Illinois Department of Insurance

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Governor

ANN GILLESPIE
Director

TO: All Companies Writing Accident and Health Insurance and Health Maintenance Organization Health Care Plans

FROM: Ann Gillespie, Director ARG

DATE: July 8, 2025

RE: Company Bulletin 2025-12 – Inappropriate Claims Denials and Exclusions Based on Location, Site of Care, or Setting

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The Illinois Department of Insurance has become aware that certain "utilization review" programs are being used to determine whether services are "medically necessary" based on location, site of care, or setting in a manner that may be contrary to law. This may have resulted in denials for otherwise covered benefits and appears to operate as administrative denials in practice.

Determinations for "medically necessary" services shall be based upon "generally accepted standards of care" as defined in 215 ILCS 134/10 or "generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" as defined at 215 ILCS 5/370c(h). While the Healthcare External Review Act recognizes that adverse determinations can include denials based on "health care setting," this does not mean that all denials based on health care setting are under the category of medical necessity. A determination whether a service is medically necessary does not include determinations made "primarily for the economic benefit of the health care plan, purchaser, or utilization review organization, or for the convenience of the patient, treating physician, or other health care provider." 215 ILCS 134/10 (definition of "medically necessary"). *See also* 215 ILCS 5/370c(h). Therefore, if an issuer determines that a health care setting, site of care, or location is not medically necessary, and if the issuer's grounds for that determination are not based on generally accepted standards of care but instead are primarily for the issuer, purchaser, or URO's economic benefit or for the convenience of the patient, treating physician, or other health care provider, then the issuer's denial cannot validly be a medical necessity determination.

Concern has arisen recently in situations when the same outpatient health care service is available from a hospital and a freestanding clinic, and both the particular hospital and the particular freestanding clinic have all the necessary facilities and licensed, trained health care professionals to render the outpatient service, but the issuer deems the outpatient service not medically necessary at the hospital because it can be obtained at the freestanding clinic. The Department is not aware of any generally accepted standard of care in the practice of medicine under which, based on facility type alone and not taking into account economic benefit or convenience, a hospital forfeits its status as a clinically appropriate site or becomes somehow less clinically appropriate than the freestanding clinic specifically because the freestanding clinic is an available, proximate option for the outpatient service.

The Department may object to policy forms that purport to distinguish the medical necessity of health care settings in this manner and will disapprove the policy form if the issuer is unable to substantiate that, without regard for economic benefit or convenience, this distinction is based on "generally accepted standards of care" or "generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" as defined in statute. Likewise, the Department's consumer complaint unit may ask an issuer to substantiate its utilization review criteria's basis in generally accepted standards of care when relevant to a consumer's case, and the market conduct unit may review an issuer or URO's compliance with relevant statutes during any market conduct action. The Department will evaluate each issuer's substantiation on its own merits under the statute. This authority applies regardless of whether the issuer offers an HMO, PPO, or traditional indemnity plan.

As of January 1, 2026, the Healthcare Protection Act (P.A. 103-650) will limit utilization review programs to three types of sources of utilization review criteria for medical and surgical services:

1) an unaffiliated, nonprofit professional association for the relevant clinical specialty;
2) a third-party entity that develops treatment criteria that: (i) are updated annually; (ii) are not paid for clinical care decision outcomes; (iii) do not offer different treatment criteria for the same health care service unless otherwise required by State or federal law; and (iv) are consistent with current generally accepted standards of care; or
3) the Department of Healthcare and Family Services if the criteria are consistent with current generally accepted standards of care.[1]

215 ILCS 134/87(b). Health insurance issuers and utilization review organizations will be prohibited from using utilization review criteria from a non-permitted source to determine medical necessity once this provision takes effect.[2] By standardizing utilization review criteria across health insurance issuers and UROs in this manner, the new law will substantially inhibit a health insurance issuer from using, or from requiring or permitting a URO to use, custom utilization review criteria for medical and surgical services. An issuer or URO's utilization review criteria would only validly be unique in the Illinois market if the issuer or URO were unique in its choice among the statutorily permitted sources.

The Department will not approve policy forms to be offered on or after January 1, 2026 if they provide for medical necessity determinations contrary to these statutorily permitted sources, including policy provisions that unjustifiably restrict coverage based on the purported medical necessity of the setting or geographic location or proximity of a site of care. The Department may object to policy forms that appear to determine medical necessity based on custom utilization review criteria, and will disapprove the policy form if the issuer is unable to substantiate that it is using a statutorily permitted source. Likewise, the Department's consumer complaint unit may ask an issuer to substantiate its utilization review criteria's basis in statutorily permitted sources when relevant to a consumer's case, and the market conduct unit may review an issuer or URO's compliance with relevant statutes during any market conduct action. The Department will evaluate each issuer's substantiation on its own merits under the statute. This authority applies regardless of whether the issuer offers an HMO, PPO, or traditional indemnity plan. Nothing in this bulletin should be construed to prohibit an issuer or URO from determining medical necessity of a health care setting based on utilization review criteria from a statutorily permitted source.

[1] Specific to Medicaid.
[2] Mental health and substance use disorder coverage is already subject to restrictions on permitted sources of utilization review criteria under 215 ILCS 5/370c(h)-(n).

Additionally, issuers are reminded that, if the insured is covered by a PPO plan, the insured may choose to receive a health care service at either an in-network facility or an out-of-network facility with the understanding that the cost-sharing or coinsurance will be lower if they remain in-network. Even if an individual covered by a PPO plan has an available in-network provider for the services they are seeking, the insured retains the right to choose an out-of-network provider. Also, when an insured wishes to use the services of a preferred provider, the PPO plan must allow the insured to use the qualified preferred provider of the insured's own choice, subject to potential differences in cost-sharing if the PPO network has more than one tier. No PPO issuer should hinder or attempt to prevent such an insured from receiving care from the qualified provider or facility of their choosing. *See* 215 ILCS 5/357.10, 5/367(3), and 5/370i. The Department also encourages issuers to educate members on the cost difference between different sites of service and the impact it may have on the member's cost-sharing. The Code states:

> Anything in this code to the contrary notwithstanding, any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services, may, at the insurer's option, be paid directly to the hospital or person rendering such services; **but the policy may not require that the service be rendered by a particular hospital or person**. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. Nothing in this subsection (3) shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

215 ILCS 5/367(3) (emphasis added). *See also* 215 ILCS 5/357.10 (applicable to individual policies).[3] "'Person' includes an individual, aggregation of individuals, corporation, association and partnership." 215 ILCS 5/2(l). Limiting an insured to specific providers within a provider network, to preferred providers generally, or to in-network or out-of-network providers within a geographic area are forms of requiring services to be rendered by particular hospitals or persons and are therefore prohibited in a PPO product. Insureds who have a PPO policy must not be subjected to a closed network in which there are no insurance benefits outside the PPO network or outside the PPO network's geographic area. Non-network indemnity products are subject to 215 ILCS 5/357.10 and 5/367(3), as well, and therefore cannot limit insureds to providers within a geographic area.

Policy forms for a PPO or indemnity product containing such exclusions or limitations are in direct violation of Illinois Insurance Code for including "provisions which encourage misrepresentation or are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, contrary to law or to the public policy of this State, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy." *See* 215 ILCS 143(1). Issuers offering a PPO policy are required to provide indemnity benefits outside the issuer's preferred provider network, subject to higher cost sharing as explained in 215 ILCS 5/356z.3.

To the extent that a Point-of-Service Plan is an indemnity product layered on top of an HMO product, the indemnity coverage for a Point-of-Service Plan cannot contain restrictions that the Illinois Insurance Code prohibits for out-of-network coverage under a PPO.

[3] Section 357.10 describes the policy language as "at the option of the company," but only in the sense that Section 357.10 does not require insurers to reimburse providers directly. If the issuer does reimburse providers directly - whether voluntarily or when required by other laws - then the language in Section 357.10 language is mandatory, though the Director may approve slightly different phrasing that is no less favorable to the insured or beneficiary. *See* 215 ILCS 5/357.1.