

WHITE PAPER

FH[®] Healthcare Indicators and FH[®] Medical Price Index 2023

An Annual View of Place of Service Trends and Medical Pricing

A FAIR Health White Paper, March 30, 2023



Summary

This is the sixth annual edition of FH[®] Healthcare Indicators and FH[®] Medical Price Index, two measures developed by FAIR Health to provide clarity in a rapidly changing healthcare environment. Drawing on the independent nonprofit's national database of billions of privately insured healthcare claims—the largest in the country—these two measures apply different approaches to illuminate different aspects of the national healthcare sector, including, among other factors, trends in the place of service and billed charge and allowed amounts for professional services.

FH Healthcare Indicators analyze trends involving the place of service, or setting (e.g., office, inpatient hospital, retail clinic, urgent care center, telehealth, ambulatory surgery center [ASC] and emergency room [ER]), for healthcare in recent years. Focusing on alternative places of service—retail clinics, urgent care centers, telehealth and ASCs—as well as ERs, FH Healthcare Indicators evaluate changes in utilization, geographic and demographic factors, diagnoses, procedures and costs. In the new edition, all time frames shift forward one year from the previous edition. For example, if a chart last year showed usage trends from 2015 to 2020, this year's chart shows 2016 to 2021. Here are some of the key findings from the period ending in 2021:

- From 2020 to 2021, the second year of the COVID-19 pandemic, telehealth utilization declined 76 percent nationally. National telehealth utilization grew 5,017 percent nationally from 2016 to 2021, which was a high rate of growth due in large part to widespread limits on in-office services imposed at the start of the COVID-19 pandemic in 2020.¹
- Of all other places of service studied for changes in utilization from 2020 to 2021, utilization increased the most in retail clinics (51 percent). In that period, utilization increased 14 percent in urgent care centers and decreased 7 percent in ASCs and 15 percent in ERs.
- Among the alternative places of service studied (retail clinics, urgent care centers, telehealth and ASCs), as well as ERs, telehealth held the highest percentage of medical claim lines in 2021, with 3.7 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 1.8 percent for ERs, 1.5 percent for urgent care centers, 0.6 percent for ASCs and 0.1 percent for retail clinics. The remainder of the services were rendered in traditional places of service, such as physician offices.
- In 2021 as in previous years, more claim lines were submitted for females than males in most age groups in these alternative places of service and ERs.
- However, in some places of service, such as retail clinics, urgent care centers and ERs, the gap between males and females continued to narrow in some age groups. For example, whereas the female share in the 19-30 age range in retail clinics had been close to 70 percent in 2019, it was 64 percent in 2020 and 60 to 63 percent in 2021.
- In 2021, the five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines were (from greatest to least) Rhode Island, Maine, Arkansas, Connecticut and Georgia. Minnesota fell off the list after having ranked first in 2018, third in 2019 and fifth in 2020.
- In 2021, COVID-19 joined the list of most common diagnostic categories in retail clinics, urgent care centers, telehealth and ERs (for individuals over the age of 22).
- Across offices, urgent care centers and retail clinics in 2021, the highest median charge amount for CPT^{®2} 99203 (new patient outpatient visit, total time 30-44 minutes) was in urgent care

¹ Utilization in this study is a relative, normalized measure, not an absolute one. See Methodology section.

² CPT © 2022 American Medical Association (AMA). All rights reserved.

centers at \$240, while the median charge for offices was \$226; in 2020, offices had had the highest median charge for that code.

FH Medical Price Index tracks the weighted average growth in median procedure billed charges and median allowed amounts in six procedure categories. This report does not consider facility fees. The categories are:

- Professional evaluation and management (E&M; excluding E&Ms performed in a hospital setting);
- Hospital E&M (excluding E&Ms performed in a professional setting, such as typical office visits);
- Medicine (excluding E&Ms);
- Surgery (procedures for which the physician would bill);
- Pathology and laboratory (including both technical and professional components, e.g., both equipment and professional services); and
- Radiology (including both technical and professional components).

May 2012 is the base month, to which values in later periods are compared; therefore, FH Medical Price Index establishes a consistent point of reference that makes it easy to identify and compare shifts.

In the first edition, FH Medical Price Index presented an overview from May 2012 to May 2017, which was extended in the second edition to November 2018; in the third to November 2019; in the fourth to November 2020; and in the fifth to November 2021. In the new edition, the indices are extended to November 2022. Findings include the following, all for the period November 2021 to November 2022:

- Of the six procedure categories, hospital E&Ms had the greatest percent increase in charge amount index, six percent. The allowed amount index for hospital E&Ms increased three percent.
- Surgery and pathology and laboratory each had the greatest percent increase in allowed amount index, four percent. The charge amount index for surgery increased five percent, while the charge amount index for pathology and laboratory increased four percent.
- Radiology was the only category to stay completely flat in charge amount index, at zero percent change. The allowed amount index for radiology grew two percent.
- Professional E&Ms had the smallest percent increase in allowed amount index, one percent. The charge amount index for professional E&Ms grew three percent.
- The medicine charge amount index increased two percent, while the medicine allowed amount index grew three percent.

Background

In a white paper published in March 2018, FAIR Health launched two new measures of healthcare information: FH[®] Healthcare Indicators and FH[®] Medical Price Index.³ Designed to provide clarity in a rapidly changing healthcare environment, these two measures for deriving insights from data elicited a welcome public response; stakeholders expressed appreciation for being offered this “macro” view into the nation’s healthcare system. From the start, the measures were intended to be released annually to

³ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index: A New View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, March 2018, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Medical%20Price%20Index%20and%20FH%20Healthcare%20Indicators--whitepaper.pdf>.

reflect ongoing changes. FAIR Health has since released the second,⁴ third,⁵ fourth⁶ and fifth⁷ annual editions, and this is the sixth.

Since the first edition, the healthcare sector has continued to evolve and grow more complex. Healthcare stakeholders continue to need information that will enable them to discern fundamental trends and patterns, and to make decisions on that basis. FH Healthcare Indicators and FH Medical Price Index are intended to serve all such constituents, including insurers and companies that self-insure, third-party administrators, hospitals and health systems, physicians and other individual providers, pharmaceutical and device manufacturers, federal and state government officials, legislators, policy makers, economists and academic researchers.

Both FH Healthcare Indicators and FH Medical Price Index use the same data source: FAIR Health's database of over 40 billion claim records, which is growing at a rate of over 2 billion claim records a year. The data are contributed by payors and administrators who insure or process claims for private insurance plans. A national, independent nonprofit organization, FAIR Health uses this repository—the nation's largest collection of private healthcare claims data—in furtherance of its mission of bringing transparency and integrity to healthcare costs and health insurance information.

Like previous releases, this year's edition of FH Healthcare Indicators and FH Medical Price Index is intended to assist healthcare stakeholders in a variety of ways. For example, health systems can use the information in budgeting and considering affiliations or market expansion; insurers in designing plan benefits and provider networks, informing reimbursement policies and setting premiums; government agencies and policy makers in framing public health campaigns and responses, framing legislation and/or evaluating the impact of existing legislative and regulatory initiatives; investors in researching the healthcare sector; and economists and researchers in seeking to track and evaluate important trends.

In this edition, as in previous editions, FH Healthcare Indicators and FH Medical Price Index each advance one year in the data they report: FH Healthcare Indicators to 2021 and FH Medical Price Index to 2022.

Methodology

FH Healthcare Indicators Methodology

To segregate FAIR Health claims data into venues of care, FAIR Health used standard Centers for Medicare & Medicaid Services (CMS) place of service codes to identify retail clinics (CMS place of service 17), urgent care centers (CMS place of service 20) and office (CMS place of service 11). Other

⁴ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index 2019: An Annual View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, April 2019, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202019%20-%20A%20FAIR%20Health%20White%20Paper.pdf>.

⁵ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index 2020: An Annual View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, March 2020, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202020--A%20FAIR%20Health%20White%20Paper.pdf>.

⁶ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index 2021: An Annual View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, March 31, 2021, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202021--A%20FAIR%20Health%20White%20Paper--FINAL.pdf>.

⁷ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index 2022: An Annual View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, March 31, 2022, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202022--A%20FAIR%20Health%20White%20Paper.pdf>.

methodologies were used to identify ERs (e.g., CMS place of service 23, bill type of 131 and/or an emergency department visit CPT code [CPTs 99281 through 99285]); telehealth (telehealth CPT codes such as CPT 99441, place of service 02 or telehealth modifiers such as GQ); and ASCs (bill type of 83* or CMS place of service 24).

The data were then aggregated by a variety of key fields, including state, urban/rural, diagnostic categories (e.g., urinary tract infection, ear infection, acute respiratory infection), year of service and patient demographics (age and gender), to identify trends and patterns in utilization and variation in cost. Diagnostic categories were consolidated from the International Classification of Diseases–Clinical Modification (ICD-CM) into clinically relevant groups to make them consumer-friendly. The data were evaluated with single and multiple variables to look for distinct trends and associations, which were then used to create graphical representations of the information.

In the graphical representations, the term “claim lines” refers to the individual procedures listed on insurance claims. A single claim for one patient may have multiple claim lines, with each line reflecting a separate procedure. To normalize the data and avoid fluctuations due to natural changes within plan data (e.g., the addition of a new plan contributor, the closing of a major employer and the loss of those members, or the addition of a major employer to a plan from which FAIR Health receives data, which would create a net influx of data from those members), FAIR Health calculates each data point as a percentage of the total number of medical claim lines for each year. When evaluating rural or urban data for a place of service, the denominator is all medical claim lines within that year and region. When evaluating total national data for a place of service, the entirety of medical claim lines for that year is the denominator. Once this claim line percentage is established, FAIR Health creates two separate types of trend charts.

“Percent of claim lines” is the percentage of all normalized claim line percentages as described above associated with a given grouping (e.g., a place of service) in a given time period in a particular chart. For example, in figure 1, which shows normalized claim line shares with retail clinic usage by rural, urban and national settings from 2016 to 2021, each year’s data point for national usage is the percentage share of all the normalized claim lines in the national usage grouping from 2016 to 2021. If one were to add up all the data points for national usage from all the years in this period, they would total 100 percent.

Other graphs present “percent of all medical claim lines.” In this case, the number of claim lines for the place of service being evaluated in a particular location (state, rural, urban or national) in a particular year is presented as a percentage of all claim lines within the FAIR Health database that are designated as medical claim lines (not including dental or pharmacy claim lines) in that location in that year. The rural/urban designation is based on where the patient was receiving care. For example, in figure 2, rural retail clinic claim lines in 2016 are shown as a percentage of all rural medical claim lines in that year.

FH Medical Price Index Methodology

FAIR Health used two of its benchmark products, FH[®] Medical and FH[®] Allowed Medical, to calculate, respectively, charge amounts and allowed amounts for FH Medical Price Index. For each procedure code, the benchmark products (modules containing cost data based on recent claims) include a median value, which is the dollar value used for all codes included in the indices. For the 2022 indices, 22 releases of the benchmark products were used to establish the price component of the indices: May and November of each year from 2012 to 2022. The total frequency across the entire time period for each procedure code within the selected categories (professional E&M, hospital E&M, medicine, surgery, pathology and laboratory, and radiology) was used to select codes for inclusion or exclusion. Each procedure code that had a total combined frequency of one million or more occurrences in the last 11 module releases on or before the date of the index was included in the indices. This allowed for natural

inclusion of new codes and eventual exclusion of deleted codes in a gradual and controlled manner so as not to create potentially misleading fluctuations.

Once the list of codes to be included in the 2022 indices was established, the median charge or allowed amount for each code from the most recent benchmark product release was used as the price and multiplied by the corresponding frequency for that code for the last 11 releases, producing the release code median total. Then, all release code median totals in a category were summed to get a total dollar value for each release in that category (the release median total). That release median total was divided by the total frequency to generate a release average median. Each index was then created by using the following index formula: dividing each release average median for each month and year by the first release average median established (May 2012, the base):

$$\frac{\text{Release Weighted Average of Median}_{\text{MONTH YEAR}}}{\text{Release Weighted Average of Median}_{\text{BASE}}} = \text{Index Value}_{\text{MONTH YEAR}}$$

The table below provides a sample calculation of how an FH Medical Price Index value is derived.

Table. Calculation of FH Medical Price Index for professional E&M charge amounts over a sample of the period May 2012-November 2022

Release	Release Median Total	Total Frequency	Release Median Total/Total Frequency = Release Average Median	Index Formula	FH Medical Price Index Value
May 2012	\$280,020,108,863	2,013,522,941	\$139.07 (base)	$\left(\frac{\$139.07}{\$139.07}\right)$	1.00
Nov 2022	\$612,641,712,418	2,955,137,821	\$207.31	$\left(\frac{\$207.31}{\$139.07}\right)$	1.49

Limitations

The data used in this report comprise claims data for privately insured patients who are covered by insurers and third-party administrators who voluntarily participate in FAIR Health’s data contribution program. Medicare Advantage (Medicare Part C) enrollees from contributing insurers are included, but not participants in Medicare Parts A, B and D.⁸ In addition, data from Medicaid, CHIP and other state and local government insurance programs are not included, nor are data collected regarding uninsured patients.

This is an observational report based on the data FAIR Health receives from private payors regarding care rendered to covered patients.

The report was not subject to peer review.

⁸ It should be noted that FAIR Health also receives data for traditional Medicare Parts A, B and D under the Centers for Medicare & Medicaid Services Qualified Entity Program, but those data are not a source for this report.

FH Healthcare Indicators

As in last year's report, FAIR Health studied four alternative places of service—retail clinics, urgent care centers, telehealth and ASCs—and compared them to more traditional venues of care, i.e., offices and ERs.

Retail Clinic

The normalized share of claim lines for retail clinics grew nationally 128 percent from 2016 to 2021 (figure 1), a faster pace of growth than that documented in last year's report (35.5 percent from 2015 to 2020).

From 2016 to 2021, more growth occurred in urban areas (111 percent) than in rural areas (17 percent). But from 2020 to 2021, the increase in the percentage share of retail clinic utilization was greater in rural areas (78 percent) than in urban areas (50 percent); nationally, the increase was 51 percent.

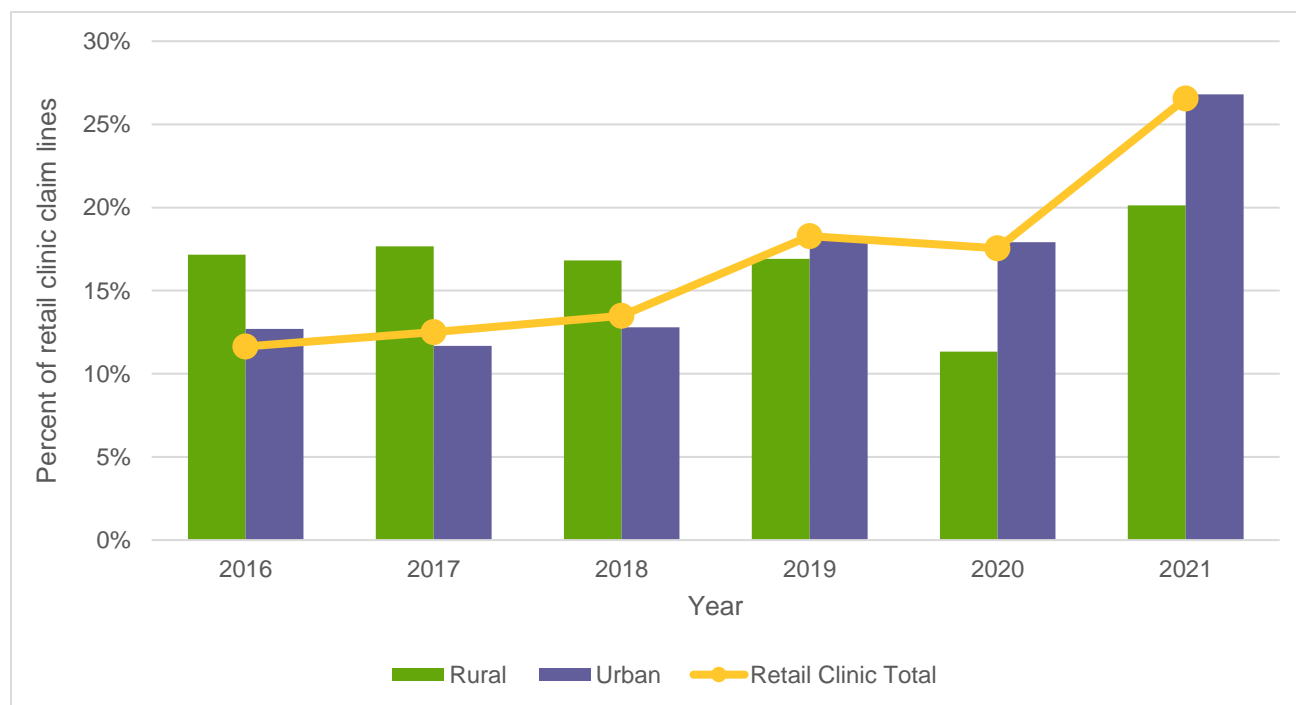


Figure 1. Percent of claim lines with retail clinic usage by rural, urban and national settings, 2016-2021

In figure 1 above, rural and urban retail clinic usage in 2016 is shown as a percentage of all rural and urban retail clinic usage, respectively, measured by claim lines, from 2016 to 2021. But in figure 2 below, rural and urban retail clinic usage in 2016 is shown as a percentage of all rural and urban normalized medical claim lines, respectively, in that year.

In rural, urban and national settings from 2016 to 2021, the percentage of all medical claim lines attributed to retail clinics was less than 0.1 percent, just as it had been from 2015 to 2020. As noted, relative use increased in urban areas 111 percent, from 0.035 percent in 2016 to 0.073 percent in 2021; use increased in rural areas 17 percent, from 0.044 percent in 2016 to 0.052 percent in 2021. In the nation as a whole, use increased 128 percent, from 0.031 percent in 2016 to 0.071 percent in 2021.



Figure 2. Claim lines with retail clinic usage as a percentage of all medical claim lines by rural, urban and national settings, 2016-2021

In the heat map below, states in which claim lines with retail clinic usage were a greater percentage of all medical claim lines than other states in 2021 are darker, while states with a lower percentage are lighter (figure 3). The five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines were (from greatest to least) Rhode Island, Maine, Arkansas, Connecticut and Georgia. Rhode Island rose from third place in 2020 to first place in 2021, while Maine climbed from fourth to second place. Minnesota fell off the list after having ranked first in 2018, third in 2019 and fifth in 2020.

The five states with the lowest retail clinic usage in 2021, in order from least to most, were Wyoming, Mississippi, South Dakota, Alabama and Utah. Wyoming, the state in last place in 2021, had been in second to last place in 2020, while Mississippi, in second to last place in 2021, had been in fourth from last place in 2020.

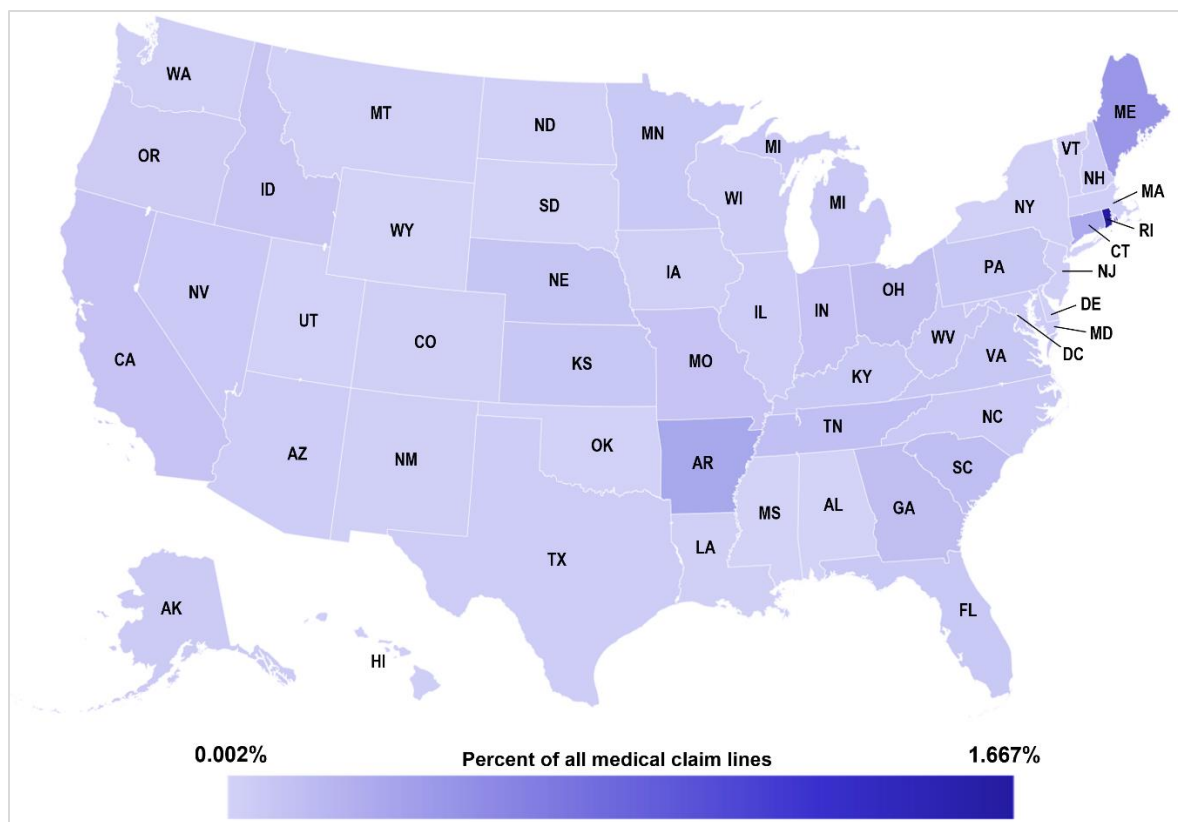


Figure 3. Percent of claim lines with retail clinic usage compared to all medical claim lines by state, 2021

The age distribution of retail clinic claim lines in 2021 (figure 4) was similar to that in 2020, but there were some changes. In 2020, the age groups 0-10, 11-18 and 19-22 each had accounted for less than 10 percent of the distribution, but in 2021 the age group 11-18 accounted for 11 percent. In 2021 as in 2020, individuals aged 31-40 had the greatest share of claim lines for retail clinics, but their share fell from 19 to 18 percent. In contrast, the age groups 41-50 and 51-60 each rose from 15 to approximately 16 percent.

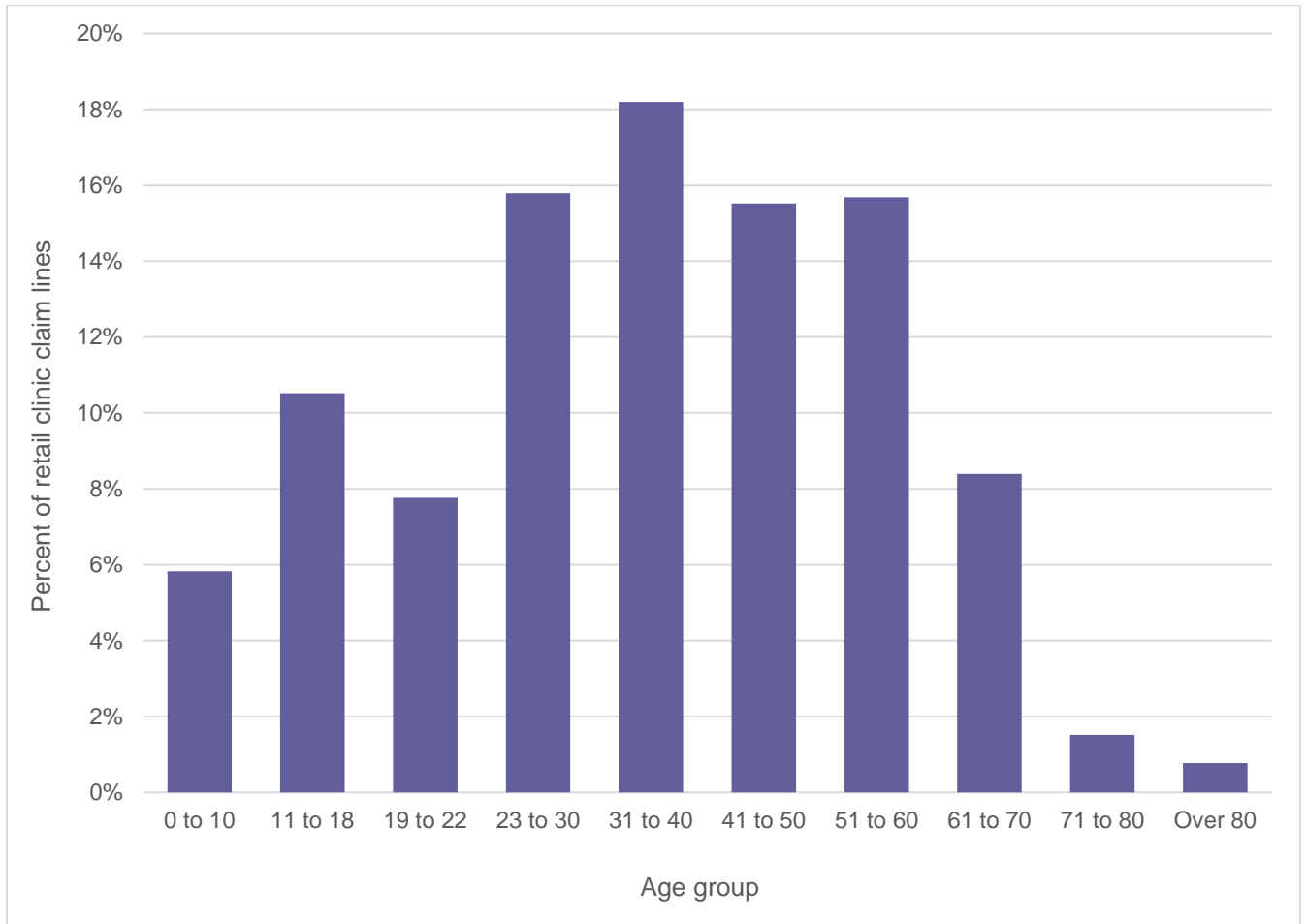


Figure 4. Percent of claim lines with retail clinic usage by age group, 2021

In 2021 as in previous years, more claim lines were submitted for women than for men in most age groups in alternative places of service and ERs. As noted in past editions, this is consistent with the findings of other researchers that women are more likely than men to visit physicians⁹ and make use of healthcare services.¹⁰

In 2021 as in 2020, the only age group in which retail clinic claim lines for males outnumbered those for females was that of children aged 0-10 (figure 5). In both years, males accounted for 51 percent of the distribution in that age group and females 49 percent. In other age groups, there was a general trend, begun in 2020, toward males using retail clinics more, even though females were still in the majority. For example, whereas the female share in the 19-30 age range had been close to 70 percent in 2019, it was 64 percent in 2020 and 60 to 63 percent in 2021. In the 31-60 age range, the female share was from 60 to 61 percent in 2020 and from 57 to 58 percent in 2021.

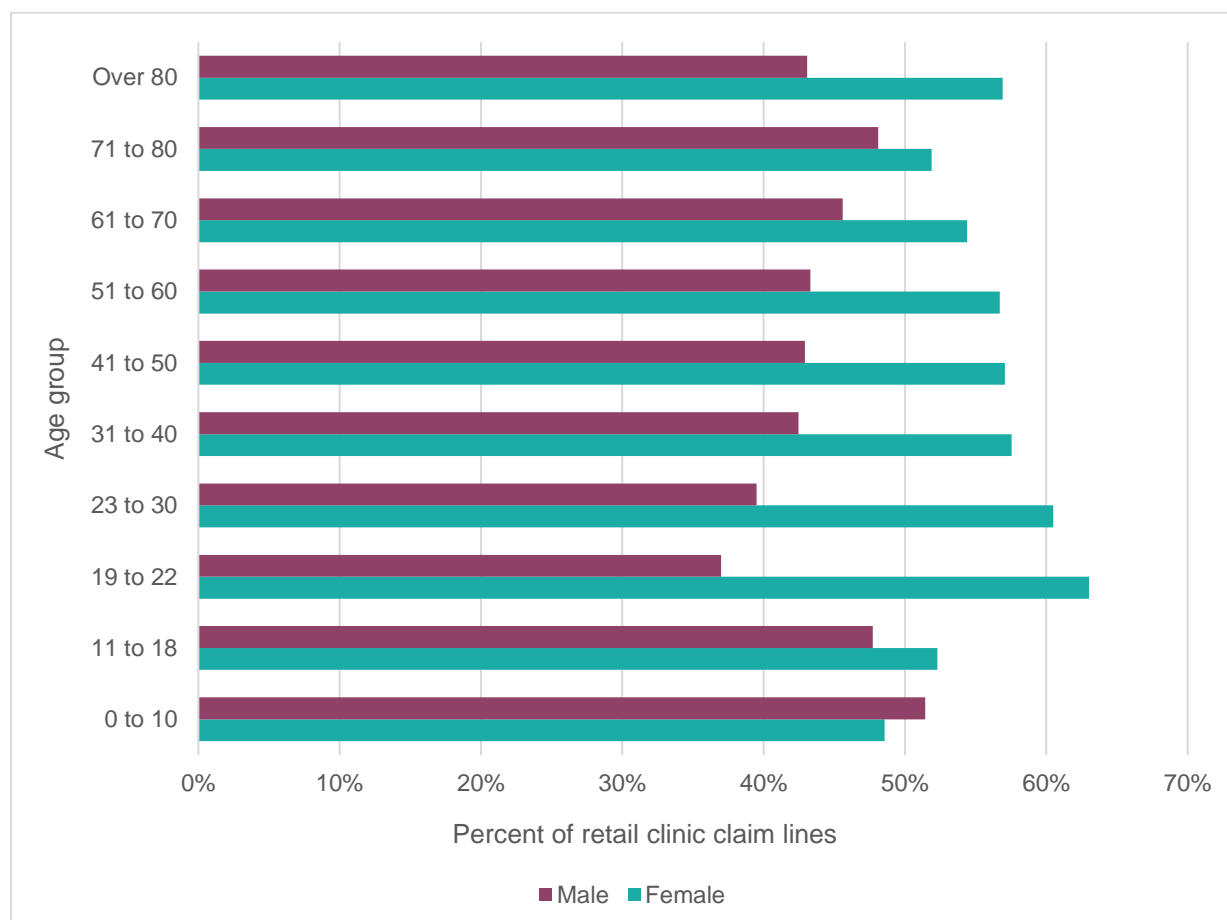


Figure 5. Percent of claim lines with retail clinic usage by age and gender, 2021

⁹ Jill J. Ashman, Esther Hing and Anjali Talwalkar, *Variation in Physician Office Visit Rates by Patient Characteristics and State, 2012*, NCHS Data Brief, no. 212 (Hyattsville, MD: National Center for Health Statistics, 2015), <https://www.cdc.gov/nchs/data/databriefs/db212.pdf>.

¹⁰ Klea D. Bertakis et al., "Gender Differences in the Utilization of Health Care Services," *Journal of Family Practice* 49, no. 2 (2000):147-52, <https://www.ncbi.nlm.nih.gov/pubmed/10718692>.

The most common diagnostic category in retail clinics in 2021, at 22 percent of the distribution, was exposure to communicable diseases, which had been in third place at 10 percent in 2020 (figure 6). Growth in this category was likely driven by patients seeking COVID-19 testing. As shown below in figure 8, COVID-19 tests and specimen collection were among the eight most common procedures in retail clinics in 2021. Acute respiratory diseases and infections, which had been in first place among diagnostic categories in retail clinics at 25 percent in 2020, fell to fourth place in 2021, accounting for 10 percent of the distribution. In 2021 as in 2020, encounter for immunization was the second largest diagnostic category, rising from 13 percent in 2020 to 17 percent in 2021. Encounter for examination, which had been in 10th place in 2020 at 2 percent, rose to third place in 2021, with 14 percent of the distribution. In 2021, COVID-19 appeared for the first time in the top 10 retail clinic diagnostic categories, in seventh place with three percent of the distribution.

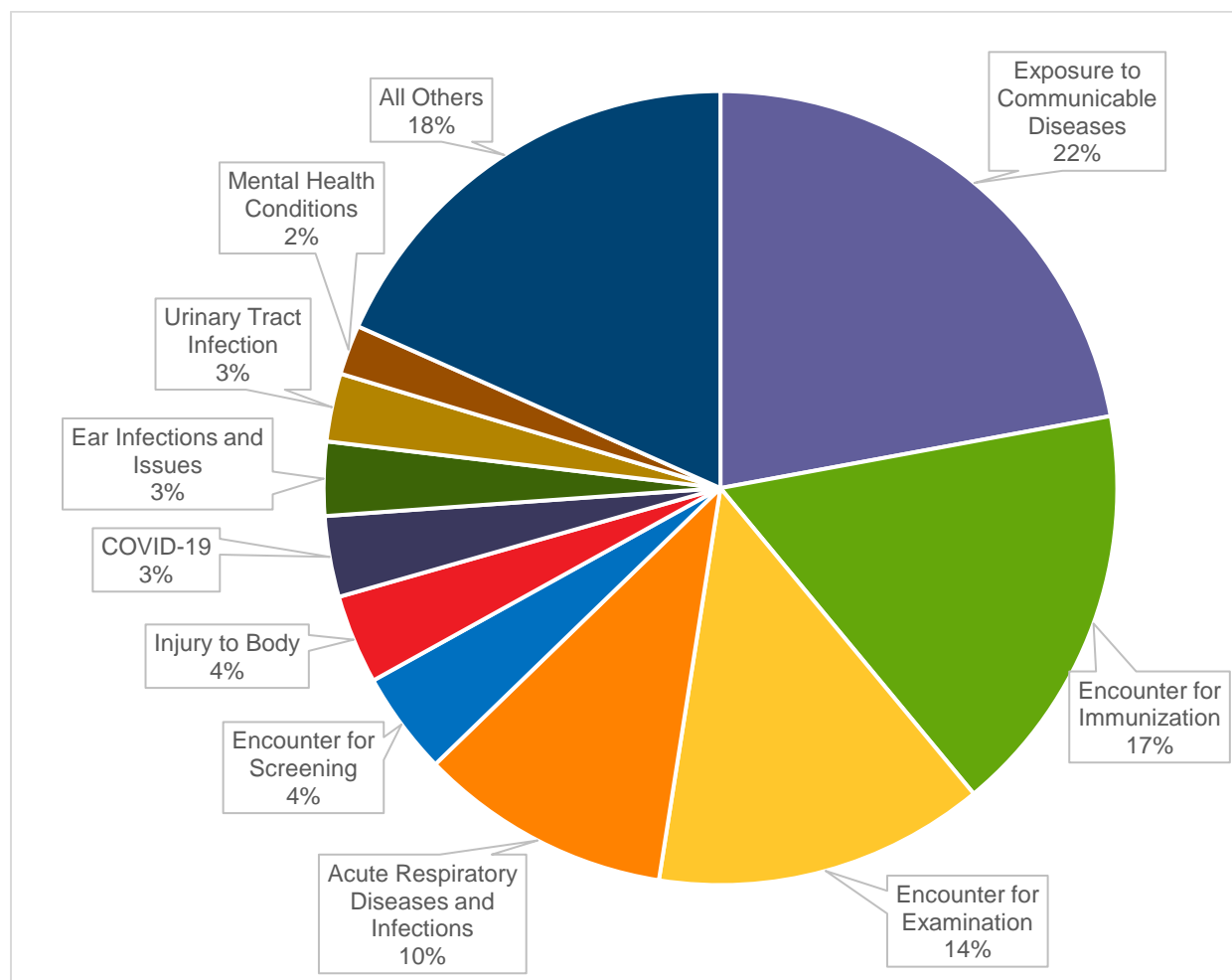


Figure 6. Distribution of claim lines with retail clinic usage by diagnostic category, 2021

As in previous years, the type of procedure most commonly performed in retail clinics in 2021 was established patient office or other outpatient services (figure 7). Its share of the distribution of retail clinic claim lines remained at 26 percent from 2020 to 2021. Immunization administration for vaccines/toxoids moved from third place in 2019 (16 percent) to second place in 2021 (19 percent).

Whereas in 2020 microbiology procedures and urinalysis procedures had been among the top procedure categories, in 2021, these categories fell from that group. Instead, infectious agent antigen detection joined the group in third place at 13 percent and COVID-19 specimen collection joined in fifth place at 6 percent. New patient office or other outpatient services fell from the fifth most common procedure at eight percent in 2020 to the seventh most common at five percent.

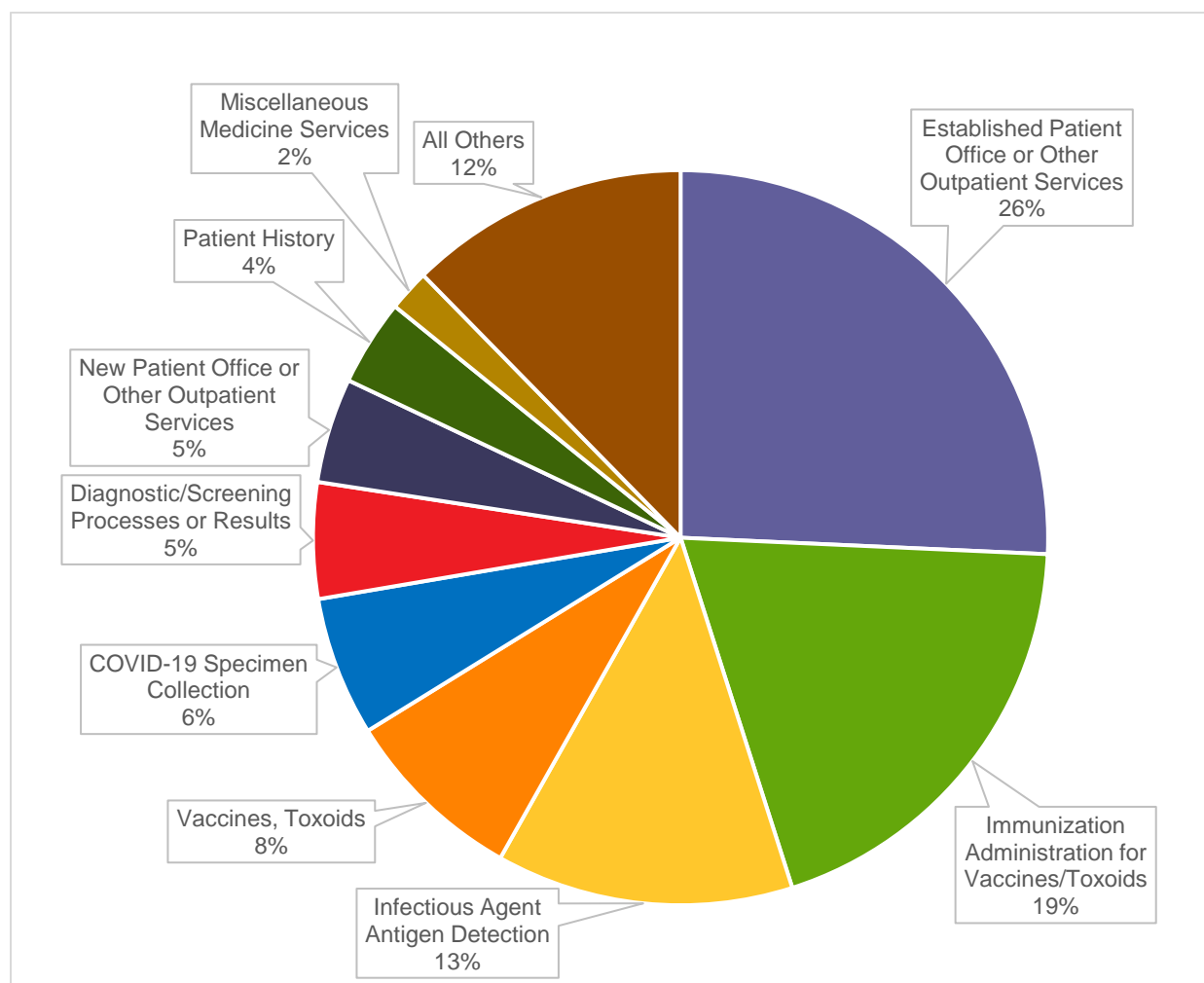
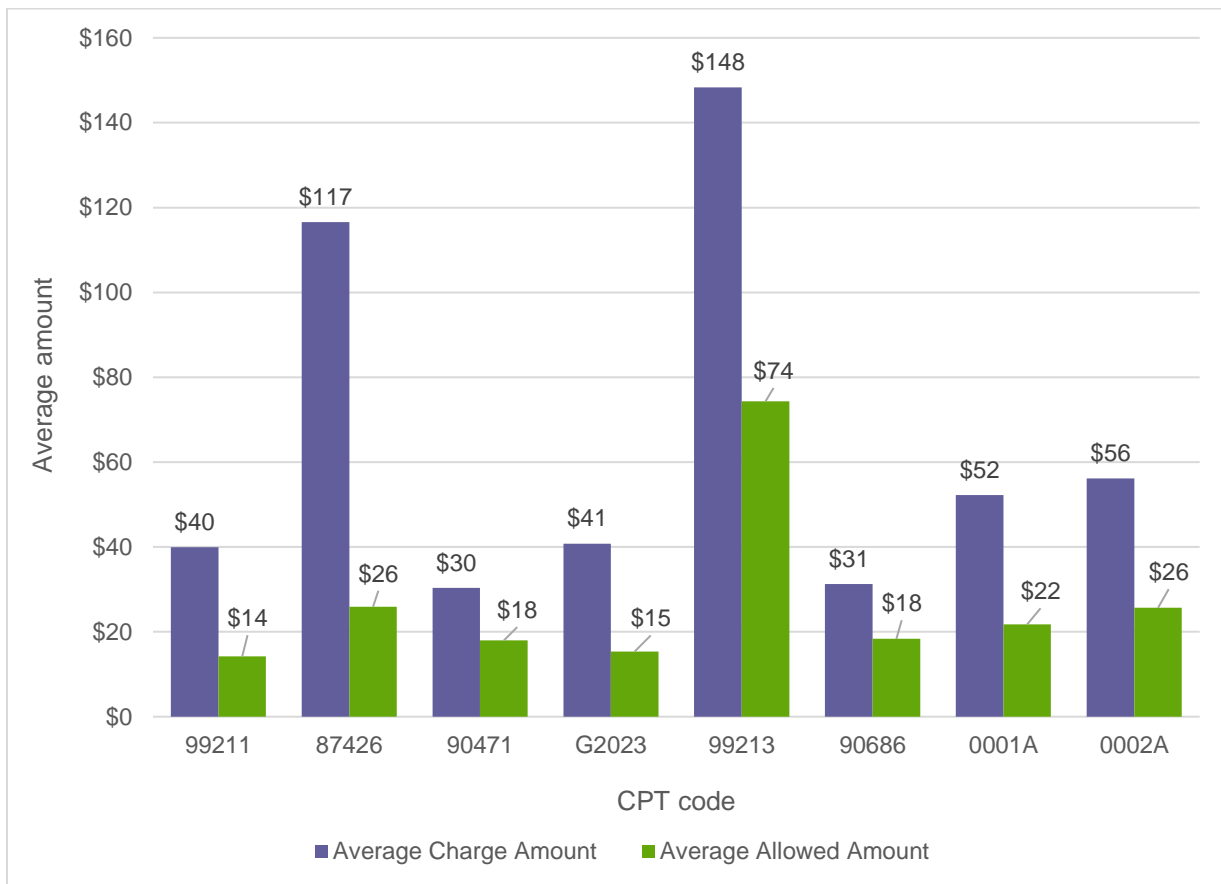


Figure 7. Distribution of claim lines with retail clinic usage by procedures, 2021

The average charges and allowed amounts for the most common procedures performed in retail clinics in 2021, as identified by CPT code, are shown in figure 8.



CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
99211	Established patient outpatient visit, minimal presenting problem	99213	Established patient outpatient visit, total time 20-29 minutes
87426	ELISA detection of severe acute respiratory syndrome coronavirus 2 (COVID-19) antigen	90686	Vaccine for influenza for administration into muscle, 0.5 ml dosage, quadrivalent, preservation free
90471	Administration of 1 vaccine	0001A	Intramuscular administration of single severe acute respiratory syndrome coronavirus 2 (COVID-19) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose
G2023	COVID-19 specimen collection	0002A	Intramuscular administration of single severe acute respiratory syndrome coronavirus 2 (COVID-19) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose

Figure 8. Average charges and average allowed amounts for the most common procedures performed in retail clinics, 2021

Five of the top eight codes by volume were new to the list in 2021 as compared to 2020. Of these, four were COVID-19-related: a test (CPT 87426), specimen collection (G2023) and vaccinations (CPT 0001A, CPT 0002A). A fifth new code designated the lowest level of an established patient outpatient visit (CPT 99211). As a result of the addition of these codes, five services dropped off the list, including several office outpatient visits and streptococcus and influenza tests. In 2021, CPT 99213 (established patient outpatient visit, 20-29 minutes) had the highest average charge (\$148) and allowed amount (\$74) of the top eight. The lowest average charge was \$30, for CPT 90471 (administration of one vaccine). The lowest average allowed amount was \$14 for CPT 99211.¹¹

Urgent Care

The normalized share of claim lines for urgent care centers grew overall 125 percent from 2012 to 2021 (figure 9). This was a lower increase than that from 2011 to 2020 (140 percent). The increase from 2012 to 2021 was 127 percent for urban areas and 123 percent for rural areas. There was an increase in normalized national utilization of 14 percent from 2020 to 2021; the increase was 15 percent in urban areas and 2 percent in rural areas.

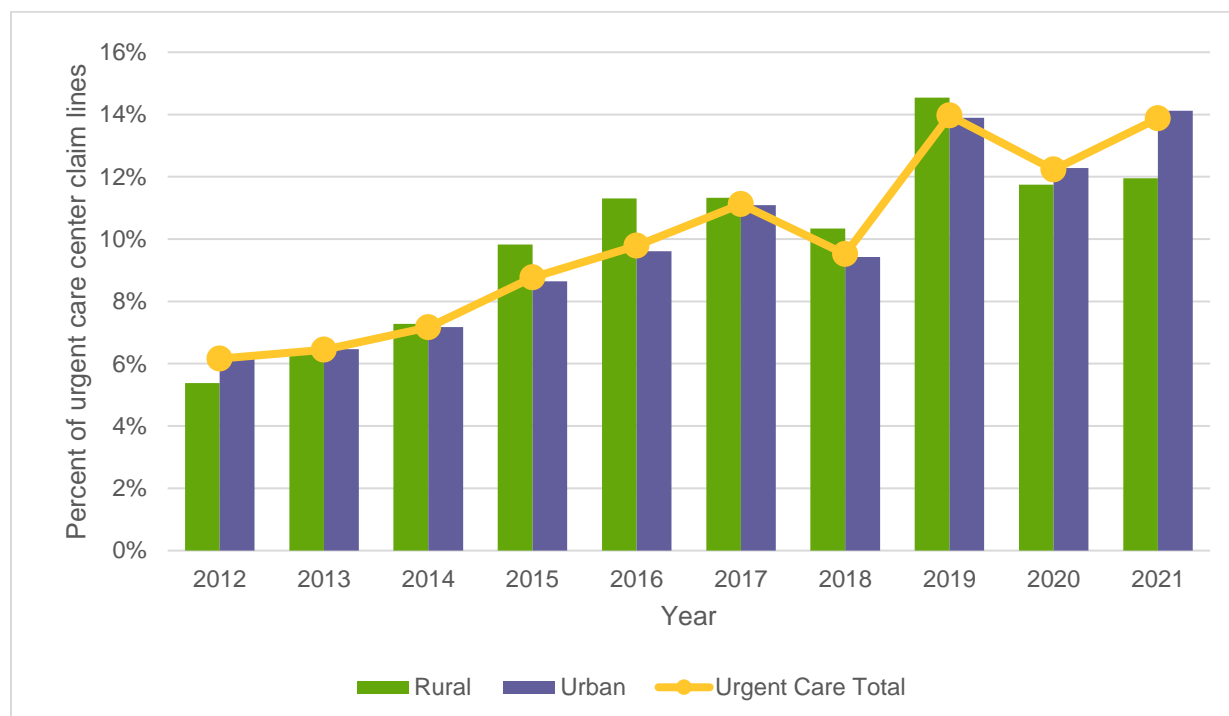


Figure 9. Percent of claim lines with urgent care center usage by rural, urban and national settings, 2012-2021

¹¹ Although certain charts in this paper report average charges and allowed amounts, actual charges and allowed amounts may vary greatly from the average.

Figure 10 presents claim lines with urgent care center usage as a percentage of all medical claim lines by rural, urban and national settings. In all three settings, the percentage of all medical claim lines attributed to urgent care centers exceeded one percent from 2016 to 2021.

From 2020 to 2021, nationally and in urban areas, urgent care usage as a percentage of medical claim lines rose from 1.3 percent to 1.5 percent, but in rural areas it remained the same at 1.3 percent.

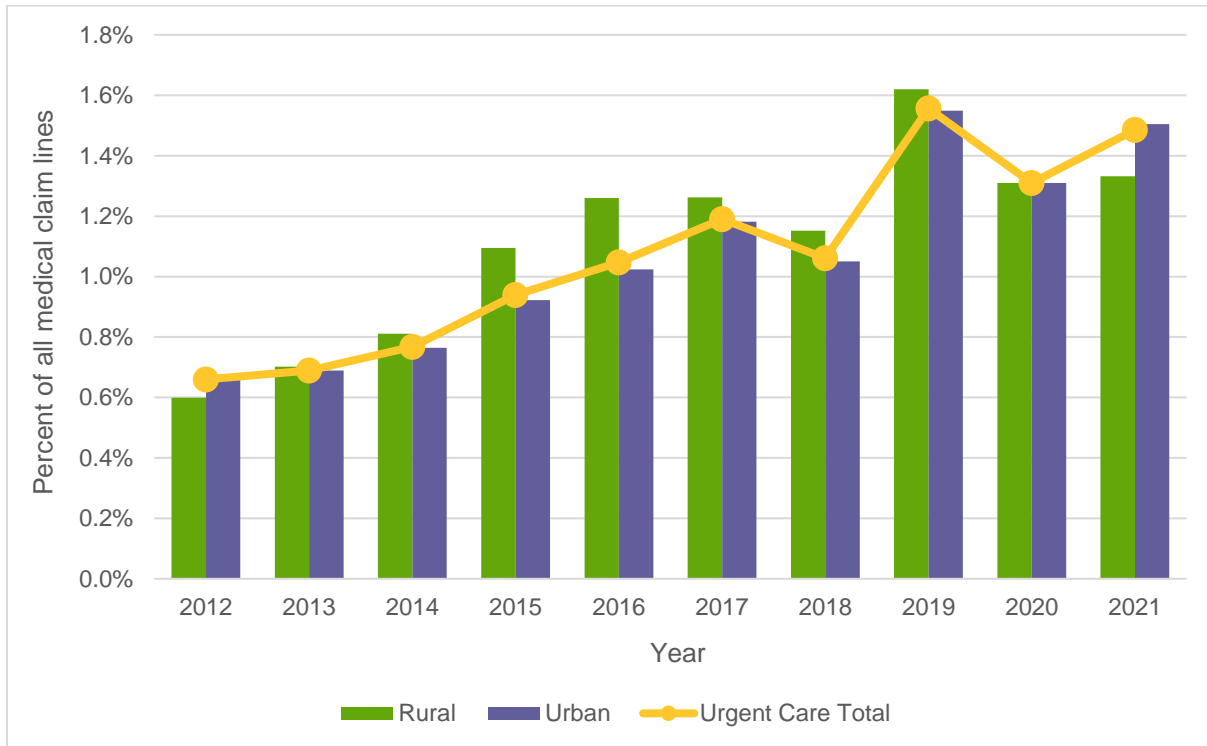


Figure 10. Claim lines with urgent care center usage as a percentage of all medical claim lines by rural, urban and national settings, 2012-2021

In 2021, the top five states for claim lines with urgent care center usage as a percentage of all medical claim lines by state were New Mexico, Hawaii, New York, Georgia and Maryland (figure 11). Only two of the top five states were on the list in both 2020 and 2021: Hawaii, which had been first and was now second, and Maryland, which had been third and was now fifth.

The five jurisdictions with the lowest urgent care center usage in 2021 were North Dakota; Iowa; Nebraska; Washington, DC; and Wisconsin. Four of these—all but Wisconsin—had been on the list in 2020. Washington, DC, moved from the lowest position to the fourth lowest, while North Dakota moved from the third lowest to the lowest.

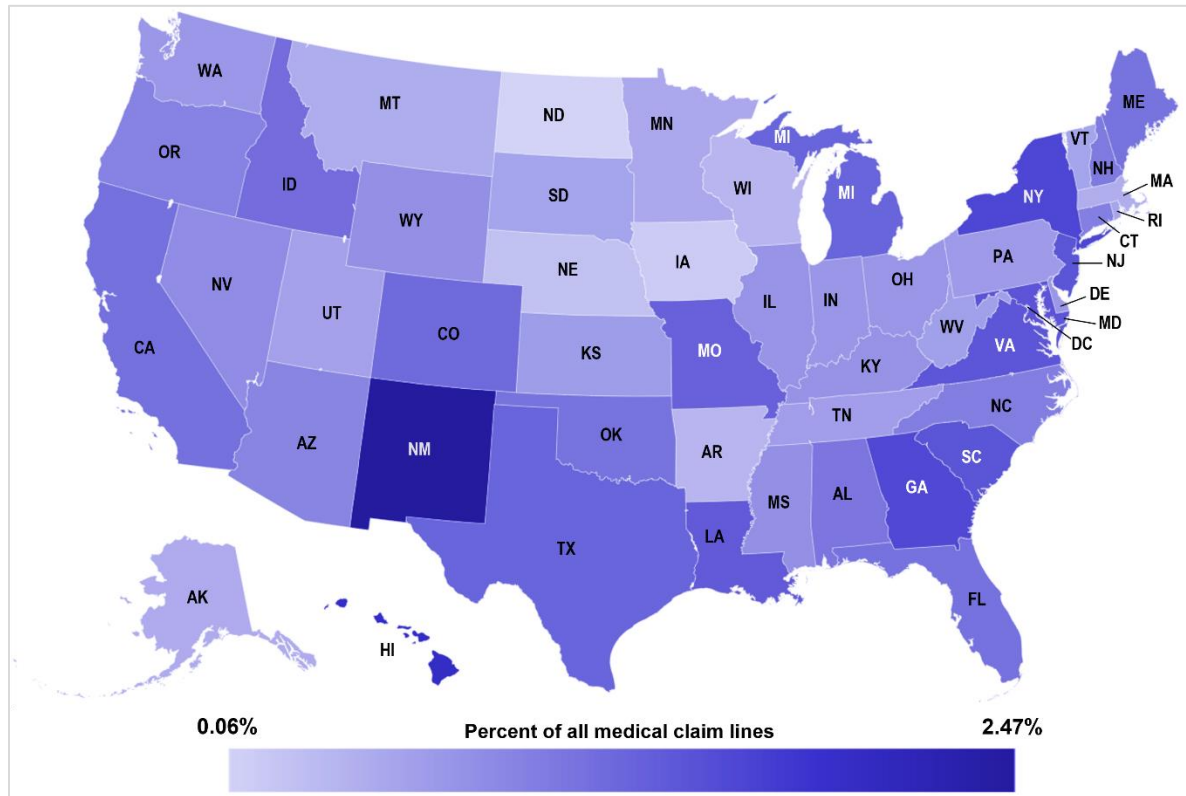


Figure 11. Percent of claim lines with urgent care center usage compared to all medical claim lines by state, 2021

As in previous years, the age group with the greatest share of claim lines for urgent care center usage in 2021 was that of individuals aged 31-40, with the same percentage as in 2020, 19 percent (figure 12). It was part of an age range, 23-50, that together accounted for 51 percent of the distribution in 2021 and had accounted for 52 percent in 2020. Other small changes in the age distribution included a shift in the age group 19-22, which increased its share from 9 percent in 2020 to 10 percent in 2021.

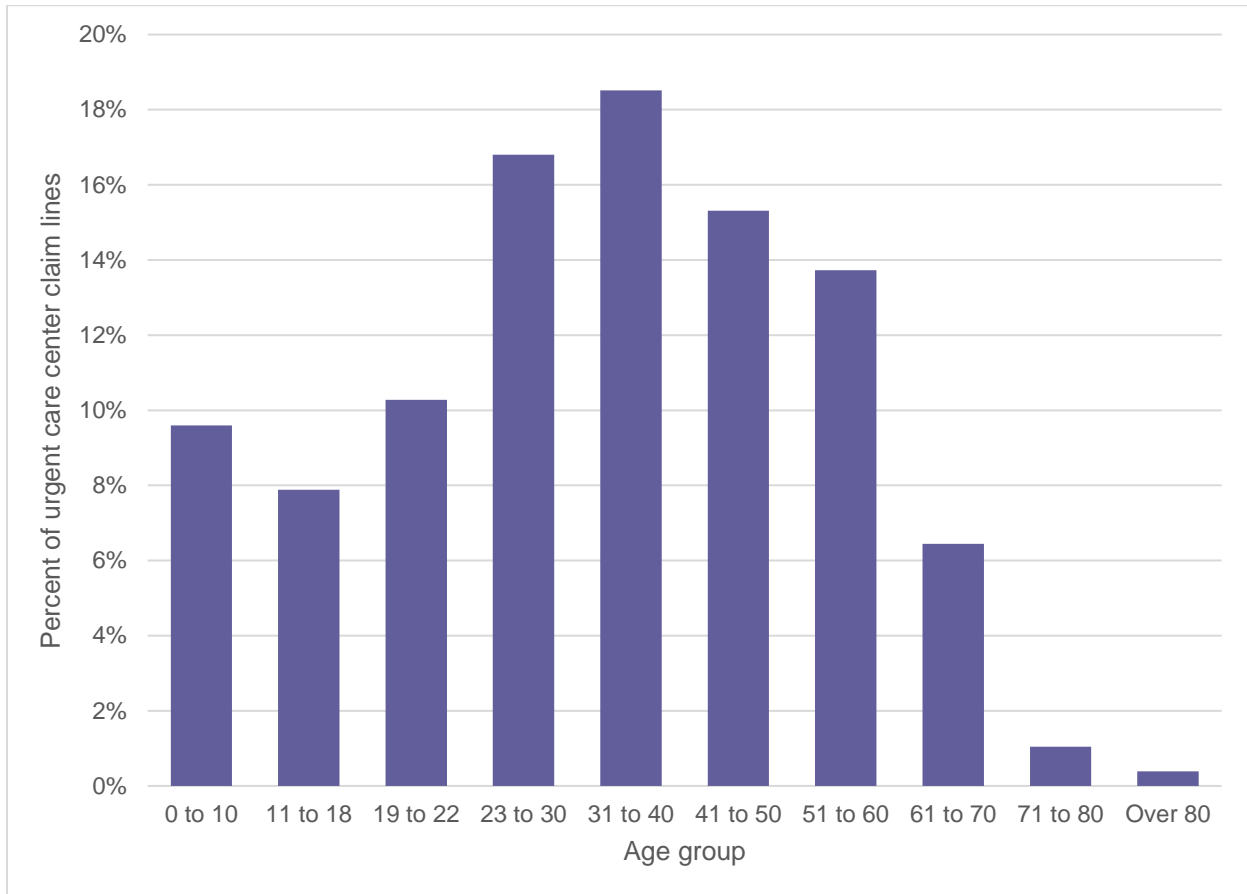


Figure 12. Percent of claim lines with urgent care center usage by age group, 2021

In 2021, as in previous years, urgent care center claim lines for females exceeded those for males in every age group except 0-10 (figure 13). The gender disparity of females over males continued to become smaller in many age groups from 2020 to 2021, as it had from 2019 to 2020. In the age range from 31 to 80, for example, the female percentage had varied from 56 to 58 percent in 2020, but in 2021 it varied from 56 to 57 percent. In the group of individuals aged over 80, however, the female share increased, from 59 percent in 2020 to 61 percent in 2021.

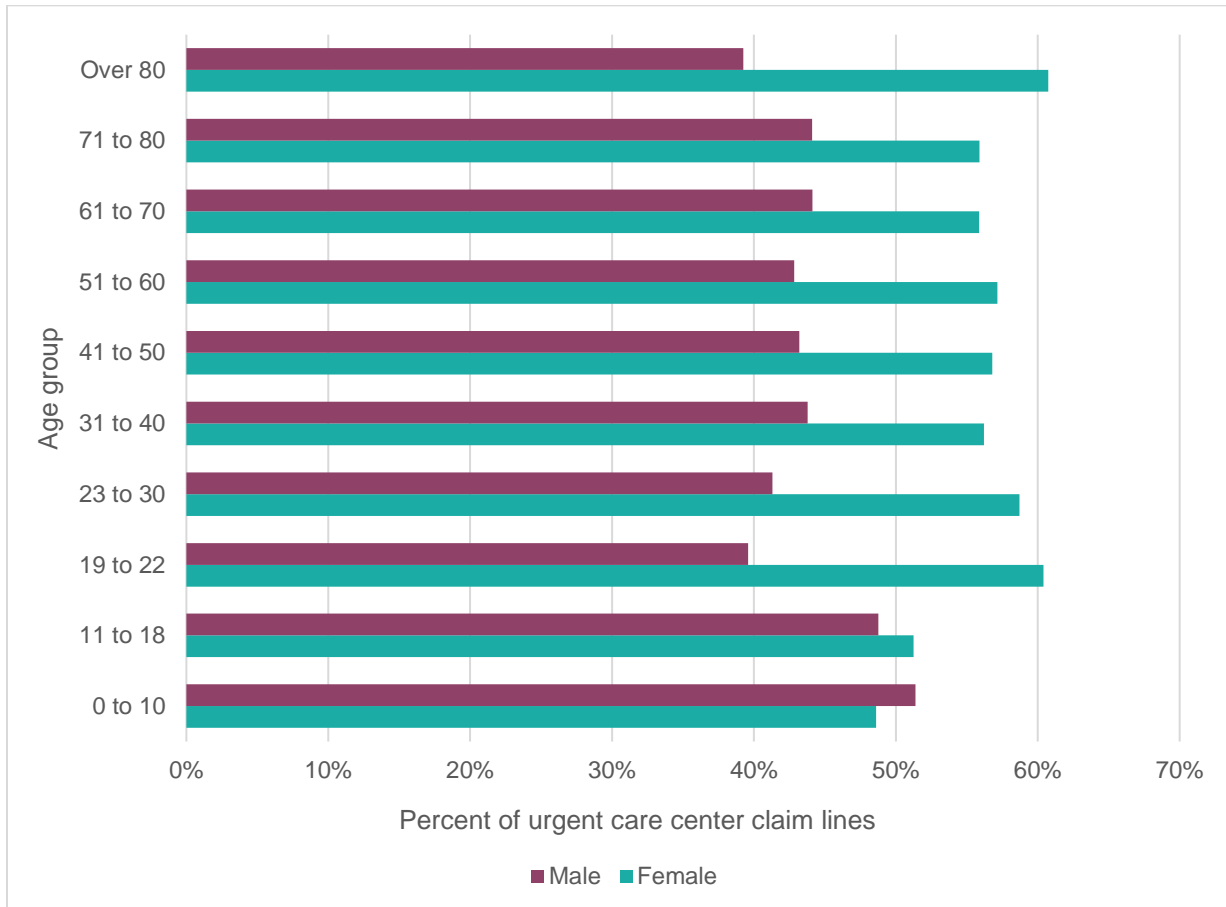


Figure 13. Percent of claim lines with urgent care center usage by age and gender, 2021

As in previous years, acute respiratory diseases and infections constituted the most common diagnostic category in urgent care centers in 2021 (figure 14). The share of the claim line distribution held by this category, however, fell from 23 percent in 2020 to 15 percent in 2021. In contrast, exposure to communicable diseases, which continued to rank in second place, rose from 8 percent in 2020 to 13 percent in 2021. COVID-19 entered the list of top diagnostic categories at number three in 2021, with eight percent of the distribution. Influenza and pneumonia, which had ranked in third place with 6 percent of the distribution in 2020, fell off the list in 2021 to 26th place in the distribution, with 0.6 percent of total urgent care claim lines.

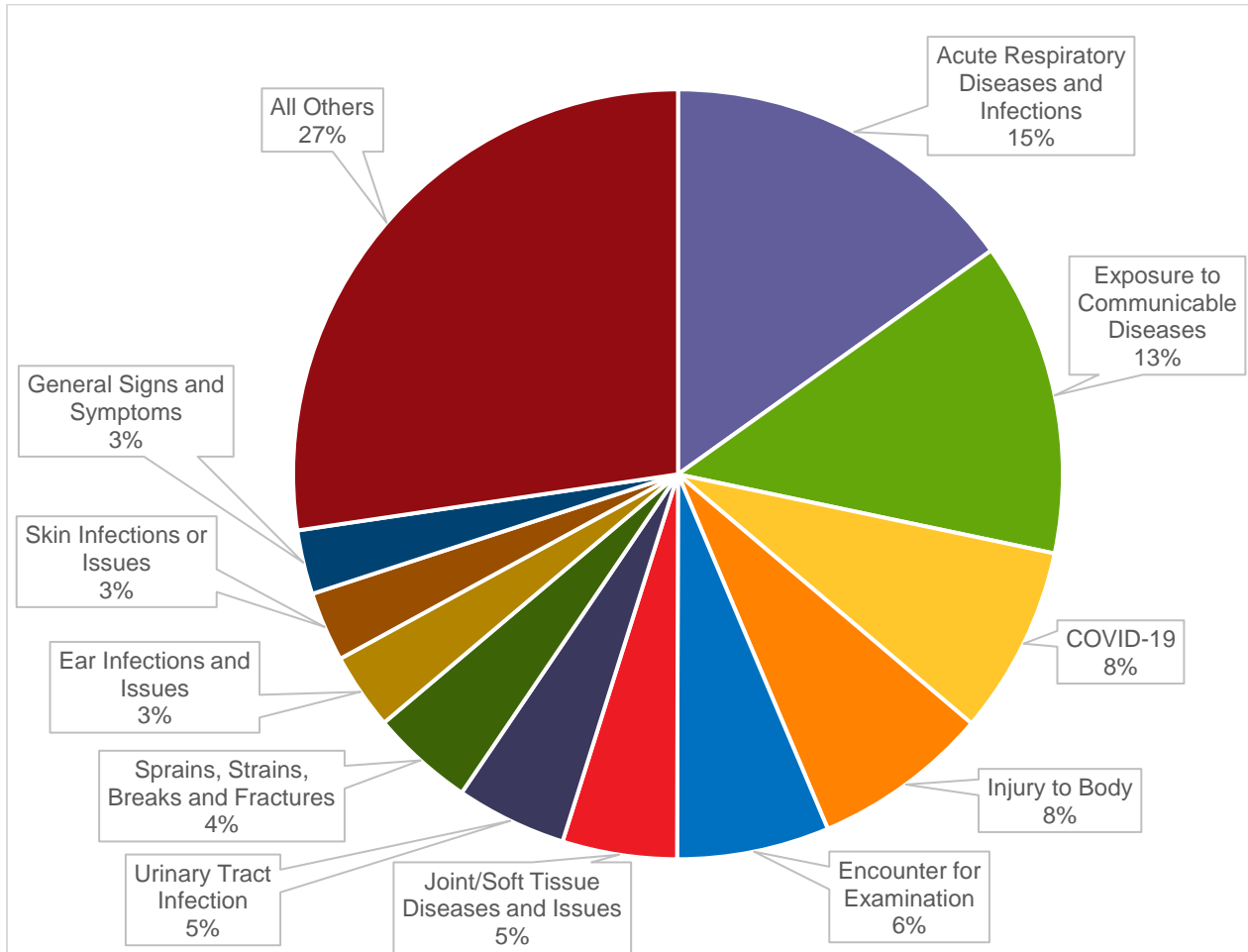


Figure 14. Distribution of claim lines with urgent care center usage by diagnostic category, 2021

As in retail clinics (figure 7), and as in previous years in urgent care centers, established patient office or other outpatient services constituted the most common procedure in urgent care centers in 2021 (figure 15). This procedure accounted for 24 percent of claim lines in 2021 for that place of service, the same as in 2020. Urgent care visit services decreased from 18 to 16 percent, and fell from second to third place in the ranking. Infectious agent antigen detection, which largely consisted of influenza and COVID-19 testing, rose from fourth place in 2020, with 13 percent, to second place in 2021, with 18 percent. New patient office or other outpatient services fell from third place in 2020, with 16 percent, to fourth place in 2021, with 14 percent.

COVID-19 lab test and COVID-19 specimen collection both entered the list of top procedures in 2021, with four percent and one percent of the distribution, respectively, while diagnostic radiology of the chest and of the lower extremities fell off the list.

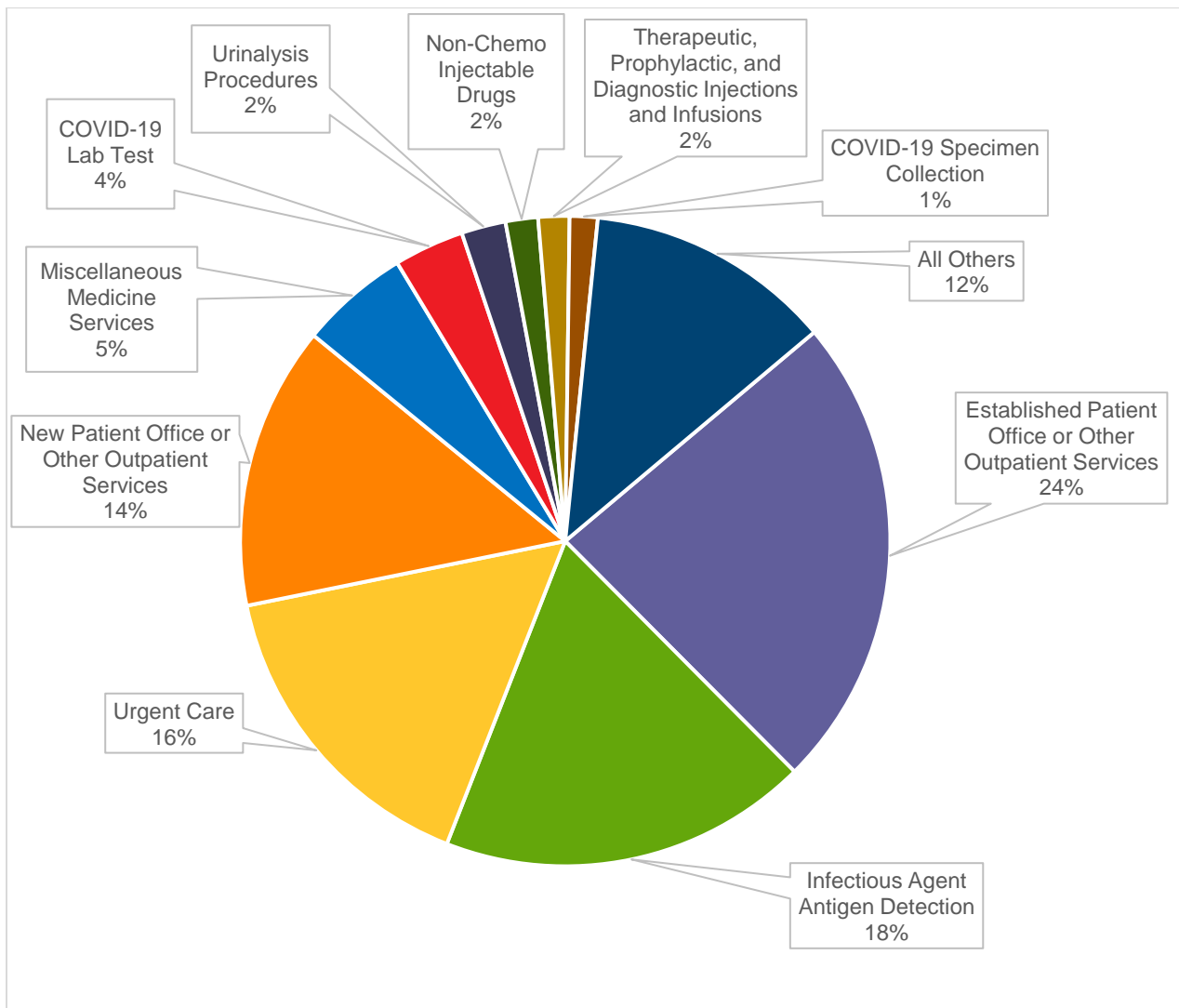
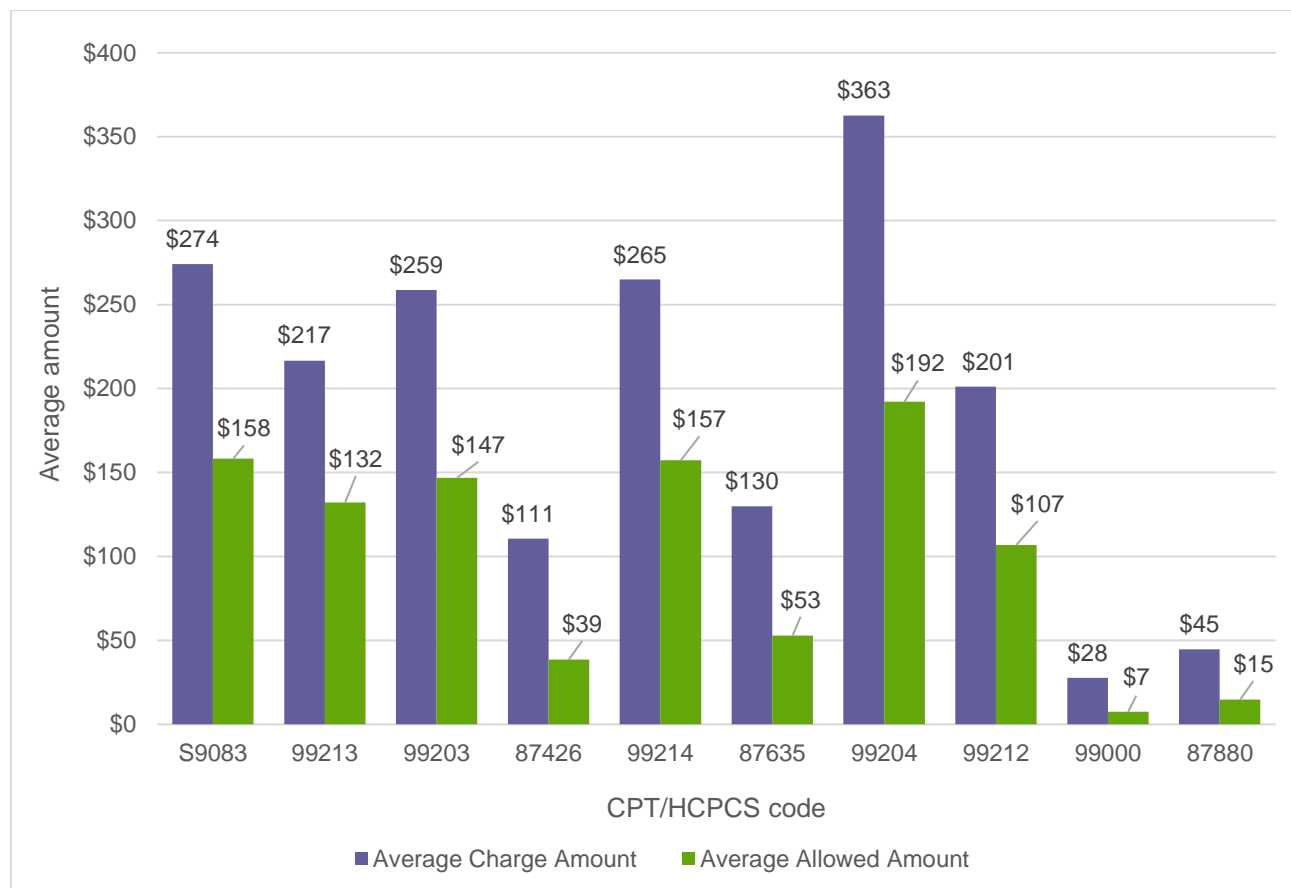


Figure 15. Distribution of claim lines with urgent care center usage by procedures, 2021

Four of the 10 most common codes billed in an urgent care center were new in 2021 as compared to 2020 (figure 16). Two of these were COVID-19 tests (CPT 87426, CPT 87635); the others were a 10-19-minute established patient outpatient visit (CPT 99212) and specimen handling and/or conveyance (CPT 99000).



CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
S9083	Global fee for urgent care center	87635	Amplified DNA or RNA probe detection of severe acute respiratory syndrome coronavirus 2 (COVID-19) antigen
99213	Established patient outpatient visit, total time 20-29 minutes	99204	New patient outpatient visit, total time 45-59 minutes
99203	New patient outpatient visit, total time 30-44 minutes	99212	Established patient outpatient visit, total time 10-19 minutes
87426	ELISA detection of severe acute respiratory syndrome coronavirus 2 (COVID-19) antigen	99000	Handling and/or conveyance of specimen for transfer from physician office to laboratory
99214	Established patient outpatient visit, total time 30-39 minutes	87880	Strep test by immunoassay for Streptococcus

Figure 16. Average charges and average allowed amounts for the most common procedures performed in urgent care centers, 2021

S9083, the global urgent care center fee, rose from fourth place in 2020 to first place in 2021 (where it had been in 2019). CPT 99214, 30-39-minute established patient outpatient visit, fell from first place in 2020 to fifth place in 2021.

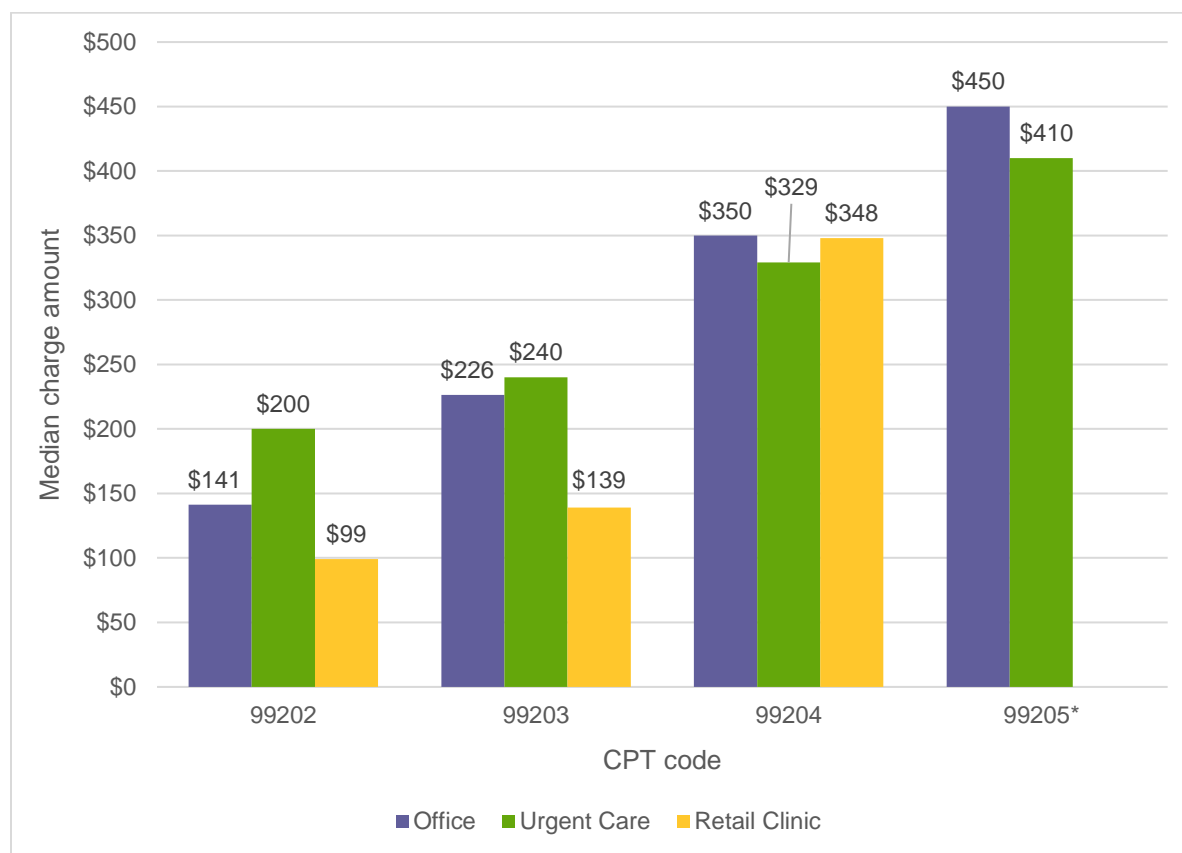
The highest average charge amount in 2021 was \$363 for CPT 99204, 45-59-minute new patient outpatient visit; that code also had the highest average allowed amount, \$192. The lowest average charge amount (\$28) and average allowed amount (\$7) were for CPT 99000 (specimen handling and/or conveyance).¹²

¹² As noted, although certain charts in this paper report average charges and allowed amounts, actual charges and allowed amounts may vary greatly from the average.

Retail Clinic, Urgent Care Center and Office: A Price Comparison

As in previous years, for a comparison of prices at retail clinics, urgent care centers and traditional offices, FAIR Health analyzed claims data for new patient E&M codes. A new patient E&M visit includes a detailed history for the patient, a detailed examination and medical decision making. Counseling and coordination of care with other providers also may occur. The visits are coded by length of time: CPT 99202 is 15-29 minutes, CPT 99203 is 30-44, CPT 99204 is 45-59 and CPT 99205 is 60-74.

In 2021, the median charge amounts across offices, urgent care centers and retail clinics (figure 17) were similar to those seen in 2020 for CPT 99202, with urgent care centers having the highest median charge in both years. But for CPT 99203, offices had the highest median charge in 2020, whereas in 2021 urgent care centers had the highest (\$240). CPT 99204 also differed between years: In 2020, offices had the highest median charge, followed by urgent care centers and then retail clinics, but in 2021, the order from highest to lowest was offices (\$350), retail clinics (\$348) and urgent care centers (\$329).



CPT Code	Description
99202	New patient outpatient visit, total time 15-29 minutes
99203	New patient outpatient visit, total time 30-44 minutes
99204	New patient outpatient visit, total time 45-59 minutes
99205	New patient outpatient visit, total time 60-74 minutes

* Retail clinics did not have enough volume to establish any values for CPT 99205.

Figure 17. Median charge amounts for offices, urgent care centers and retail clinics for new patient E&M codes, 2021

As in previous years, CPT 99205 was not billed at sufficient volume in retail clinics to establish values. For this code, as in 2020, offices had a higher median charge (\$450) than urgent care centers (\$410) in 2021.

When the same comparisons among retail clinics, urgent care centers and offices were made on the basis of median allowed amounts, the results for 2021 (figure 18) were similar to those for charge amounts in the same year (figure 17), except for CPT 99204. For that code, retail clinics had a lower median allowed amount (\$159) than urgent care centers (\$177) or offices (\$188), whereas charge amounts for retail clinics were higher than for urgent care centers, though not for offices.



CPT Code	Description
99202	New patient outpatient visit, total time 15-29 minutes
99203	New patient outpatient visit, total time 30-44 minutes
99204	New patient outpatient visit, total time 45-59 minutes
99205	New patient outpatient visit, total time 60-74 minutes

* Retail clinics did not have enough volume to establish any values for CPT 99205.

Figure 18. Median allowed amounts for offices, urgent care centers and retail clinics for new patient codes, 2021

Telehealth

Normalized telehealth usage grew 5,017 percent nationally from 2016 to 2021 (figure 19), which was a high rate of growth. By comparison, however, the growth rate had been 41,919 percent from 2015 to 2020, largely due to the start of the COVID-19 pandemic in 2020. In that year, limits had been imposed on certain in-office services amid widespread concern about the risk of infection from in-person encounters; in 2021, vaccines became widely distributed and, for a time, COVID-19 case levels fell.¹³ From 2020 to 2021, telehealth utilization declined 76 percent nationally, 75 percent in urban areas and 80 percent in rural areas. From 2016 to 2021, telehealth usage grew 5,089 percent in urban areas and 4,412 percent in rural areas. The rural/urban designation is based on where the patient was receiving care.

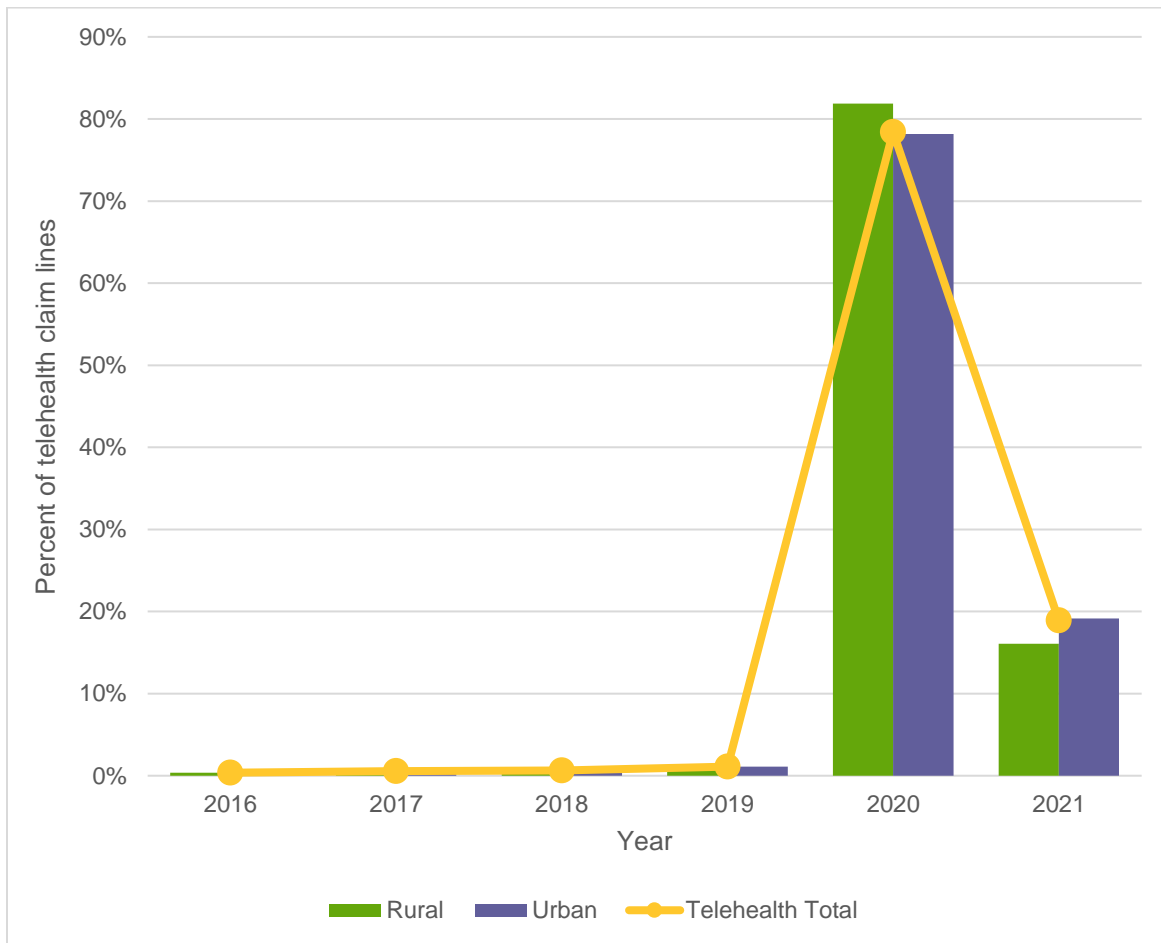


Figure 19. Percent of claim lines with telehealth usage by rural, urban and national settings, 2016-2021

¹³ FAIR Health, *The Evolution of Telehealth during the COVID-19 Pandemic: A Multiyear Retrospective of FAIR Health's Monthly Telehealth Regional Tracker*, A FAIR Health Brief, June 14, 2022, <https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/The%20Evolution%20of%20Telehealth%20during%20the%20COVID-19%20Pandemic-A%20FAIR%20Health%20Brief.pdf>.

Figure 20 shows claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings. In 2021, telehealth utilization fell from its peak in 2020, but remained well above its pre-pandemic levels. Telehealth's national share of medical claim lines climbed from 0.22 percent in 2019 to 15.41 percent in 2020, then fell to 3.72 percent in 2021—still approximately 17 times higher than its 2019 level. In urban areas, telehealth declined from 16.08 percent in 2020 to 3.94 percent in 2021; in rural areas, the decrease was from 9.77 percent in 2020 to 1.92 percent in 2021.

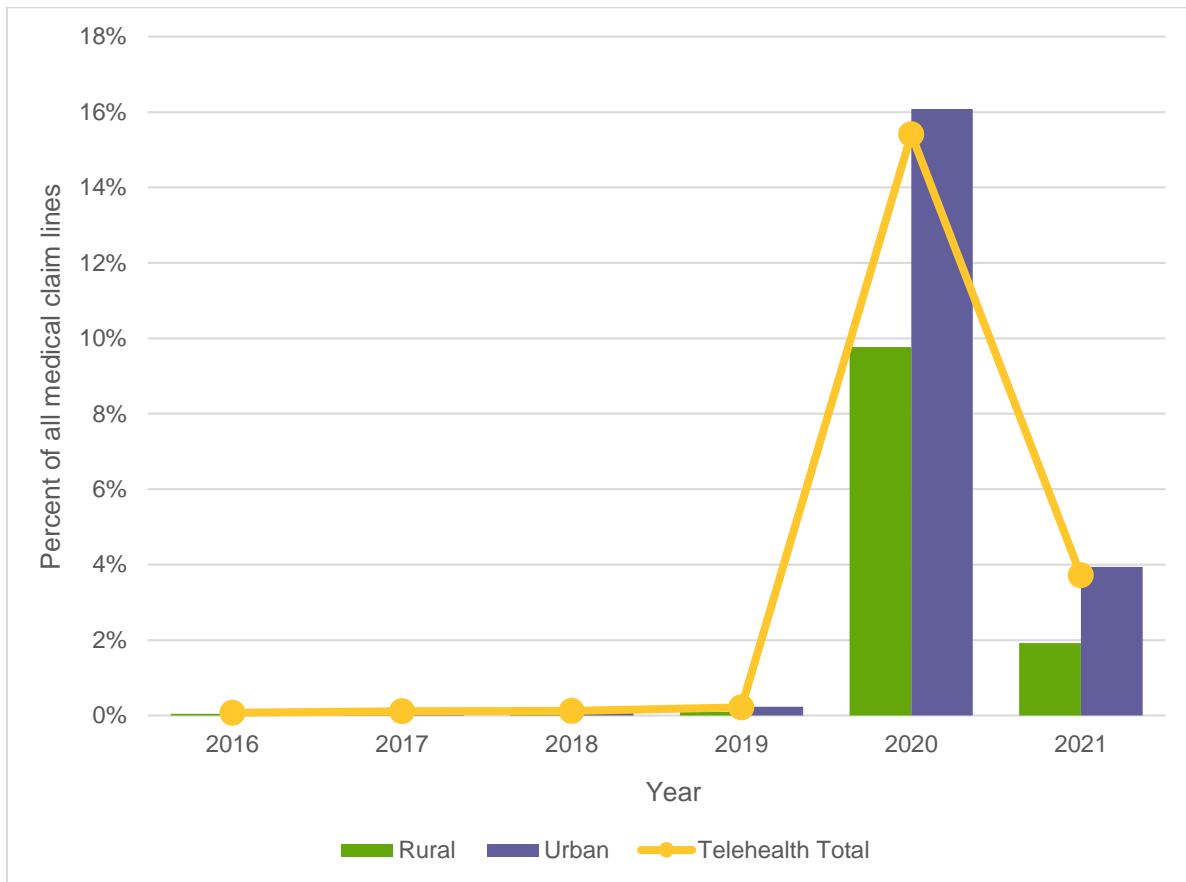


Figure 20. Claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings, 2016-2021

In 2021, the top five jurisdictions for telehealth claim lines as a percentage of all medical claim lines by state (or district) were Massachusetts; Washington, DC; Vermont; Oregon; and Connecticut (figure 21). New Mexico, which had been the top state in 2020, fell out of the top five to 16th place; Delaware, which had been 4th in 2020, fell to 9th place. From 2020 to 2021, Massachusetts moved from second to first place and Washington, DC, shifted from third to second place. Connecticut remained in fifth place. The state designation for telehealth is based on where the patient received care.

Of the five states with the lowest telehealth use rates in 2021 (Mississippi, North Dakota, South Dakota, Alabama and Iowa), three had been on that list in 2020. Mississippi was in the lowest place both years; Alabama had been second from the bottom in 2020 and moved to fourth from the bottom in 2021; and South Dakota moved from the fourth from the bottom to the third from the bottom.

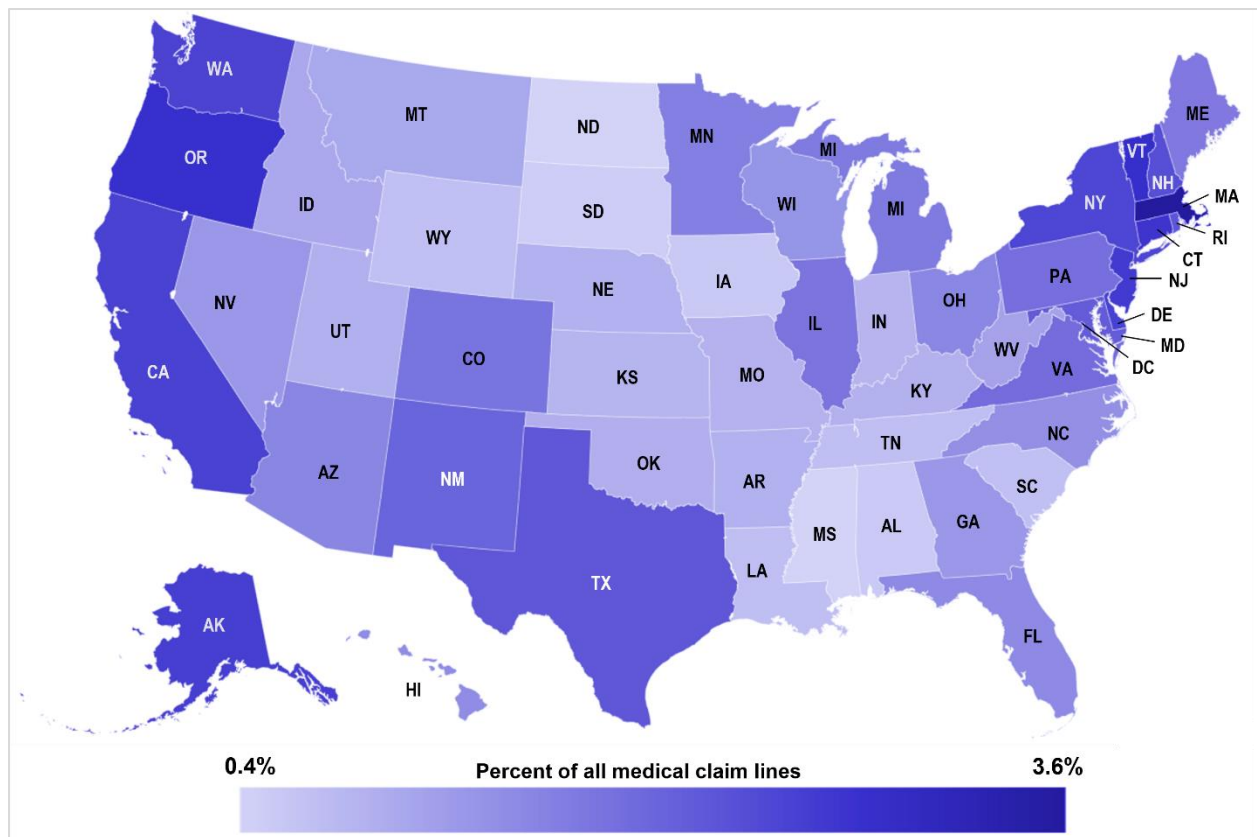


Figure 21. Percent of claim lines with telehealth usage compared to all medical claim lines by state, 2021

As in previous years, the age group with the largest share of telehealth claim lines in 2021 was that of individuals aged 31-40 (21 percent; figure 22). In 2021, the age groups 23-30 and 41-50 were matched as having the second largest share of telehealth claim lines, each constituting 16 percent of the distribution. In 2020, the two age groups had differed, with the age group 23-30 accounting for 14 percent and the age group 41-50 accounting for 16 percent. The age group 51-60 fell in its share of the distribution from 2020 (16 percent) to 2021 (14 percent).

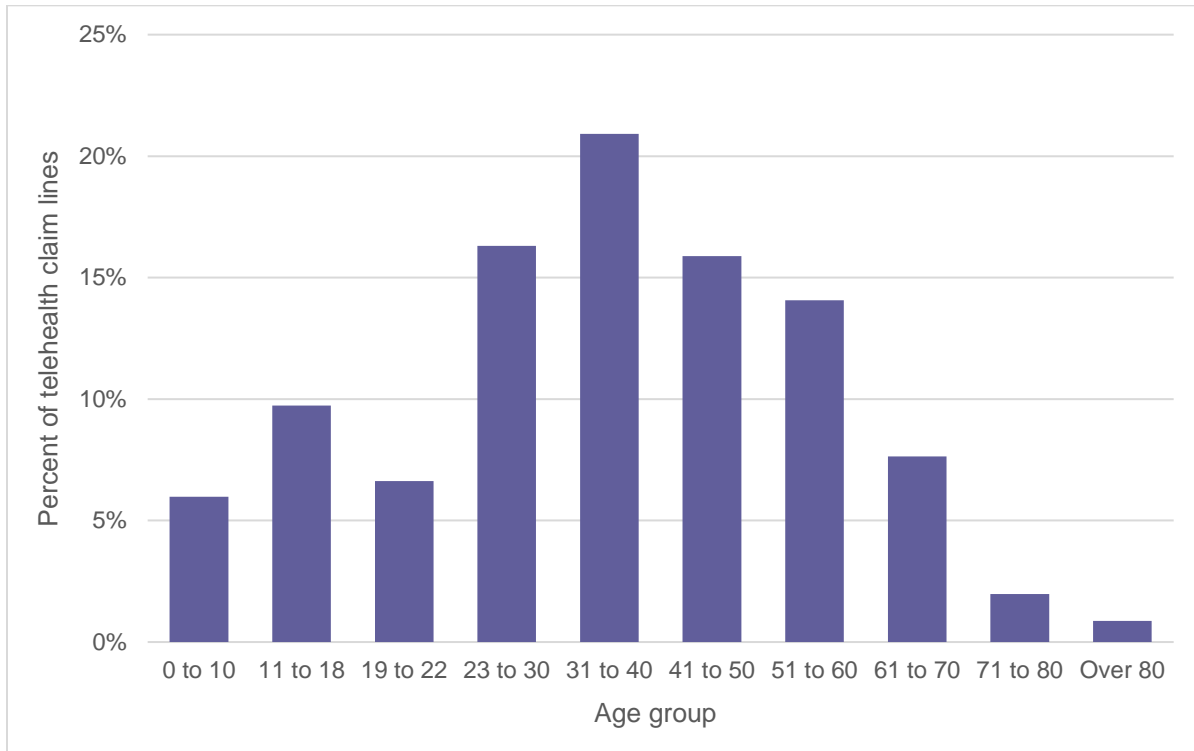


Figure 22. Percent of claim lines with telehealth usage by age group, 2021

In 2021, as in 2020, claim lines with telehealth usage were submitted more for females than males in every age group except children aged 0-10 (figure 23). In the 0-10 age group, the male share was 61 percent in 2021. Males accounted for less than 40 percent of the distribution in all other age groups except 61-70 (40 percent) and 71-80 (43 percent).

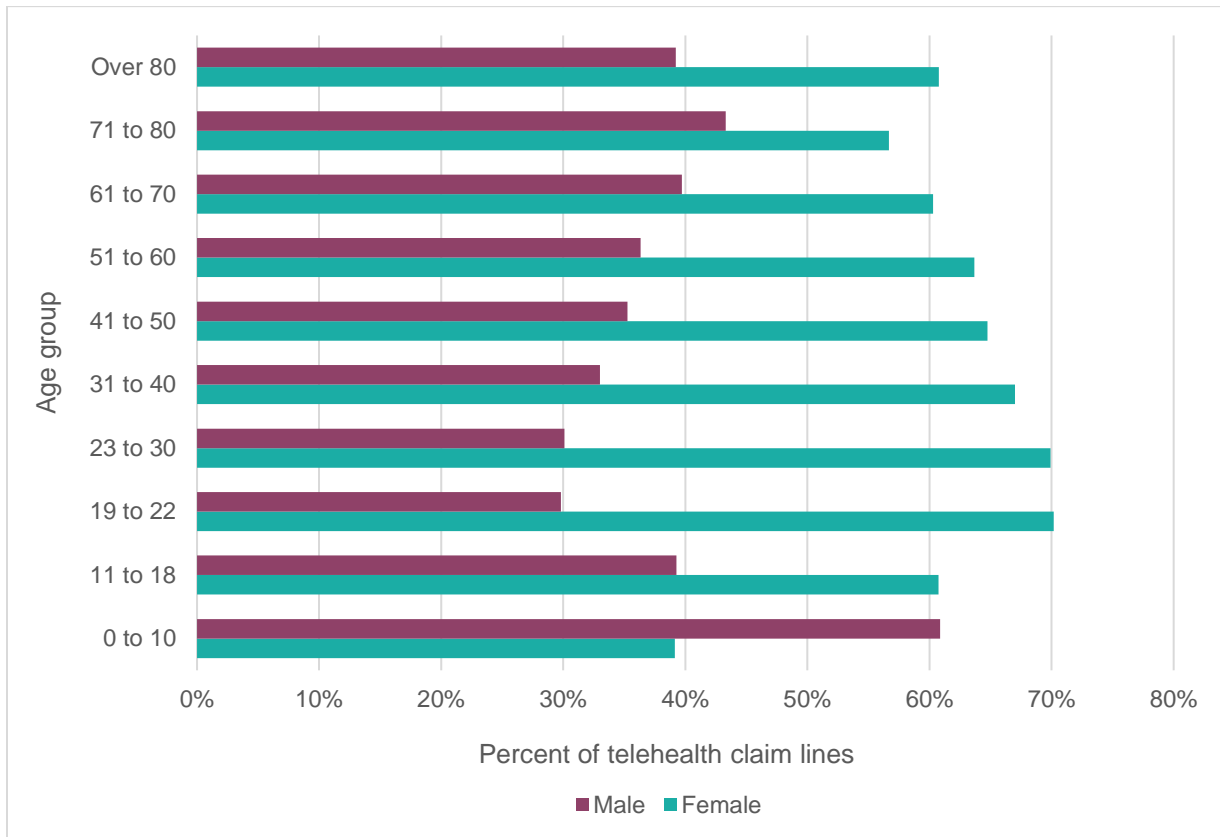


Figure 23. Percent of claim lines with telehealth usage by age and gender, 2021

As in 2019 and 2020, the most common telehealth diagnostic category in 2021 was mental health conditions, which continued to grow from 44 percent of the distribution in 2020 to 57 percent in 2021 (figure 24). Acute respiratory diseases and infections moved from the fourth most common reason for a telehealth visit in 2020 to the second most common in 2021. Developmental disorders remained the third most common reason and joint/soft tissue diseases and issues fell from second to fourth most common. In 2021, COVID-19 joined the list of most common telehealth diagnostic categories, entering in 5th place, while substance use disorders moved from 12th to 9th place. Month-to-month details of changes in top telehealth diagnostic categories and other telehealth trends can be found in FAIR Health’s Monthly Telehealth Regional Tracker.¹⁴

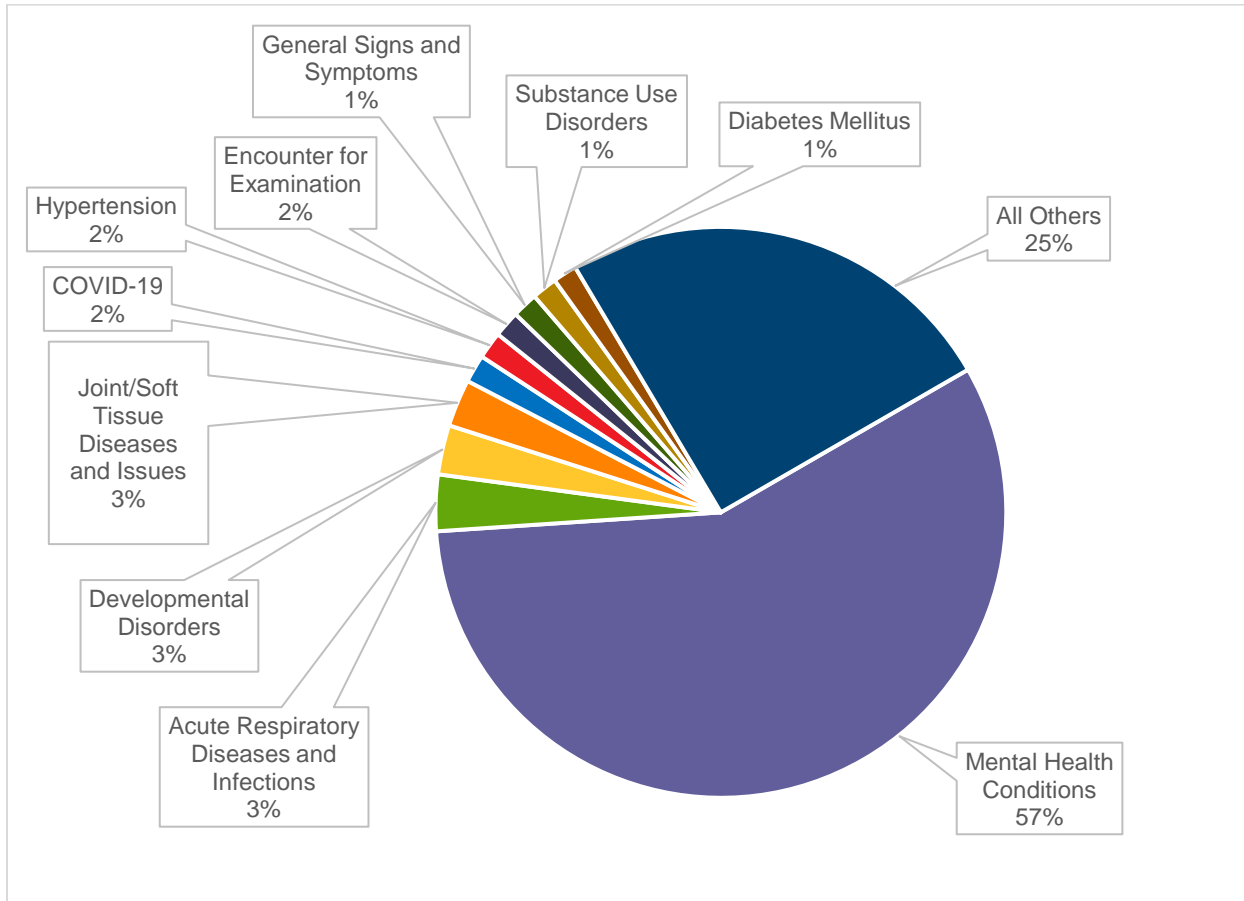


Figure 24. Distribution of claim lines with telehealth usage by diagnostic category, 2021

¹⁴ “Monthly Telehealth Regional Tracker,” FAIR Health, accessed February 8, 2023, <https://www.fairhealth.org/states-by-the-numbers/telehealth>.

Ambulatory Surgery Center

In 2021, normalized ASC usage continued the decline that had begun in 2020 (figure 25). From 2020 to 2021, national ASC usage fell 7 percent; in rural areas the decline was 16 percent and in urban areas 6 percent. Whereas the decrease in 2020 was likely due in large part to restrictions on elective surgery at the start of the COVID-19 pandemic,¹⁵ contributing factors to the decrease in 2021 may have included shortages of supplies and of staffing.¹⁶ Over the longer term, the normalized share of claim lines for ASCs fell five percent nationally from 2012 to 2021, compared to growth of four percent from 2011 to 2020. The decline from 2012 to 2021 was greater in rural (20 percent) than urban areas (3 percent).

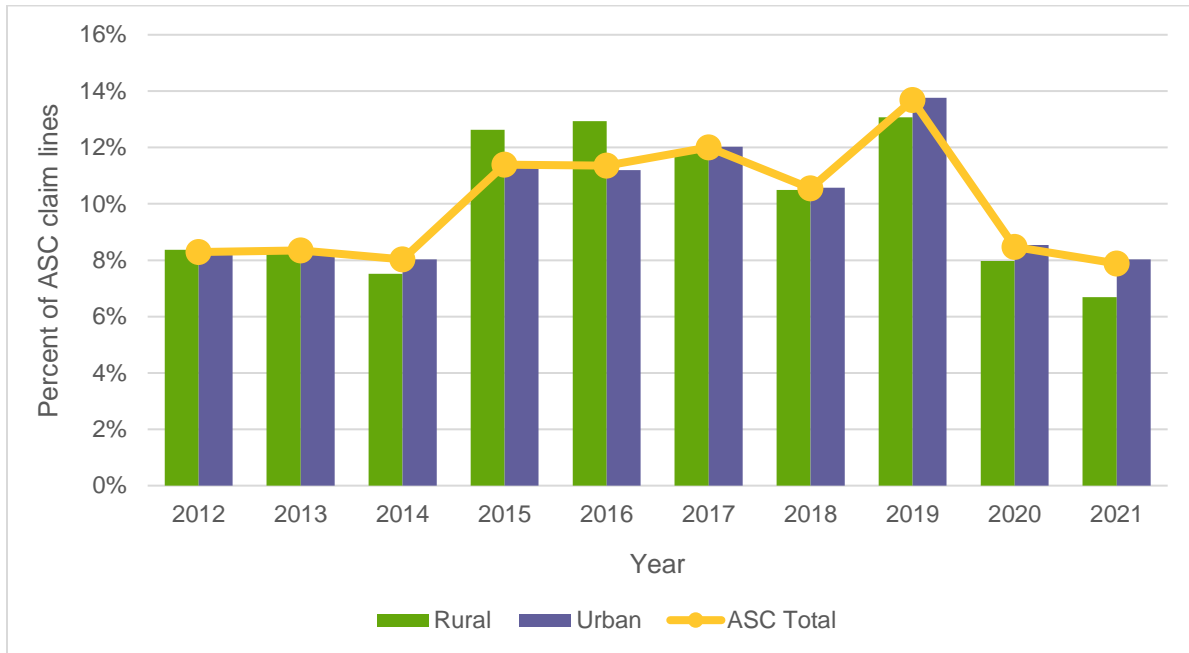


Figure 25. Percent of claim lines with ASC usage by rural, urban and national settings, 2012-2021

¹⁵ Angie Stewart, "5 Ways COVID-19 Affected ASCs in 2020," *Becker's ASC Review*, December 4, 2020, <https://www.beckersasc.com/asc-news/5-ways-covid-19-affected-ascs-in-2020.html>.

¹⁶ Laura Dyrda, "COVID-19 Is Still Out There: 7 Ways ASCs Are Affected Heading into 2022," *Becker's ASC Review*, December 16, 2021, <https://www.beckersasc.com/or-clinical-quality/covid-19-is-still-out-there-7-ways-ascs-are-affected-heading-into-2022.html>.

In 2021, national ASC utilization fell to 0.60 percent, below where it had stood in 2012 (0.63 percent), erasing the gains made between those two years (figure 26). Urban ASC utilization fell to 0.61 percent in 2021 from 0.63 percent in 2012, and rural ASC utilization fell to 0.47 percent in 2021 from 0.59 percent in 2012.

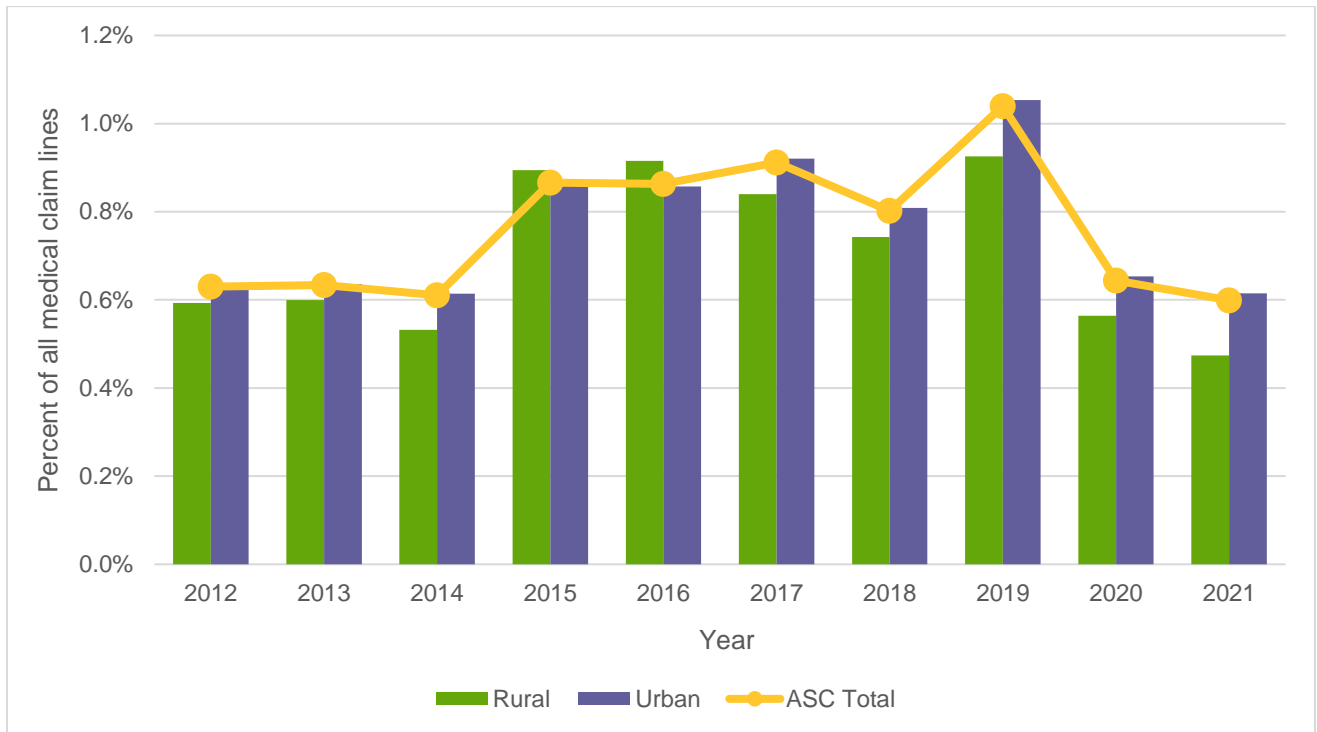


Figure 26. Claim lines with ASC usage as a percentage of all medical claim lines by rural, urban and national settings, 2012-2021

As in previous years, more ASC claim lines in 2021 were submitted for females than males in almost every age group (figure 27). The cases where males outnumbered females, as in previous years, were the age groups 0-10 (males 61 percent) and 11-18 (males 54 percent). In the one age group, those over 80, in which the distribution in 2020 had been approximately 50 percent female and 50 percent male, the distribution in 2021 was 47 percent male and 53 percent female. More generally, however, males in the age groups over 50 continued to be close to equal in percentage share to females. In 2021, males accounted for 46 percent of the age group 51-60 and 48 percent of the age groups 61-70 and 71-80.

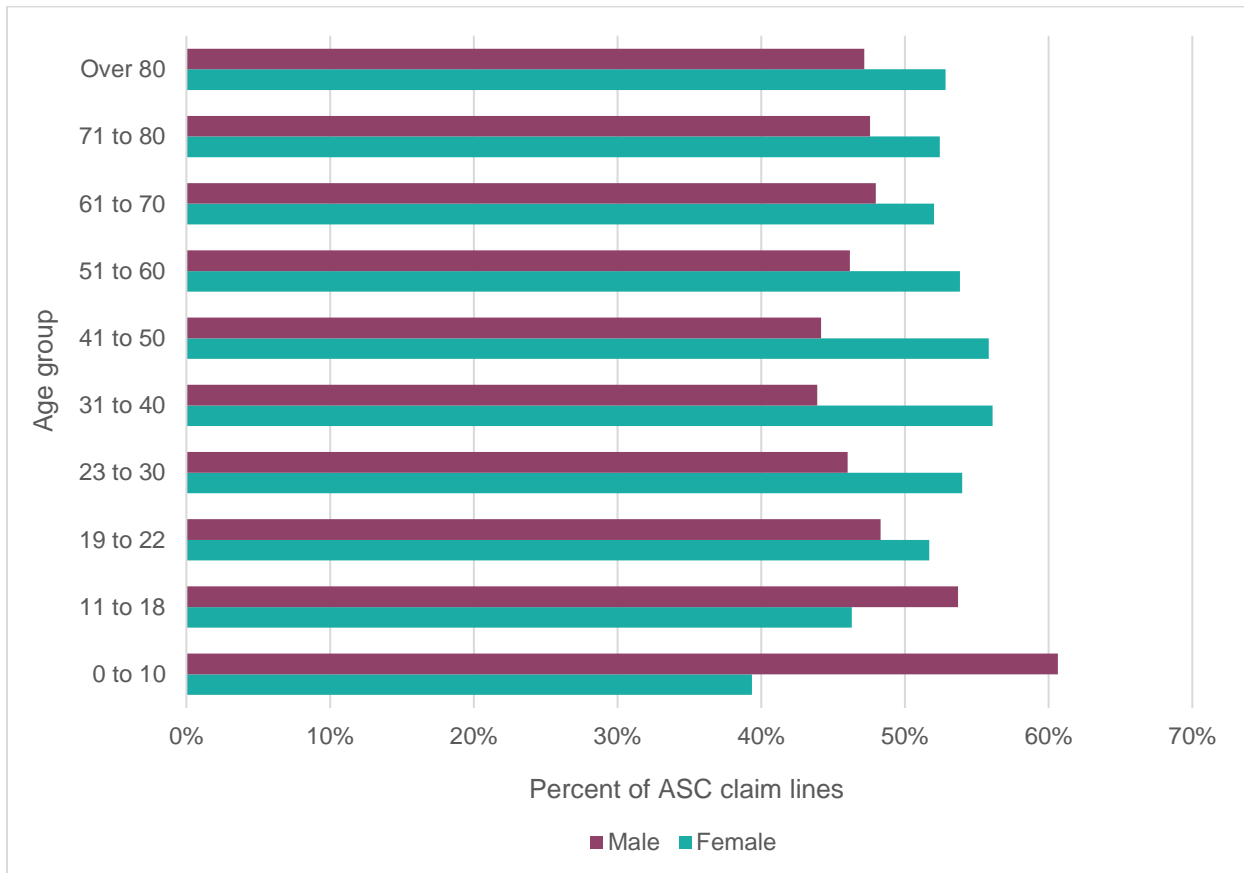


Figure 27. Percent of claim lines with ASC usage by age and gender, 2021

Emergency Room

In the single year from 2020 to 2021, ER usage decreased in national, urban and rural settings by 15 percent (figure 28). This trend continued the decline driven by the COVID-19 pandemic from 2019 to 2020. Over the longer term, the normalized share of claim lines for ERs from 2012 to 2021 decreased nationally and in urban areas 1 percent, while falling 15 percent in rural areas. This contrasts with the growth recorded from 2011 to 2020 in national (15 percent), urban (14 percent) and rural (7 percent) areas.

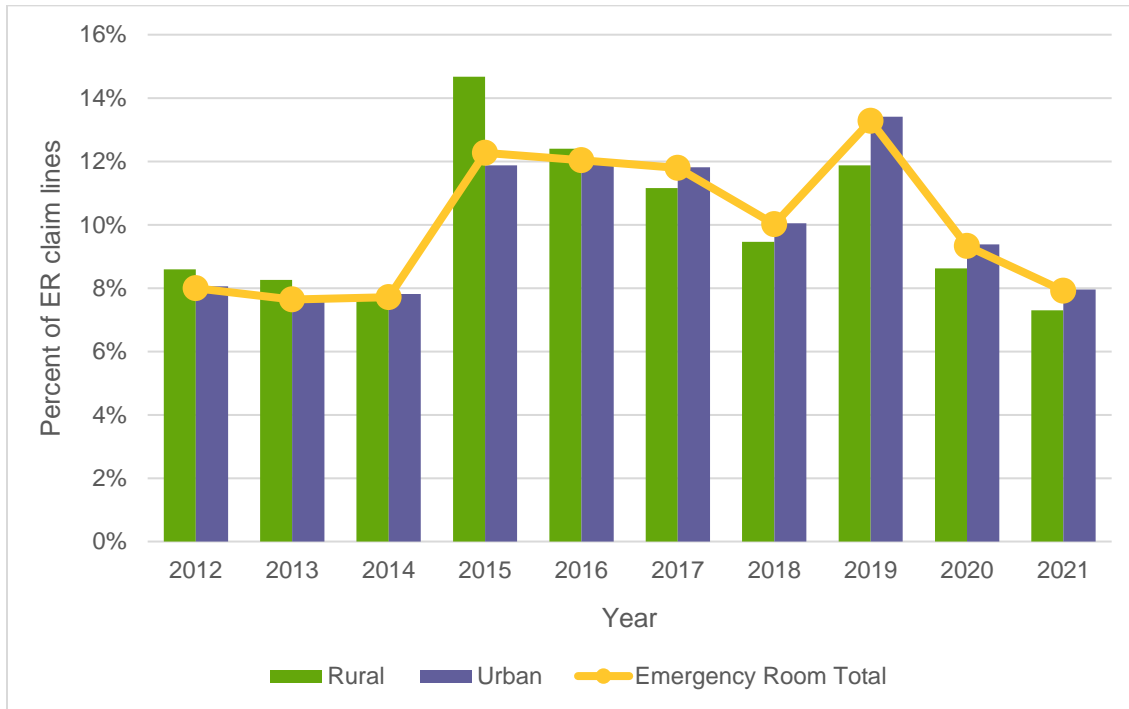


Figure 28. Percent of claim lines with ER usage by rural, urban and national settings, 2012-2021

From 2020 to 2021, the national ER percentage of all medical claim lines fell from 2.1 percent to 1.8 percent (figure 29). In urban areas, the decline was from 2.0 percent to 1.7 percent, and in rural areas from 2.4 percent to 2.0 percent.

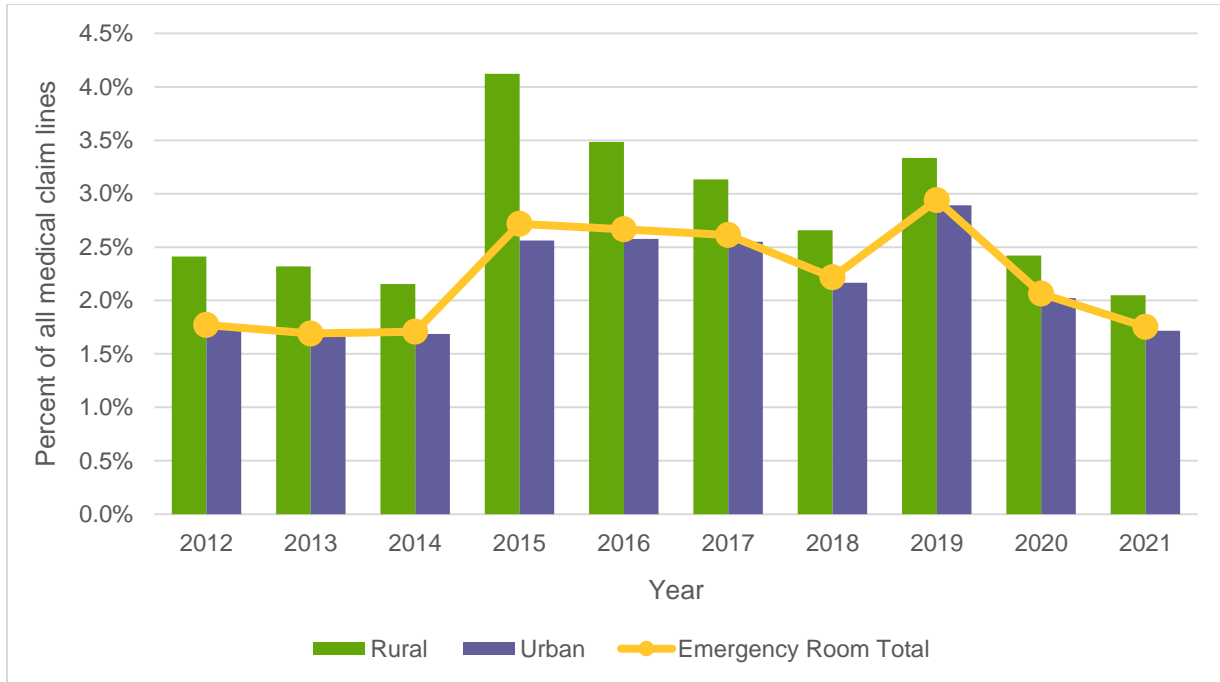


Figure 29. Claim lines with ER usage as a percentage of all medical claim lines by rural, urban and national settings, 2012-2021

The age distribution for ERs in 2021 (figure 30) was almost identical to that recorded for 2020. The major difference was that the two oldest age groups, 71-80 and over 80, each had four percent of the distribution in 2021 compared to five percent in 2020. As in previous years, the age group with the greatest share of claim lines for ER usage in 2021 was 51-60 (17 percent). The next largest age groups were 31-40 and 41-50, each with 16 percent of the distribution.

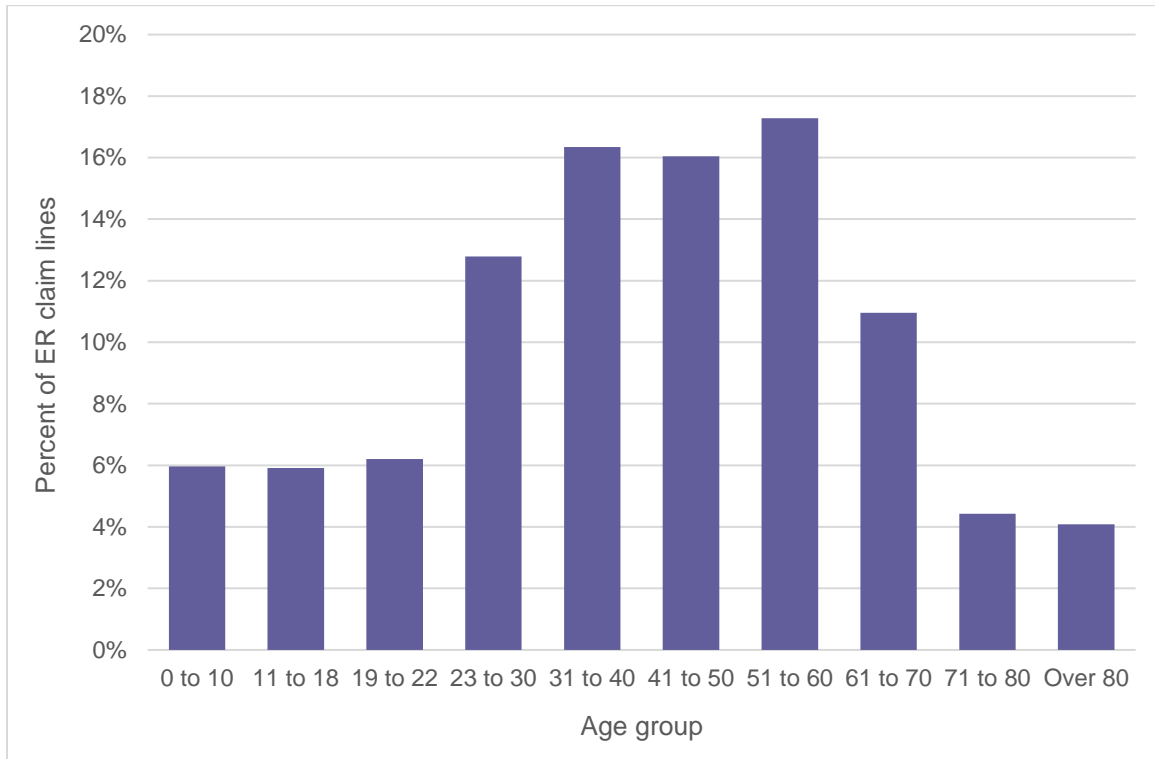


Figure 30. Percent of claim lines with ER usage by age group, 2021

As with all of the other places of service studied for gender, and as in 2020, more claim lines with ER usage in 2021 were submitted for females than males in most age groups (figure 31). The sole case in which the male share exceeded the female share was the age group 0-10, in which claim lines for boys (56 percent) outnumbered those for girls (44 percent). In all age groups, unlike in previous years, males accounted for no less than 40 percent of the distribution. In several age groups, males grew in their share of the distribution; for example, in the age group 23-30, males grew from 39 percent in 2020 to 40 percent in 2021. As in 2020, there was one case in 2021 (the age group 61-70) in which the male and female shares were approximately equal (50 percent).

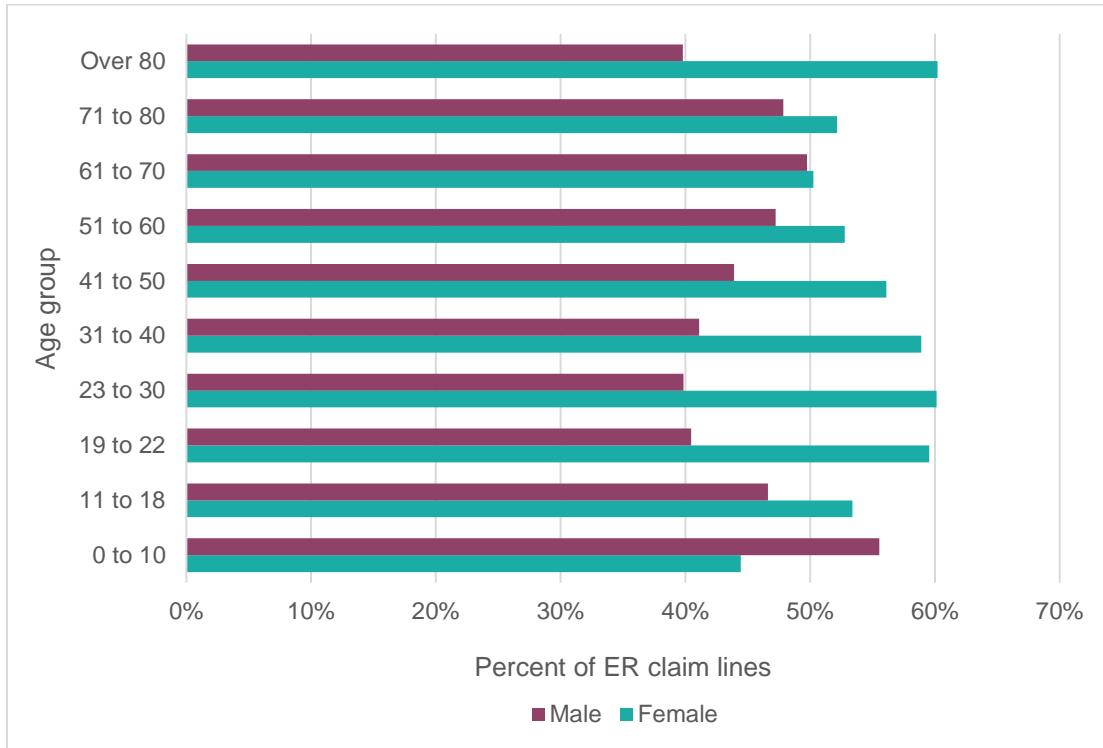


Figure 31. Percent of claim lines with ER usage by age and gender, 2021

Figure 32 shows the 2021 distribution of claim lines with ER usage by diagnostic category for individuals over the age of 22. As in 2020, chest pain was the number one ER diagnostic category in 2021, but injury to body rose from fourth place to second place in 2021. COVID-19 entered the list of top diagnostic categories in fifth place in 2021. Digestive system issues fell from second to tenth place in 2021, and abdominal and pelvic pain and tenderness entered the list in third place. Overall, the diversity of conditions seen in the ER continued to expand, with the category of “All Others” growing from 35 percent of the distribution in 2020 to 38 percent in 2021.

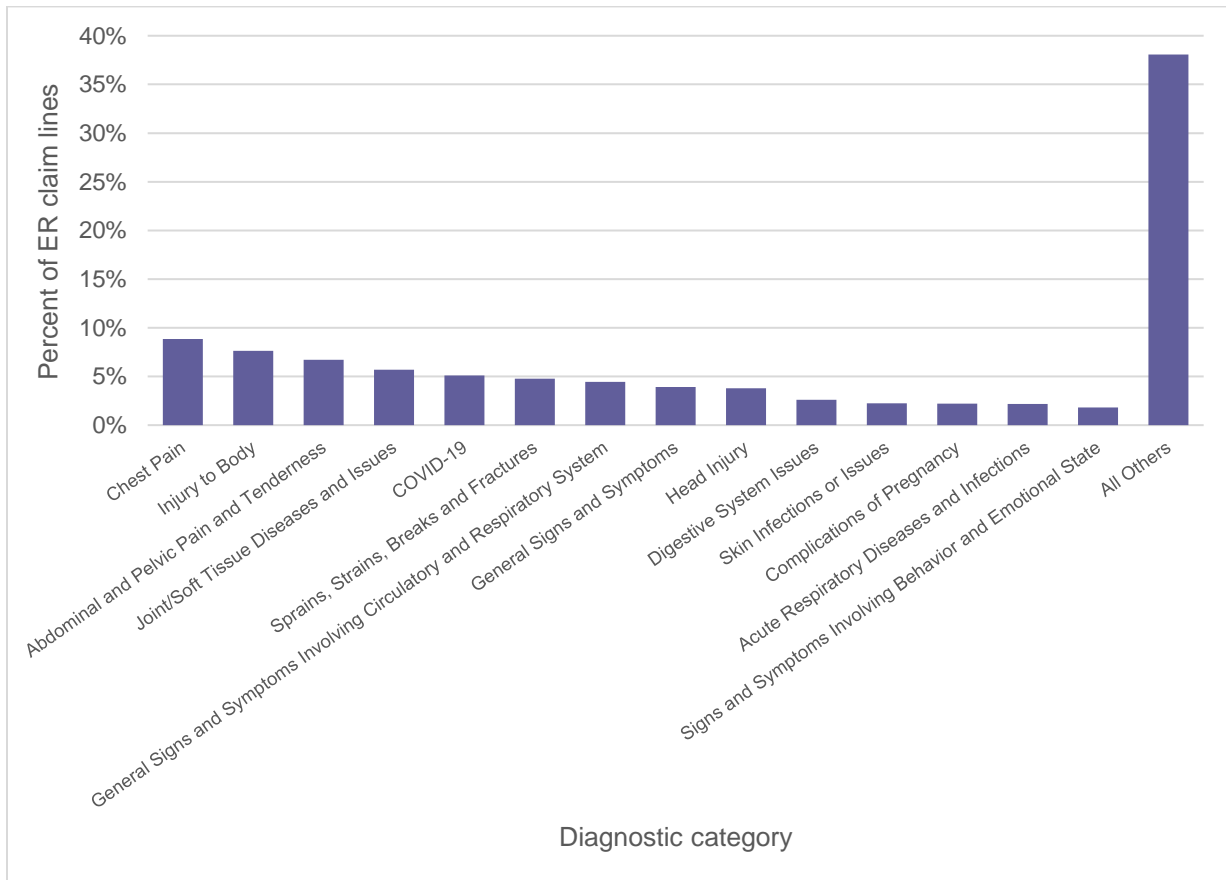


Figure 32. Distribution of claim lines with ER usage by diagnostic category for individuals over 22 years of age, 2021

The 2021 distribution of claim lines with ER usage by procedures for individuals in all age groups, not including E&Ms (figure 33), was similar to that in 2020. Again, diagnostic radiology of the chest was the most common procedure, with 15 percent of the 2021 distribution as compared to 13 percent of the 2020 distribution. The other procedure categories were all in the same order, most with a larger share than the previous year. The category of “All Others” decreased from 37 percent in 2020 to 27 percent in 2021.

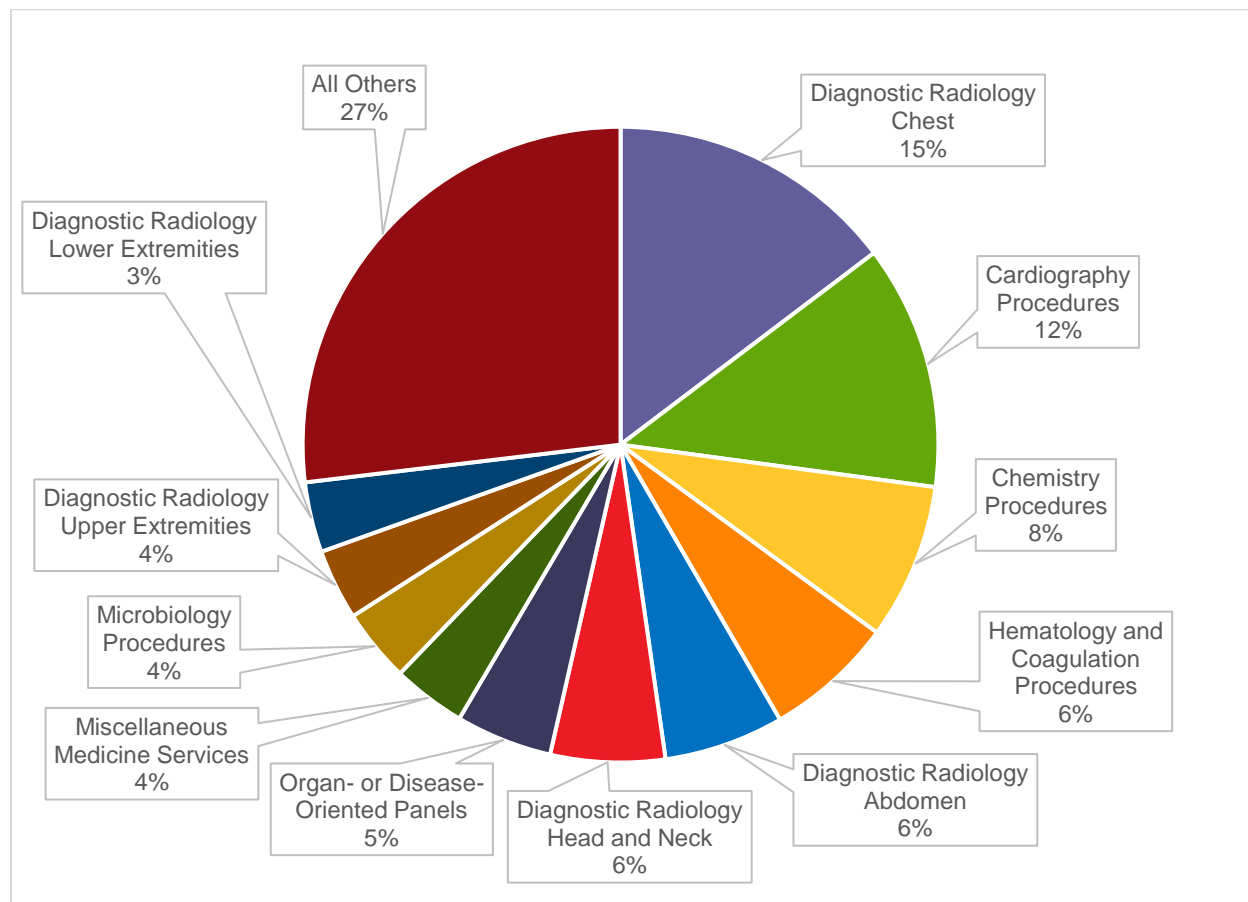
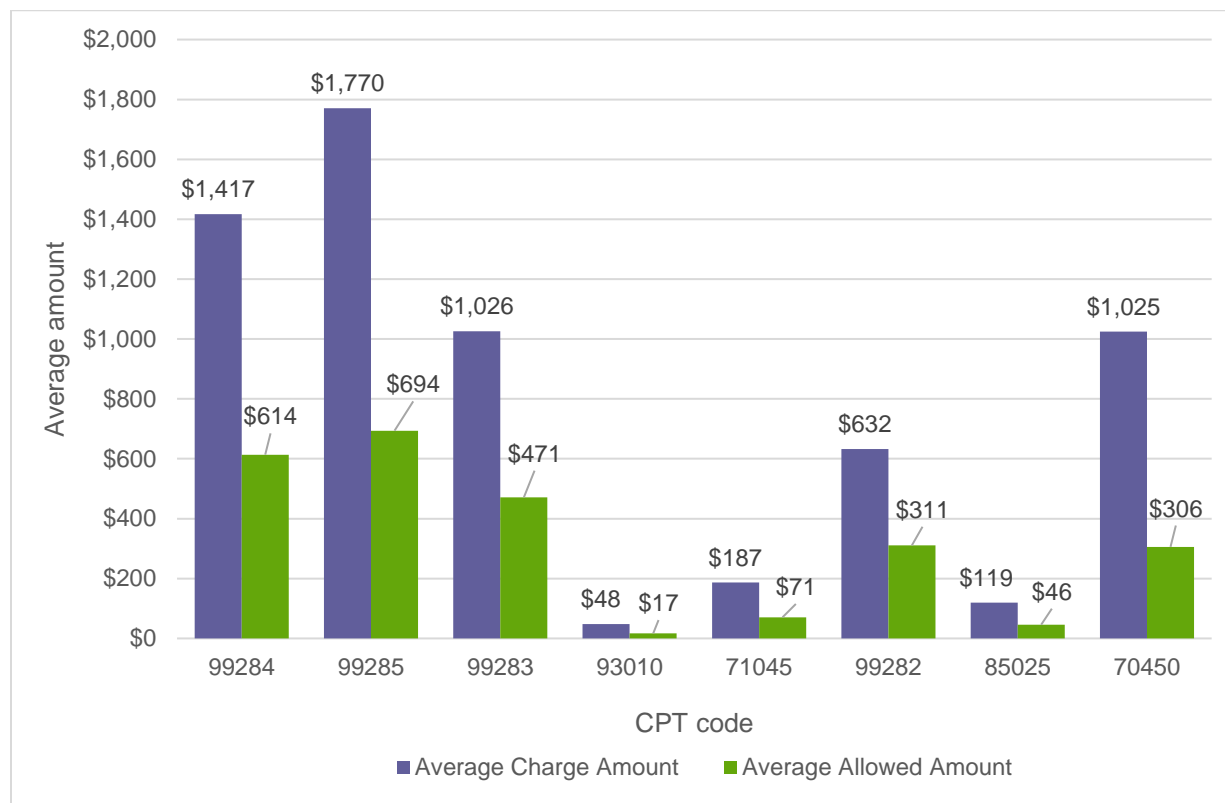


Figure 33. Distribution of claim lines with ER usage by procedures for individuals in all age groups, not including E&Ms, 2021

Figure 34 shows average charges and allowed amounts for the eight most common ER procedure codes in 2021. There were some changes in the codes from 2020 to 2021. CPT 99284 (emergency department visit, problem of high severity) replaced CPT 99285 (emergency department visit, problem with significant threat to life or function) as the number one procedure code, with the latter moving to second place. CPT 71046 (two-view chest X-ray) fell off the list completely. CPT 99282 (emergency department visit, low to moderately severe problem) moved up in the rankings from eighth to sixth place, and CPT 85025 (complete blood cell count, automated test and automated differential white blood cell count) entered the list in seventh place. As in 2020, the highest average charge amount (\$1,770) and average allowed amount (\$694) in 2021 were for CPT 99285. As in 2020, the lowest average charge amount (\$48) and average allowed amount (\$17) were for CPT 93010 (routine electrocardiogram).



CPT Code	Description	CPT Code	Description
99284	Emergency department visit, problem of high severity	71045	X-ray of chest, 1 view
99285	Emergency department visit, problem with significant threat to life or function	99282	Emergency department visit, low to moderately severe problem
99283	Emergency department visit, moderately severe problem	85025	Complete blood cell count (red cells, white blood cell, platelets), automated test and automated differential white blood cell count
93010	Routine electrocardiogram (EKG) using at least 12 leads with interpretation and report	70450	CT scan head or brain

Figure 34. Average charges and allowed amounts for the most common procedures performed in ERs, 2021

FH Medical Price Index

As stated in the Methodology section, FH Medical Price Index uses median charge amounts and median allowed amounts and calculates the changes in those amounts across the years. FH Medical Price Index is based on FAIR Health's benchmark products. FAIR Health conducts rigorous testing and analysis on each of its benchmark modules to assure consistency and validity prior to release.

Changes in the indices may not be entirely driven by prices, but also by CPT code mix and changes in relative utilization.

Professional E&M

The professional E&M indices include CPT codes in the AMA CPT code category Evaluation and Management Services for procedures typically performed in a professional setting as opposed to a hospital setting. This includes office visits such as CPT 99213 and consultations such as CPT 99241.

In 2022, the professional E&M charge amount index continued the steady upward trend seen since the base period of May 2012 (figure 35). The index grew from 1.44 in November 2021 to 1.49 in November 2022, a three percent increase.

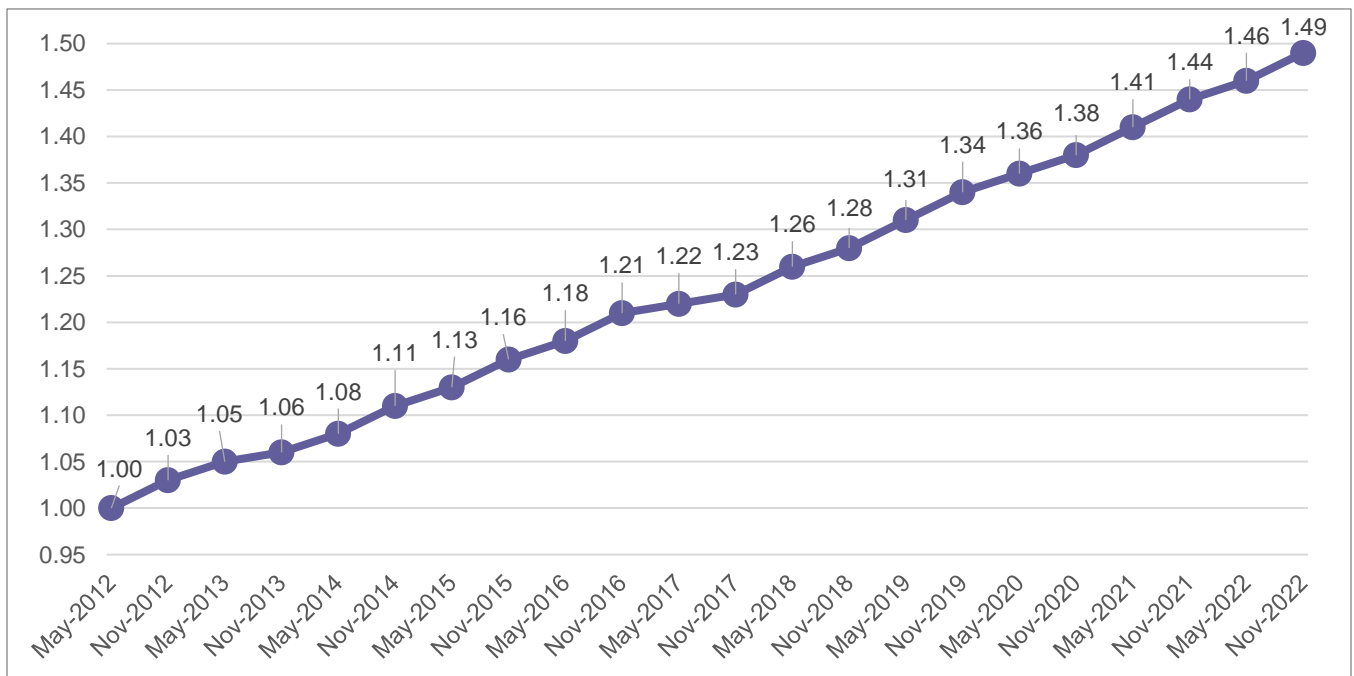


Figure 35. Professional E&M charge amount index

In 2022, the professional E&M allowed amount index saw a slowdown in growth for the first time since the base period (figure 36). The index grew from 1.44 in November 2021 to 1.46 in November 2022, a one percent increase.

Of the six categories, professional E&Ms had the smallest percent increase in allowed amount index from November 2021 to November 2022.

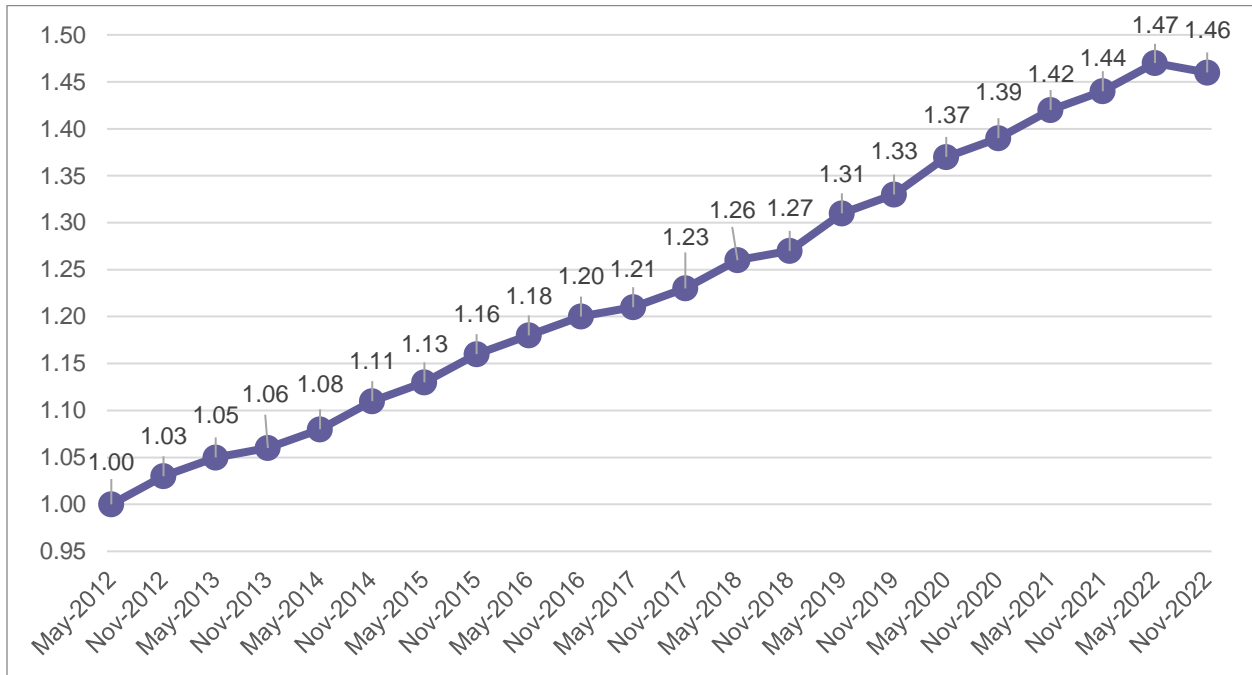


Figure 36. Professional E&M allowed amount index

Hospital E&M

The hospital E&M indices include CPT codes in the AMA CPT code category Evaluation and Management Services for procedures typically performed in a hospital setting, such as CPT 99223, initial hospital care per day, 70 minutes, or CPT 99283, emergency department visit of moderate severity. These indices exclude E&Ms typically performed in a professional setting, such as common office visits. Facility fees are not included.

In 2022, the hospital E&M charge amount index continued to increase at close to the same pace as the year before (figure 37). The index grew from 1.72 in November 2021 to 1.83 in November 2022, a six percent increase.

CPT 99285, a high-severity emergency department visit with immediate threat to life or function, and CPT 99284, a high-severity emergency department visit without immediate threat to life or function, were both the main drivers of the increase in this index. This was due to an increase in the median values of both procedures.

Of the six categories, hospital E&Ms had the greatest percent increase in charge amount index from November 2021 to November 2022.

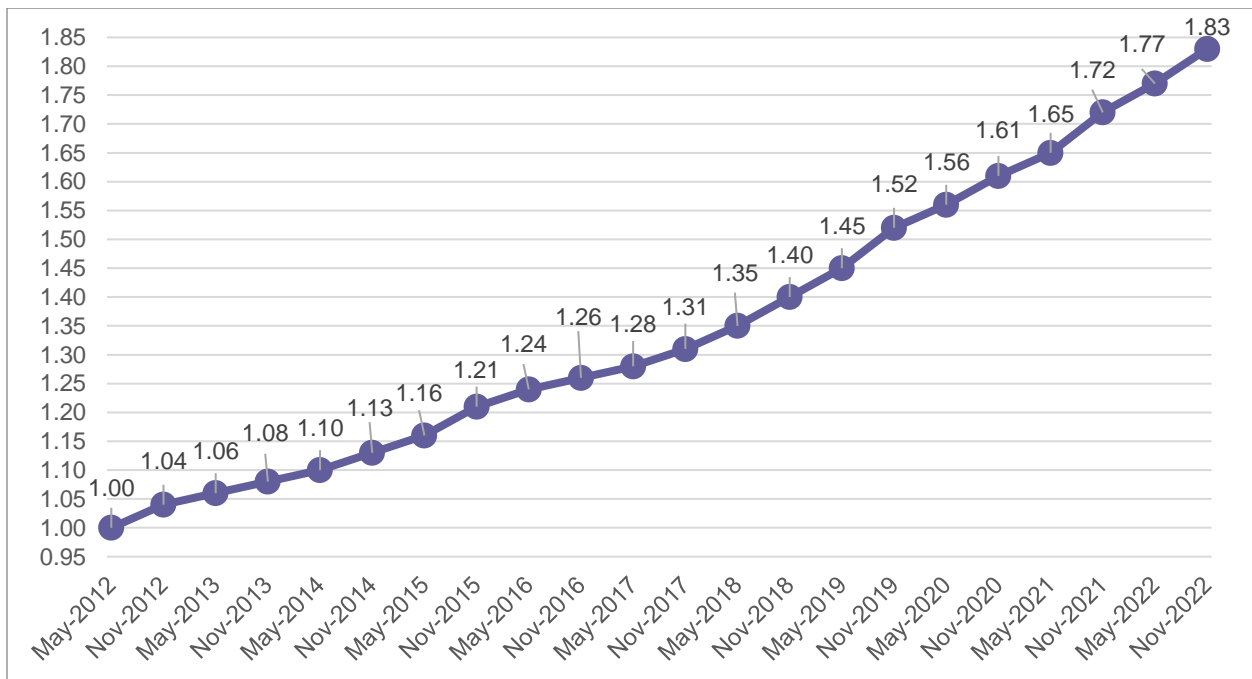


Figure 37. Hospital E&M charge amount index

In 2022, the hospital E&M allowed amount index continued the flattening trend seen the year before and was therefore no longer keeping in step with the charge index, as it once did (figure 38). The index grew from 1.68 in November 2021 to 1.73 in November 2022, a three percent increase.

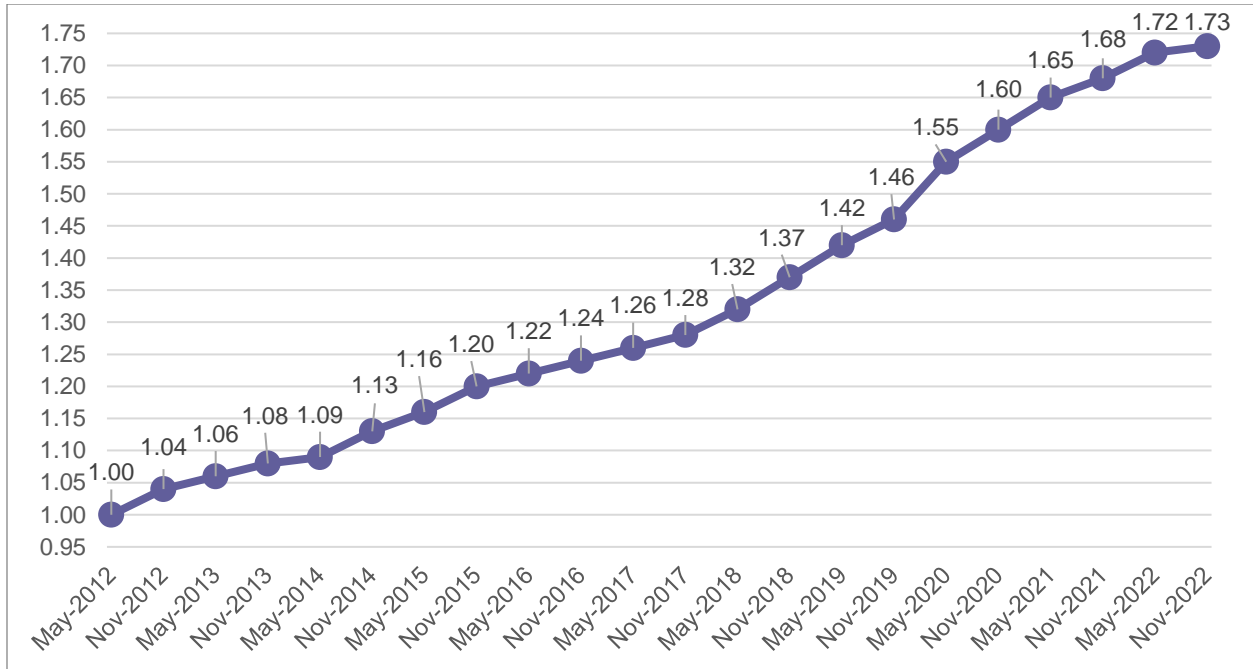


Figure 38. Hospital E&M allowed amount index

Medicine

The medicine indices include all procedures that are not E&Ms, meet the frequency criterion of one million or more and are found in the CPT code ranges from CPT 90281 to CPT 99199 and CPT 99500 to CPT 99607. They include services such as immunizations, psychiatry services, dialysis procedures and allergy and immunology procedures.

The medicine charge amount index increased at a steady pace in 2022, in keeping with recent past releases (figure 39). The index grew from 1.29 in November 2021 to 1.31 in November 2022, a two percent increase.

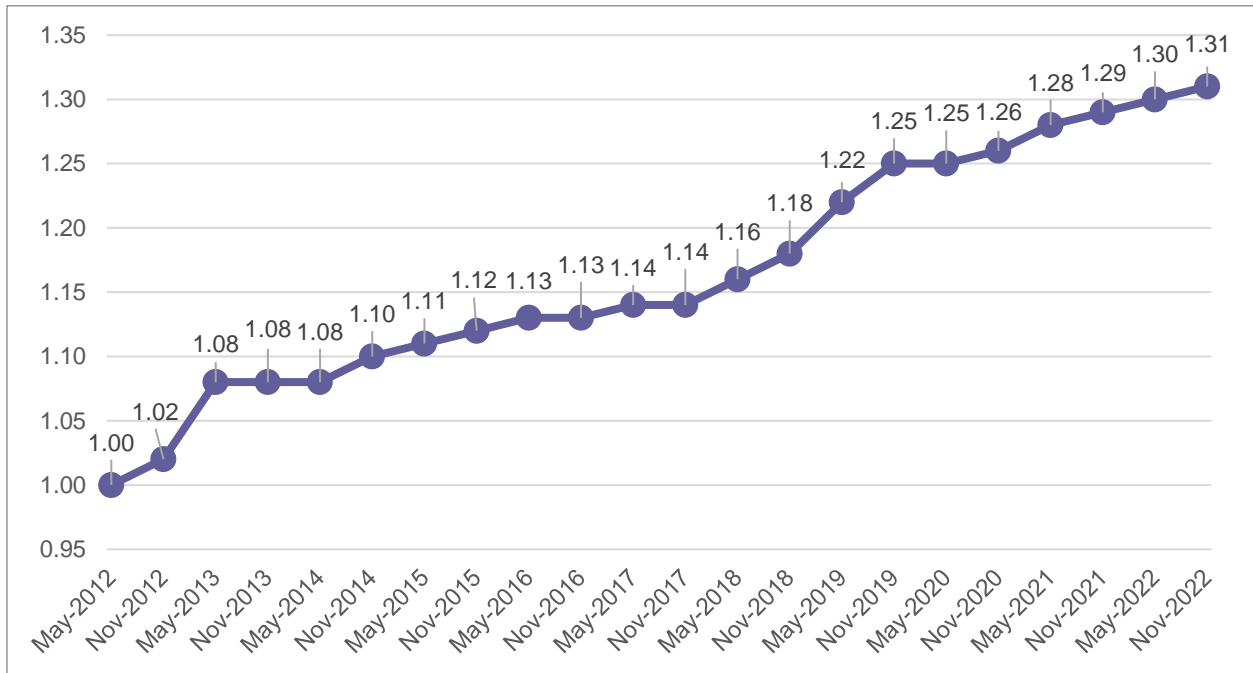


Figure 39. Medicine charge amount index

The medicine allowed amount index increased in its rate of growth due to the large change from November 2021 to May 2022 (figure 40). The index grew from 1.43 in November 2021 to 1.48 in November 2022, a three percent increase.

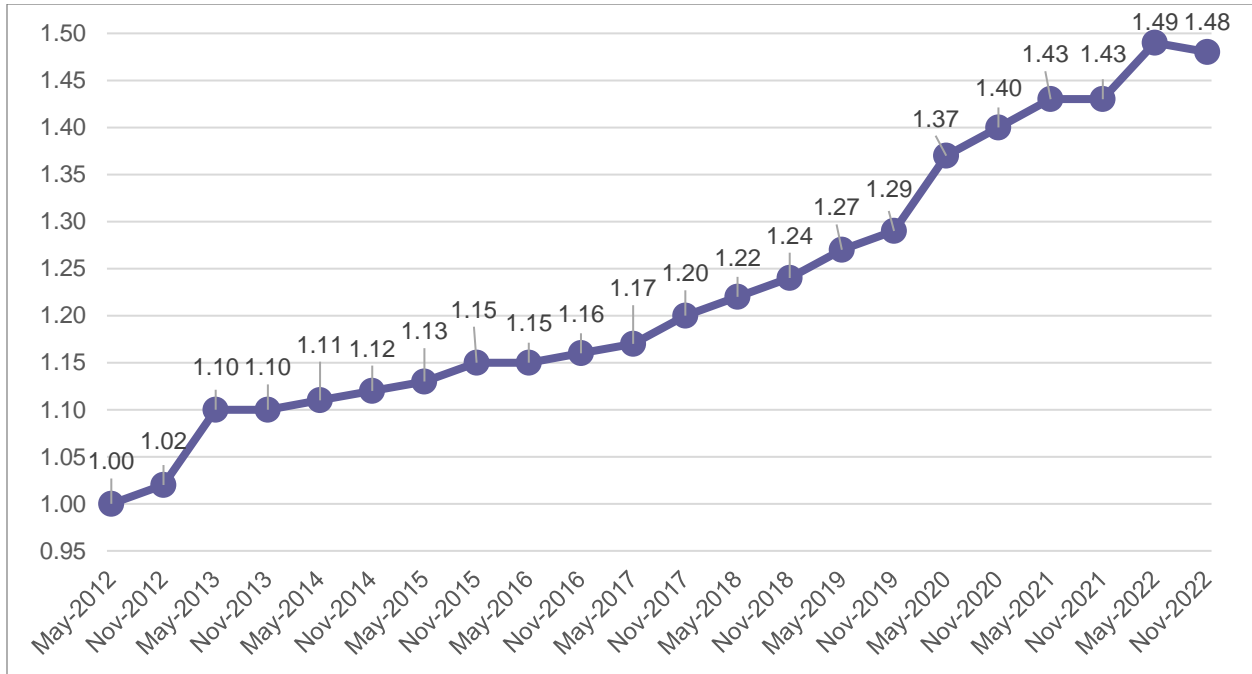


Figure 40. Medicine allowed amount index

Surgery

The surgery indices include codes typically found in the surgical portion of the CPT code book, such as CPT 17003, which is a destruction of a premalignant lesion, and CPT 43239, which is a biopsy during an endoscopy. These are procedures for which the physician would bill; facility fees, if any, are not reflected in the surgery indices.

In 2022, the surgery charge amount index continued increasing at a rate of growth characteristic of the years since 2017 (figure 41). The index grew from 1.26 in November 2021 to 1.32 in November 2022, a five percent increase.

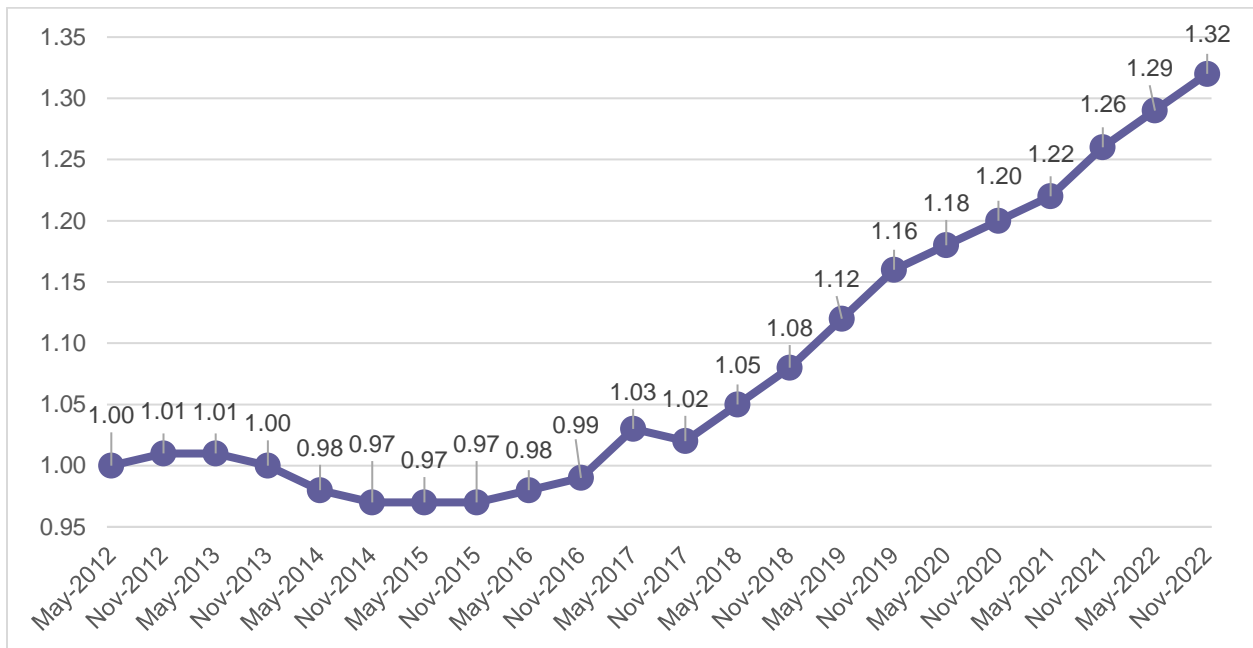


Figure 41. Surgery charge amount index

In 2022, the surgery allowed amount index, while continuing to increase, showed signs of slowing down (figure 42). The index grew from 1.32 in November 2021 to 1.37 in November 2022, a four percent increase (Figure 8).

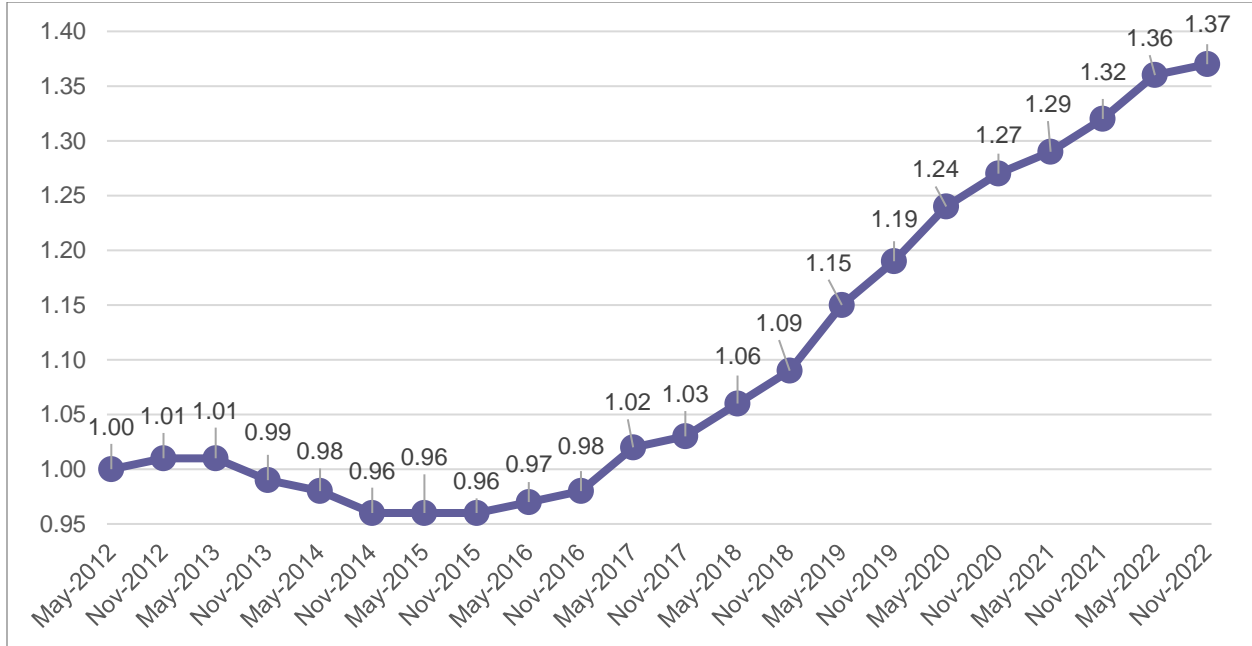


Figure 42. Surgery allowed amount index

Pathology and Laboratory

The pathology and laboratory indices include the CPT code range 80047 through 89398, which identifies such procedures as organ- or disease-oriented panels, drug testing, therapeutic transfusion medicine, microbiology, anatomic pathology (postmortem), cytopathology and in vivo laboratory procedures. Technical (e.g., equipment) and professional costs are included, but not facility fees.

In 2022, the pathology and laboratory charge amount index continued the pace of growth that started in 2019, though the pace was somewhat slower than in 2021 (figure 43). The index grew from 1.29 in November 2021 to 1.34 in November 2022, a four percent increase.

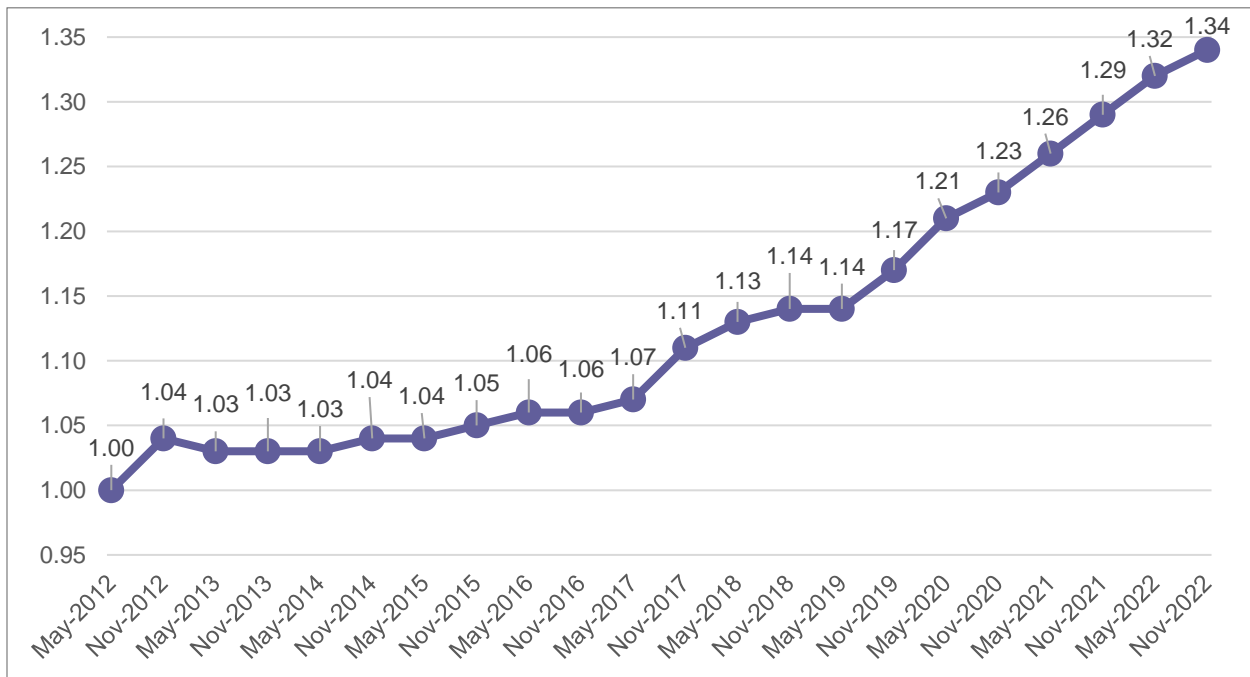


Figure 43. Pathology and laboratory charge amount index

The pathology and laboratory allowed amount index returned to a pattern of growth since the period of flattening out from May 2020 to May 2021 (figure 44). The index grew from 1.20 in November 2021 to 1.25 in November 2022, a four percent increase.

Of the six categories, pathology and laboratory, along with surgery, had the greatest increase in allowed amount index from November 2021 to November 2022; both categories had a four percent increase.

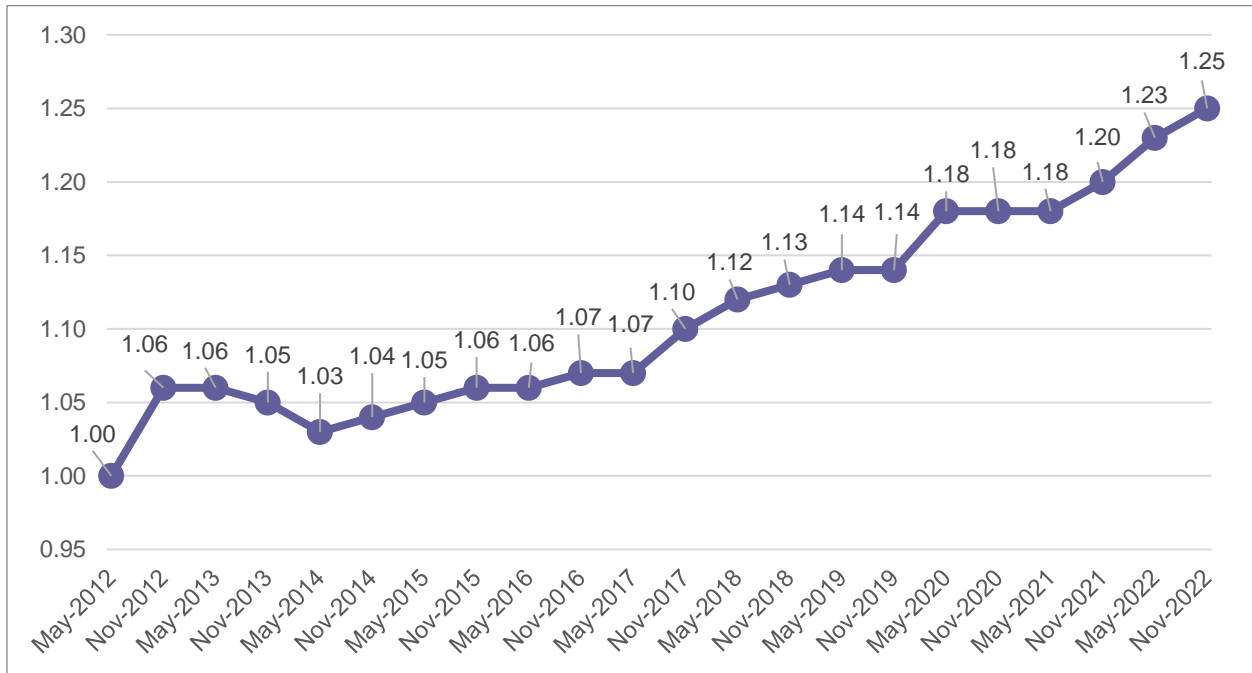


Figure 44. Pathology and laboratory allowed amount index

Radiology

The radiology indices include CPT codes from 70010 to 79999, representing a variety of imaging techniques to diagnose or treat diseases. X-rays, radiographs, ultrasounds, positron emission tomography (PET), computed tomography (CT) and nuclear medicine are included in this category. Both technical and professional components are included, but not facility fees.

The radiology charge amount index did not change from November 2021 to November 2022 (figure 45). The index stayed flat at a value of 1.10 during that period, a zero percent change.

Of the six categories, radiology was the only category to stay completely flat in charge amount index from November 2021 to November 2022.

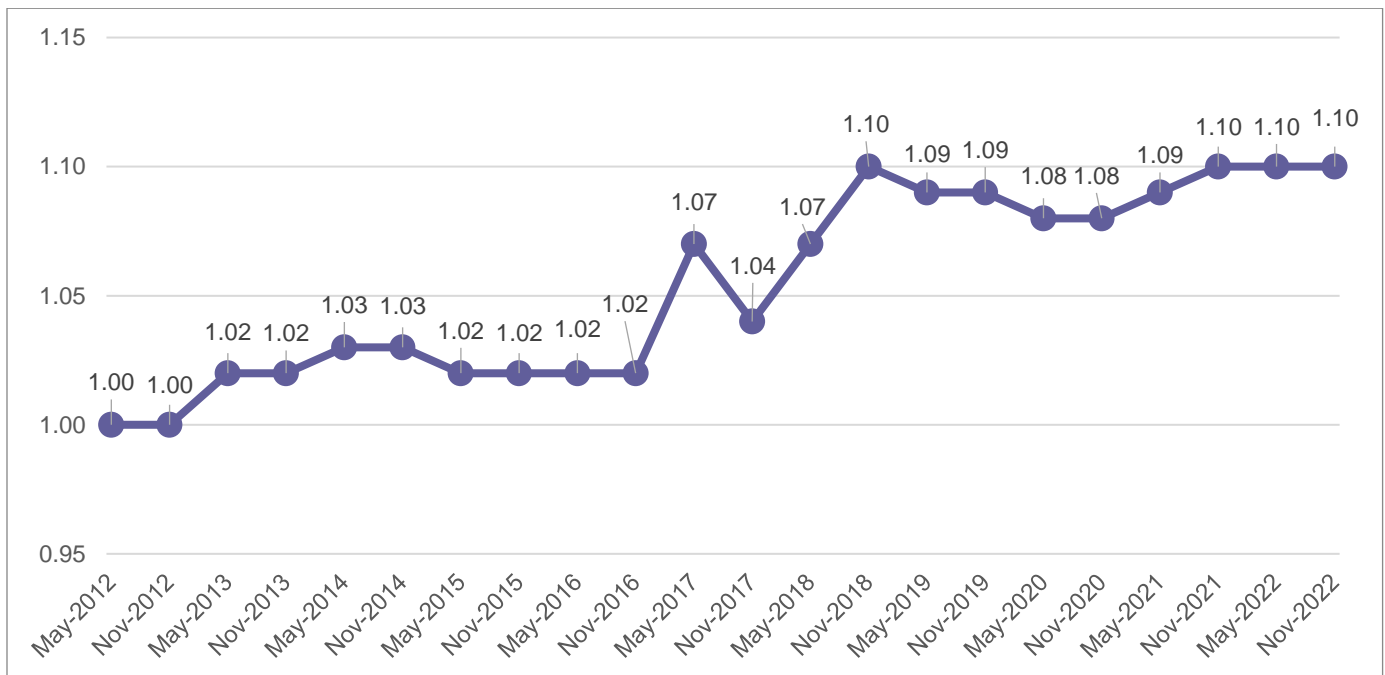


Figure 45. Radiology charge amount index

In 2022, the radiology allowed amount index grew from 1.18 in November 2021 to 1.20 in November 2022, a two percent increase.

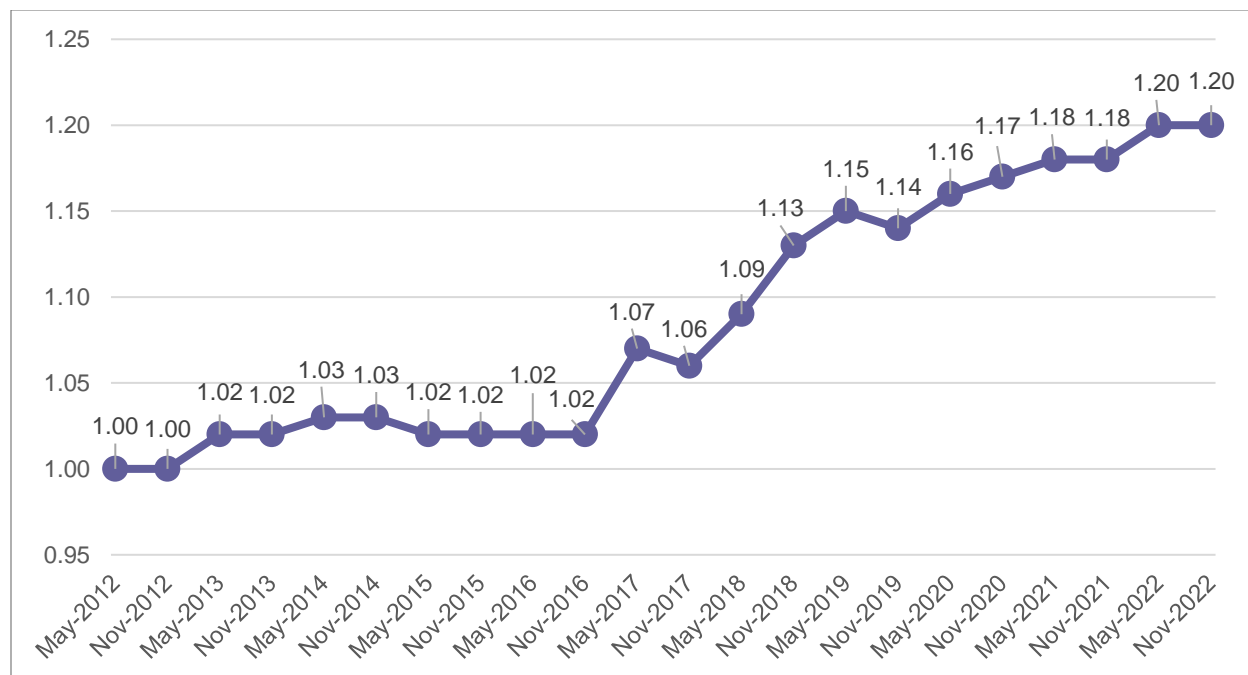


Figure 46. Radiology allowed amount index

Conclusion

This year’s edition of FH Healthcare Indicators showed that, in 2021, the second year of the COVID-19 pandemic, telehealth utilization declined 76 percent nationally, the greatest decrease of all places of service studied for changes in utilization, but remained substantially higher than it had been pre-pandemic. Utilization increased the most in retail clinics (51 percent); it increased 14 percent in urgent care centers and decreased 7 percent in ASCs and 15 percent in ERs. Despite the relatively greater decrease in telehealth utilization, telehealth held the highest percentage of medical claim lines in 2021 among alternative places of service and ERs, with 3.7 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 1.8 percent for ERs, 1.5 percent for urgent care centers, 0.6 percent for ASCs and 0.1 percent for retail clinics.

In 2021, COVID-19 joined the list of most common diagnostic categories in retail clinics, urgent care centers, telehealth and ERs (for individuals over the age of 22).

In 2021 as in previous years, more claim lines were submitted for females than males in most age groups in alternative places of service and ERs. However, in some places of service, such as retail clinics, urgent care centers and ERs, the gap between males and females continued to narrow in some age groups.

As in previous years, there were shifts in the distribution of places of service by state. In 2021, Minnesota fell off the list of the five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines, after having ranked first in 2018, third in 2019 and fifth in 2020.

According to this year’s edition of FH Medical Price Index, in the period November 2021 to November 2022, of the six procedure categories, hospital E&Ms had the greatest percent increase in charge amount

index, six percent. Surgery and pathology and laboratory each had the greatest percent increase in allowed amount index, four percent. Radiology was the only category to stay completely flat in charge amount index, at zero percent change. Professional E&Ms had the smallest percent increase in allowed amount index, one percent.

Because of its importance to the US economy and the lives of Americans, understanding the trends and shifts in the healthcare sector is vital. By issuing this new edition of FH Healthcare Indicators and FH Medical Price Index, FAIR Health seeks to provide insights that can inform decision making by stakeholders throughout the healthcare sector, including payors, providers, government officials, policy makers and others. As part of its mission, FAIR Health will continue to issue these reports annually. In addition, FAIR Health makes available customized indicators and indices that offer specific data subsets (e.g., based on clinical category, geographic region, time period) of particular interest to stakeholders. Contact FAIR Health at info@fairhealth.org or 855-301-3247 to learn more about such customized studies.

About FAIR Health

FAIR Health is a national, independent nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information through data products, consumer resources and health systems research support. FAIR Health qualifies as a public charity under section 501(c)(3) of the federal tax code. FAIR Health possesses the nation's largest collection of private healthcare claims data, which includes over 40 billion claim records and is growing at a rate of over 2 billion claim records a year. FAIR Health licenses its privately billed data and data products—including benchmark modules, data visualizations, custom analytics and market indices—to commercial insurers and self-insurers, employers, providers, hospitals and healthcare systems, government agencies, researchers and others. Certified by the Centers for Medicare & Medicaid Services (CMS) as a national Qualified Entity, FAIR Health also receives data representing the experience of all individuals enrolled in traditional Medicare Parts A, B and D; FAIR Health includes among the private claims data in its database, data on Medicare Advantage enrollees. FAIR Health can produce insightful analytic reports and data products based on combined Medicare and commercial claims data for government, providers, payors and other authorized users. FAIR Health's free, award-winning, national consumer websites are fairhealthconsumer.org and fairhealthconsumidor.org. For more information on FAIR Health, visit fairhealth.org.

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