Sen. David Koehler

Filed: 5/6/2026

AMENDMENT TO SENATE BILL 3114

AMENDMENT NO. _____. Amend Senate Bill 3114 by replacing everything after the enacting clause with the following:

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

Section 2. Findings. The General Assembly finds that:

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

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

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

Section 5. Definitions. As used in this Act:

"CARC" means Claim Adjustment Reason Codes, which provide the reason for a financial adjustment specific to a particular claim or service referenced in the transmitted Accredited Standards Committee (ASC) X12 835 standard transaction adopted by the United States Department of Health and Human Services under 45 CFR 162.1602.

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

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

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

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

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

"Health care professional" means a physician licensed to

practice medicine in all its branches under the Medical Practice Act of 1987, a physician assistant licensed under the Physician Assistant Practice Act of 1987, or an advanced practice registered nurse licensed under the Nurse Practice Act.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

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

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

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

Section 10. Applicability; scope.

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

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

(2) State, employee, county, municipality, or school

district group health plans; and

(3) subject to federal law, rules, regulations, and guidance, policies issued or delivered in this State to the Department of Healthcare and Family Services and providing coverage to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act. This Act does not diminish the ability of the Department of Healthcare and Family Services' Office of the Inspector General to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct.

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

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

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

(d) The regulation of downcoding of medical claims in policies issued, amended, delivered, or renewed on or after January 1, 2028 is an exclusive power and function of the

State. A home rule unit may not regulate downcoding of medical claims in policies issued, amended, delivered, or renewed on or after January 1, 2028. All home rule units must comply with this Act. This subsection is a denial and limitation of home rule powers and functions under subsection (h) of Section 6 of Article VII of the Illinois Constitution.

Section 15. Prohibition of automatic downcoding.

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

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

Section 20. Prohibition on diagnosis-based downcoding. A

health care payor shall not downcode a claim based solely on the reported diagnosis codes.

Section 25. Notification requirements for downcoded claims. When a claim is downcoded, the health care payor shall notify the billing health care professional using the appropriate CARCs and RARCs to clearly indicate that the claim has been downcoded and provide:

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

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

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

Section 30. Dispute process for downcoded claims.

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

review.

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

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

(2) not have been directly involved in making the decision to downcode the claim;

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

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

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

Section 35. Protections for patients with chronic conditions. A health care payor shall not use downcoding practices in a targeted or discriminatory manner against

health care professionals who routinely treat patients with complex or chronic conditions.

Section 40. Administration and enforcement.

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

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

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

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

(305 ILCS 5/5-5.12g new)

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

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

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