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HOUSE BILL NO. 184

Offered January 14, 2026

Prefiled January 7, 2026

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.15:9, relating to health carrier contracts; site-neutral payment policy for applicable services; annual report; civil penalty.

Patron—Helmer

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3407.15:9 as follows:

§ 38.2-3407.15:9. Carrier contracts; site-neutral payment policy for applicable services; annual report; civil penalty.

A. As used in this section:

"Applicable services" means outpatient or ambulatory items or services that can be provided safely and appropriately across ambulatory care settings, including (i) the services, as identified by Current Procedural Terminology or Healthcare Common Procedure Coding System codes, contained within the ambulatory payment classifications identified by the Medicare Payment Advisory Commission's June 2023 report recommending a site-neutral payment policy and any ambulatory payment classifications or services subsequently designated; (ii) any outpatient or ambulatory item or service recommended or required to be paid on a site-neutral basis by federal or state statute, the U.S. Department of Health and Human Services, or the Medicare Payment Advisory Commission, including evaluation and management office visits, wellness visits, physical therapy, occupational therapy, speech language pathology, and both screening and diagnostic mammography; and (iii) any other outpatient or ambulatory items or services as designated by the Medicare Payment Advisory Commission as safe and appropriate to be provided in lower-cost settings.

"Carrier," "health plan," and "provider contract" have the same meanings as provided in subsection A of § 38.2-3407.15.

"Health system" means (i) a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership, or other means or (ii) a hospital and any entity affiliated with such hospital through ownership, governance, membership, or other means. "Health system" includes any facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided, including an outpatient department of a hospital.

"Medicare non-hospital rate" means the amount paid by Medicare for the same services pursuant to the Medicare Physician Fee Schedule, set forth in 42 U.S.C. § 1395w-4, or the Ambulatory Surgical Center Payment System, set forth in 42 U.S.C. § 1395l(i)(2)(D), according to the site of service recommended by the Medicare Payment Advisory Commission as a reference rate where applicable.

"Participating provider" means a provider under contract with a carrier who has agreed under such contract to provide health care services to the health plan's beneficiaries with an expectation of receiving payment, other than coinsurance, copayments, or deductibles from any beneficiary of the health plan, only from the carrier under the terms of the contract.

"Site-neutral payment policy" means a policy of reimbursing health care providers the same amount for a substantially similar service, regardless of the site or setting of the service.

B. Any provider that enters into a provider contract with a carrier to be a participating provider under a health plan shall accept as payment in full for all applicable services rates that shall not exceed 150 percent of the amount paid as the Medicare non-hospital rate for the same services.

1. No participating provider shall charge, bill, or accept payment for any applicable services that exceeds the lesser of (i) 150 percent of the amount paid by the Medicare non-hospital rate or (ii) the negotiated rate agreed upon by the provider and carrier.

2. No participating provider shall charge, bill, collect, or otherwise demand payment for any applicable services on an institutional claim form, such as a UB-04 or CMS-1450. A professional claim form, such as a CMS-1500 or successor form, shall be used exclusively to bill for any applicable service. In no circumstances should both a professional claim and institutional claim be charged or billed for the same service. The provisions of this subdivision apply to billing for all individuals and carriers that reimburse for applicable services under a provider contract, including self-pay individuals and health plans that do not have an existing contract with the provider.

3. No beneficiary of a health plan or self-pay individual shall be liable to a provider for any amounts in excess of the rates set forth in this subsection or for claims, charges, or bills prohibited by this subsection, including any copayments, deductibles, or coinsurance for any portion of such prohibited rates.

C. No provider shall enter into a provider contract that contains provisions to reimburse the provider for any applicable services in excess of the rates set forth in subsection B. No carrier shall enter into a provider contract for or reimburse a provider for any applicable services in amounts in excess of the rates set forth in subsection B or for claims, charges, or bills prohibited by subsection B. Any provider contract provisions that violate this subsection shall be void, unenforceable, and subject to penalties as provided under subsection G.

D. The Commission, in consultation with the Department of Health, shall collect and compile all available and relevant hospital, health system, and payer-reported data, including data submitted to the All-Payer Claims Database created under § 32.1-276.7:1 and other publicly available data sources on pricing and utilization of the applicable services provided by health care providers. Beginning on July 1, 2027, and annually thereafter, the Commission shall submit a report to the Governor and General Assembly on trends, stratified by site of service, in (i) prices relative to Medicare's non-hospital rates, allowed amounts, and patient cost-sharing for applicable services; (ii) volumes of applicable services; (iii) total spending for applicable services; (iv) price variation for applicable services; and (v) effects on total commercial health care prices, spending, and patient cost-sharing in the Commonwealth on non-applicable services. The report shall also include a detailed analysis of such metrics for the largest health systems in the Commonwealth, separated by payer and all providers within the health system. The report shall also include any instances of noncompliance and actions taken by the Commission and an estimate of savings for payers and consumers compared with rates charged for applicable services in the contract year 2025, accounting for inflation. The Commission is authorized to request additional data reports from providers annually as needed to efficiently and fully report on pricing and utilization trends of applicable services.

E. The Commission shall publish the report submitted under subsection D on a publicly accessible website with average rates for applicable services charged, billed, and allowed during the preceding calendar year and the average percent of Medicare non-hospital rate paid per service, separated by site of service, provider, and contract. Any providers with prices above the cap shall be listed on such website.

F. Each carrier shall submit an annual report to the Commission detailing rates for applicable services agreed to, paid, or allowed during the preceding calendar year, separated by site of service and contract, in a form and manner as specified by the Commission.

G. A provider that violates any provision of this section shall be subject to a civil penalty in an amount of the greater of $1,000 per claim improperly billed or a minimum civil penalty of $100,000 per contract occurrence.

2. That the provisions of this act shall apply to contracts entered into, amended, or renewed on or after July 1, 2026.