IDOI FINAL LETTER TO ISSUERS – PLAN YEAR 2026

This notice is for all issuers writing ACA individual and small group major medical plans and stand-alone dental plans ("SADPs") for Plan Year 2026. 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 (4) 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, 2025** 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, 2025.***
  - 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 2026

- Single risk pool form(s) individual and small group filings are due **no later than 12:00 p.m. EST on May 14, 2025**.
  - Rate filings are due **no later than 12:00 p.m. on June 10, 2025**.
  - 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 6, 2025.**
    - All QHP issuers **MUST** have final and active URLs completed by this

date.
        - 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 13, 2025.
- SADP forms filings are due **no later than 12:00 p.m. on June 10, 2025.**
    - Rate filings are due **no later than 12:00 p.m. EST on June 10, 2025.**
    - 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 6, 2025.**
        - All SADP issuers **MUST** have final and active URLs completed by this date.
        - 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 13, 2025.

Item	Deadline
Individual and Small Group Form Filings	May 14, 2025 by 12:00 p.m. EST
SADP Form Filings	June 10, 2025 by 12:00 p.m. EST
Individual, Small Group, and SADP Rate Filings	June 10, 2025 by 12:00 p.m. EST
Updates to Rates and Forms	August 6, 2025 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:
    - **10 days**: before June 27, 2025
    - **4 days**: June 30, 2025, to July 11, 2025
    - **2 days**: July 14, 2025, to August 6, 2025
- **All** data change requests must be provided to the IDOI two (2) 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 2026

- Indiana will retain the current 2017 essential health benefit benchmark plan for the 2026 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

- In the 2025 Marketplace Integrity and Affordability Proposed Rule, CMS proposes to widen the de minimis ranges to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans, for which CMS proposes a de minimis range of +5/-4 percentage points.
- CMS also proposes removing from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs and specifying a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations.
- This proposed policy would allow for greater flexibility in plan design, providing consumers with increased plan options and potentially lower premiums as issuers adjust plan designs to attract a broader range of enrollees, improving market competition and stability.
- The IDOI encourages issuers to review information contained within the proposed rule and fact sheet
    - Please note proposed changes to de minimis ranges may result in issues with uniform modification requirements.
    - Please refer to 45 C.F.R. § 147.106(e).

CSR Loading

- For Plan Year 2026, loading for CSRs will continue to be applied to all metal levels, for both on and off exchange plans.
- CMS is finalizing codifying that CSR loading practices are allowed when the adjustments are actuarially justified and follow state law, provided the issuer does not otherwise receive reimbursement for such amounts.
- Please refer to 2026 Notice of Benefit and Payment Parameters.

SERFF Plan Management Instructions

General Information

- 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.

Plan Year 2026 Rates and Enhanced Subsidies

Issuers should develop rates based on the assumption that subsidies are NOT extended, and issuers should prepare all submitted documents and templates consistent with this assumption. In addition, issuers should provide the IDOI with an estimate of the average change in rates (from the submitted rates) that would be required if the subsidies are extended, and this estimate should be supported by a thorough description of the assumptions used for its development. If the estimated change is expected to vary significantly by metal level, rating area, network, etc., issuers should provide detail on this also. The IDOI strongly recommends preparing rates and templates assuming the subsidies are continued, even though we are not requiring these to be

submitted at this time.

URRT and Supporting Documentation Tabs

- The IDOI discovered last year that information on the URRT tab is not accessible through the SERFF Filing Access portal and that SERFF is not able to change this in time for Plan Year 2026 filings.
- Because of this situation, please attach copies of the URRT, Part III Actuarial Memorandum, and Consumer Justification (if applicable) to the Supporting Documentation tab in addition to the URRT tab.

Actuarial Memorandum and Effective Rate Review Information

- The IDOI noticed that some issuers attach 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 2026, rather than a separate actuarial memorandum.

Network Adequacy Review Updates

- 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 2025.
    - Information on the submission requirements will be released in a separate email
- The ECP provider participation standard is set at 35 percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the 35 percent threshold.
- For Plan Year 2026, CMS has provided guidance for time and distance standards, appointment wait times, and the network adequacy justification process, and the IDOI encourages you to review the 2026 Final Letter to Issuers.
    - 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 for additional information.
    - Also, please see 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.

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.
- 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 2026 may be found in Attachment 1 of this document.

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.

Standardized and Non-Standardized Plan Options (for QHP Issuers Only)

- For Plan Year 2026, CMS will continue to require standardized QHP options in FFE at

every product network type to include:
    - One bronze plan;
    - One bronze plan that meets the requirements to have an AV up to 5 points above the 60 percent standard as specified in 45 CFR §156.140(c) (known as expanded bronze plan);
    - One silver plan;
    - One version of each of the three income-based silver CSR plan variations;
    - One gold plan; ***and***
    - One platinum plan.
- CMS finalized the requirement that issuers offering multiple standardized plan options within the same product network type, metal level, and service area meaningfully differentiate these plans from one another to reduce the risk of duplicative offerings.

State Legislative Considerations

The 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:

- 2026 Final Letter to Issuers
- 2026 Notice of Benefit and Payment Parameters
- 2026 Plan Management/CMS Templates
- Executive Order: Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information
- Executive Order: Improving Price and Quality Transparency in American Healthcare to Put Patients First
- No Surprises Act Rules and Fact Sheets
- Program Integrity Proposed Rule

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