62J.812 PRIMARY CARE PRICE TRANSPARENCY.

(a) Each provider shall maintain a list of the services over $25 that correspond with the provider's 25 most frequently billed current procedural terminology (CPT) codes, including the provider's ten most commonly billed evaluation and management codes, and of the ten most frequently billed CPT codes for preventive services. If the provider is associated with a health care system, the health care system may develop the list of services required under this paragraph for the providers within the health care system.

(b) For each service listed in paragraph (a), the provider shall disclose the provider's charge, the average reimbursement rate received for the service from the provider's health plan payers in the commercial insurance market, and, if applicable, the Medicare allowable payment rate and the medical assistance fee-for-service payment rate. For purposes of this paragraph, "provider's charge" means the dollar amount the provider charges to a patient who has received the service and who is not covered by private or public health care coverage.

(c) The list described in this subdivision must be updated annually and must be posted in the provider's reception area of the clinic or office and made available on the provider's website, if the provider maintains a website.

(d) For purposes of this subdivision, "provider" means a primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this section.

History: *2018 c 168 s 2*
NOTE: This section, as added by Laws 2018, chapter 168, section 2, is effective July 1, 2019. Laws 2018, chapter 168, section 2, the effective date.