

WHITE PAPER

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



Summary

This is the fifth 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 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 2014 to 2019, this year's chart shows 2015 to 2020. ***This means that, for the first time, this edition shows changes that occurred in 2020 as a result of the COVID-19 pandemic.*** Here are some of the key findings from the period ending in 2020:

- Due to the pandemic and the limits imposed on certain in-office services, coupled with the increased risk of infection from in-person encounters, telehealth grew in 2020 on a scale unseen in previous years. Telehealth utilization increased nationally 41,919 percent from 2015 to 2020, a more than 40-fold increase over the growth of 1,019 percent from 2014 to 2019 reported in last year's edition. From 2019 to 2020, national growth was 7,060 percent.¹
- In all other places of service studied for changes in utilization, utilization decreased from 2019 to 2020, probably because of the impact of COVID-19. Utilization fell 38 percent in ASCs, 30 percent in ERs, 16 percent in urgent care centers and 4 percent in retail clinics.
- Among the places of service studied, telehealth held the highest percentage of medical claim lines in 2020, with 15.41 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 2.07 percent for ERs, 1.31 percent for urgent care centers, 0.64 percent for ASCs and 0.05 percent for retail clinics.
- In 2020 as in previous years, more claim lines were submitted for females than males in most age groups in the places of service in which FAIR Health studied gender-related patterns—retail clinics, urgent care centers, telehealth, ASCs and ERs.
- However, in some places of service, such as retail clinics, urgent care centers, ASCs and ERs, the gap between males and females narrowed. For example, in ERs, in the age group 61-70, the male and female shares were approximately equal (50 percent) in 2020, a change from 2019, when the female share had been 52 percent and the male share 48 percent. This trend bears monitoring in the future.
- In 2020, the five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines were (from greatest to least) Arkansas, Missouri, Rhode Island, Maine and Minnesota. In 2018, Minnesota had ranked first in this list; in 2019, it ranked third, and in 2020 it fell to fifth.
- Connecticut, which had been fourth from the bottom in its use of telehealth as a percentage of all medical claim lines by state in 2019, rose to fifth from the top in 2020.
- In 2020, exposure to communicable diseases joined the list of most common diagnostic categories in retail clinics, urgent care centers and telehealth. This category largely was associated with testing and/or treatment for COVID-19 when a patient was exposed to the condition.

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

- Across offices, urgent care centers and retail clinics in 2019, urgent care centers had the highest median charge amount for CPT^{®2} 99203 (30-44-minute new patient office visit), but in 2020 the median charge for an office (\$226) was slightly higher than that for an urgent care center (\$221).

FH Medical Price Index tracks the weighted average growth in median procedure 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 and in the fourth to November 2020. In the new edition, the indices are extended to November 2021. Findings include the following, all for the period November 2020 to November 2021:

- Of the six procedure categories, hospital E&Ms had the greatest percent increase in charge amount index, seven percent, and in allowed amount index, five percent.
- Radiology and medicine each had the smallest percent increase in charge amount index, two percent.
- Radiology had the smallest percent increase in allowed amount index, one percent.
- The medicine allowed amount index increased two percent.
- The professional E&M charge amount index and allowed amount index each grew four percent.
- The surgery charge amount index increased five percent and allowed amount index four percent.
- The pathology and laboratory charge amount index increased five percent and allowed amount index two 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

² CPT © 2021 American Medical Association (AMA). All rights reserved.

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. In the last three years, FAIR Health released the second,⁴ third⁵ and fourth⁶ annual editions, and this is the fifth.

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 36 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 2020 and FH Medical Price Index to 2021. For this reason, FH Healthcare Indicators include data from the first year of the COVID-19 pandemic, and FH Medical Price Index includes data from both the first and second year.

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 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

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>.

such as CPT 99441 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 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 2015 to 2020, each year’s data point for national usage is the percentage share of all the normalized claim lines in the national usage grouping from 2015 to 2020. 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 2015 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 2021 indices, 20 releases of the benchmark products were used to establish the price component of the indices: May and November of each year from 2012 to 2021. 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 erroneous fluctuations.

Once the list of codes to be included in the 2021 indices was established, the median charge or allowed amount for each code in each 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 2021

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 2021	\$553,888,612,070	2,762,816,011	\$200.48	$\left(\frac{\$200.48}{\$139.07}\right)$	1.44

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.⁷ 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.

⁷ 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, offices and ERs.

Retail Clinic

The normalized share of claim lines for retail clinics grew nationally 35.5 percent from 2015 to 2020 (figure 1), a much slower pace of growth than that documented in last year's report (306 percent from 2014 to 2019).

Growth occurred in urban areas from 2015 to 2020 (45.9 percent), but there was a decline in rural areas during that period (33.6 percent). From 2019 to 2020, the total decrease in the percentage share of retail clinic utilization was 3.93 percent; in urban areas it was 0.95 percent and in rural areas 33.01 percent.

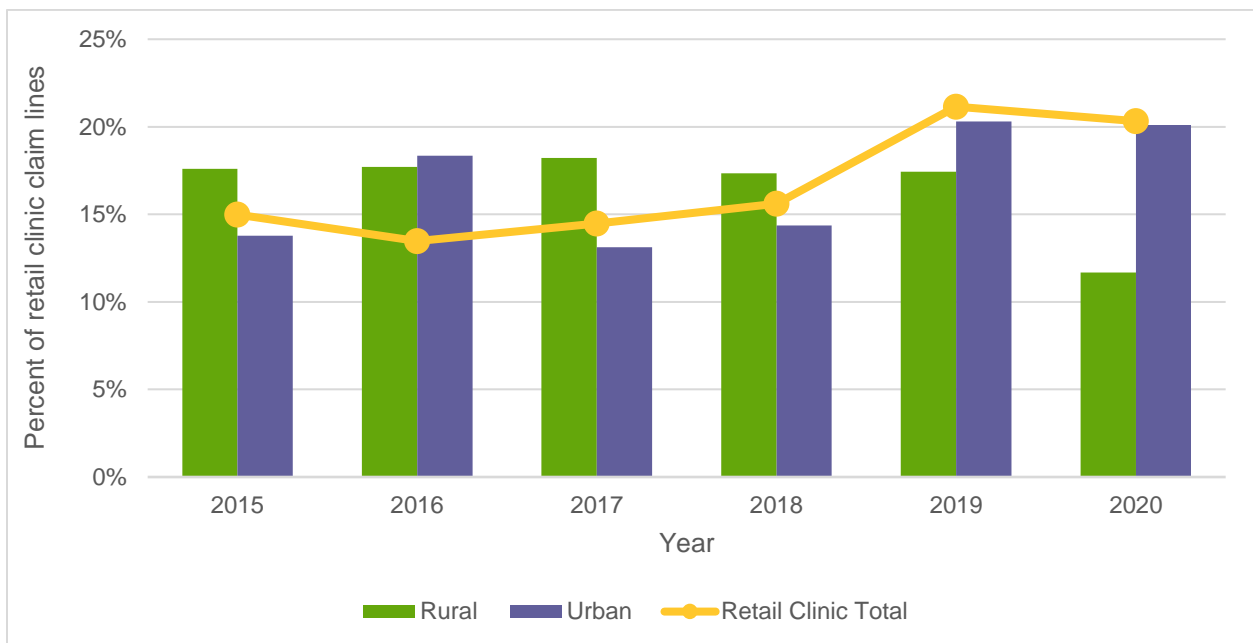


Figure 1. Percent of claim lines with retail clinic usage by rural, urban and national settings, 2015-2020

In figure 1 above, rural and urban retail clinic usage in 2015 is shown as a percentage of all rural and urban retail clinic usage, respectively, measured by claim lines, from 2015 to 2020. But in figure 2 below, rural and urban retail clinic usage in 2015 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 2015 to 2020, the percentage of all medical claim lines attributed to retail clinics was less than 0.1 percent, just as it had been from 2014 to 2019. As noted, relative use increased in urban areas 45.9 percent, from 0.03 percent in 2015 to 0.05 percent in 2020; use declined in rural areas 33.6 percent, from 0.04 percent in 2015 to 0.03 percent in 2020. In the nation as a whole, use increased 35.5 percent, from 0.04 percent in 2015 to 0.05 percent in 2020.



Figure 2. Claim lines with retail clinic usage as a percentage of all medical claim lines by rural, urban and national settings, 2015-2020

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 2020 are on the red end of the spectrum, while states with a lower percentage are on the green end (figure 3). The five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines were (from greatest to least) Arkansas, Missouri, Rhode Island, Maine and Minnesota. In 2018, Minnesota had ranked first in this list; in 2019, it ranked third, and in 2020 it fell to fifth.

The five jurisdictions with the lowest retail clinic usage in 2020, in order from least to most, were Washington, DC; Wyoming; North Carolina; Mississippi; and Louisiana. Louisiana had had the lowest retail clinic usage in 2019, but in 2020 it had the fifth lowest.

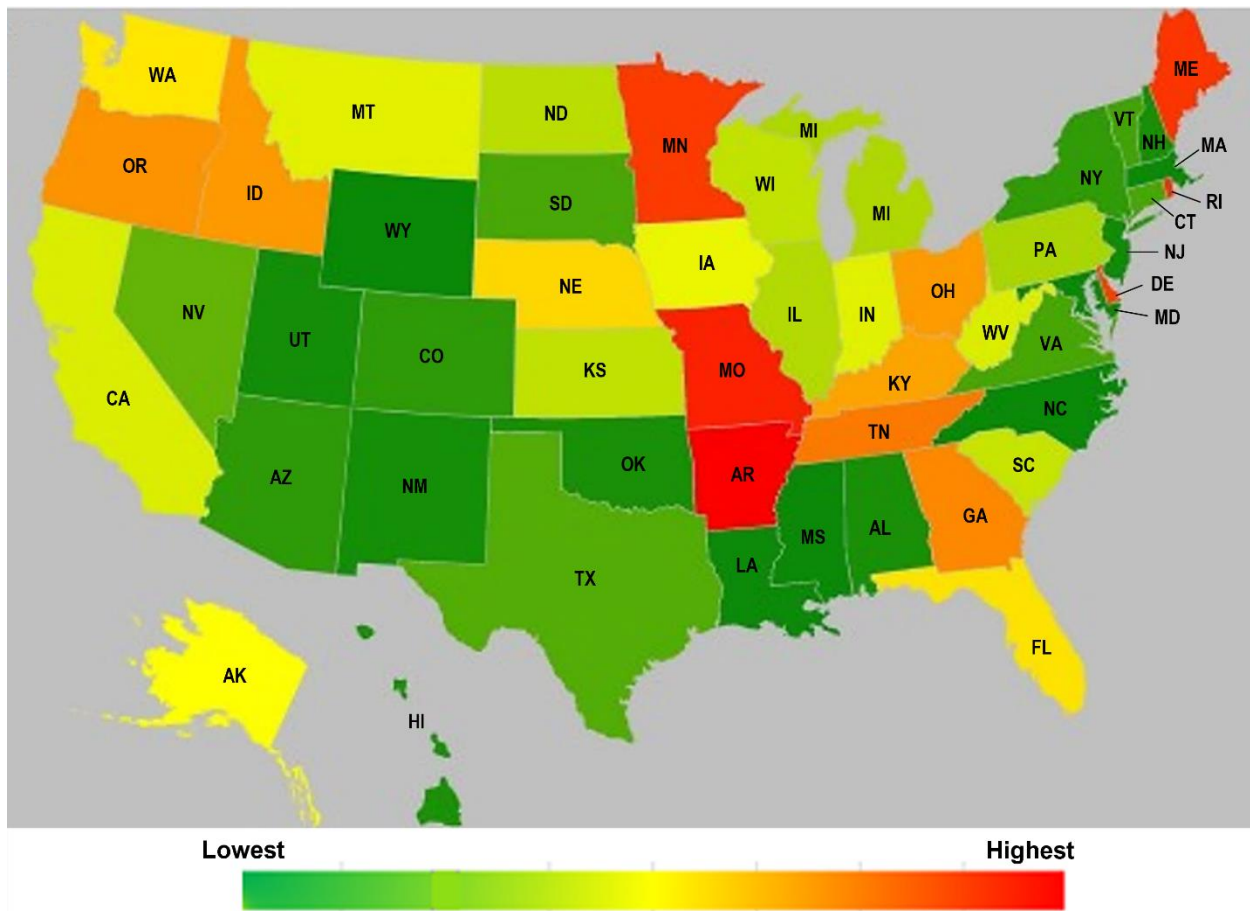


Figure 3. Percent of claim lines with retail clinic usage compared to all medical claim lines by state, 2020

The age distribution of retail clinic claim lines in 2020 (figure 4) was similar to that in 2019, but there were some changes. In 2020, the age groups 0-10 and 11-18 each accounted for less than 10 percent of the distribution, whereas in 2019 they had each accounted for more than 10 percent. In 2020 as in 2019, individuals aged 31-40 were the highest utilizers of retail clinics. But in 2020 the second highest utilizers were those aged 23-30, compared to those aged 41-50 in 2019.

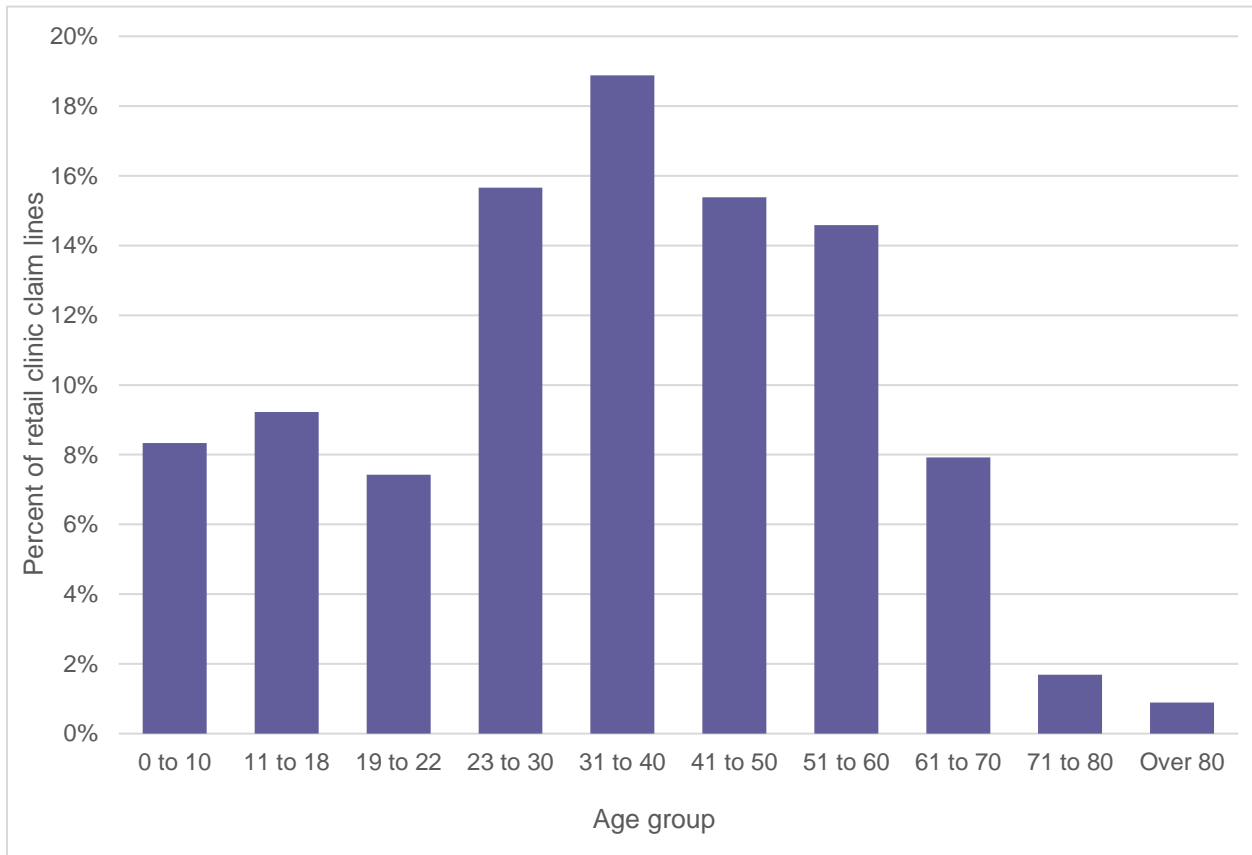


Figure 4. Percent of claim lines with retail clinic usage by age group, 2020

In 2020 as in previous years, more claim lines were submitted for women than for men in most age groups in the places of service in which FAIR Health studied gender-related patterns—retail clinics, urgent care centers, telehealth, ASCs 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 physicians⁸ and make use of healthcare services.⁹

In retail clinics from 2016 to 2018, the only age group in which claim lines for males outnumbered those for females was that of children aged 0-10. In 2019, the gender distribution for that age group was almost even, with males and females each accounting for approximately 50 percent. In 2020, the gender distribution for that age group was again close to even, with males accounting for 51 percent and females 49 percent (figure 5).

In general, in 2020 there was a shift toward males using retail clinics more, even though females were still in the majority in most age groups. 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.

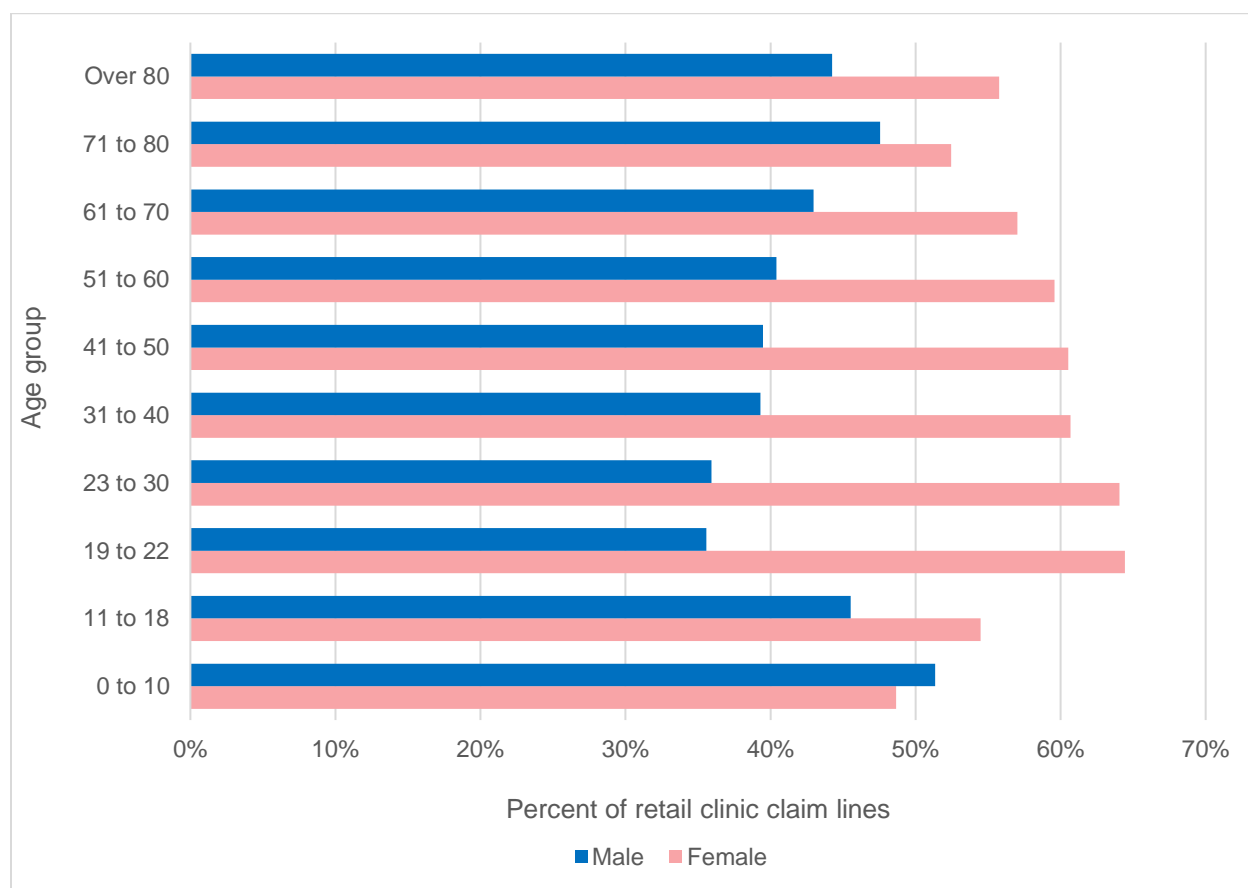


Figure 5. Percent of claim lines with retail clinic usage by age and gender, 2020

⁸ 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>.

⁹ 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>.

As in previous years, the most common diagnostic category in retail clinics in 2020 was acute respiratory diseases and infections, which accounted for 25 percent of retail clinic claim lines that year (figure 6). Its share of the distribution was smaller than the year before (37 percent). In 2020 as in 2019, encounter for immunization was the second largest diagnostic category, though at 13 percent in 2020, its share was larger than it had been in 2019 (9 percent).

The third largest diagnostic category in 2020, exposure to communicable diseases, had not been among the top 10 diagnostic categories in 2019. The growth in this category, which reached 10 percent of the distribution in 2020, was likely due to patients seeking COVID-19 testing through their local retail clinics.

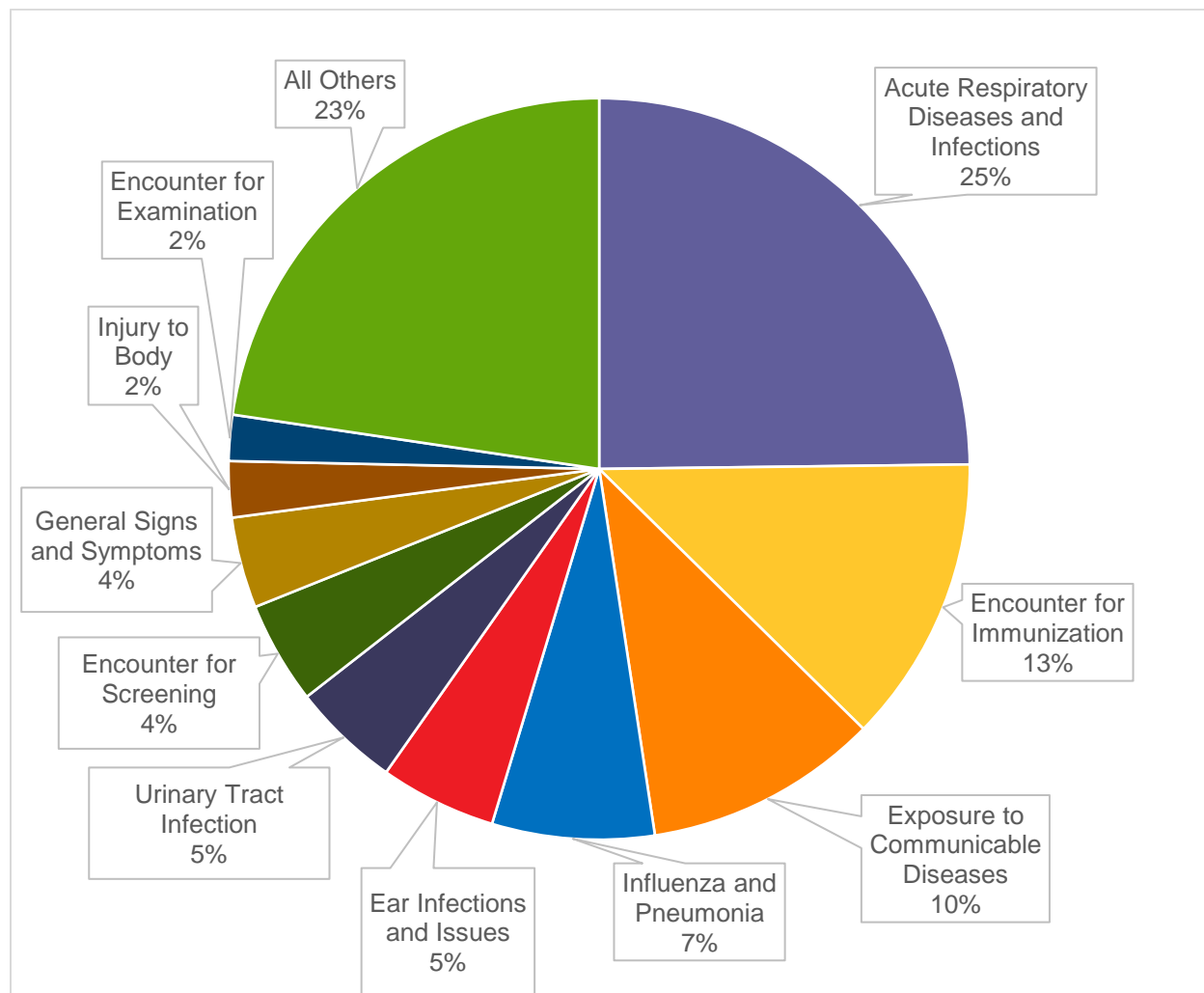


Figure 6. Distribution of claim lines with retail clinic usage by diagnostic category, 2020

As in previous years, the type of procedure most commonly performed in retail clinics in 2020 was established patient office or other outpatient services (figure 7). Its share of the distribution of retail clinic claim lines fell from 30 percent in 2019 to 26 percent in 2020. Vaccines, toxoids moved from third place in 2019, with 12 percent of the distribution, to second place in 2020, with 17 percent. Immunization administration for vaccines/toxoids moved from fourth place in 2019 (11 percent) to third place in 2020 (16 percent).

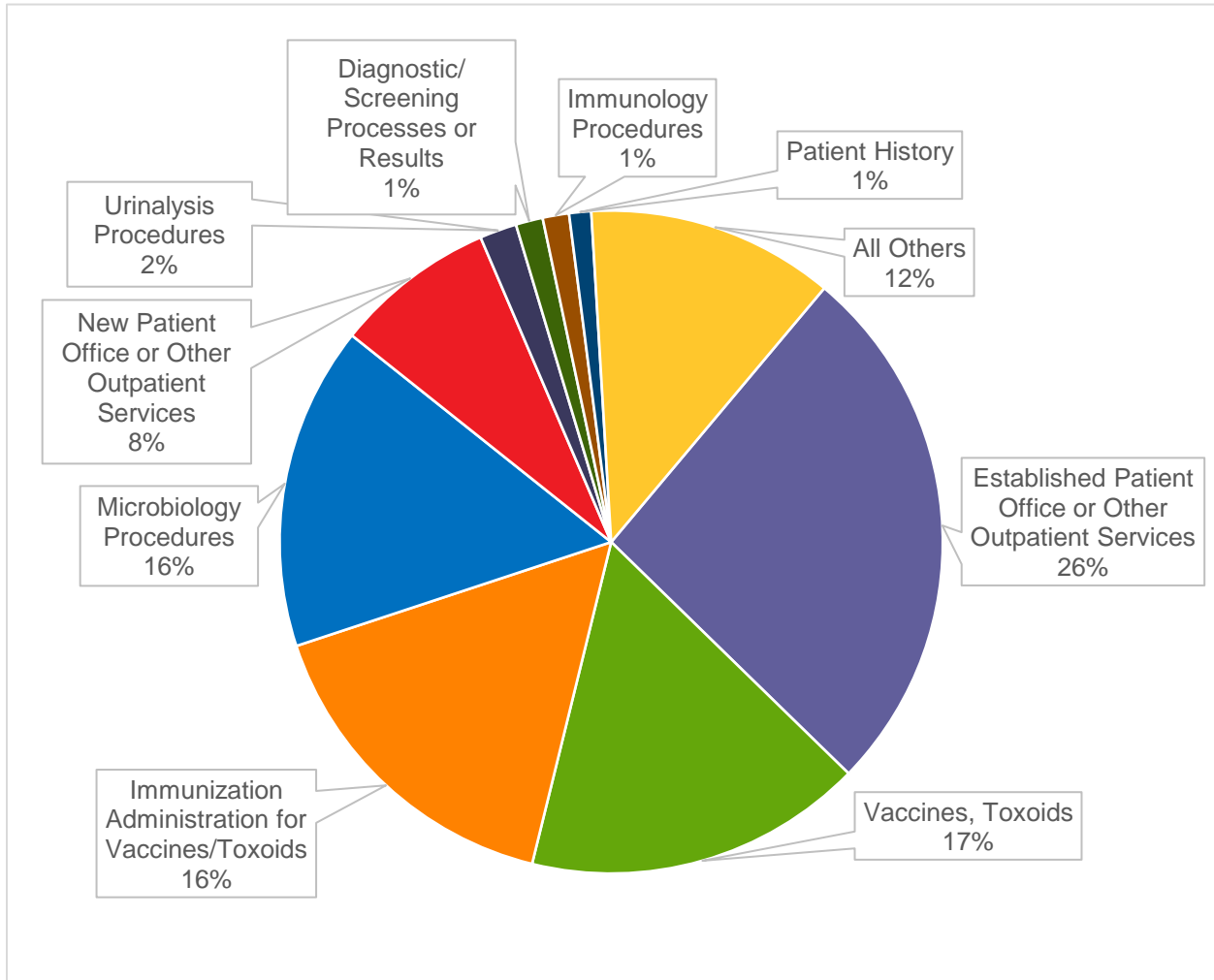
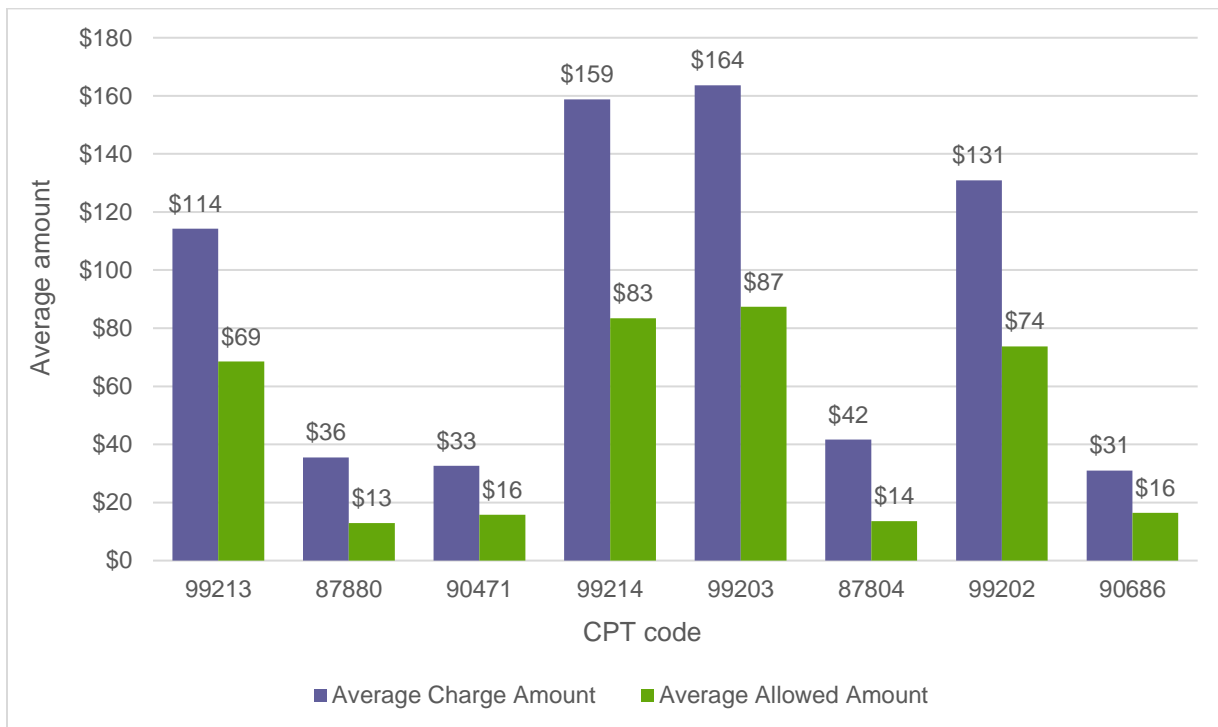


Figure 7. Distribution of claim lines with retail clinic usage by procedures, 2020

The average charges and allowed amounts for the most common procedures performed in retail clinics in 2020, as identified by CPT code, are shown in figure 8. The top eight codes by volume were similar to 2019, though the order differed slightly, with CPT 87804, the influenza test, moving from fourth to sixth place. Also, CPT 90750 (shingles vaccine) fell out of the top eight while CPT 90686 (influenza vaccine) joined the list. CPT 99203 (office outpatient visit—new—30-44 minutes) had the highest average charge (\$164) and allowed amount (\$87) of the top eight. The lowest average charge was \$31, for CPT 90686 (influenza vaccine). The lowest average allowed amount was \$13 for CPT 87880 (streptococcus test).



CPT Code	Description	CPT Code	Description
99213	Office outpatient visit – 20-29 minutes	99203	Office outpatient visit – new – 30-44 minutes
87880	Streptococcus test	87804	Influenza test
90471	Immunization administration	99202	Office outpatient visit – new – 15-29 minutes
99214	Office outpatient visit – 30-39 minutes	90686	Influenza vaccine

Figure 8. Average charges and average allowed amounts for the most common procedures performed in retail clinics, 2020

Urgent Care

The normalized share of claim lines for urgent care centers grew overall 140 percent from 2011 to 2020 (figure 9). This was a lower increase than that from 2010 to 2019 (425 percent). There was a decrease in normalized national utilization of 16 percent from 2019 to 2020; the decrease was 15 percent in urban areas and 19 percent in rural areas. The decrease was likely due in large part to patients avoiding, or being unable to access, in-person medical care due to COVID-19.

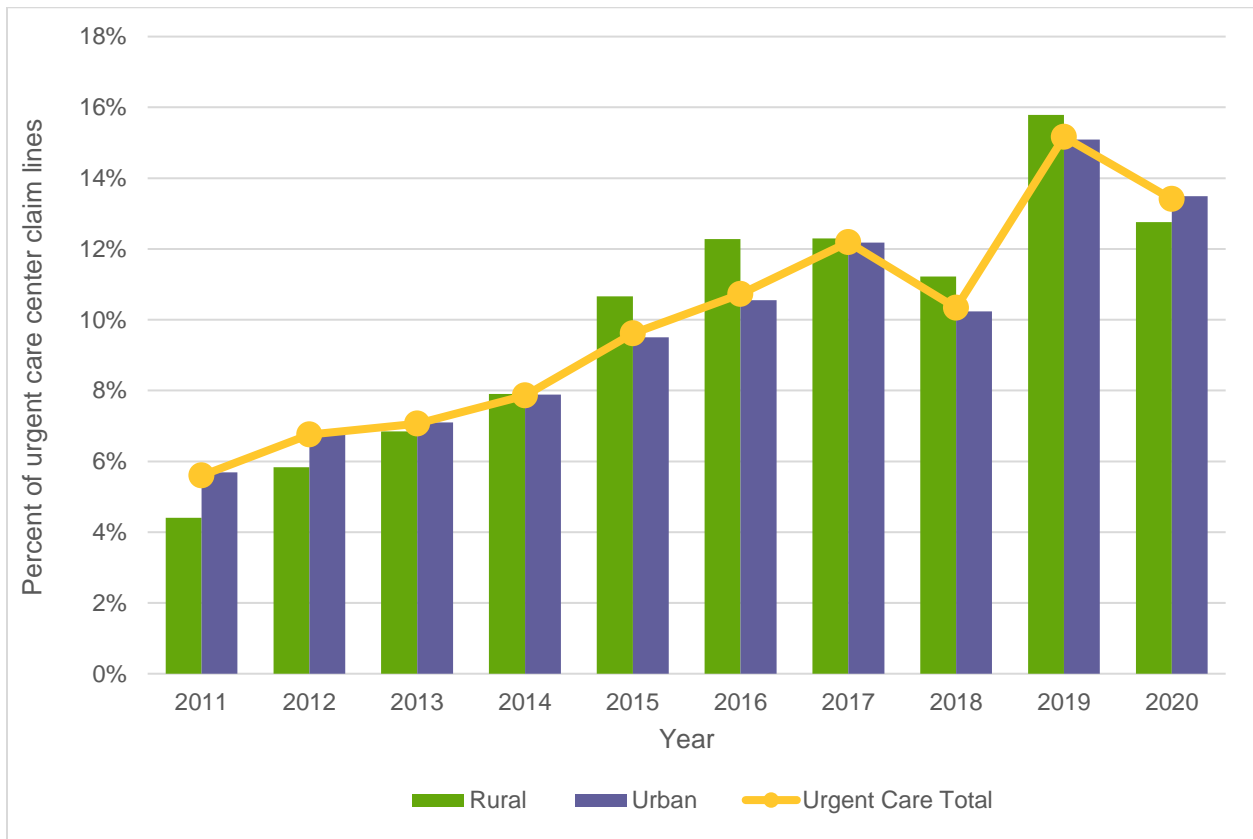


Figure 9. Percent of claim lines with urgent care center usage by rural, urban and national settings, 2011-2020

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 reached over one percent from 2016 to 2020.

In 2020, urgent care usage as a percentage of national, rural and urban medical claim lines was the same: 1.31 percent. This was a decrease from the percentages in 2019: 1.56 percent national, 1.62 percent rural and 1.55 percent urban.

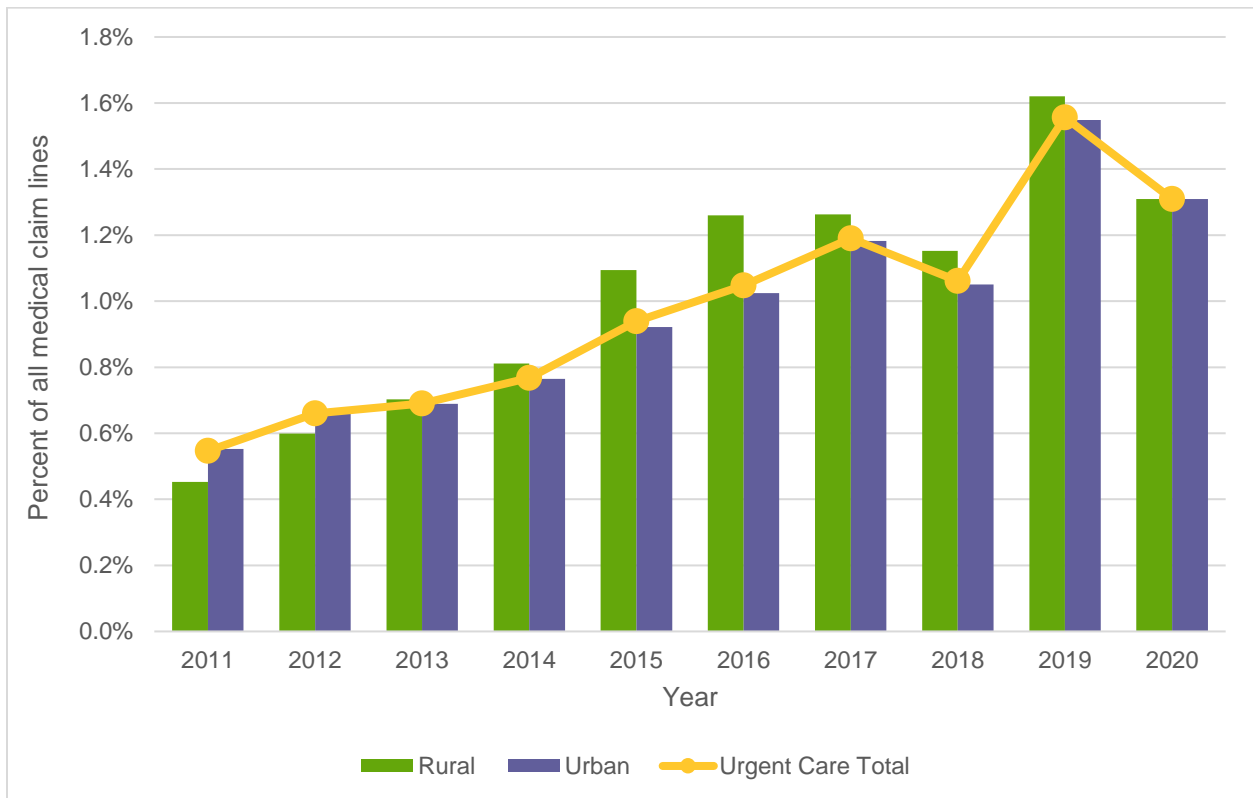


Figure 10. Claim lines with urgent care center usage as a percentage of all medical claim lines by rural, urban and national settings, 2011-2020

In 2020, four of the same states as in 2019 ranked in the top five for claim lines with urgent care center usage as a percentage of all medical claim lines by state (figure 11). The four were Hawaii, Virginia, Maryland (fourth in 2019 and third in 2020) and Louisiana (fifth in 2019 and fourth in 2020). New Mexico, which had been in third place in 2019, fell off the top five list in 2020; it was replaced by Missouri in fifth place.

The five jurisdictions with the lowest urgent care center usage in 2020 were Washington, DC; Iowa; North Dakota; Alaska; and Nebraska. The only changes from 2019 were that Alaska moved from fifth to fourth place, Massachusetts dropped off the list and Nebraska joined the list.

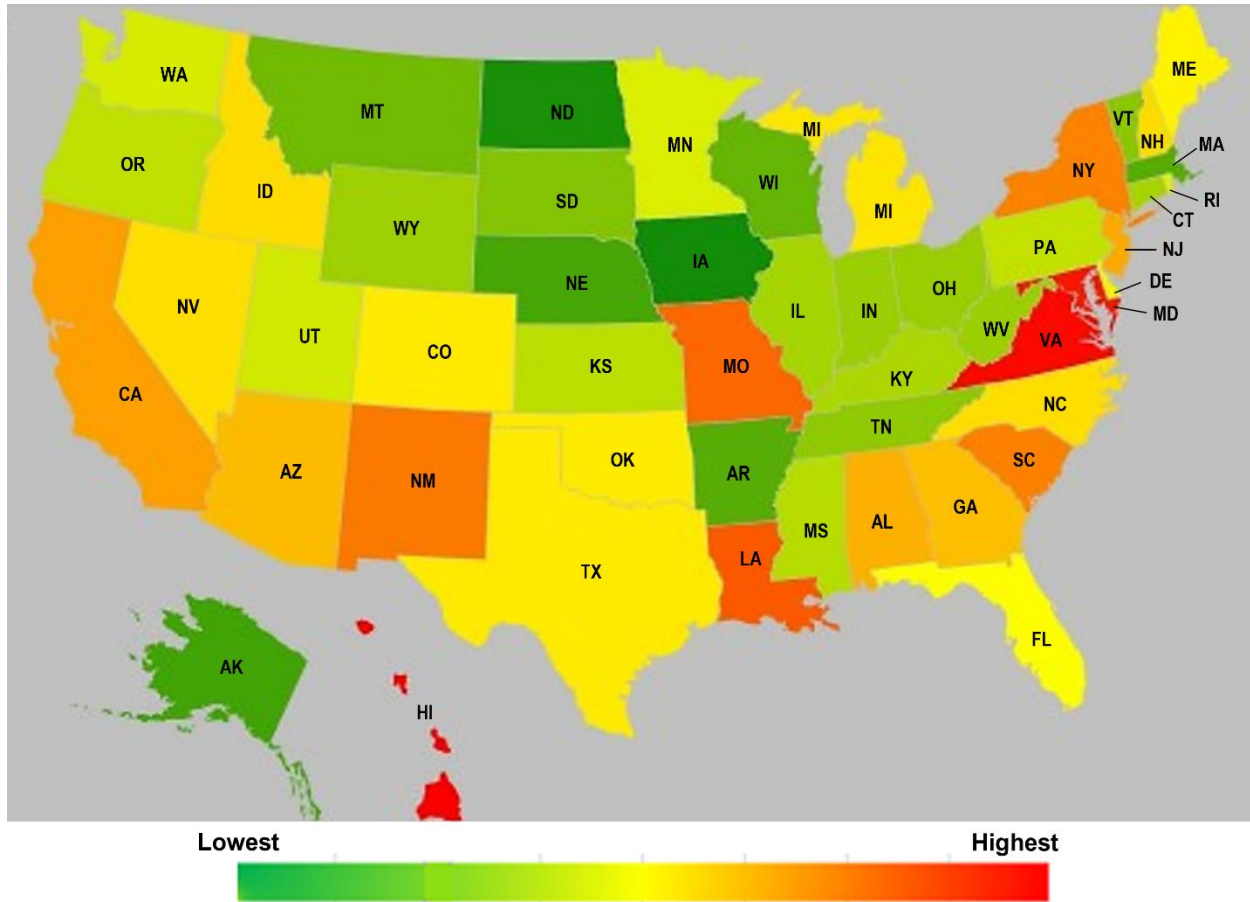


Figure 11. Percent of claim lines with urgent care center usage compared to all medical claim lines by state, 2020

As in previous years, the age group with the greatest share of claim lines for urgent care center usage in 2020 was that of individuals aged 31-40 (19 percent; figure 12). The age distribution changed somewhat from 2019 in the younger cohorts. Whereas in 2019 the age group 19-22 had made up seven percent of the total distribution of urgent care visits, in 2020 it made up nine percent. During the same period, the age group 0-10 dropped from 12 percent to 9 percent, and the age group 11-18 fell from 10 percent to 8 percent.

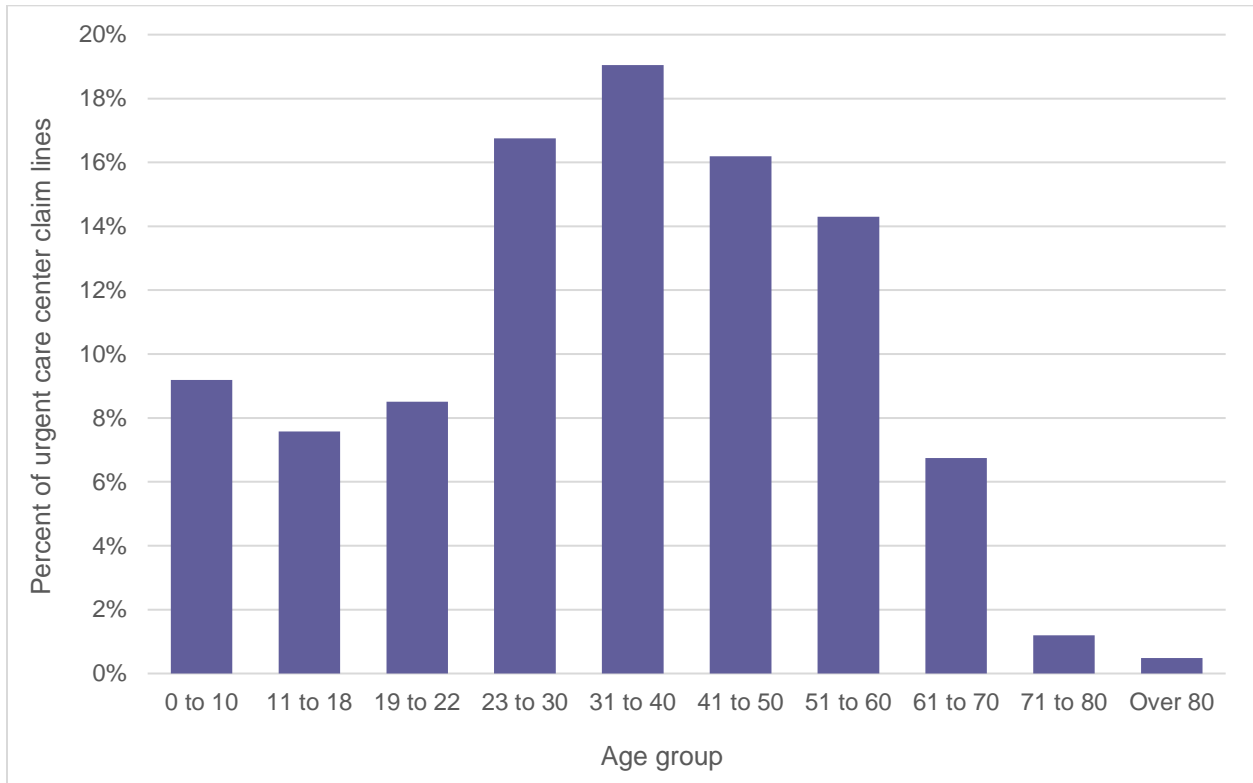


Figure 12. Percent of claim lines with urgent care center usage by age group, 2020

In 2020, 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 in the age range 19 and older became smaller, however, from 2019 to 2020. Whereas in 2019, most age groups in the range 19 and older had shown female predominance of 60 percent or more over males, in 2020 only the 19-22 age group showed such predominance (61 percent); in all older age groups, the female share was under 60 percent.

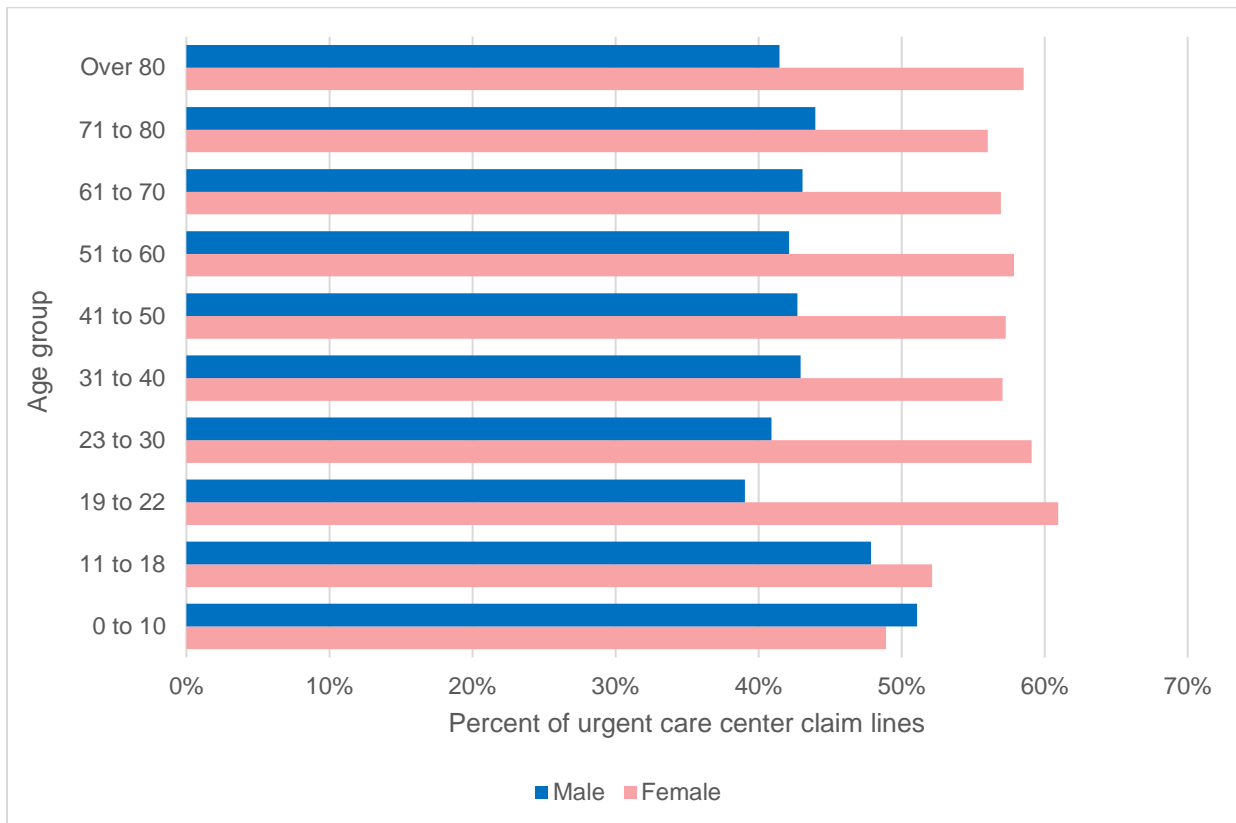


Figure 13. Percent of claim lines with urgent care center usage by age and gender, 2020

As in previous years, acute respiratory diseases and infections were the most common diagnostic category in urgent care centers in 2020, accounting for 23 percent of the claim line distribution in that place of service (figure 14). The distribution of diagnostic categories in 2020 was similar to that in 2019 with the major exception of exposure to communicable diseases ranking in second place (at eight percent) in 2020—even though it had not been among the 10 most common diagnostic categories in 2019. This category largely was associated with testing and/or treatment for COVID-19 when a patient was exposed to the condition.

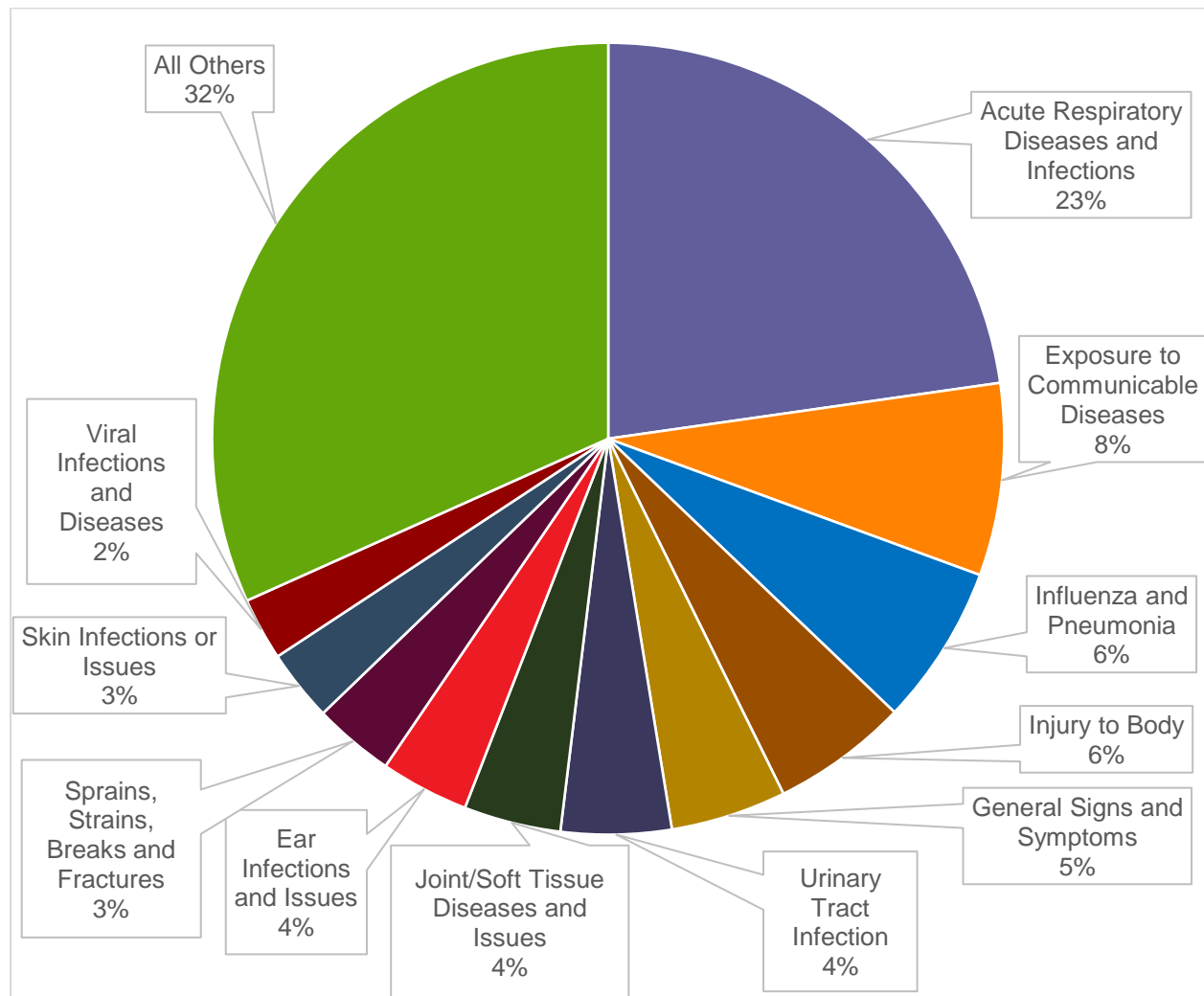


Figure 14. Distribution of claim lines with urgent care center usage by diagnostic category, 2020

As in retail clinics (figure 7), and as in previous years in urgent care centers, the most common procedure in urgent care centers in 2020 was established patient office or other outpatient services, accounting for 24 percent of claim lines that year for that place of service (figure 15). There were few changes in top procedure codes from 2019 to 2020. Injections and infusions climbed from eighth place in 2019 to fifth in 2020, while urinalysis procedures dropped from fifth place to seventh. Pulmonary testing and therapies, which had been in ninth place in 2019, dropped out of the top 10 in 2020, possibly because of patients going to the ER instead of the urgent care center with concerns regarding COVID-19.

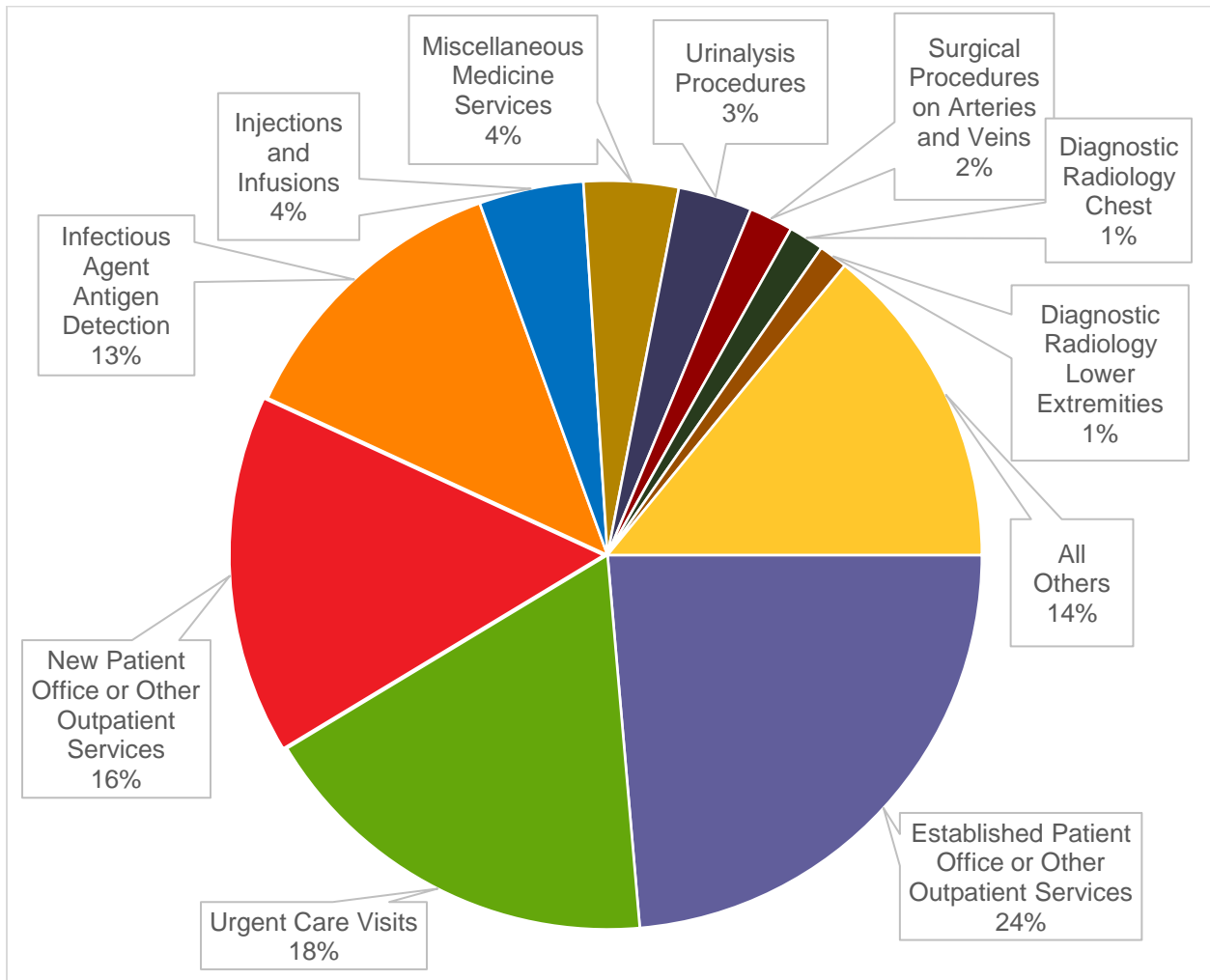
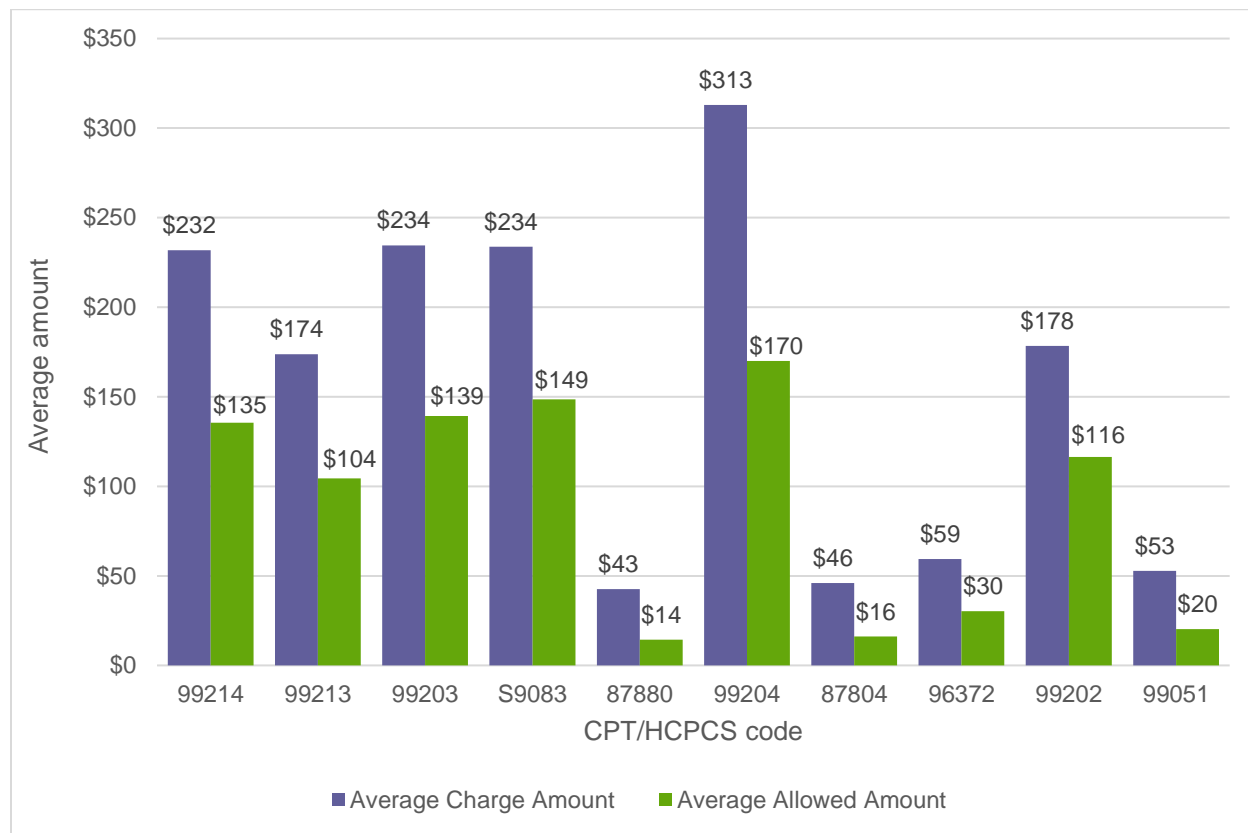


Figure 15. Distribution of claim lines with urgent care center usage by procedures, 2020

There were few changes from 2019 to 2020 among the most common codes being billed in urgent care centers (figure 16). Most notably, S9083, the global urgent care center fee, dropped from first place to fourth place. The highest average charge amount in 2020 was \$313 for CPT 99204, new office outpatient, 45-59-minute visit; that code also had the highest average allowed amount, \$170. The lowest average charge amount (\$43) and average allowed amount (\$14) were for CPT 87880, streptococcus test.



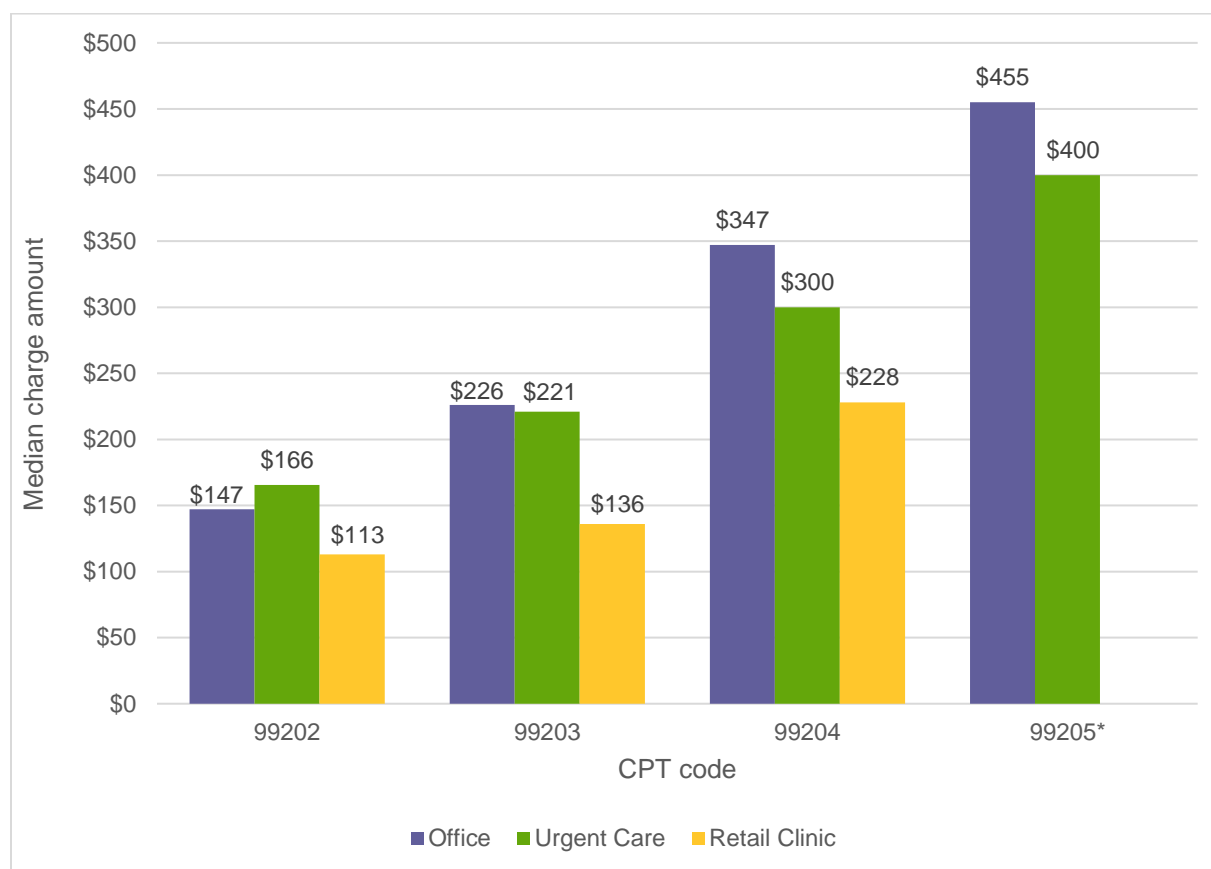
CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
99214	Office outpatient visit – 30-39 minutes	99204	Office outpatient visit – new – 45-59 minutes
99213	Office outpatient visit – 20-29 minutes	87804	Influenza test
99203	Office outpatient visit – new – 30-44 minutes	96372	Therapeutic, prophylactic or diagnostic injection
S9083	Global fee urgent care centers	99202	Office outpatient visit – new – 15-29 minutes
87880	Streptococcus test	99051	Regularly scheduled evening, weekend or holiday office hours

Figure 16. Average charges and average allowed amounts for the most common procedures performed in urgent care centers, 2020

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 2020, the median charge amounts across offices, urgent care centers and retail clinics (figure 17) showed relative differences similar to those seen in 2019, except for CPT 99203. In 2019, urgent care had had the highest median charge amount for that code, but in 2020 the median charge for an office (\$226) was slightly higher than that for an urgent care center (\$221).



CPT Code	Description
99202	Office outpatient visit – new – 15-29 minutes
99203	Office outpatient visit – new – 30-44 minutes
99204	Office outpatient visit – new – 45-59 minutes
99205	Office outpatient visit – new – 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, 2020

In both 2019 and 2020, urgent care had the highest median charge for CPT 99202 and offices had the highest for CPT 99204 and CPT 99205. As in previous years, CPT 99205 was not billed at sufficient volume in retail clinics to establish values.

When the same comparisons among retail clinics, urgent care centers and offices were made on the basis of median allowed amounts, the results for 2020 (figure 18) were similar to those for charge amounts in the same year (figure 17), except for two codes. For CPT 99203, the median allowed amount for an urgent care center (\$139) was higher than that for an office (\$120), rather than lower, as occurred with median charge amounts. Another difference from the charge amounts was that offices had the lowest median allowed amount (\$81) for CPT 99202, rather than occupying the middle position. As with charge amounts, median allowed amounts were highest for urgent care centers for CPT 99202 and highest for offices for CPT 99204 and CPT 99205. Relative differences for median allowed amounts in 2020 generally resembled those in 2019.



CPT Code	Description
99202	Office outpatient visit – new – 15-29 minutes
99203	Office outpatient visit – new – 30-44 minutes
99204	Office outpatient visit – new – 45-59 minutes
99205	Office outpatient visit – new – 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, 2020

Telehealth

Due to the pandemic and the limits imposed on certain in-office services, coupled with the increased risk of infection from in-person encounters, telehealth grew in 2020 on a scale unseen in previous years (figure 19). Of all claim lines associated with telehealth from 2015 to 2020, 96 to 97 percent were submitted in 2020—96 percent nationally and in urban areas, 97 percent in rural areas. Normalized telehealth usage increased nationally 41,919 percent from 2015 to 2020, a more than 40-fold increase over the growth of 1,019 percent from 2014 to 2019 reported in last year’s edition. The rural increase in the normalized share of telehealth claim lines from 2015 to 2020 was 29,589 percent and the urban increase 43,245 percent. In the last year of that period, from 2019 to 2020, rural areas increased 9,731 percent and urban areas 6,916 percent; national growth was 7,060 percent. The rural/urban designation is based on where the patient was receiving care. FAIR Health’s results mirrored reports from other researchers on the COVID-related increase in telehealth utilization.^{10,11,12}

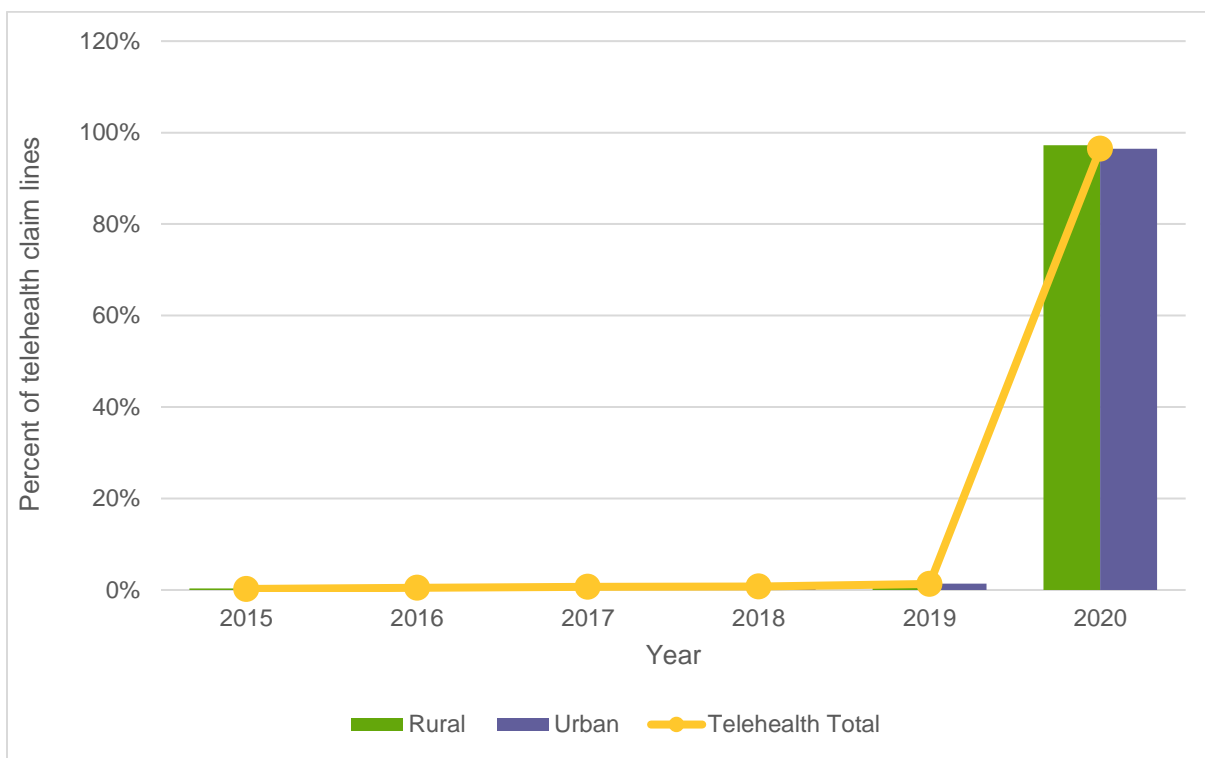


Figure 19. Percent of claim lines with telehealth usage by rural, urban and national settings, 2015-2020

¹⁰ Hanna B. Demeke et al., “Trends in Use of Telehealth among Health Centers during the COVID-19 Pandemic — United States, June 26–November 6, 2020,” *Morbidity and Mortality Weekly Report* 70, no. 7 (February 19, 2021): 240-44, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7007a3.htm>.

¹¹ Lok Wong Samson et al., “Medicare Beneficiaries’ Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location,” Office of the Assistant Secretary for Planning and Evaluation (ASPE), December 3, 2021, <https://aspe.hhs.gov/reports/medicare-beneficiaries-use-telehealth-2020>.

¹² Oleg Bestsennyy et al., “Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?,” McKinsey & Company, July 9, 2021, <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>.

Figure 20 shows claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings. Telehealth's national share of medical claim lines jumped approximately 70-fold from 0.22 percent in 2019 to 15.41 percent in 2020. In urban areas, telehealth increased from 0.23 percent of medical claim lines in 2019 to 16.08 percent in 2020; in rural areas, the increase was from 0.10 percent in 2019 to 9.77 percent in 2020.

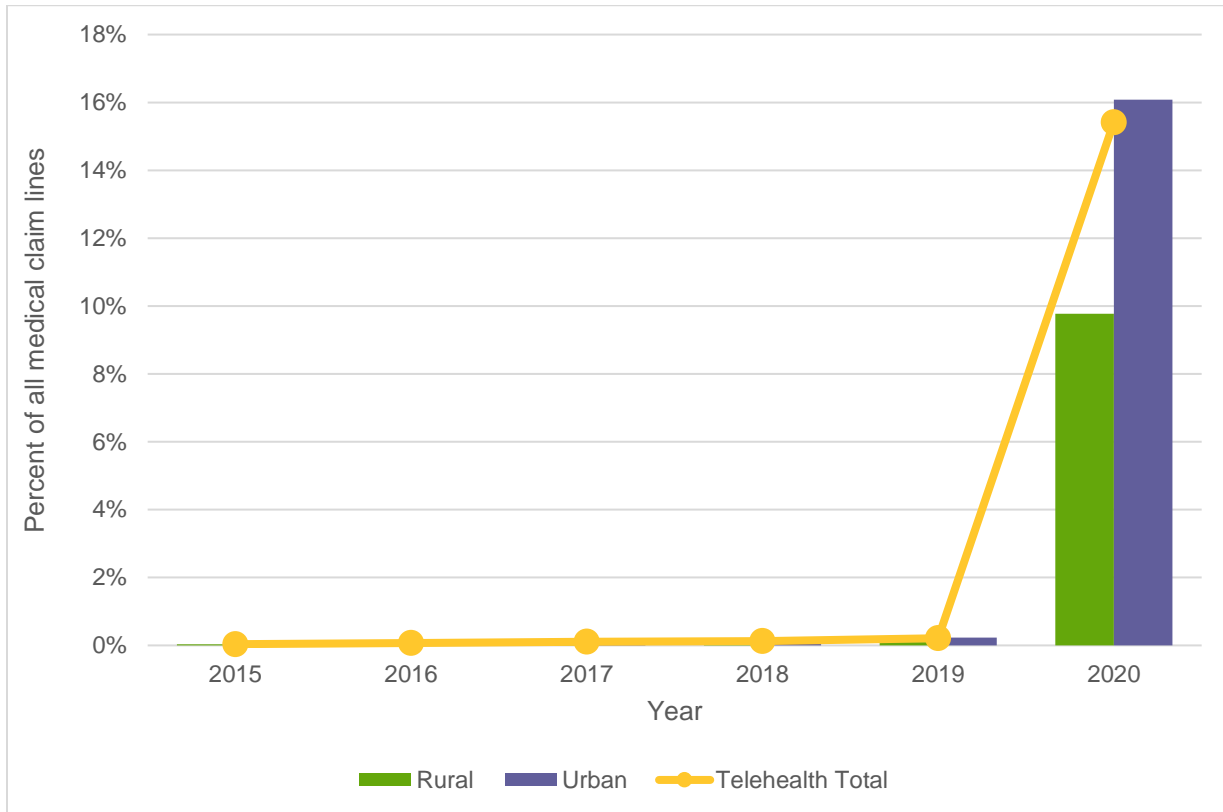


Figure 20. Claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings, 2015-2020

The top five jurisdictions for telehealth claim lines as a percentage of all medical claim lines by state (or district) changed completely from 2019 to 2020 (figure 21). In 2020, they were New Mexico; Massachusetts; Washington, DC; Delaware; and Connecticut. Many other states had proportions of telehealth utilization similar to those in the top five, as most of the Northeast and much of the West opted increasingly for telehealth because of the COVID-19 pandemic,^{13,14} aided by legislation and regulation that had the effect of expanding utilization. Of note, Connecticut, which had been fourth from the bottom in its use of telehealth in 2019, rose to fifth from the top in 2020.

Of the five states with the lowest telehealth use rates in 2020 (Mississippi, Alabama, Tennessee, South Dakota and South Carolina), two had been on that list in 2019: Mississippi and Alabama. Mississippi moved from third from the bottom in 2019 to the lowest place in 2020; Alabama, which had been in the lowest place in 2019, moved to second from the bottom.

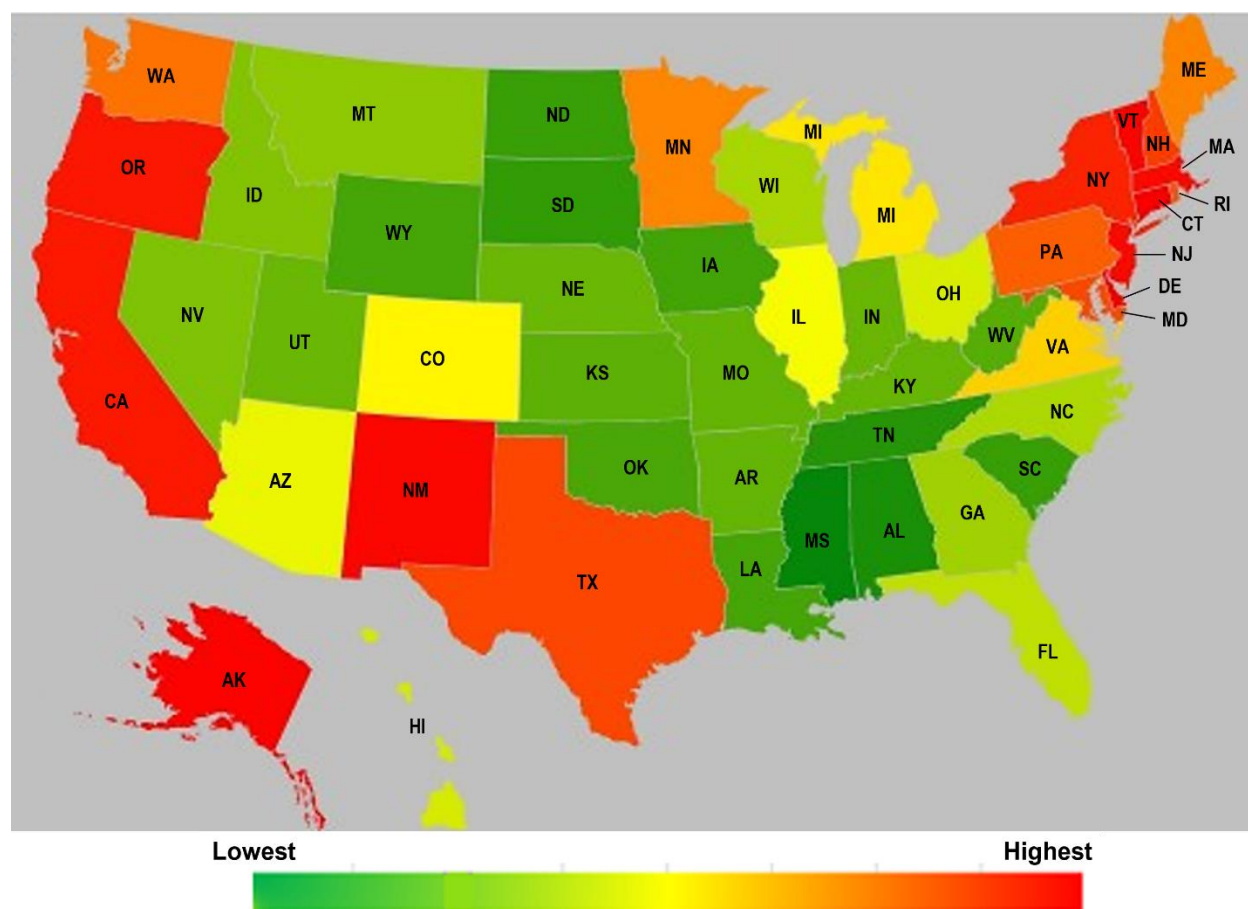


Figure 21. Percent of claim lines with telehealth usage compared to all medical claim lines by state, 2020

¹³ Demeke et al., “Trends in Use of Telehealth among Health Centers during the COVID-19 Pandemic.”

¹⁴ Samson et al., “Medicare Beneficiaries’ Use of Telehealth in 2020.”

As in previous years, the age group with the largest share of telehealth claim lines in 2020 was that of individuals aged 31-40 (18 percent; figure 22). In several other ways, however, the age distribution changed in 2020. The share of the age group 51-60 increased to 16 percent, reaching the same level as that of the age group 41-50. The age group 61-70 also grew in its share, reaching nine percent, as did the age range 71 and older, which made up more than four percent. The share of the age group 0-10 fell to eight percent, but that of the age group 11-18 increased to nine percent.

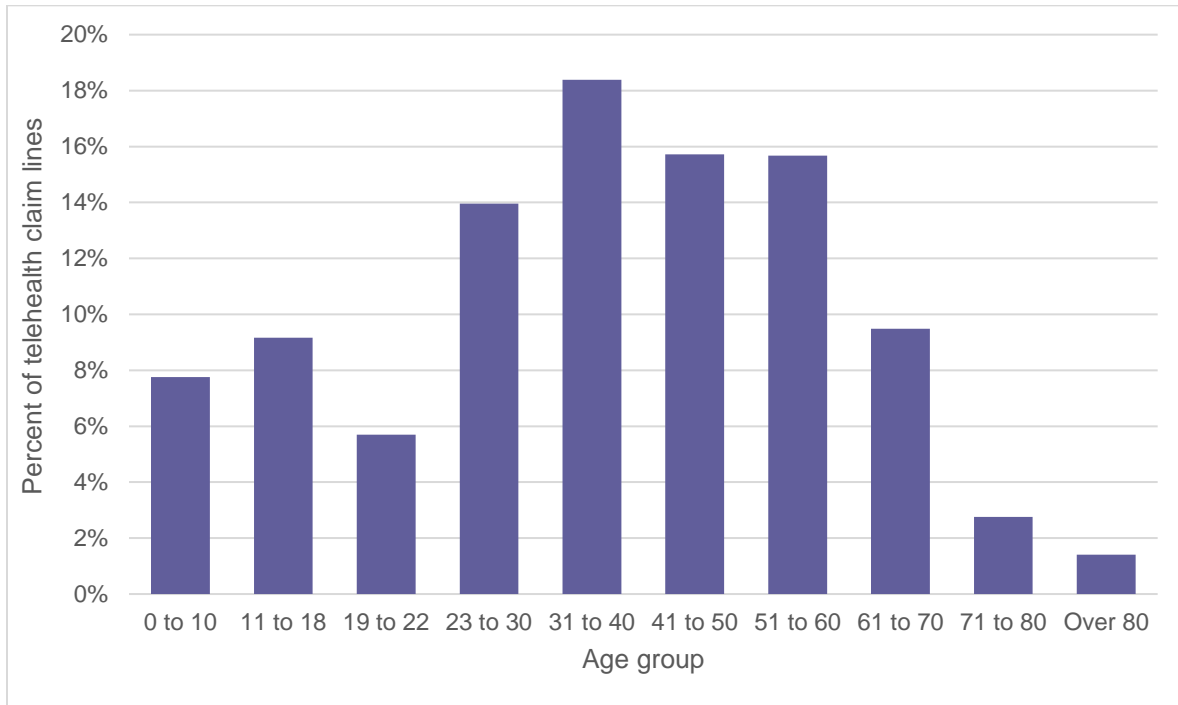


Figure 22. Percent of claim lines with telehealth usage by age group, 2020

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). That was different from 2019, when males accounted for more claim lines than females in one adult age group: 71-80. In the 0-10 age group, the male share grew in 2020 to 62 percent from 54 percent in 2019.

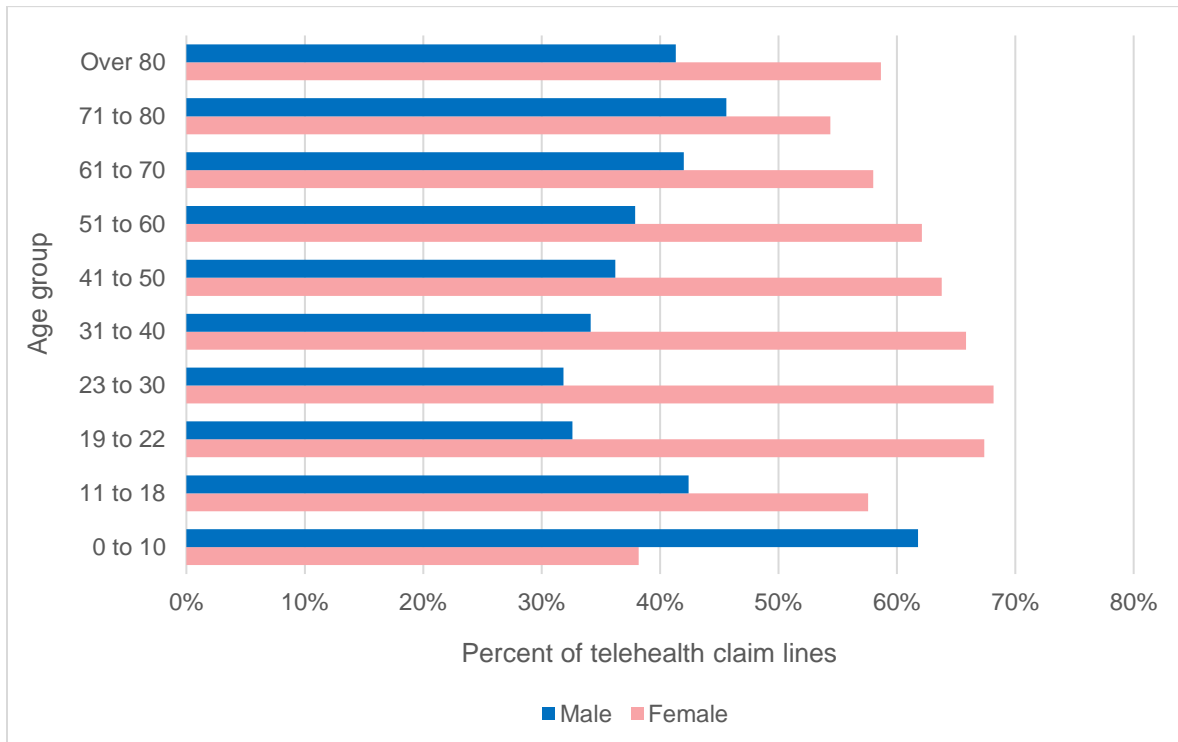


Figure 23. Percent of claim lines with telehealth usage by age and gender, 2020

As in 2019, the most common telehealth diagnostic category in 2020 was mental health conditions, which grew from 35 percent of the distribution in 2019 to 44 percent in 2020 (figure 24). As documented in FAIR Health’s Monthly Telehealth Regional Tracker,¹⁵ joint/soft tissue diseases and issues moved up the list of most common telehealth diagnoses (from seventh place in 2019 to second place in 2020) and many other diagnoses joined the list. Those included developmental disorders, hypertension, general signs and symptoms, exposure to communicable diseases, diabetes mellitus, endocrine and metabolic disorders, encounter for examination and substance use disorders.

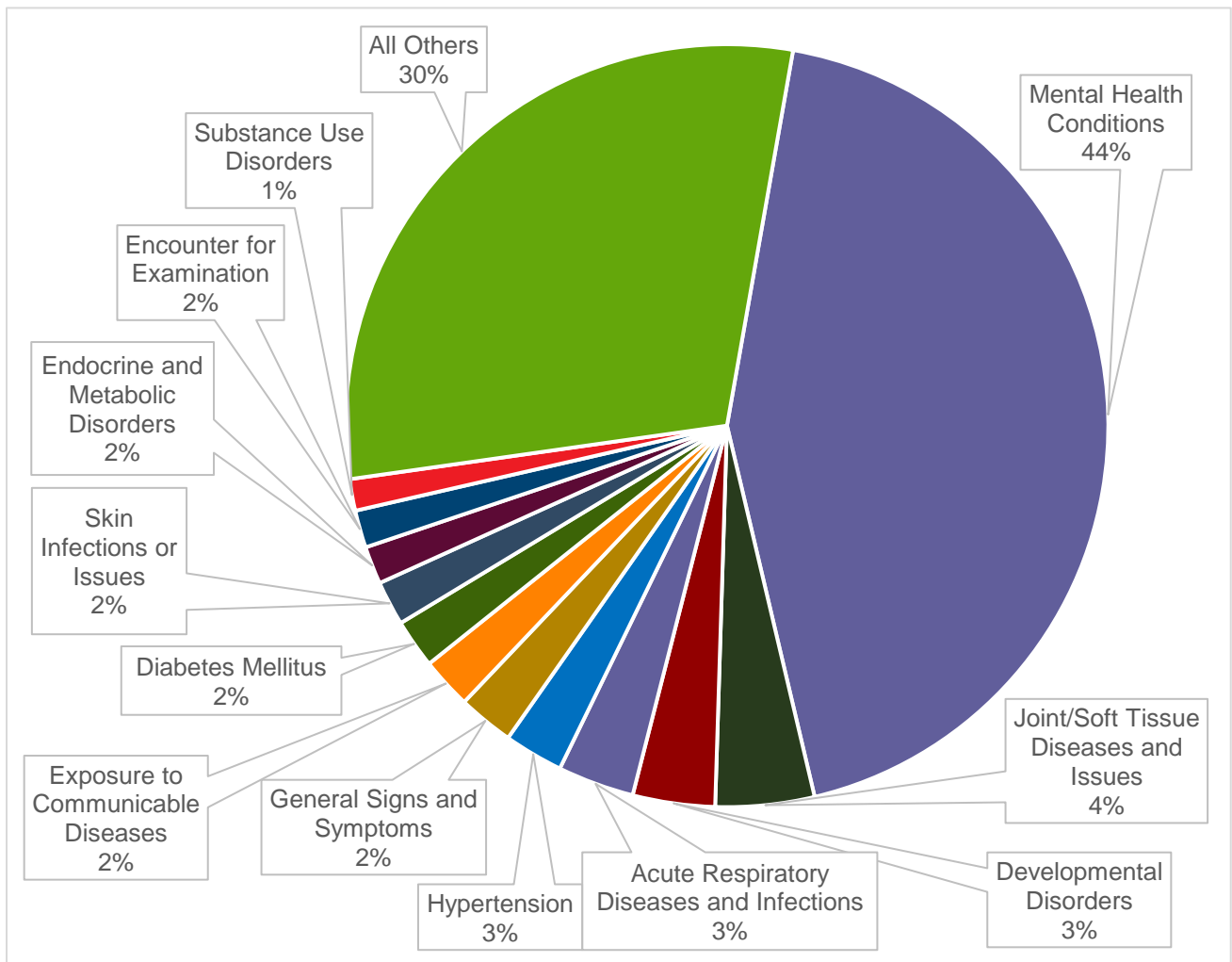


Figure 24. Distribution of claim lines with telehealth usage by diagnostic category, 2020

¹⁵ “Monthly Telehealth Regional Tracker,” FAIR Health, accessed March 7, 2022, <https://www.fairhealth.org/states-by-the-numbers/telehealth>.

Ambulatory Surgery Center

After an increase from 2018 to 2019, normalized ASC usage decreased 38 percent nationally and in urban areas in the single year from 2019 to 2020; the decrease in rural areas was 39 percent that year. The decrease in 2020 was likely due in large part to COVID-19 pandemic restrictions, with elective surgery banned for a period of time.¹⁶ Over the longer term, the normalized share of claim lines for ASCs grew 4 percent overall from 2011 to 2020 (figure 25), compared to 60 percent from 2010 to 2019. As in the period 2010-2019, growth from 2011 to 2020 was greater in rural (6 percent) than urban areas (4 percent).

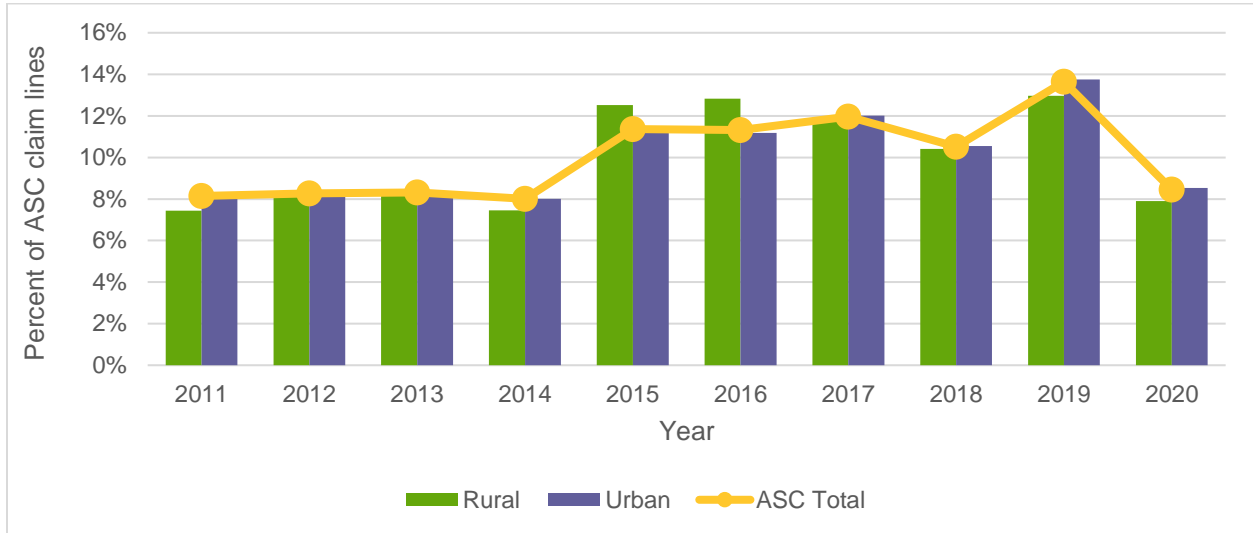


Figure 25. Percent of claim lines with ASC usage by rural, urban and national settings, 2011-2020

¹⁶ 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>.

In 2019, ASCs surpassed one percent of all medical claim lines in urban (1.05 percent) and national (1.04 percent) settings, though not in rural (0.93 percent) settings. But the COVID-related decrease in ASC utilization in 2020 put ASCs' share of medical claim lines below one percent in all three settings: 0.65 percent in urban areas, 0.64 percent nationally and 0.56 percent in rural areas (figure 26).

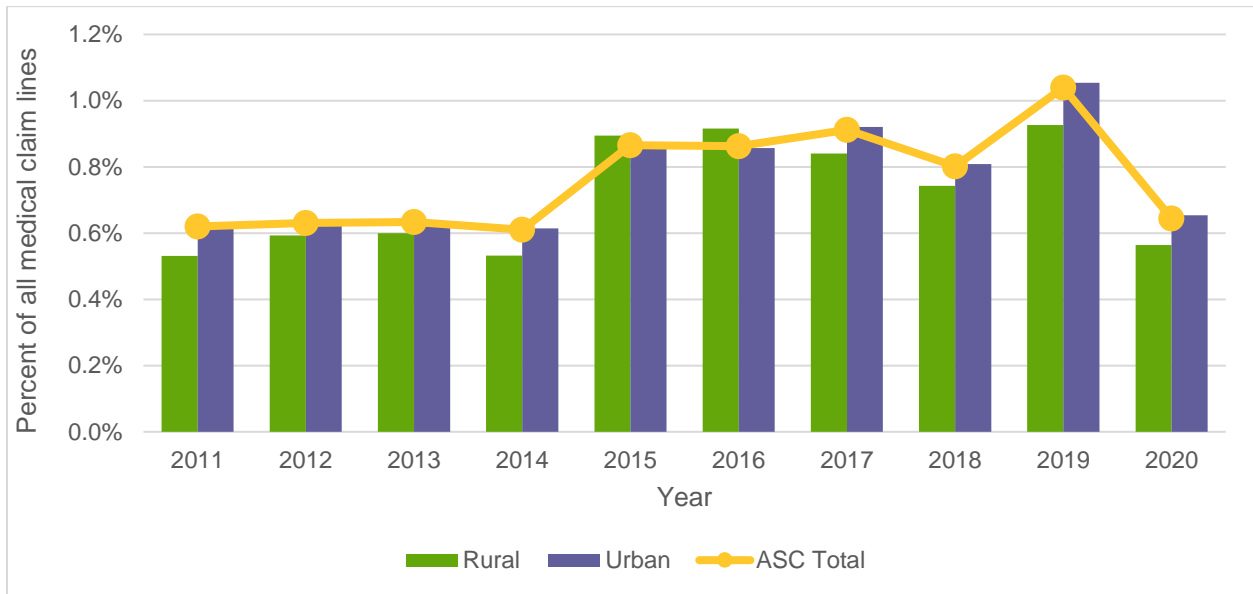


Figure 26. Claim lines with ASC usage as a percentage of all medical claim lines by rural, urban and national settings, 2011-2020

As in previous years, more ASC claim lines in 2020 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 60 percent) and 11-18 (males 51 percent). However, in one age group, those over 80, the distribution was approximately 50 percent female and 50 percent male, a change from 2019, when the distribution had been 53 percent female, 47 percent male. Similarly, in the 71-80 age group, the gender disparity in 2020 narrowed to 51 percent female, 49 percent male, compared to 54 percent female, 46 percent male in 2019.

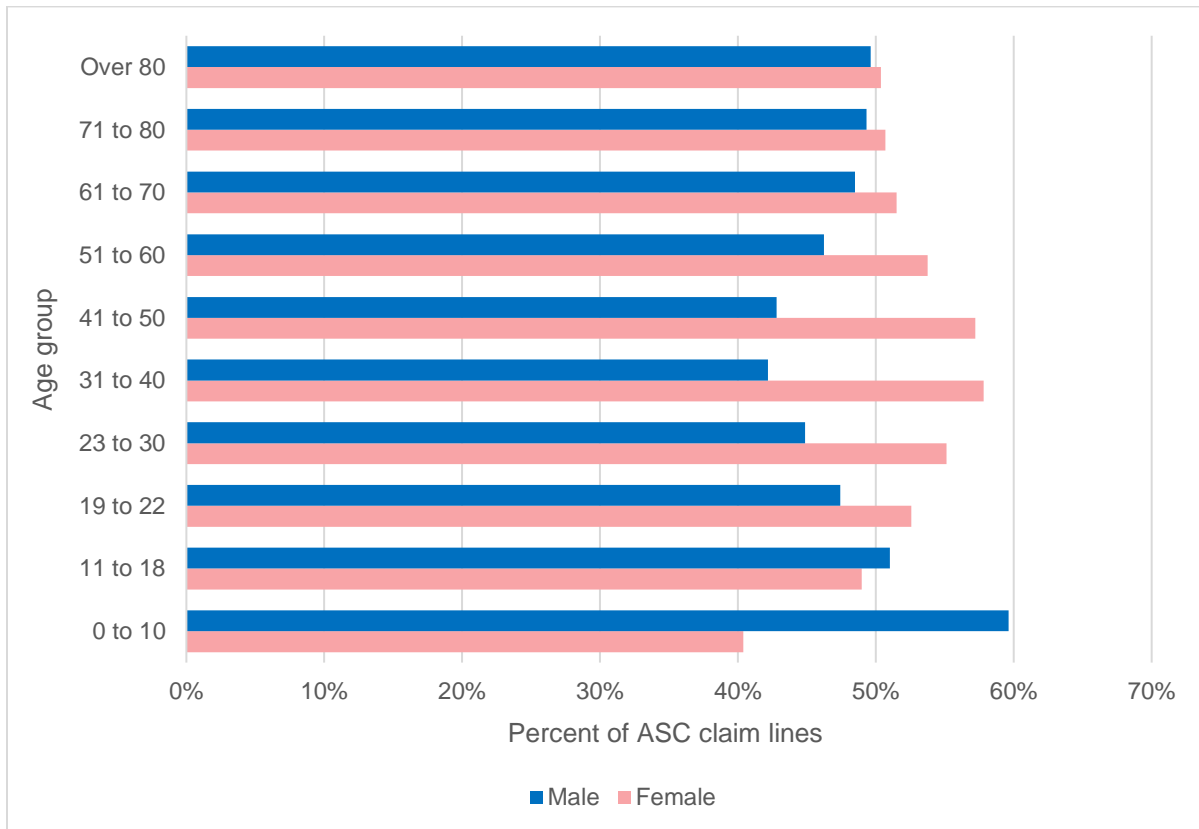


Figure 27. Percent of claim lines with ASC usage by age and gender, 2020

Emergency Room

In the single year from 2019 to 2020, ER usage decreased in national (30 percent), urban (30 percent) and rural (27 percent) settings. The decrease was expected because of the impact of COVID-19 on ER visits, which had been reported widely.^{17,18,19} Over the longer term, the normalized share of claim lines for ERs increased nationally 15 percent from 2011 to 2020 (figure 28), a sharp reduction from the 100 percent growth recorded from 2010 to 2019. Urban growth from 2011 to 2020 was 14 percent and rural growth 7 percent.

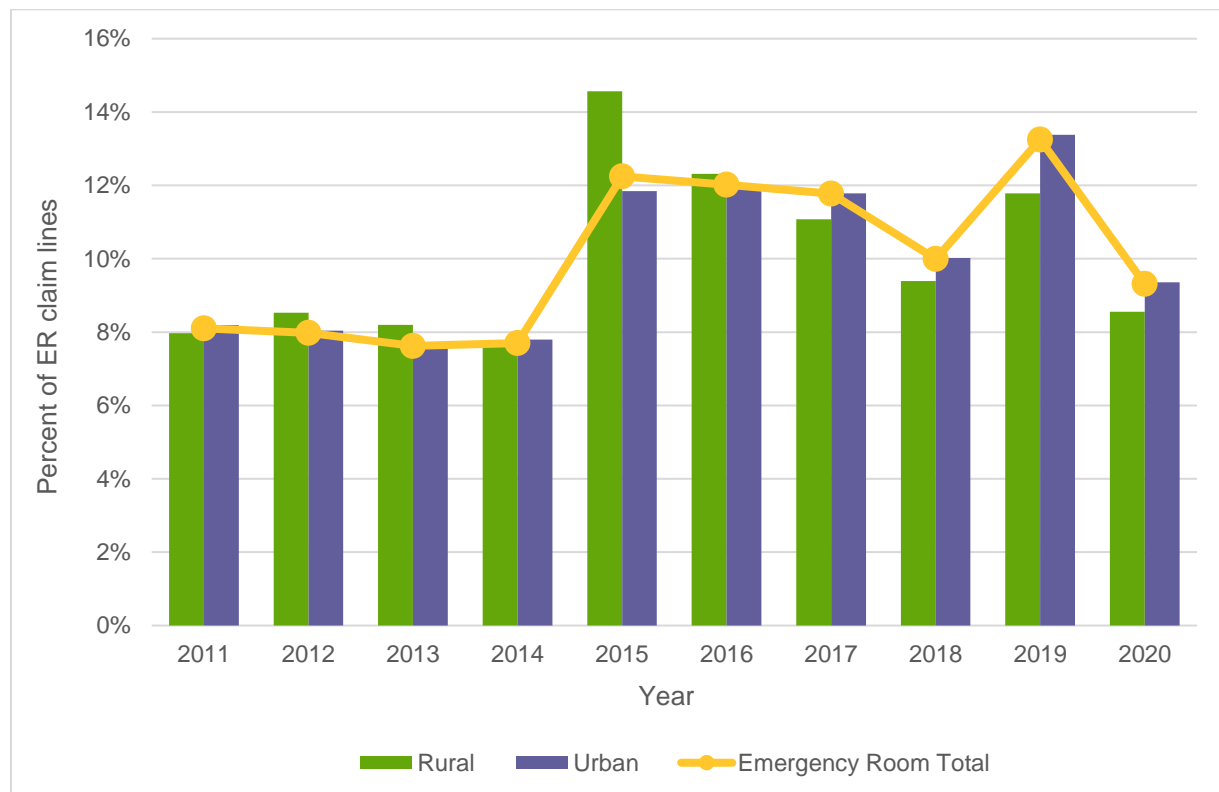


Figure 28. Percent of claim lines with ER usage by rural, urban and national settings, 2011-2020

¹⁷ David L. Schriger, “Learning from the Decrease in US Emergency Department Visits in Response to the Coronavirus Disease 2019 Pandemic,” *JAMA Internal Medicine* 180, no. 10 (August 3, 2020): 1334-35, <https://doi.org/10.1001/jamainternmed.2020.3265>.

¹⁸ Christopher Cheney, “Non-COVID-19 Emergency Department Visits Fell for All Acuity Levels during Pandemic, Study Finds,” *HealthLeaders*, June 7, 2021, <https://www.healthleadersmedia.com/clinical-care/non-covid-19-emergency-department-visits-fell-all-acuity-levels-during-pandemic-0>.

¹⁹ Kathleen P. Hartnett et al., “Impact of the COVID-19 Pandemic on Emergency Department Visits — United States, January 1, 2019–May 30, 2020,” *Morbidity and Mortality Weekly Report* 69, no. 23 (June 12, 2020): 699-704, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm>.

In previous years, ERs accounted for a larger percentage of all medical claim lines than any of the other places of service studied for that variable in this report (figure 29). From 2019 to 2020, however, the national ER percentage of all medical claim lines fell from 2.94 percent to 2.07 percent; in urban areas, the decline was from 2.89 percent to 2.02 percent, and in rural areas from 3.33 percent to 2.42 percent. By comparison, the levels achieved by telehealth in 2020 were much greater: 15.41 percent nationally, 16.08 percent in urban areas and 9.77 percent in rural areas (figure 20). These were the largest percentages of all medical claim lines of any place of service studied for that variable in this report.

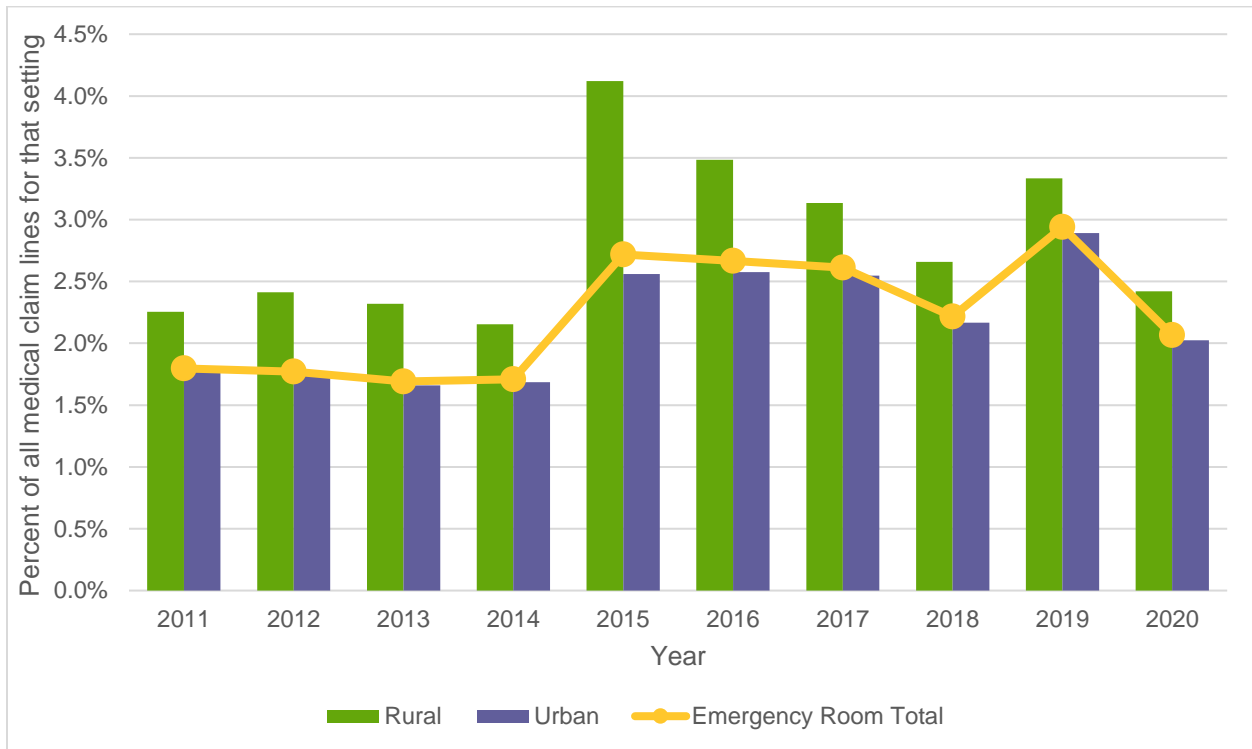


Figure 29. Claim lines with ER usage as a percentage of all medical claim lines by rural, urban and national settings, 2011-2020

As in previous years, the age group with the greatest share of claim lines for ER usage in 2020 was 51-60 (17 percent; figure 30). There was growth from 2019 in the age groups 31-40 and 41-50: in 2020, each reached 16 percent of the distribution, compared to 13 percent and 14 percent, respectively, in 2019. The age range 0-22 stayed approximately the same from year to year, but the age groups 71-80 and over 80 dropped from eight percent each in 2019 to five percent each in 2020.

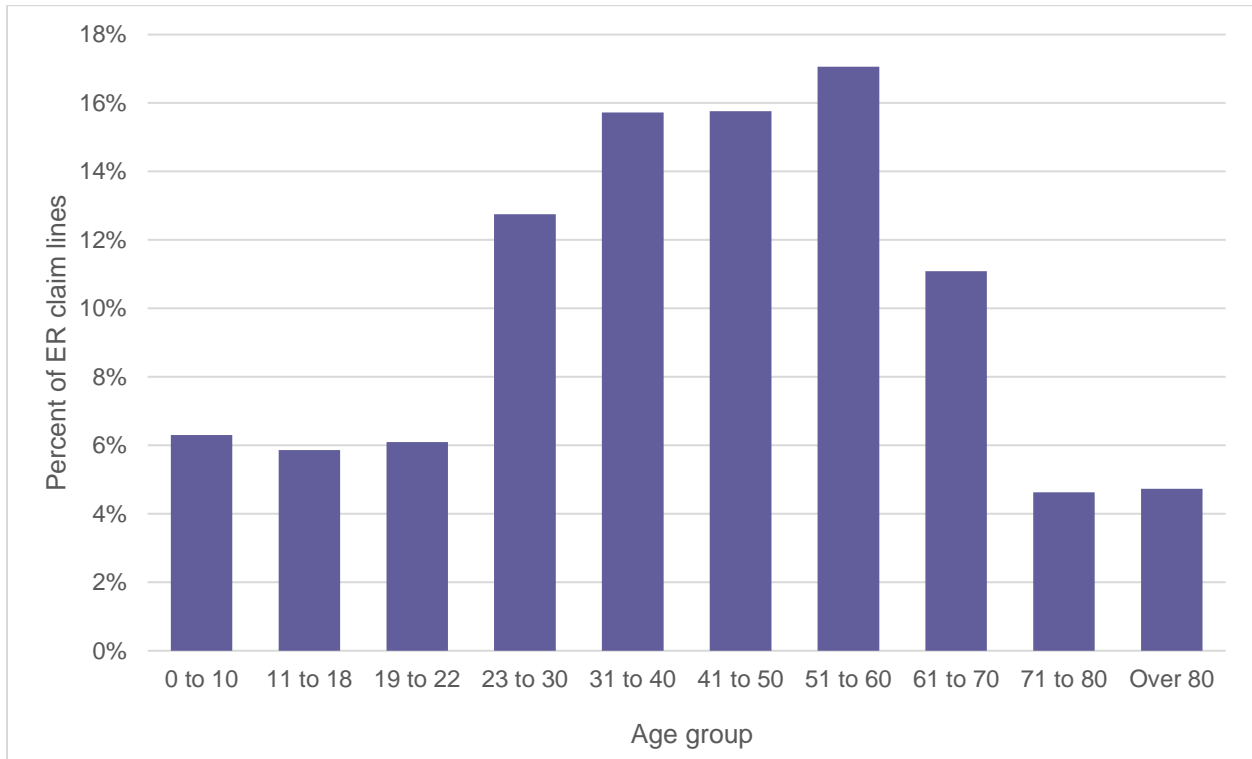


Figure 30. Percent of claim lines with ER usage by age group, 2020

As with all of the other places of service studied for gender, and as in 2019, more claim lines with ER usage in 2020 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 (55 percent) outnumbered those for girls (45 percent). But there also was one case in 2020 (the age group 61-70) in which the male and female shares were approximately equal (50 percent), a change from 2019, when the female share had been 52 percent and the male share 48 percent.



Figure 31. Percent of claim lines with ER usage by age and gender, 2020

Figure 32 shows the 2020 distribution of claim lines with ER usage by diagnostic category for individuals over the age of 22. Digestive system issues, which had been number one in 2019, dropped to second place in 2020, while chest pain rose from second to first place. Joint/soft tissue diseases and issues dropped from fourth to sixth place. Complications of pregnancy, which had been the 15th most common diagnostic category in 2019, rose to 10th most common. Overall, the diversity of conditions seen in the ER continued to expand, with the category of “All Others” growing from 33 percent of the distribution in 2019 to 35 percent in 2020.

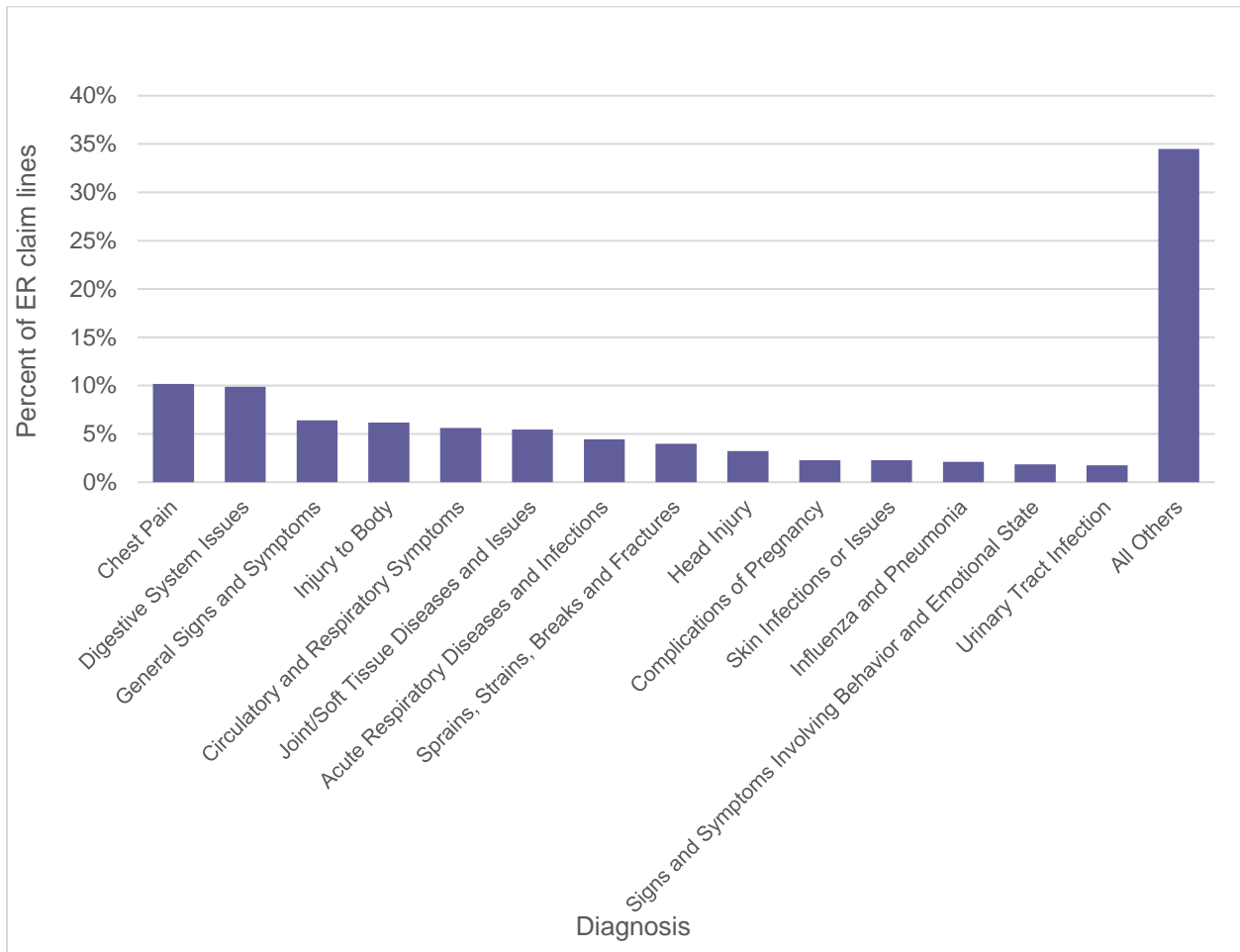


Figure 32. Distribution of claim lines with ER usage by diagnostic category for individuals over 22 years of age, 2020

The 2020 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 2019. Again, diagnostic radiology of the chest was the most common procedure, with 13 percent of the 2020 distribution, and again cardiography procedures were in second place (11 percent). As in 2019, in 2020 chemistry procedures and hematology and coagulation procedures were, respectively, in third and fourth place. Diagnostic radiology of the abdomen rose from sixth to fifth place, while diagnostic radiology of the head and neck fell from fifth to sixth place. The trend toward more diversity of procedures continued. In the 2019 distribution, “All Others” accounted for 30 percent, but in the 2020 distribution, that category accounted for 37 percent.

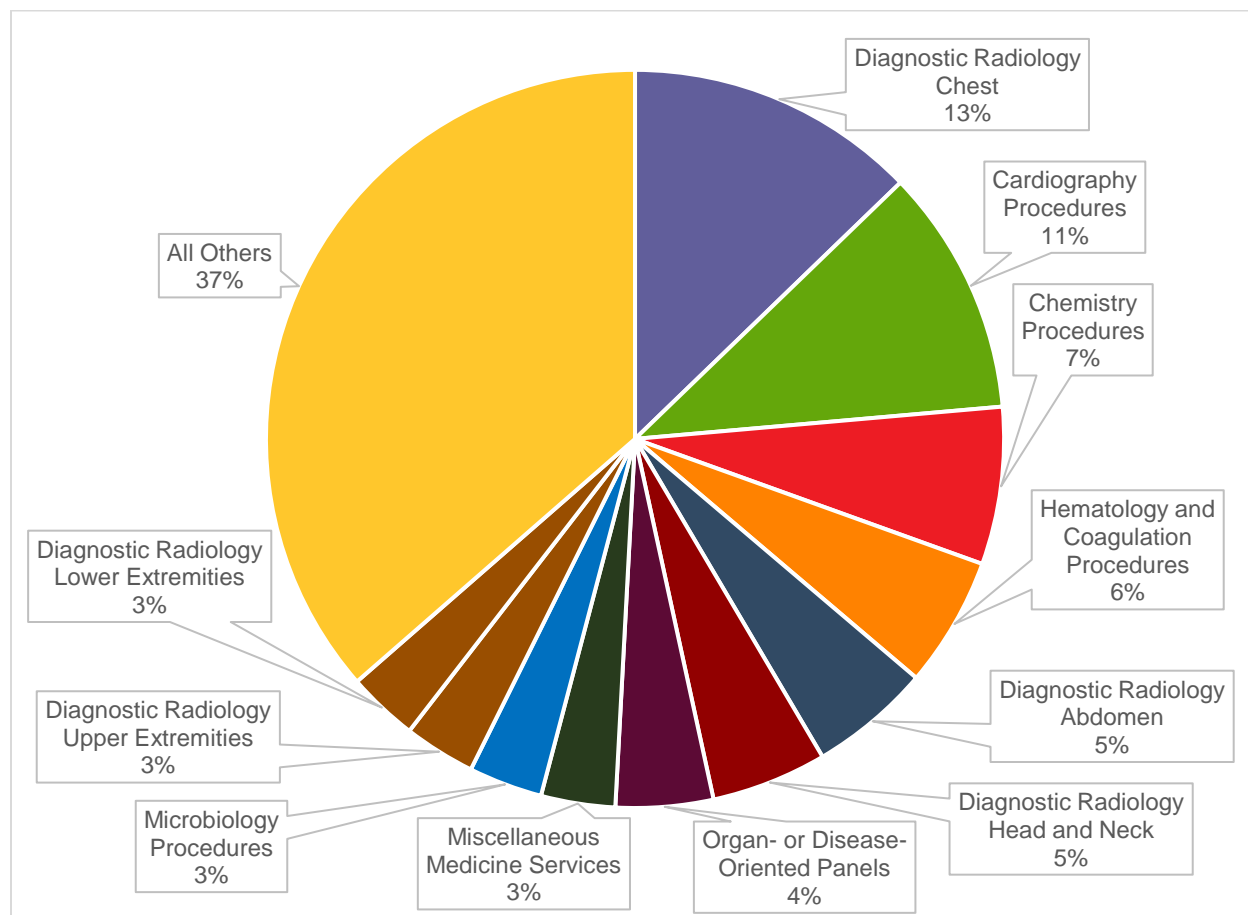
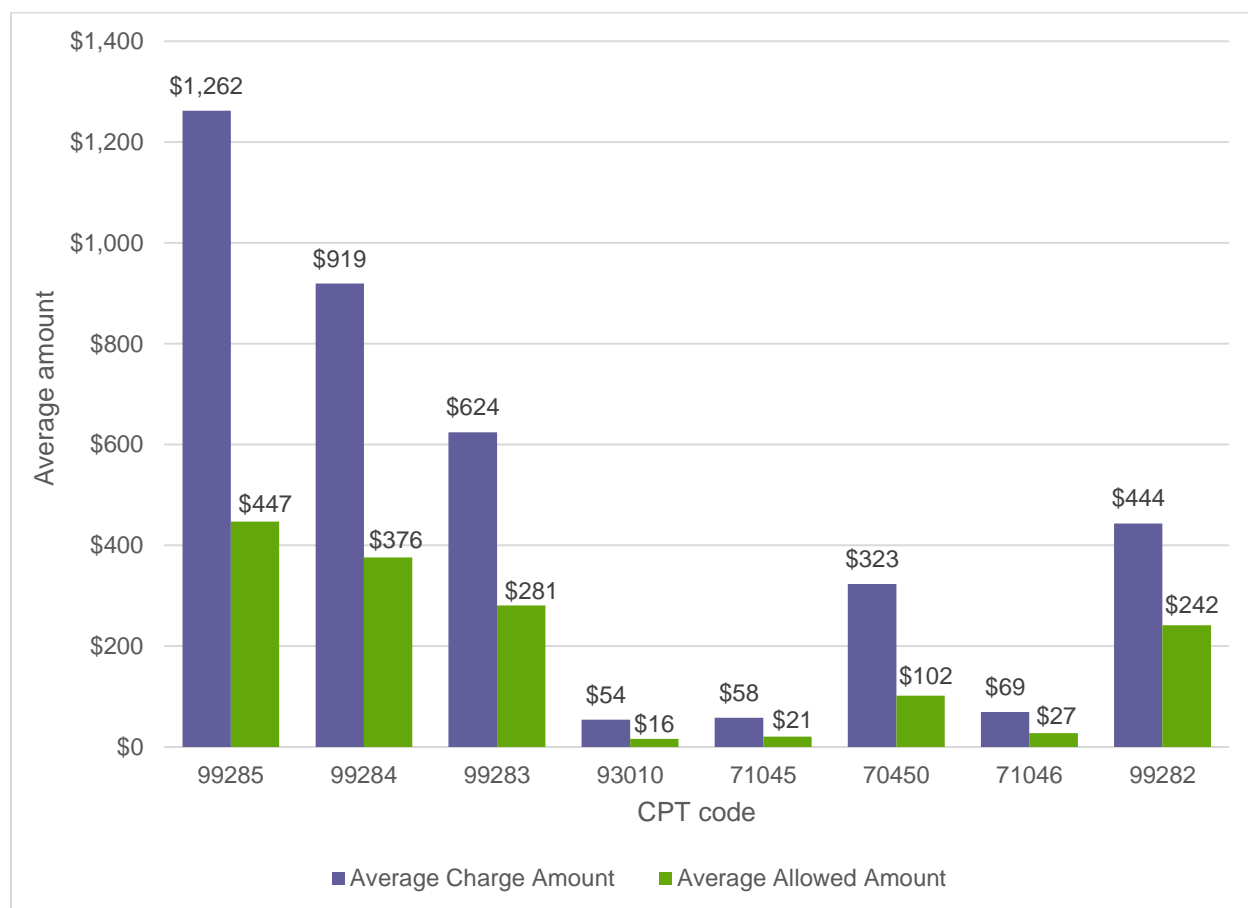


Figure 33. Distribution of claim lines with ER usage by procedures for individuals in all age groups, not including E&Ms, 2020

Figure 34 shows average charges and allowed amounts for the eight most common ER procedure codes in 2020. There were some changes in the codes from 2019 to 2020. CPT 85025 (blood count; complete [CBC], automated) fell off the list and CPT 99282 (emergency department visit—low/moderate severity) joined the list. CPT 70450 (CT head/brain without contrast material) rose from eighth to sixth place while CPT 71046 (two-view chest X-ray) fell from sixth to seventh place. As in 2019, the highest average charge amount (\$1,262) and average allowed amount (\$447) in 2020 were for CPT 99285 (emergency department visit—high severity—life threatening). The lowest average charge amount (\$54) and average allowed amount (\$16) were for CPT 93010 (electrocardiogram).



CPT Code	Description	CPT Code	Description
99285	Emergency department visit – high severity – life threatening	71045	Single-view chest X-ray
99284	Emergency department visit – high/urgent severity	70450	CT head/brain w/o contrast material
99283	Emergency department visit – moderate severity	71046	Two-view chest X-ray
93010	Electrocardiogram	99282	Emergency department visit – low/moderate severity

Figure 34. Average charges and allowed amounts for the most common procedures performed in ERs, 2020

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 ensure consistency and validity prior to release.

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.

E&M codes in the Office or Other Outpatient Services Category for both new and established patients were redefined in 2021. For example, CPT 99213 used to be defined as a 15-minute office visit for an established patient but is now defined as a 20-29 minute office visit for an established patient. Since these codes are dominant within this index based on frequency of use, more variation is likely in this category in the future.

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 1.38 in November 2020 to 1.44 in November 2021, a four percent increase.

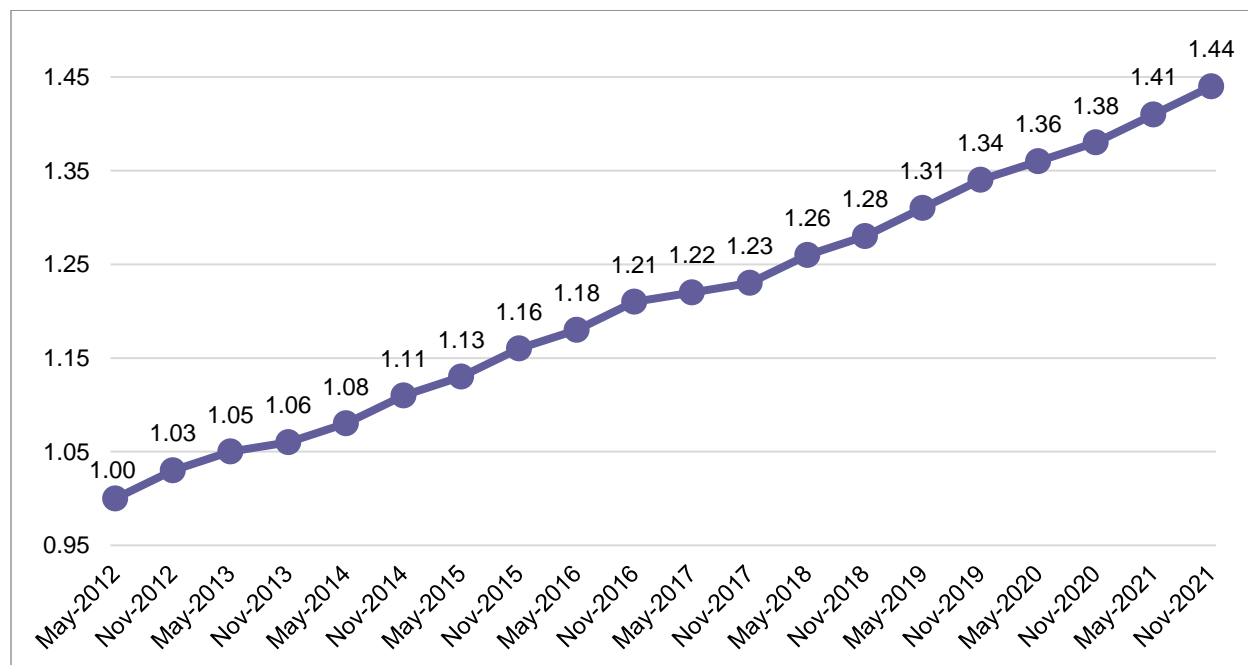


Figure 35. Professional E&M charge amount index

The professional E&M allowed amount index saw similar steady growth (figure 36). The index grew from 1.39 in November 2020 to 1.44 in November 2021, a four percent increase.

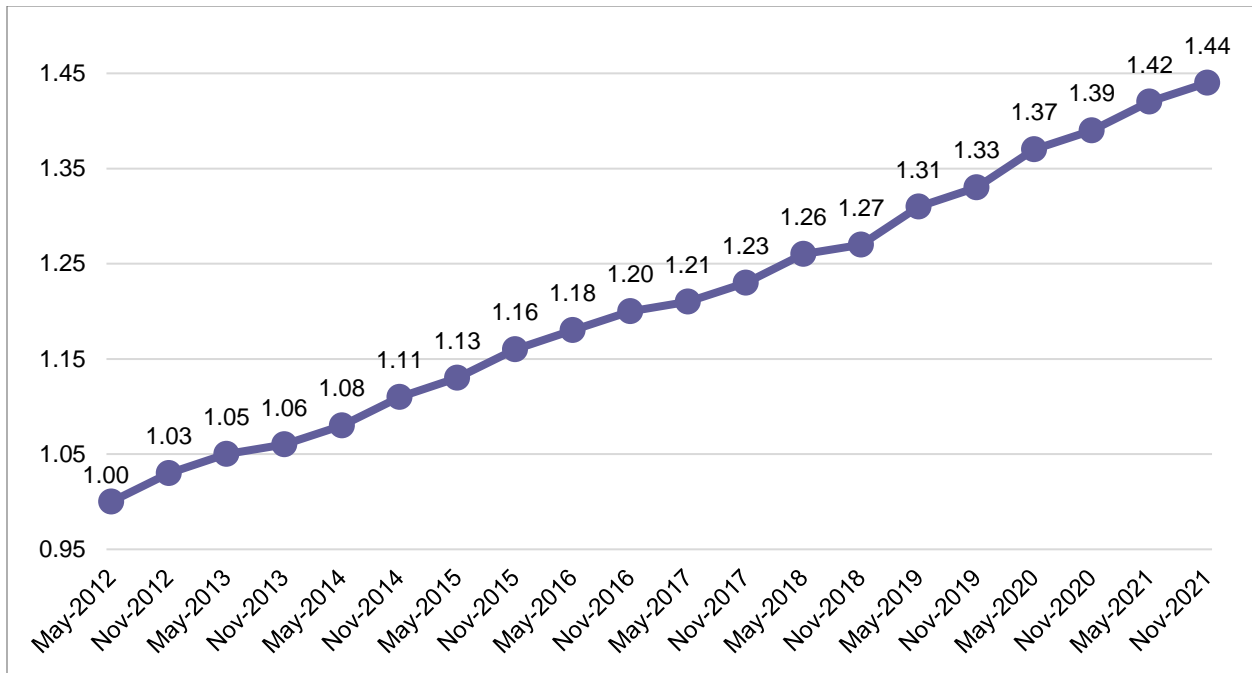


Figure 36. Professional E&M allowed amount index

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.

The hospital E&M charge amount index saw a relatively large jump in value from May to November 2021 (figure 37). The index grew from 1.61 in November 2020 to 1.72 in November 2021, a seven 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 integral to the increases in the two releases in 2021. Median charges as well as frequencies increased.

Of the six categories, hospital E&Ms had the greatest percent increase in charge amount index from November 2020 to November 2021.

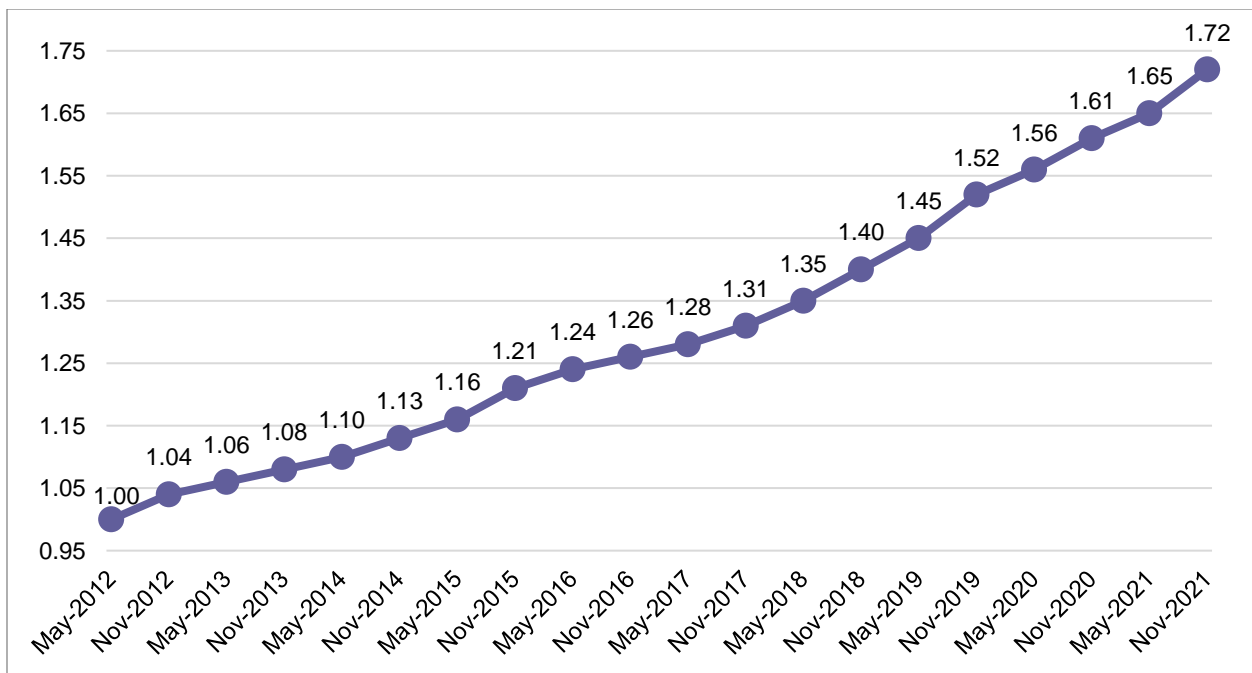


Figure 37. Hospital E&M charge amount index

The hospital E&M allowed amount index had slower growth in 2021 than 2020 (figure 38). The index grew from 1.60 in November 2020 to 1.68 in November 2021, a five percent increase. CPT 99285, a high-severity emergency department visit with immediate threat to life or function, had the largest impact on the change in this index, with an increased median allowed amount and increased frequency. Of the six categories, hospital E&Ms had the largest percent increase in allowed amount index from November 2020 to November 2021.

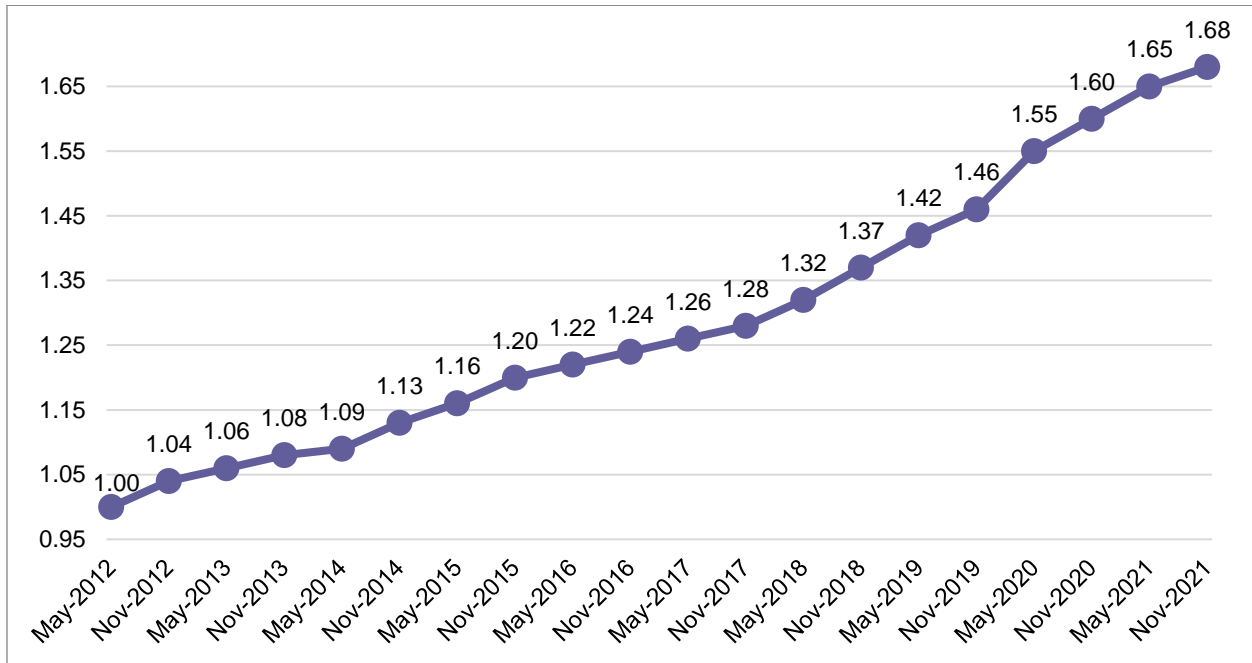


Figure 38. Hospital E&M allowed amount index

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 saw a modest uptick in growth since November 2020 (figure 39). The index grew from 1.26 in November 2020 to 1.29 in November 2021, a two percent increase.

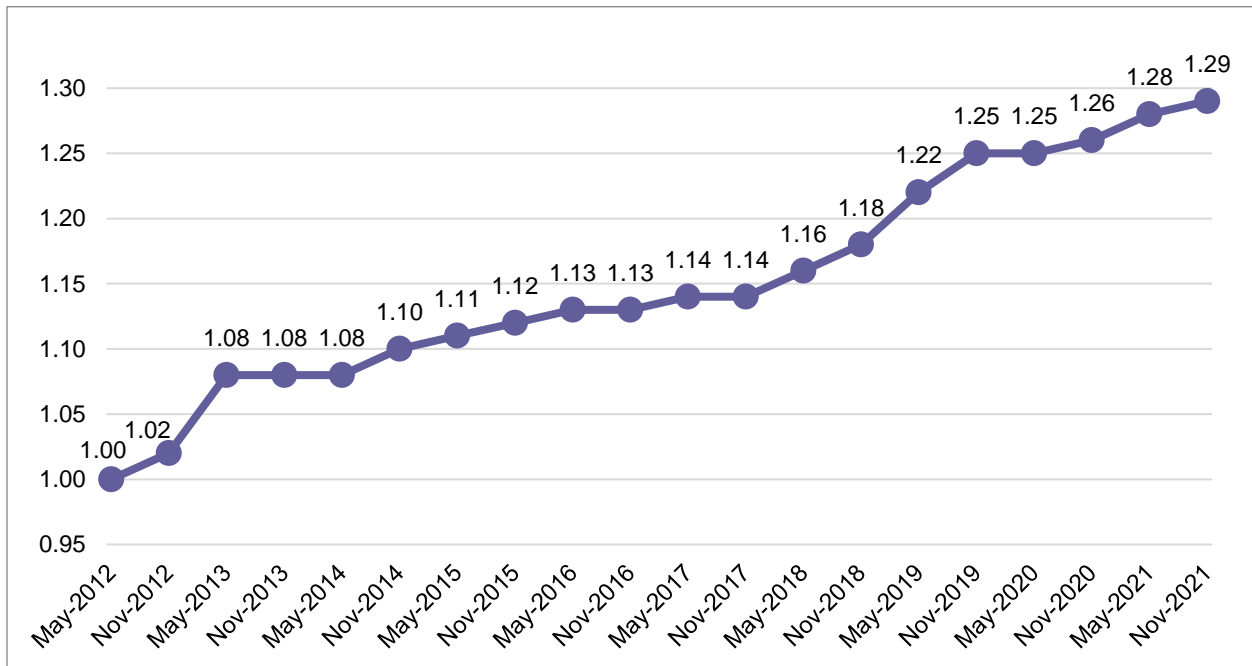


Figure 39. Medicine charge amount index

The growth of the medicine allowed amount index slowed in 2021 after a period of rapid growth (figure 40). The index grew from 1.40 in November 2020 to 1.43 in November 2021, a two percent increase.

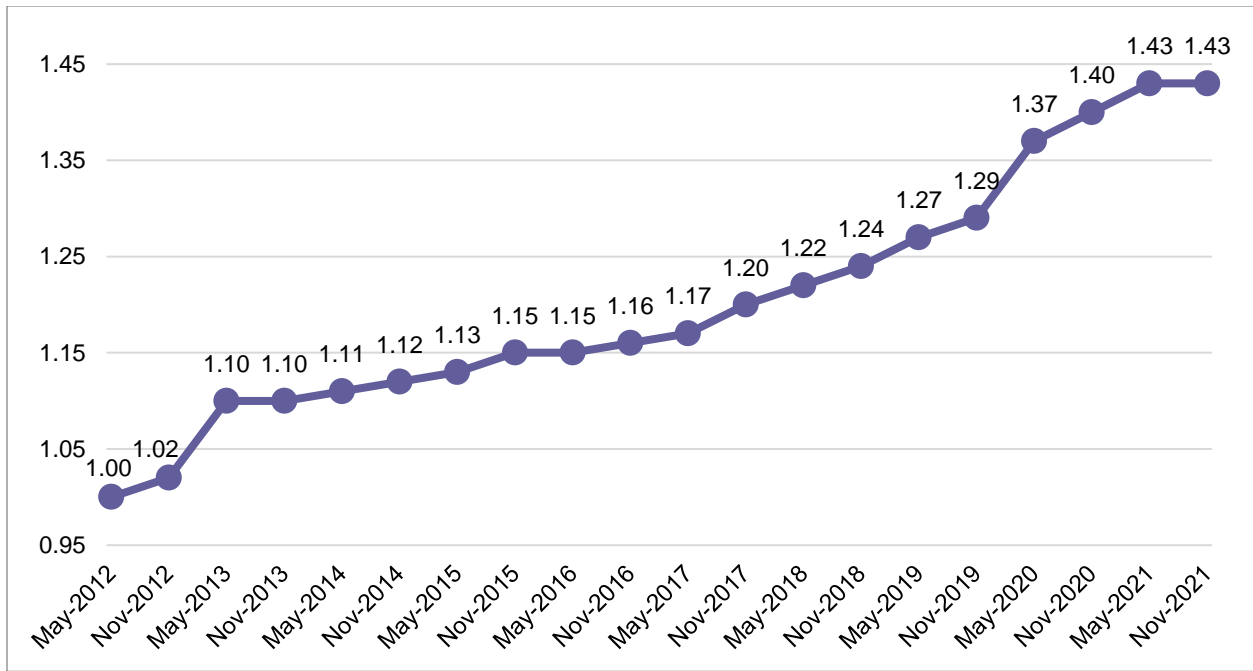


Figure 40. Medicine allowed amount index

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.

Since November 2020, the surgery charge amount index returned to a high rate of growth characteristic of the 2018-2019 time frame (figure 41). The index grew from 1.20 in November 2020 to 1.26 in November 2021, a five percent increase.

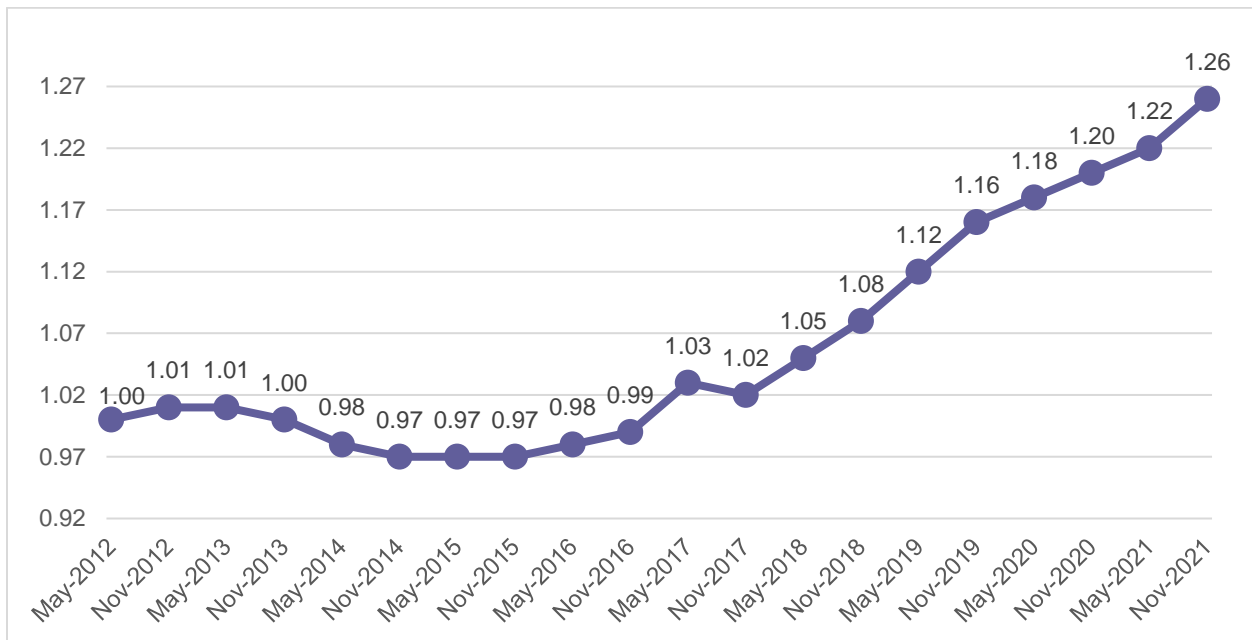


Figure 41. Surgery charge amount index

In 2021, the surgery allowed amount index continued its steady increase, but slowed slightly from 2020 (figure 42). The index grew from 1.27 in November 2020 to 1.32 in November 2021, a four percent increase.

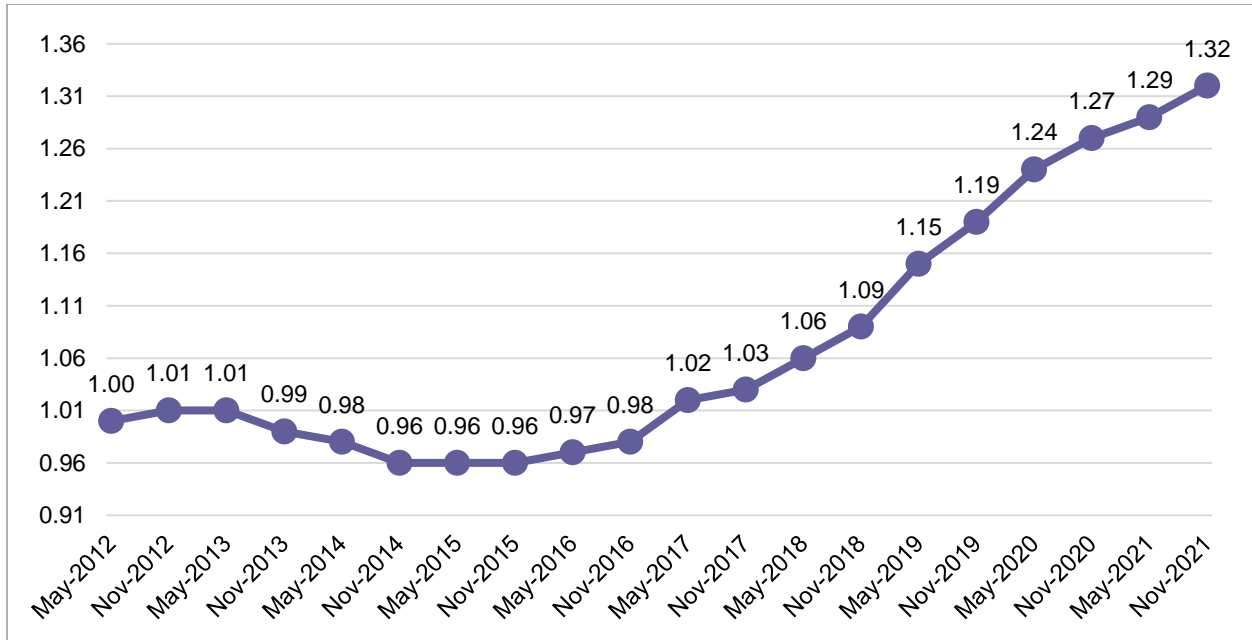


Figure 42. Surgery allowed amount index

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 2021, the pathology and laboratory charge amount index continued the quick pace of growth that started in 2019 (figure 43). The index grew from 1.23 in November 2020 to 1.29 in November 2021, a five percent increase.

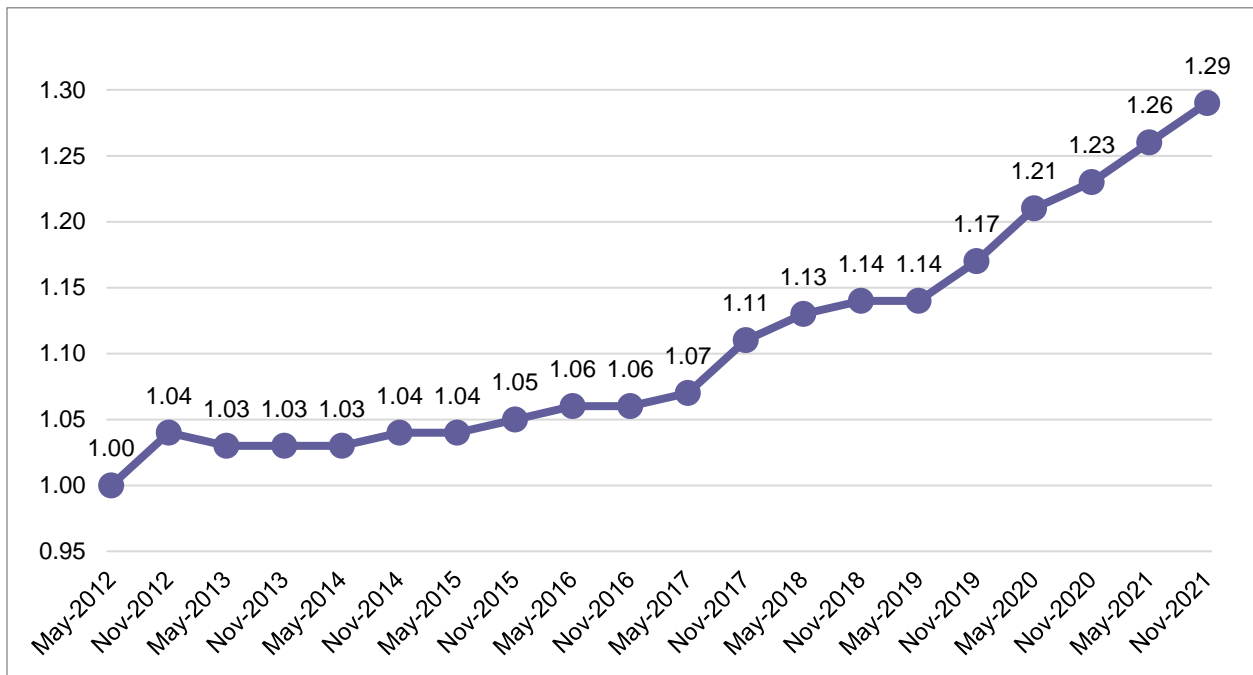


Figure 43. Pathology and laboratory charge amount index

After a year of flattening out (May 2020 to May 2021), the pathology and laboratory allowed amount index had a small uptick (figure 44). The index grew from 1.18 in November 2020 to 1.20 in November 2021, a two percent increase.

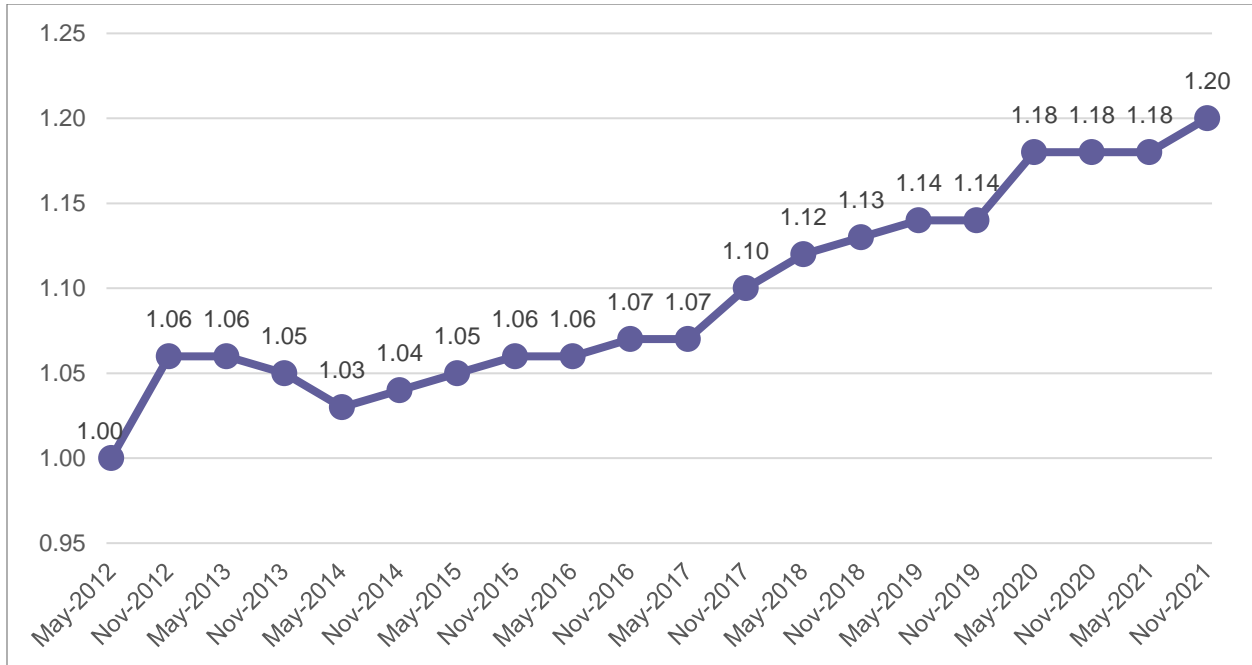


Figure 44. Pathology and laboratory allowed amount index

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.

After a period of decline, the radiology charge amount index changed direction and began to increase (figure 45). The index grew from 1.08 in November 2020 to 1.10 in November 2021, a two percent increase. Of the six categories, radiology and medicine each had the smallest percent increase in charge amount index from November 2020 to November 2021.

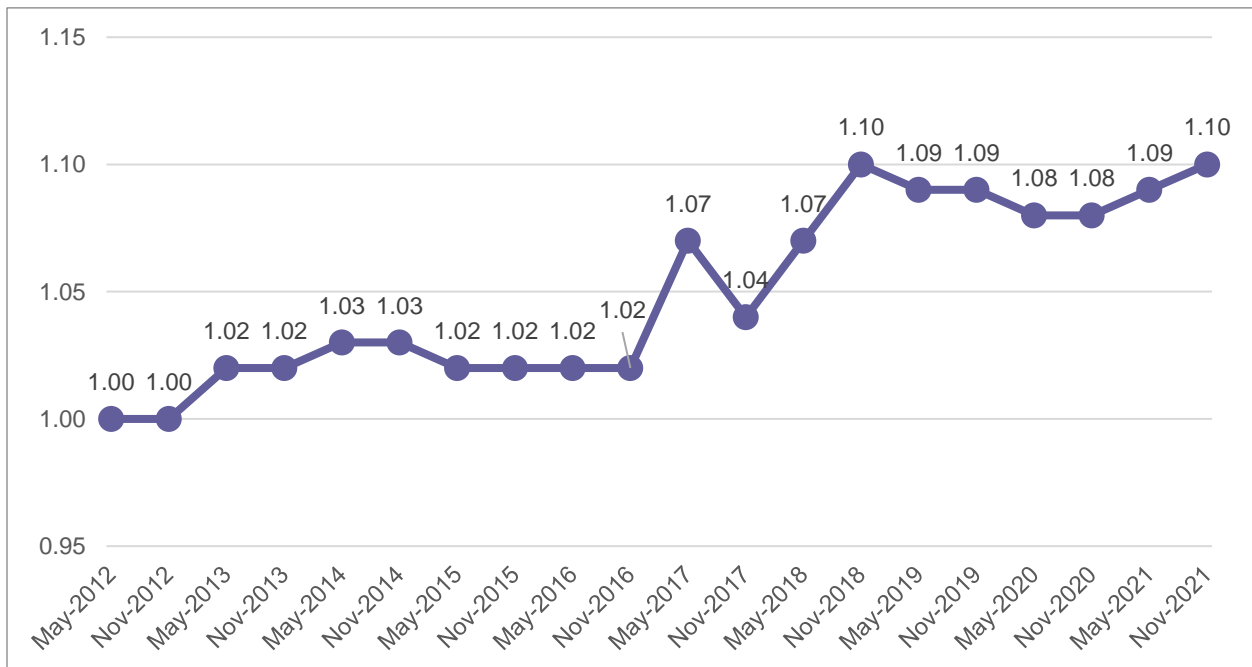


Figure 45. Radiology charge amount index

In 2021, the radiology allowed amount index began to flatten out with only a slight increase (figure 46). The index grew from 1.17 in November 2020 to 1.18 in November 2021, a one percent increase. Of the six categories, radiology had the smallest percent increase in allowed amount index from November 2020 to November 2021.

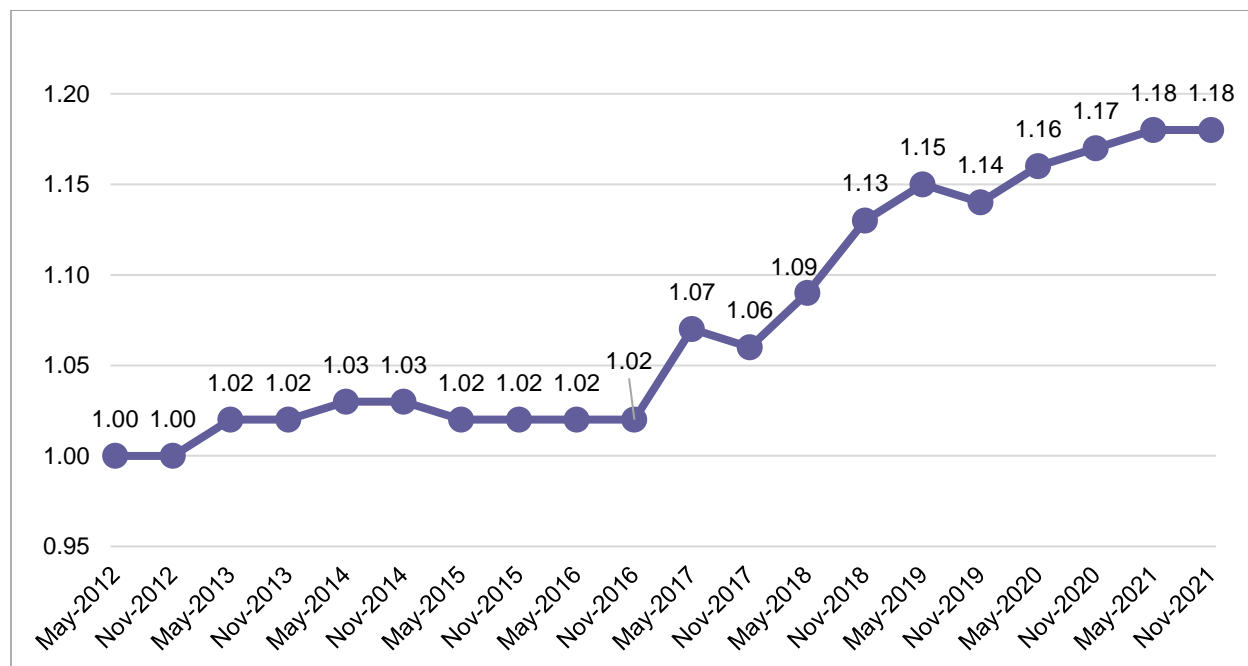


Figure 46. Radiology allowed amount index

Conclusion

This year’s edition of FH Healthcare Indicators revealed the impact of COVID-19 on several healthcare places of service in 2020. For example, due to risk of infection or lack of access to certain in-person healthcare venues, telehealth grew in 2020 on a scale unseen in previous years. Telehealth utilization increased nationally 41,919 percent from 2015 to 2020; from 2019 to 2020, national growth was 7,060 percent. In all other places of service studied for change in utilization, utilization decreased from 2019 to 2020, probably because of temporary COVID-related restrictions on elective services and because the risk of contracting COVID-19 discouraged people from seeking in-person care. Utilization fell 38 percent in ASCs, 30 percent in ERs, 16 percent in urgent care centers and 4 percent in retail clinics.

Among the places of service studied, telehealth held the highest percentage of medical claim lines in 2020, with 15.41 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 2.07 percent for ERs, 1.31 percent for urgent care centers, 0.64 percent for ASCs and 0.05 percent for retail clinics.

In 2020, exposure to communicable diseases joined the list of most common diagnostic categories in retail clinics, urgent care centers and telehealth. This category largely was associated with testing and/or treatment for COVID-19 when a patient was exposed to the condition.

Because of the growth of telehealth in 2020, there was considerable change in the state-by-state distribution of telehealth. Connecticut, for example, which had been fourth from the bottom in its use of telehealth as a percentage of all medical claim lines by state in 2019, rose to fifth from the top in 2020.

In 2020 as in previous years, more claim lines were submitted for females than males in most age groups in every place of service studied. But in some places of service, the gap between males and females narrowed. For example, in ERs, in the age group 61-70, the male and female shares were approximately equal (50 percent) in 2020, a change from 2019, when the female share had been 52 percent and the male share 48 percent.

This year's edition of FH Medical Price Index shows growth of charge amounts and allowed amounts from November 2020 to November 2021 in every procedure category. Hospital E&Ms had the greatest percent increase in charge amount index, seven percent, and in allowed amount index, five percent. Radiology and medicine each had the smallest percent increase in charge amount index, two percent. Radiology had the smallest percent increase in allowed amount index, one percent. The medicine allowed amount index increased two percent. The professional E&M charge amount index and allowed amount index each grew four percent. The surgery charge amount index increased five percent and allowed amount index four percent. The pathology and laboratory charge amount index increased five percent and allowed amount index two percent.

Because of the importance of the healthcare sector to the US economy and the lives of Americans, understanding the trends and shifts in that sector is vital. By issuing this new edition of FH Healthcare Indicators and FH Medical Price Index, FAIR Health intends 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 36 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](https://www.fairhealthconsumer.org) and [fairhealthconsumidor.org](https://www.fairhealthconsumidor.org). For more information on FAIR Health, visit [fairhealth.org](https://www.fairhealth.org).

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