

1 AN ACT concerning regulation.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the  
5 Transparency in Downcoding Act.

6 Section 2. Findings. The General Assembly finds that:

7 (1) Downcoding of medical claims, when done without  
8 clear justification or transparency, undermines fair  
9 payment of health care professionals and threatens the  
10 stability of medical practices.

11 (2) Improper downcoding may result in harm to patients  
12 by disincentivizing care for individuals with complex  
13 medical conditions.

14 (3) It is in the public interest to ensure that all  
15 coding adjustments are clinically supported, transparent,  
16 appealable, and free from discriminatory targeting.

17 Section 5. Definitions. As used in this Act:

18 "CARC" means Claim Adjustment Reason Codes, which provide  
19 the reason for a financial adjustment specific to a particular  
20 claim or service referenced in the transmitted Accredited  
21 Standards Committee (ASC) X12 835 standard transaction adopted  
22 by the United States Department of Health and Human Services

1 under 45 CFR 162.1602.

2 "Downcoding" means the unilateral alteration by a health  
3 care payor of the level of evaluation and management service  
4 code or other service code submitted on a claim, resulting in a  
5 lower payment. "Downcoding" does not include the practice of  
6 addressing instances when providers submit multiple codes for  
7 2 or more services that must be included in one group code  
8 pursuant to federal and State program integrity requirements.

9 "Excepted benefits" has the meaning given to that term in  
10 42 U.S.C. 300gg-91(c) and implementing regulations.

11 "Group health plan" has the meaning given to that term in  
12 Section 5 of the Illinois Health Insurance Portability and  
13 Accountability Act.

14 "Group health plan sponsor" means the plan sponsor of a  
15 group health plan.

16 "Health care payor" means a group health plan sponsor,  
17 health insurance issuer, or Medicaid managed care  
18 organization.

19 "Health care professional" means a physician licensed to  
20 practice medicine in all its branches under the Medical  
21 Practice Act of 1987, a physician assistant licensed under the  
22 Physician Assistant Practice Act of 1987, or an advanced  
23 practice registered nurse licensed under the Nurse Practice  
24 Act.

25 "Health insurance issuer" has the meaning given to that  
26 term in Section 5 of the Illinois Health Insurance Portability

1 and Accountability Act.

2 "Medicaid managed care organization" has the meaning given  
3 to the term "managed care organization" in Section 5H-1 of the  
4 Illinois Public Aid Code.

5 "Plan sponsor" has the meaning given to that term in 29  
6 U.S.C. 1002(16) (B).

7 "RARC" means Remittance Advice Remark Codes, which provide  
8 supplemental information about a financial adjustment  
9 indicated by a CARC or information about remittance  
10 processing.

11 Section 10. Applicability; scope.

12 (a) This Act applies to the following if they are issued,  
13 amended, delivered, or renewed on or after the effective date  
14 of this Act:

15 (1) a policy or contract for health insurance coverage  
16 as defined in the Illinois Health Insurance Portability  
17 and Accountability Act;

18 (2) State, employee, county, municipality, or school  
19 district group health plans; and

20 (3) subject to federal law, rules, regulations, and  
21 guidance, policies issued or delivered in this State to  
22 the Department of Healthcare and Family Services and  
23 providing coverage to persons who are enrolled under  
24 Article V of the Illinois Public Aid Code or under the  
25 Children's Health Insurance Program Act. This Act does not

1           diminish the ability of the Department of Healthcare and  
2           Family Services' Office of the Inspector General to  
3           prevent, detect, and eliminate fraud, waste, abuse,  
4           mismanagement, and misconduct.

5           This Act does not apply to employee or employer  
6           self-insured health benefit plans under the federal Employee  
7           Retirement Income Security Act of 1974 and health care  
8           provided pursuant to the Workers' Compensation Act or the  
9           Workers' Occupational Diseases Act, and excepted benefits,  
10          including stand-alone dental plans.

11          (b) This Act shall not diminish a health care payor's  
12          duties and responsibilities under other federal or State law  
13          or the rules adopted thereunder.

14          (c) This Act is not intended to alter or impede the  
15          provisions of any consent decree or judicial order to which  
16          the State or any of its agencies is a party.

17          (d) The regulation of downcoding of medical claims in  
18          policies issued, amended, delivered, or renewed on or after  
19          January 1, 2028 is an exclusive power and function of the  
20          State. A home rule unit may not regulate downcoding of medical  
21          claims in policies issued, amended, delivered, or renewed on  
22          or after January 1, 2028. All home rule units must comply with  
23          this Act. This subsection is a denial and limitation of home  
24          rule powers and functions under subsection (h) of Section 6 of  
25          Article VII of the Illinois Constitution.

1 Section 15. Prohibition of automatic downcoding.

2 (a) A health care payor shall not implement any policy or  
3 use any algorithm or other automated process, system, or tool  
4 that bypasses the evaluation of information included by the  
5 billing health care professional to downcode a claim.

6 (b) A health care payor may use an automated process to  
7 identify claims that may justify a downcoding determination  
8 following American Medical Association Current Procedural  
9 Terminology (CPT) coding guidelines in effect at the time of  
10 service. All downcoding determinations must be made or  
11 reviewed by a natural person following American Medical  
12 Association Current Procedural Terminology (CPT) coding  
13 guidelines in effect at the time, and the health care payor  
14 must maintain and implement policies and procedures requiring  
15 a natural person to consider information included by the  
16 billing health care professional on the claim submission in  
17 such determination.

18 Section 20. Prohibition on diagnosis-based downcoding. A  
19 health care payor shall not downcode a claim based solely on  
20 the reported diagnosis codes.

21 Section 25. Notification requirements for downcoded  
22 claims. When a claim is downcoded, the health care payor shall  
23 notify the billing health care professional using the  
24 appropriate CARCs and RARCs to clearly indicate that the claim

1 has been downcoded and provide:

2 (1) the specific reason for the downcoding, including  
3 reference to the clinical information and coding guidance  
4 used to justify the downcoding;

5 (2) the original and revised service codes and payment  
6 amounts; and

7 (3) the process to initiate a dispute for a downcoding  
8 decision.

9 Section 30. Dispute process for downcoded claims.

10 (a) A health care payor shall provide health care  
11 professionals with a clear and accessible process for  
12 disputing downcoded claims, including a written or electronic  
13 notice detailing how to initiate a dispute, contact  
14 information for the entity or department managing the dispute,  
15 reasonable timelines for submission by the billing health care  
16 professional of a dispute that are no less than 90 days, and  
17 timelines for adjudication of the dispute consistent with  
18 applicable State law or regulations governing utilization  
19 review.

20 (b) A health care payor must ensure that all downcoding  
21 disputes are reviewed by a natural person. The reviewing  
22 natural person must:

23 (1) be knowledgeable of, and have experience  
24 providing, the health care services under dispute;

25 (2) not have been directly involved in making the

1 decision to downcode the claim;

2 (3) perform a document review of the clinical  
3 information supporting the billed service, including, but  
4 not limited to, a review of all pertinent medical records  
5 provided to the health care payor and any medical  
6 literature provided to the health care payor from the  
7 billing health care professional; and

8 (4) follow American Medical Association Current  
9 Procedural Terminology (CPT) coding guidelines in effect  
10 at the time of service.

11 (c) Use of a dispute process for downcoded claims does not  
12 preclude the health care professional's or enrollee's right to  
13 appeal any adverse determination under applicable State and  
14 federal law, rules, or regulations governing utilization  
15 review.

16 Section 35. Protections for patients with chronic  
17 conditions. A health care payor shall not use downcoding  
18 practices in a targeted or discriminatory manner against  
19 health care professionals who routinely treat patients with  
20 complex or chronic conditions.

21 Section 40. Administration and enforcement.

22 (a) The Department of Insurance shall enforce the  
23 provisions of this Act pursuant to the enforcement powers  
24 granted to it by law, including, but not limited to, any powers

1 granted to enforce the Illinois Insurance Code. Such  
2 enforcement shall extend to health care payors' compliance  
3 with this Act's procedural requirements and restrictions,  
4 compliance with this Act's standards for personnel and  
5 automated processes, and any pattern or practice of violating  
6 Section 20 of this Act. Nothing in this Act shall authorize the  
7 Department of Insurance to conduct any process under which a  
8 health care provider may submit an appeal for the purpose of  
9 receiving a determination from the Department of Insurance  
10 that is binding on the health care payor and the billing health  
11 care professional about the correctness of any particular  
12 downcoding decision under applicable coding guidelines, but  
13 the Department of Insurance shall have the authority to use  
14 any of its powers, including, but not limited to, the  
15 investigation of complaints, to enforce subsection (b) of  
16 Section 15.

17 (b) A health care payor shall be responsible for the  
18 compliance with this Act by any third party to whom the health  
19 care payor delegates any functions related to downcoding.

20 (c) The Department of Healthcare and Family Services shall  
21 enforce the provisions of this Act, subject to federal laws,  
22 rules, regulations, and regulatory guidance, as it applies to  
23 all Medicaid managed care organizations serving persons  
24 enrolled under Article V of the Illinois Public Aid Code or  
25 under the Children's Health Insurance Program Act.

1           Section 500. The Illinois Public Aid Code is amended by  
2 adding Section 5-5.12g as follows:

3           (305 ILCS 5/5-5.12g new)

4           Sec. 5-5.12g. Compliance with the Transparency in  
5 Downcoding Act. Notwithstanding any other provision of law to  
6 the contrary, all managed care organizations shall comply with  
7 the requirements of the Transparency in Downcoding Act.

8           Section 997. Severability. The provisions of this Act are  
9 severable under Section 1.31 of the Statute on Statutes.

10           Section 999. Effective date. This Act takes effect January  
11 1, 2028.