be provided in the actuarial memorandum to include the following:

- Any concerns related to the treatment of catastrophic plans.
- Any concerns related to non-network plans.
- Any impact tariffs may have had on rate development.
- Any changes you have experienced regarding utilization.
- Any other information that is unique to this filing year.

In past years, actuarial memoranda have been submitted with confidentiality or trade secret language. The IDOI is not considering confidentiality requests for rate or form filings, so please

do not include such verbiage in the actuarial memorandum or any other submitted material.

*EHB Verification Template*
For the Benchmark Benefits Package tab, changes from the prior year's filing should be entered in red text. Any items that did not change from last year should remain in black text.

**Network Adequacy Review Updates**
*General Information*
CMS will conduct network adequacy reviews for on-exchange and dental submissions. Requirements for Individual or Small Group Major Medical submissions that are completely Off-Exchange are expected to be similar to those used for Plan Year 2026. **Information on the submission requirements will be released in a separate email.**

CMS proposes revising the minimum percentage of ECPs that issuers must contract with in each plan's service area to participate in the plan's provider network from **35 percent to 20 percent**, applicable to the overall ECP threshold and, separately, to the federally qualified health center (FQHC) and family planning provider thresholds.

For Plan Year 2027, time and distance standards remain unchanged. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers). The Provider Specialty Types and Appointment Wait Time Standards are as follows:

| Provider Specialty Type | Maximum Wait Time |
|---|---|
| Behavioral Health | 10 business days |
| Primary Care (Routine) | 15 business days |
| Specialty Care (Non-urgent) | 30 business days |

CMS requires medical QHP issuers to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards. To demonstrate compliance with these standards, such surveys must begin on or shortly after January 1 and completed by May 31 of each plan year. QHP issuers also must report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities. Please see the 2026 Final Letter to Issuers and Appointment Wait Time Secret Shopper Survey Technical Guidance for additional information. The IDOI will require that the secret shopper surveys be completed for both individual and small group off exchange filings.

*Non-Network Plan Provider Access*
In the proposed 2027 NBPP, CMS proposed to rescind the requirement that all plans must use a network of providers and has instead proposed to allow plans that do not use a network (non-network plans) to obtain QHP certification by demonstrating sufficient access to a broad range of providers in a manner.

CMS proposed a non-network QHP would be required to ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and

providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

**Formulary Review Updates**

Major medical formularies must comply with all federal review requirements using all of the federal review tools available at QHP Certification Information and Guidance. For any drug class category not meeting the requirements for any required prescription drug template, please provide an appropriate justification with the binder submission. Guidance related to the state specific IDOI Clinical Appropriateness Review Tool will be released in a separate email.

**MHPAEA**

On the MHPAEA tab of the EHB Verification Template, the IDOI requires that the classifications be listed separately on the template and must remain separate for the determination of "substantially all" and "predominant" level tests. It is now IDOI policy that Outpatient Office Visits (In-Network) for Medical/Surgical must use the same cost-sharing type (copay/coinsurance) as Mental Health/Substance Use Disorder. Plans that do not comply with this standard will not be approved.

The IDOI will require completion of the federal Self-Compliance Toolkit. Additional information on expectations for Plan Year 2027 may be found in Attachment 1 of this document.

**Cost Sharing; Out-of-Pocket Expense Sharing Credit Certification**

Each insurer and administrator is to certify to the Insurance Commissioner that they have fully and completely complied with cost sharing requirements during the previous calendar year in accordance with HB 1604.

**Product Discontinuance/Renewal Notifications**

Notification must be sent to policyholders at least 90 calendar days in advance of the date the coverage will be discontinued. Issuers should also send written notice of the product discontinuance to the Commissioner. Notification to policyholders should be approved by the IDOI prior to sending it to policyholders.

Notification requirements are applicable for both grandfathered and non-grandfathered coverage in the large group, small group and individual market on and off Marketplace. Additional information regarding notice requirements may be found at CMS Notice Guidance.

**Exchange User Fees**

Federal-facilitated Exchange user fee 2.5% of monthly premiums.

**Premium Adjustment Percentage**

The premium adjusted percentage for the 2027 benefit year is 1.8916224814 ($8,919/$4,715), which represents an increase in PHI premiums (excluding Medigap and property and casualty insurance).

**Maximum Annual Limitation on Cost sharing/ Reduced Annual Limitation on Cost-sharing**

The 2027 maximum annual limitation on cost sharing is $12,000 for self-only coverage and $24,000 for other than self-only coverage. This represents an approximately 13.2 percent increase from the 2026 parameters of $10,600 for self-only coverage and $21,200 for other than self-only coverage. Reduction for 94% AV/CSR is $4,000 S/$8,000 NS, 87% AV CSR $4,000 S/ $8,000 NS, and 73% AV/CSR $9,600 S/ $19,200 NS.

**The IRS Released Guidance on Direct Primary Care Service Arrangements**
For plan years beginning in 2026, please note that recent federal tax law changes permit, in many cases, the combination of Exchange coverage, a Health Savings Account (HSA), and a qualifying Direct Primary Care Service (DPC) arrangement. Enrollment in a qualifying DPC arrangement is no longer treated as disqualifying coverage for HSA eligibility. Also, many bronze and catastrophic plans offered as individual coverage are now treated as high-deductible health plans for HSA purposes under Internal Revenue Code section 223. DPC arrangements remain separate from insurance coverage, and DPC fees do not count toward health plan deductibles or out-of-pocket maximums.

**Standardized Plan Options (for QHP Issuers Only)**
For Plan Year 2027, CMS has proposed the following changes:

- The definition of "standardized options"
- All requirements pertaining to standardized plan options; the requirement for the plans to meaningfully differ from one another
- The differential display of standardized plan options on HealthCare.gov
- The corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a Direct Enrollment pathway to facilitate consumer enrollment through an FFE or SBE-FP.

**Non-standardized Plan Options (for QHP Issuers Only)**
CMS proposes to discontinue non-standardized plan option limits and exceptions effective beginning in the 2027 Plan Year. Under CMS's proposed approach, issuers would no longer be subject to the non-standardized plan option limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, in any service area at Section 156.202(a) through (c), for Plan Year 2027 and subsequent years. Issuers are no longer be required to utilize the non-standardized plan option limit exceptions process to offer additional non-standardized plan options given that they would no longer be limited in the number of non-standardized plan options they may offer for PY 2027.

Issuers may discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether, and enrollees in these plans would be auto re-enrolled to a different plan in accordance with the crosswalk hierarchy. Additionally, issuers may also wish to continue offering the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process with the same cost sharing structures, and enrollees in these plans would continue to be auto reenrolled in these plans from one plan year to the next. Issuers may wish to continue offering the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process with modifications to the plans' cost sharing structures, but these issuers would continue to be subject to the requirements under the definition of "plan" at Section 144.103

and to the uniform modification requirements at Section 147.106.

**Non-network Plans**
CMS proposes to allow non-network plans to receive QHP certification beginning with Plan Year 2027 by demonstrating a sufficient choice of providers, consistent with Sections 1311(c)(1)(B) and (C) of the ACA. Unlike network-based plans, non-network plans do not rely on a contracted set of providers that agree in advance to specific terms and negotiated payment rates, nor do they condition or differentiate benefits to enrollees based on whether the issuer has a network participating agreement with a provider that furnishes covered services. These plans set specific benefit amounts for covered services and communicate those benefit amounts to enrollees who may then seek covered services from any provider.

**Catastrophic Plans**
CMS proposes to codify requirements under which issuers of catastrophic coverage may enroll individuals for multiple plan or policy year terms with periods of up to 10 years and proposes modifying the requirements for catastrophic plans in § 156.155 to specify that a catastrophic plan has a plan term of either one plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years.

CMS proposes that catastrophic plans with terms of at least two plan or policy years may utilize value-based insurance designs to offer benefits for preventive services pursuant to Section 2713(c) of the PHS Act, without the enrollee having to first satisfy their deductible or annual cost-sharing limitation. CMS requests comment on the proposal at § 156.130, that issuers of multiyear catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, over the life of the contract.

CMS also proposes to amend § 156.80(d)(2)(ii) to allow issuers of multi-year catastrophic plans to make a plan-level adjustment to the index rate. CMS further proposes that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment in the plan under Section 1302(e)(2) of the Affordable Care Act at the time of enrollment may enroll in the multi-year plan.

**Bronze/ Catastrophic Cost-sharing**
CMS proposes to add new § 156.136 that states, for plan years beginning on or after January 1, 2027, if an issuer offers a bronze plan (as defined at § 156.140(b)(1)) in the individual market that complies with the cost-sharing requirements at § 156.130 and the levels of coverage requirements at § 156.140, it may also offer, within the same service area, bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing at § 156.130 by amounts in increments of 50 dollars in order to achieve an AV within the standard bronze *de minimis* variation at § 156.140(c), calculated as described in § 156.135.

CMS further proposes, that, in order for an issuer to avail itself of the ability to offer individual market bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing, the issuer must also offer at least one individual market bronze plan in the same service area that utilizes a cost-sharing design that does not exceed the maximum annual limitation on cost sharing at § 156.130 and complies with the levels of coverage

requirements at § 156.140.

CMS further proposes that this flexibility would apply only in the individual market. Specifically, they believe that individual market consumers in particular would be interested in more plan choices offering lower deductibles and lower premiums.

**State Legislative Considerations**

IDOI encourages issuers to keep up-to date with all legislative proposals currently in the Indiana General Assembly. Additional information on pending legislation may be found by visiting the Indiana General Assembly.

**Reference Documents**

The IDOI recognizes that there are pending changes which may impact form and/or rate filings and **STRONGLY** encourage issuers to stay up-to-date on all federal changes. Please review the following documents that may be used in the form or rate review:

- 2027 Proposed Letter to Issuers
- 2027 Proposed Notice of Benefit and Payment Parameters
- Expanded Availability of Health Savings Accounts under the One, Big, Beautiful Bill Act (OBBBA)

**General Instructions**

In the event you are unable to respond to messages/objections in SERFF in the allotted time, **immediately** let IDOI know via note to reviewer AND email to the person you are corresponding with.

If you receive a request for data/information from IDOI, there is a date associated with the response time. If you are unable to meet the deadline as indicated, immediately let IDOI know via contacting the individual who has emailed you.

If your company experiences any sort of issue which impacts your filing/existing consumers, immediately let IDOI know so that we may adequately prepare for any questions we may encounter. It is our preference to be made aware in the beginning states of the issue at hand. Please email the below individuals with concerns, number of individuals impacted, and a course for remediation:

- apeck@idoi.in.gov
- sshover@idoi.in.gov
- ttetrick@idoi.in.gov
- ghockwalt@idoi.in.gov
- compliance@idoi.in.gov

**Meet Our Team**

The Healthcare Reform team at IDOI is available to assist you with any questions or concerns you may have. You may receive correspondence from the following individuals:

**Alexandria (Alex) Peck,** Chief Deputy Commissioner of Compliance and Actuarial Services
Alex manages the healthcare reform team. Her primary correspondence with insurers involves immediate concerns which may have a large impact on consumers or legal concerns.

**Scott Shover,** Chief Actuary
Scott oversees the actuarial team at the IDOI and is a primary contact for any questions regarding rate development and review, plan management concerns, and network adequacy review.

**Connor Gibb,** Associate Actuary
Connor assists the Chief Actuary with the rate review process including plan management and network adequacy review.

**Teresa Tetrick,** Health Oversight Manager
Teresa assists the health care reform team in overall project management and may interact with insurers regarding specialized concerns/issues.

**Bobbi Henn**, A&H Analyst
Bobbi is responsible for the form review process of accident and health filings. Her main interaction with insurers includes correspondence in SERFF concerning compliance concerns and/or questions.

**Kim Burdick**, A&H Analyst
Bobbi is responsible for the form review process of accident and health filings. Her main interaction with insurers includes correspondence in SERFF concerning compliance concerns and/or questions.

**Kim Van Rooy,** Health Care Attorney
Kim provides legal support to the IDOI's Health Care Reform Team for all matters related to regulatory compliance and the rate review process.

**Greta Hockwalt,** Rate Review Consultant
Greta is a contractor for the IDOI. She assists with reviewing form and rate filings, serves as a subject matter expert for ACA filings, and is a project manager.

## Attachment 1: Consolidated Appropriations Act MHPAEA Guidance

The Consolidated Appropriations Act ("CAA") amended MHPAEA to require certain plans to perform and document an analysis that demonstrates compliance with the non-quantitative treatment limitations ("NQTLs") requirements of the MHPAEA (i.e., the requirement that the application of NQTLs to mental health and substance use benefits are "in parity" with the application of NQTLs to medical/surgical benefits). As of February 10, 2021, plans and issuers must provide a comparative analysis if requested by plan participants, the Departments, or relevant state agencies.

### What information must a NQTL comparative analysis contain?

The comparative analysis must contain a written detailed explanation of whether processes, strategies, evidentiary standards, or other factors that apply a NQLT to MU/SUD benefits are comparable and are not applied more stringently than to medical/surgical benefits. The CAA requires, at a minimum, that the comparative analysis contains a robust discussion of 9 elements:

- A clear description of the specific NQTL, plan terms, and policies at issue;
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies;
- Identification of any factors, evidentiary standards, or processes considered in the application of the NQTL to MH/SUD and medical/surgical benefits;
- If any factors, evidentiary standards, strategies, or processes are defined in a quantitative manner, the precise definitions used;
- Explanation of whether there is any variation in the application of a guideline or standard between MH/SUD and medical/surgical benefits;
- If the application of the NQTL turns on specific decisions, the nature of the decisions, the decision makers, the timing of the decisions, and the qualifications of the decision makers;
- If the plan relies on experts, the experts' qualifications and the extent to which the plan relies on the experts' evaluations when setting recommendations for MH/SUD and medical/surgical benefits;
- A discussion of the plan's findings and conclusions as to the comparability of the process, strategies, evidentiary standards, and factors of the above categories and the plan's compliance with MHPAEA; *and*
- The date of the analysis and the name, title, and position of the persons who performed the comparative analysis.

### What documentation may be requested from the Departments to support the comparative analysis?

Plans and issuers should be prepared to provide documents that support the conclusions of the NQTL comparative analysis. The DOL highlights the following documents that it may request from a plan to support a comparative analysis:

- Records documenting NQTL processes and how NQTLs are applied to medical/surgical and MH/SUD benefits;
- Any materials that have been prepared for compliance with any applicable reporting requirements under state law;

- Documentation (e.g., guidelines, claims processing policies and procedures) the plan or issuer relied upon in determining the NQTLs are applied no more stringently to MH/SUD benefits that medical/surgical benefits;
- Samples of covered and denied MU/SUD and medical/surgical claims; *and*
- Documents related to MHPAEA compliance from the plan's service providers/vendors (if the plan delegates management of some or all MU/SUD benefits to another entity).

**What enforcement action may be taken for parity violations?**
Civil monetary penalties may be levied for MHPAEA violations.

**Additional Resources**
- 2024 MHPAEA Report to Congress
- DOL MHPAEA FAQ Part 45

# IDOI Network Adequacy Standards for Plan Year 2027

### Finalized Standards:

The IDOI has decided to largely defer to CMS regarding network adequacy review for on-exchange and dental submissions. With this in mind, the proposed IDOI Network Adequacy Standards for Plan Year 2027 are finalized.

### Individual or Small Group Major Medical Submissions that Are Completely Off-Exchange:

1. Carriers may choose to use either the three county designations proposed by the IDOI (Large Metro, Metro, and Rural) or all five as shown by CMS in the Qualified Health Plan Issuer Application Instructions for Plan Year 2027.
2. Carriers may demonstrate network adequacy using distance only maps as described in this document, or carriers may choose to submit tables that demonstrate both time and distance in accordance with CMS's network adequacy requirements as defined in the 2023 through 2027 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
3. Carriers will be responsible for designing and submitting exhibits that clearly demonstrate how all criteria are met. Most criteria are evaluated at the network/county level. For this reason, the information entered into Network Adequacy template must be complete and accurate, especially regarding the county that is listed. A provider/facility must be in network in order to be listed in the Network Adequacy template and be counted towards satisfying network adequacy standards.
4. Indiana requires that Outpatient Dialysis be covered in-network and satisfy a distance standard of 45 miles. This can be demonstrated in the carrier's format in a document separate from the Network Adequacy template.
5. Carriers will need to submit:
   i. the Network Adequacy template,
   ii. the IDOI Active Individual Providers Template (major medical only),
   iii. a table showing the count of unique providers (facilities and individual) by specialty and network, and
   iv. justifications where any standard has not been met.
6. The IDOI is requiring all Off-Exchange submissions to comply with CMS wait-time standards:
   a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
   b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

| Provider Specialty Type | Appointments Must Be Available Within |
|---|---|
| Behavioral Health | 10 business days |
| Primary Care (Routine) | 15 business days |
| Specialty Care (Non-urgent) | 30 business days |

c. CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards.
   - To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities.
   - For Plan Year 2027, CMS is requiring that secret shopper surveys be conducted for a QHP issuer's primary care (routine) and behavioral health providers. CMS expects to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years.
   - Please see the 2025, 2026, and 2027 Federal Final Letters to Issuers for further information.

d. Please see the link Appointment Wait Time Secret Shopper Survey Technical Guidance for additional guidance.

e. Similarly to last year, carriers should submit the following items for the secret shopper survey conducted January through May of 2026:
   1. Policy and/or Process Documents for the secret shopper survey, which should include the detailed policy and/or process outlining the issuer's survey process.
   2. Third-party entity contracts for the entity contracted to execute the secret shopper surveys.
   3. Results of the secret shopper survey, including separate results files for each network. Also, there should be separate tabs within each network results file for behavioral health and primary care providers.

f. The following file types should be used for each secret shopper survey file uploaded:
   1. Policy and/or process documentation files should be provided in PDF format.
   2. Third-party entity contracts should be provided in PDF format.
   3. Results files should be provided in Excel (xlsx) format.
   4. Issuers should use separate files (.xlsx) to document the survey results for each network. For example, for an issuer with two networks, the first file would be titled "99999_Results_ALN001.xlsx," and the second file would be titled, "99999_Results_ALN002.xlsx."

g. Files should be uploaded to the Supporting Documentation tab of the SERFF binder submission, under the "IDOI Network Adequacy Documents" section. Issuers may upload to SERFF using a ZIP file if necessary. The ZIP file name should include the five-digit Issuer ID. Please see the example the table below to further explain the naming conventions:

| Document Submitted | Naming Template | Example | Preferred File Type Extensions |
|---|---|---|---|
| Policy and Process documentation | *ISSUER ID_POLICY_TITLE.PDF* | XXXXX_SURVEY-POLICY.PDF | .PDF |
| Third-Party Entity contract documentation | *ISSUER ID_THIRD-PARTY-ENTITY_NAME.PDF* | XXXXX_TOPS-SURVEYORS.PDF | .PDF |
| Results documentation | *ISSUER ID_RESULTS_NETWORK ID.XLSX* | XXXXX_RESULTS_ALN001.XLSX | .XLSX |
| Zip folder containing all files for the QHP issuer's policy, process, contracts, and network survey results documentation | *ISSUER ID_AWT-SSS.ZIP* | XXXXX_AWT-SSS.ZIP | .ZIP |

**IDOI Active Individual Providers Template:**

This is an Excel workbook, separate from the Network Adequacy template that lists active individual providers at locations that meet the following additional criteria:

1. By default, individual providers may only be listed at a single primary location. However, providers may be listed at additional locations if the carrier has paid major medical claims for care provided in-person at that location for that specialty during or after 2023. The goals for this restriction are as follows:
    a. To reduce the number of outdated or incorrect entries,
    b. To account for the fact that an individual can only provide a limited amount of care, and
    c. To more accurately identify where care is being provided.
2. The IDOI may provide additional leniency for carriers that are entering the market and thus would not have any claims in 2023, 2024, 2025, or 2026.

**Count of Unique Providers by Specialty and Network:**
For each network, carriers should provide the total number of unique providers of each specialty. These counts must only include providers listed in the Network Adequacy template. There should also be a column indicating the percentage of providers in each specialty and for each network that has billed the carrier for care they provided in that specialty at that location since 1/1/2023.

**Distance Standards and Maps:**
**County Designations:**
The IDOI uses the three county type designations of Large Metro (Marion County only), Metro (combines CMS's Metro and Micro), and Rural (combines CMS's Rural and CEAC).

| County Designation | Population |
|---|---|
| Large Metro | > 900,000 |
| Metro | 50,000 – 900,000 |
| Rural | < 50,000 |

**Distance Standards:**
The IDOI will be using the specialties and distance standards defined by CMS in their 2023 through 2027 Final Letters to Issuers.

**For Carriers that Submit Maps:**
For each network and for each specialty, carriers will need to provide 3 maps (Large Metro, Metro, and Rural). The maps should demonstrate that all policy holders will have access to at least one provider of each specialty within the distance standard of their county's designation by plotting each provider location in that network of that specialty type statewide and drawing semi-transparent circles, centered at the provider locations, with radii equal to the map's distance standard. For each map, all providers of that specialty and in that network should be plotted and should have their circles drawn, even if they are in counties of a different county designation than the map. Counties that have the same county designation as what is being shown on the map should be colored in a way to make them easy to identify. It must also be easy to identify which counties do not have plans with the map's network. Each of these counties are expected to be fully covered. Counties that have a less stringent distance standard than that being shown on the map are not expected to be fully covered.
Maps should include the following:

1. All Indiana county boundaries,
2. All county names,
3. County Designation being mapped,
4. The distance standard in miles,
5. The Network ID,
6. The provider specialty,
7. The date made,
8. Colorings of counties that make it easy to identify which counties match the county designation of the map and which counties offer plans with the map's network.

**Justifications:**

Carriers will need to demonstrate a sufficient number of each provider type, in each network, for each county in which that network is used. If a carrier is unable to meet this requirement, then the carrier must supply a justification of why the carrier was unable to meet this requirement. This justification will need to be reviewed and found adequate by the IDOI for the carrier to receive credit for meeting that standard for that network/county.

### SADPs:

1. Carriers will need to demonstrate compliance, for both their on-exchange plans and off-exchange plans, with CMS's network adequacy requirements as defined in the 2023 through 2027 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
2. Dental plans will NOT need to submit:
   i. the IDOI Active Individual Providers Template,
   ii. a table showing the count of unique providers (facilities and individual) by specialty and network.
3. All carriers must comply with wait-time standards starting with Plan Year 2025:
   a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
   b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

| Provider Specialty Type | Appointments Must Be Available Within |
|---|---|
| Behavioral Health | 10 business days |
| Primary Care (Routine) | 15 business days |
| Specialty Care (Non-urgent) | 30 business days |

   c. **As SADP issuers would generally contract with specialty care (non-urgent) providers, SADP issuers would not be required to contract with a third-party entity to conduct secret shopper surveys for the 2027 plan year. Please see the 2027 Federal Final Letter to Issuers for further information.**
   d. Please see the link Appointment Wait Time Secret Shopper Survey Technical Guidance for additional guidance.

### Submissions that Contain On-Exchange Major Medical Plans:

1. Carriers will need to demonstrate compliance, for both their on-exchange plans and off-exchange plans, with CMS's network adequacy requirements as defined in the 2023 through 2027 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
2. Indiana requires that Outpatient Dialysis be covered in-network and satisfy a distance standard of 45 miles. This can be demonstrated in the carrier's format in a document separate from the Network Adequacy template.
3. Submissions containing on-exchange plans will not need to submit:
   I. the IDOI Active Individual Providers Template,
   II. a table showing the count of unique providers (facilities and individual) by specialty and network.
4. All carriers must comply with wait-time standards starting with Plan Year 2025:

a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

| **Provider Specialty Type** | **Appointments Must Be Available Within** |
|---|---|
| Behavioral Health | 10 business days |
| Primary Care (Routine) | 15 business days |
| Specialty Care (Non-urgent) | 30 business days |

c. CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards.
   - To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities.
   - For Plan Year 2027, CMS is requiring that secret shopper surveys be conducted for a QHP issuer's primary care (routine) and behavioral health providers. CMS expects to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years.
   - Please see the 2027 Federal Final Letter to Issuers for further information.

d. Please see the link Appointment Wait Time Secret Shopper Survey Technical Guidance for additional guidance.