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INTRODUCED

HB484

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4 **HOUSE BILL NO. 484**
5 Offered January 14, 2026
6 Prefiled January 12, 2026
7 *A BILL to amend and reenact § 38.2-3407.15 of the Code of Virginia, relating to health insurance; ethics and*
8 *fairness in carrier business practices; downcoded claims.*

9 Patron—Shin

10 Committee Referral Pending

11 **Be it enacted by the General Assembly of Virginia:**

12 **1. That § 38.2-3407.15 of the Code of Virginia is amended and reenacted as follows:**
13 **§ 38.2-3407.15. Ethics and fairness in carrier business practices.**

14 A. As used in this section:

15 "Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a
16 "carrier" shall also include any person required to be licensed under this title which offers or operates a
17 managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges
18 for the provision of health care services, health plans, networks or provider panels which are subject to
19 regulation as the business of insurance under this title.

20 "Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a
21 carrier (or its intermediary, administrator or representative) with which the provider has a provider contract
22 for payment for health care services under any health plan; however, a "claim" shall not include a request for
23 payment of a capitation or a withhold.

24 "Clean claim" means a claim that does all of the following:

25 1. Identifies the provider that provided the service with industry-standard identification criteria, including
26 billing and rendering provider names, identification numbers, and address;

27 2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient
28 was an enrollee at the time of service;

29 3. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if
30 applicable, a methodology required under the provider contract. The claim shall include a complete listing of
31 all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;

32 4. Specifies the date and place of service;

33 5. If prior authorization is required for the services listed in the claim, contains verification that prior
34 authorization was obtained in accordance with the provider contract for those services; and

35 6. Includes additional documentation specific to the services rendered as required by the carrier in its
36 provider contract.

37 Notwithstanding the above criteria, a claim shall be considered a clean claim if a carrier has failed timely
38 to notify the person submitting the claim of any defect or impropriety in accordance with this section.

39 "*Downcode*" means the use of a different procedure or service code than the code originally submitted in
40 a claim that reduces the amount the carrier is required to pay.

41 "Health care services" means items or services furnished to any individual for the purpose of preventing,
42 alleviating, curing, or healing human illness, injury or physical disability.

43 "Health plan" means any individual or group health care plan, subscription contract, evidence of coverage,
44 certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or
45 certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement,
46 and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health
47 care services, which is subject to state regulation and which is required to be offered, arranged or issued in
48 the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued
49 pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the
50 Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. §
51 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE);
52 or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement,
53 Medicare supplement, or workers' compensation coverages.

54 "Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider
55 panel, intermediary or representative) relating to the provision of health care services.

56 "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a
57 carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other
58 payments currently owed to the provider, by withholding or setting off against future payments, or in any
59 other manner reducing or affecting the future claim payments to the provider.

59 B. Every provider contract entered into by a carrier shall contain specific provisions which shall require
60 the carrier to adhere to and comply with the following minimum fair business standards in the processing and
61 payment of claims for health care services:

62 1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the
63 carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific
64 information available for review by the person submitting the claim that:

65 a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or
66 dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a
67 person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of
68 the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which
69 services were accessed or provided; or

70 b. The claim was submitted fraudulently.

71 Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person
72 submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any
73 other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic
74 or facsimile confirmation of receipt of a claim.

75 2. A carrier shall, within 30 days after receipt of a claim, notify the person submitting the claim of any
76 defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the
77 information that will be required to process and pay the claim. Upon receipt of the additional information
78 necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in
79 compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant
80 to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the
81 person submitting the claim of the matters identified above unless such failure was caused in material part by
82 the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a
83 retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive
84 denial of payment of the claim would violate subdivision 8. Beginning no later than January 1, 2026, all
85 notifications and information required under this subdivision shall be delivered electronically.

86 3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider
87 contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without
88 necessity of demand, at the time the claim is paid or within 60 days thereafter.

89 4. A carrier shall notify the provider in the provider contract if the carrier, or entity completing a
90 transaction on behalf of the carrier, uses a payment method that imposes a transaction or processing fee or
91 similar charge on the provider, and shall offer the provider an alternative payment method in which the
92 carrier, or entity completing a transaction on behalf of the carrier, does not impose such a fee or similar
93 charge. If the provider elects to accept the alternative payment method and has provided all required
94 information to the carrier to enroll in such alternative method, the carrier shall pay the claim using such
95 alternative payment method.

96 5. a. Every carrier shall establish and implement reasonable policies to permit any provider with which
97 there is a provider contract (i) to confirm in advance during normal business hours by free telephone or
98 electronic means if available whether the health care services to be provided are medically necessary and a
99 covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of
100 health care services which the provider has contracted to deliver under the provider contract) for (a) pre-
101 certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or
102 authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific
103 payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of
104 claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet
105 the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a
106 carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall
107 clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its
108 provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably
109 expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2)
110 disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to
111 request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that
112 provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf
113 of a provider, a carrier shall provide the requesting provider with such policies within 10 business days
114 following the date the request is received.

115 b. *No carrier or intermediary, administrator, or representative of a carrier shall downcode a claim unless
116 the decision to downcode is reviewed by a licensed physician, advanced practice registered nurse, or
117 physician assistant. Any carrier, intermediary, administrator, or representative that downcodes a claim shall
118 notify the person submitting the claim that such claim has been downcoded and shall describe the reason for
119 the decision to downcode and the process to appeal such decision. Every carrier shall establish a process for
120 the appeal of downcoded claims, including a notice describing how to initiate an appeal, contact information*

121 for the individual managing the appeal, reasonable timelines for the submission of an appeal that are no less
 122 than 180 days after receipt of notice of the downcoded claim, and reasonable timelines for adjudication of
 123 the appeal. A person submitting more than one claim that is downcoded by a carrier, intermediary,
 124 administrator, or representative may appeal in batches of similar claims without restriction.

125 c. Every carrier shall make available to such providers within 10 business days of receipt of a request,
 126 copies of or reasonable electronic access to all such policies which are applicable to the particular provider or
 127 to particular health care services identified by the provider. In the event the provision of the entire policy
 128 would violate any applicable copyright law, the carrier may instead comply with this subsection by timely
 129 delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care
 130 services identified by the provider.

131 6. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has
 132 advised the provider or enrollee in advance of the provision of health care services that the health care
 133 services are medically necessary and a covered benefit, unless:

134 a. The documentation for the claim provided by the person submitting the claim clearly fails to support the
 135 claim as originally authorized;

136 b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has
 137 already been paid for the health care services identified on the claim, (iii) the claim was submitted
 138 fraudulently or the authorization was based in whole or material part on erroneous information provided to
 139 the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the
 140 health care services was not eligible to receive them on the date of service and the carrier did not know, and
 141 with the exercise of reasonable care could not have known, of the person's eligibility status; or

142 c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

143 7. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care
 144 service as medically necessary and during the procedure the health care provider discovers clinical evidence
 145 prompting the provider to perform a less or more extensive or complicated procedure than was previously
 146 authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not
 147 investigative in nature, but medically necessary as a covered service under the covered person's benefit plan;
 148 (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's
 149 post-service claims process, including required timing for submission to carrier.

150 8. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek
 151 recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or
 152 claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has
 153 provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was
 154 submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid
 155 for the health care services identified on the claim or the health care services identified on the claim were not
 156 delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original
 157 challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a
 158 carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future
 159 payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall
 160 notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously
 161 paid claim.

162 Beginning no later than January 1, 2026, all written communications, explanations, notifications, and
 163 related provider responses applicable to this subdivision shall be delivered electronically. The electronic
 164 method and location for delivery shall be agreed upon by the carrier and provider and included in the
 165 provider contract.

166 9. No provider contract shall fail to include or attach at the time it is presented to the provider for
 167 execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be
 168 calculated and paid that is applicable to the provider or to the range of health care services reasonably
 169 expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules,
 170 and exhibits thereto and any policies (including those referred to in subdivision 5) applicable to the provider
 171 or to the range of health care services reasonably expected to be delivered by that type of provider under the
 172 provider contract.

173 10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new
 174 addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services
 175 reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the
 176 provider has been provided with the applicable portion of the proposed amendment (or of the proposed new
 177 addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has
 178 failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention
 179 to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

180 11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10
 181 would violate any applicable copyright law, the carrier may instead comply with this section by providing a
 182 clear, written explanation of the policy as it applies to the provider.

183 12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this
184 information available to providers. If a carrier's claim denial is overturned following completion of a dispute
185 review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such
186 decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the
187 payments due.

188 13. Every carrier shall include in its provider contracts a provision that prohibits a provider from
189 discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a
190 potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a
191 health care provider to treat an enrollee who has threatened to make or has made a professional liability claim
192 against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a
193 complaint with a regulatory agency or board against the provider or the provider's employer, agents, or
194 employees.

195 14. Beginning July 1, 2025, every carrier shall make available through electronic means a way for
196 providers to determine whether an enrollee is covered by a health plan that is subject to the Commission's
197 jurisdiction.

198 C. A provider shall not file a complaint with the Commission for failure to pay claims in accordance with
199 subdivision B 1 unless:

200 1. Such provider has made a reasonable effort to confer with the carrier in order to resolve the issues
201 related to all claims that are under dispute. Any request to confer shall be made to the contact listed for such
202 purpose in the provider contract and shall include supporting documentation sufficient for the carrier to
203 identify the claims in question; and

204 2. At least 30 calendar days have passed from the date of the request provided that the carrier has been
205 responsive to the provider's request to confer. However, if in the judgment of the provider, the carrier has not
206 been responsive to such request, the provider shall not be required to wait at least 30 calendar days to file the
207 complaint.

208 The provider shall attest in any such complaint that it has satisfied the provisions of this subsection.

209 D. If the Commission has cause to believe that any provider has engaged in a pattern of potential
210 violations of subdivision B 13, with no corrective action, the Commission may submit information to the
211 Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may
212 provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why
213 the actions in question were not violations. If any provider has engaged in a pattern of potential violations of
214 subdivision B 13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy
215 a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon
216 completion of its review of any potential violation submitted by the Commission or initiated directly by an
217 enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of
218 the review, including where the violation was substantiated, and any enforcement action taken as a result of a
219 finding of a substantiated violation.

220 E. Without limiting the foregoing, in the processing of any payment of claims for health care services
221 rendered by providers under provider contracts and in performing under its provider contracts, every carrier
222 subject to regulation by this title shall adhere to and comply with the minimum fair business standards
223 required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has
224 violated the standards set forth in subsection B by failing to include the requisite provisions in its provider
225 contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair
226 business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

227 F. No carrier shall be in violation of this section if its failure to comply with this section is caused in
228 material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to
229 matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power
230 outages) which are not caused in material part by the carrier.

231 G. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of
232 any provider contract provision required by this section shall be entitled to initiate an action to recover actual
233 damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and
234 willful conduct, it may increase damages to an amount not exceeding three times the actual damages
235 sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded,
236 such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is
237 paid or processed in violation of this section or with respect to which a violation of this section exists shall
238 constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this
239 subsection.

240 H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the
241 employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize
242 any provider, for invoking any of the provider's rights under this section or under the provider contract.

243 I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers shall

244 deliver provider contracts, related amendments, and notices exclusively to providers in an electronic format
245 other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit provider
246 contracts, amendments, and notices to carriers exclusively in an electronic format other than electronic
247 facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider
248 and included in the provider contract.

249 J. This section shall apply only to carriers subject to regulation under this title and shall apply to the
250 carrier and provider, regardless of any vendors, subcontractors, or other entities that have been contracted by
251 the carrier or the provider to perform duties applicable to this section.

252 K. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and
253 regulations as it may deem necessary to implement this section.

254 L. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this
255 section.