



CALIFORNIA
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Health Care in the Express Lane: The Emergence of Retail Clinics

July 2006

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Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

Prepared by

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About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

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Foreword

WITH AVERAGE ANNUAL PREMIUMS FOR A FAMILY of four now exceeding annual earnings at the federal minimum wage, traditional health insurance products are no longer affordable for an increasing number of consumers and employers. Low-wage employees working for firms that offer insurance coverage often don't take it because they cannot afford the contribution that would be required of them. While they might not have significant assets to protect, they (and their family members) still have health care needs.

Most efforts to address escalating health care costs attempt to innovate within the insurance system but don't tackle the underlying structural costs of delivering health care. Labor, overhead, and technology expenses in the U.S. health care system are often assumed as givens, even as health insurance benefits are cut to the point that neither the scope of benefits nor the expectations of what consumers will pay provide a very compelling value proposition. As the trend in health insurance shifts more costs to consumers, the public has indicated that they are willing to approach at least their basic, routine, and elective health care needs with an eye toward price and value.

Retail clinics have emerged in drugstores, grocery chains, and "big box" stores across the United States, and they're attracting a great deal of attention. The clinics are one attempt to respond to consumer needs for which the existing health care system doesn't provide attractive options. Where do you go for a strep throat test or treatment for an ear infection at night or on the weekend? Waiting for hours in the emergency room doesn't make much sense, but for most people it's the only option. Or consider the choices faced by an uninsured person with too much income to qualify for discounted care at a community clinic—be charged the full fare, or go to the ER, wait hours, and still incur a big bill. Even patients with insurance and a primary care doctor might wait several days to be seen for a minor ailment.

As the number of Californians without coverage (or with coverage that leaves significant out-of-pocket costs) increases, we can expect to see the emergence of options such as retail clinics to meet consumer need. Whether they are able to provide quick, effective, high-quality care—and whether they connect effectively with the broader health care system—remains to be seen.

The clinics can be viewed as a “disruptive innovation” in health care—a “cheaper, simpler, good enough,” offering. In a number of other industries, companies such as Southwest Airlines, E*TRADE, and Charles Schwab have made substantial inroads by eliminating the extras consumers are willing to do without and lowering prices. Similarly the clinics don’t attempt to meet every health care need (or the needs of every consumer). Rather they offer a low-cost, low-overhead approach to addressing needs not well-met by today’s health care system. At present, they offer some consumers (those with insurance and/or a relationship with a physician) a more convenient option for receiving a very basic medical service, and those who do not have access to basic care an alternative to the emergency room.

This report is part of a broader CHCF effort to examine how concepts of disruptive innovation from other industries might be applied to health care. While retail clinics seek to disrupt a very small segment of the health care system, the principles upon which they’re developed—attention to customer needs, schedules and convenience, and a delivery system that doesn’t offer the full complement of costly personnel, technology, and treatment for minor ailments—provide an interesting lens through which to begin to think about how to control costs in health care.

The report describes the forces, individuals, and companies behind the retail clinics, where they’re located, what consumer needs they are attempting to address, and how they relate to the rest of the health care system. It is designed to provide a snapshot of retail clinics in the United States. The market is evolving and changing rapidly, and we recognize that many numbers will have changed by the time this report is released. In fact, on July 13, just before this report was published, the CVS pharmacy chain announced that it will acquire MinuteClinic, one of the early entrants in the market.

The emergence of retail clinics raises a range of operational and policy issues, some of which we’ve attempted to highlight in the final section. CHCF will continue to monitor this trend and produce more in-depth reports about specific aspects of retail clinics and other, lower-cost models of care. We welcome readers to share thoughts and insights with us and to suggest where additional analysis might be warranted.

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Executive Summary

RETAIL-BASED MEDICAL CLINICS HAVE attracted a lot of attention since they emerged a few years ago. Major retail chains, including Target, CVS, Kroger and Wal-Mart, are working with over a dozen clinic operators in selected markets to test health center concepts at grocery and drugstores. The clinical care and business models vary by operator and location, but all have a common value proposition: They offer consumers a limited menu of simple health services within a walk-in retail environment. Most clinics are staffed with non-physician practitioners (typically physician's assistants or nurse practitioners) who are able to provide basic medical care and prescriptions in about 15 minutes.

In theory, retail clinics promise to lower costs because they do away with expensive overhead, use less expensive labor, and eliminate patient billing. The evidence to date indicates that clinics do not increase overall demand for medical services, but offer an alternative for consumers facing access problems within the conventional health care system. They are also attracting the interest of insurers, some of whom are beginning to cover retail clinic services—about 40 percent of clinics now accept insurance.

Clinic companies estimate there will be thousands of clinics across the country within the next year or two. But for now most American consumers have never even seen a retail-based clinic, much less visited one. Among those who have, the early response has been positive. An online Harris poll of 2,245 people showed that while only 7 percent of respondents had visited a clinic, 92 percent of those who had visited a clinic had been satisfied with the clinics' convenience and 89 percent were satisfied with the quality of care they received.¹ Those with restricted access to quality care were more likely to be interested in trying a retail clinic, making California, with its large population of uninsured and underinsured residents, an attractive market.

Retail-based clinics bear watching because they appear to fit with a larger trend toward consumer-driven health care. Consumers are paying more of their own health care costs in the form of higher premiums and deductibles, and are being forced to make decisions about how, when and where they seek medical services. Many consumers are frustrated by the conventional health care delivery system, and are seeking alternatives. Meanwhile, regulatory changes have permitted limited medical care outside of a doctor's office, allowing clinic operators to set up shop where the consumers already are.

The retail clinic model is still very much in flux, both from a business and a medical care perspective. When it comes to in-store clinics, retailers are still trying to figure out what works. However, for most retailers, providing access to health care is not a goal in and of itself; their commitments are to their customers, their employees, and their shareholders. Retailers have yet to determine how to generate profitable revenues and most clinic companies remain in the red; the American Academy of Family Physicians has only recently issued guidelines on desired attributes of retail clinics; insurance companies worry about increased demand and a different claims system; and it is too early to predict whether consumers will embrace health care services that may be located a few feet from the produce aisle or alongside a Starbucks.

It is also too soon to foretell the impact of retail clinics on the wider health care system. How will large payers—including governments—respond to these lower-cost providers? Will they offer incentives to their employees or constituents to substitute clinic care for more expensive alternatives, as they did when they lowered copayments to encourage people to use generic (versus brand name) prescription drugs? Will hospitals, community clinics, urgent care centers, or primary care physicians try to compete by offering similar services, or will they find mutually beneficial ways to team with retail clinics?

This report explores the economic, social, and legislative forces that will shape the answers to these questions. It describes the rapidly changing national landscape of retail clinics, highlights the opportunities and challenges of the California market and notes some of the key issues and questions raised as retail clinics enter the broader health care market.

I. Overview

History of In-Store Medical Clinics

THE FIRST IN-STORE CLINICS APPEARED IN 2000 in the Minneapolis-St. Paul metropolitan area and were operated by QuickMedx, which later became MinuteClinic. The company's founder, Rick Krieger, says the business idea came to him when he tried to get his son in to see a doctor for a strep throat test. He recalls,

“We started talking about why there was not a way to just get a simple question answered or a simple test, like strep throat, done. Why was there not some way to just slip in and be seen quickly? Wasn't there some way to get care in a timely manner for a relatively simple illness? A quick, convenient way to diagnose without waiting in the ER or clinic for two hours? We are not talking about diabetes, cancer, or heart disease! We are talking about colds and throat and ear infections.”²

Krieger and two business partners (one of whom was a family doctor) set up pilot clinics in cooperation with Cub Foods, a local grocery chain. The first clinics charged a \$35 flat fee for rapid testing, diagnosis, and prescriptions for 11 common medical conditions, including strep throat, influenza, ear infection, pink eye, and seasonal allergies. They did not accept insurance, which Krieger explains as a deliberate, strategic choice “to compete on a purely retail level and be able to profit on a copayment-type basis.”

The pilot program, though limited, was considered successful, and the founders began to formulate an aggressive growth strategy. In 2005 MinuteClinic appointed a new CEO: Michael Howe, the former CEO of Arby's. Meanwhile, other clinic companies and retailers entered the game, and there are now a dozen clinic operators running about 90 clinics across the country, a dozen more planning to open clinics in the near future, and hundreds of store openings planned before 2007. As the trend has gathered momentum, the medical and business models have shifted. Most now accept insurance and have expanded their range of services.

Description of In-Store Clinics

In-store clinics typically measure between 200 and 500 square feet and are quite spare with a simple setup of a reception desk and one or two exam rooms. Retailers often use space that is generating less income per square foot than the clinics are anticipated to provide, so some clinics occupy former video game arcades, vending machine areas, or waiting areas near pharmacies. The retailer has a one-time cost of about \$20,000–\$100,000 to make the space “broom-ready”³ and the clinic companies pay for the physical retrofitting. This ranges from \$25,000 for a basic clinic with one basic room to \$145,000 for a multi-exam room clinic offering broader services; the average setup cost is about \$50,000.

Most clinics are staffed with nurse practitioners (NPs) supervised by an off-site physician who is available by phone for consultation, but some clinics employ full-time physicians.⁴ Salaries for nurse practitioners are typically much lower than those of physicians. The average salary for an NP in 2005 was \$74,812 nationally and \$86,674 in California.⁵

The clinics use proprietary software systems that claim to provide evidence-based treatment guidelines. These serve as a diagnostic tool as well as a checklist to constrain the types of conditions that can be treated at the clinic. There are referral relationships with local physicians or hospitals for more serious or unusual conditions. Clinics are open extended hours and weekends. Most visits take about 15 minutes and don't require an appointment. Prices are clearly posted and range from \$40 to \$70. Some clinics accept insurance and all provide documentation for consumers to file for reimbursement on their own.

Early usage and cost data, while still quite thin, are beginning to show some patterns. At MinuteClinic, the five most frequently treated conditions are: pharyngitis (sore throat or strep throat), bronchitis, otitis media (ear infections), sinusitis, conjunctivitis (pink eye), and female urinary tract infection. In terms of overhead cost, a preliminary analysis by HealthPartners indicates that on average, MinuteClinic episodes are about 15 percent less expensive than those initiated in a physician's office or an urgent care setting, based on one year of claims experience—producing a per-visit savings of \$31.

What is an in-store or retail-based clinic?

A medical clinic located within a larger retail operation that offers general medical services (as opposed to specialty clinics such as eye care) to the public on an ongoing (rather than one-time or seasonal) basis. These clinics differ from both urgent care clinics or the “Doc in a Box” concept in several ways: a limited service offering (increasing speed), co-location with a pharmacy (increasing convenience), and lower cost structure (reducing prices).

The “Plumbing and Privacy” Paradigm

Most in-store clinics don't have much space for private rooms, toilets, or sinks. This means that they tend to focus mostly on noninvasive procedures that don't require fluid samples or disrobing.

Retail Approach to Health Care

In many ways, in-store health clinics are a retail experiment that has captured the attention of the health care industry. Their existence depends on retail leases, while their success depends on the patronage of customers who may think of their visit as a convenient extension of a shopping trip, and not necessarily an extension of health care. Instead of a suite in a medical building or the wing of a hospital, one Florida clinic describes its location as a storefront in a local shopping mall along with “Starbucks, Quiznos, and Planet Smoothie, right next to El Pollo Loco.”⁶

Retailers are naturally consumer-centric and many of the key players in the retail clinic industry come from consumer backgrounds, such as packaged goods, fast food, and travel companies. It is important to understand how these companies make decisions. Retailers generally see two ways to gain from in-store clinics. On the revenue side, they hope the clinics will attract new customers and drive sales elsewhere in the store, especially prescription and over-the-counter purchases. On the cost savings side, some retailers see an opportunity to manage the expense of providing health care to their employees. Not only are the clinics a relatively cheap way for employers to provide health care compared with other care delivery options, but they could reduce absenteeism for doctor’s visits because employees could be treated for minor conditions within the workplace.

However, it is important to note that such scenarios come with a basic caveat: If retailers and clinic companies don’t achieve the expected results, they will close the clinics. Unlike the health care industry, retail product life cycles are very short. Retailers continually try new formats and services and are adept at removing less profitable lines of business. In fact, there have

already been closings in areas where the clinics didn’t gain sufficient traction. In Baltimore, MinuteClinic is closing its six Target locations after less than two years in operation and opening seven clinics in nearby CVS drugstores. The companies indicated that the closings were not a retreat from the retail clinic concept rather a decision to focus on other markets and create different types of service offerings more appropriate to their individual corporate strategies. Either way, this is typical of the retail mentality: fast turnaround, rapid consumer testing, and constant reinvention of the model.

It is also telling that the rollout of in-store clinics has been limited. To put this in perspective, there are more than 3,800 Wal-Mart stores in the United States. Only 14 now have in-store clinics (0.2 percent of stores) and official plans call for rolling out just fifty more in 2006–2007 (to 1.5 percent of stores). Of the 100,000,000 people who walk through Wal-Mart’s doors each week, only 1,000 visit a clinic. However, this picture could change. The company has formally stated that it will expand the use of in-store clinics.⁷ Much will depend on how aggressively Wal-Mart pursues this expansion plan.

Other retailers are approaching these clinics with similar caution, testing them in limited markets and relying on shorter-term contracts with outside clinic companies to evaluate the business impact. This phenomenon could either take off overnight or languish depending upon whether medical clinics fit into retailers’ overall business strategies and relationships with consumers.

Scope of Practice

Scope of practice varies by clinic company, by state, and by retail location, but there are strategic, practical, and regulatory reasons for in-store clinics to maintain a relatively narrow scope of practice.

Strategically, the clinic model relies on low prices, quick throughput of patients, minimal staff, and proprietary software systems that can reliably manage selective medical diagnoses and information. This is only possible with a short list of simple procedures.

Most in-store clinics are housed in small areas with physical limitations: At most, they have one or two exam rooms with a sink and/or toilet close by (and a few do not even have sinks or private rooms). The clinics explicitly aim to treat common ailments that can be diagnosed quickly and accurately, within 15 minutes. This keeps quality control manageable and overhead low. It also effectively constrains for the range of services they are able to provide for patients. Limited medical records are kept (usually electronically, unless paper backups are required by the state), very little medical equipment is needed, there are no patient gowns (hence no laundry service), and no time-consuming examinations. The diagnostic tests typically offered are compact and rapid and offer simple, accurate results, exempting them from the federal regulations that govern more complex lab procedures.⁸

Clinic companies adjust the services they offer in order to maximize profits and respond to local markets, and there are sometimes differences in scope of practice from one location to the next. To date, most clinics have opened in suburban areas, where affluent shoppers might be willing to pay extra for fast, convenient health care. They have emphasized convenience in their marketing, with slogans such as, “You’re Sick. We’re Quick” (MinuteClinic), “Get Well.

Stay Well... *Fast!*” (RediClinic), and “Great Care. Fast and Fair” (Solantic). The clinics initially required consumers to pay in cash for this convenience, but now some insurance companies cover part or all of the in-store clinic visit costs, making the clinics more cost-effective for their subscribers. For these consumers, clinics are at cost parity with a similar visit to a primary care physician, but still have a “time cost” for the consumer to submit the claim.

While the early models focused on “get well” care (diagnosing and treating acute or unexpected illness), the newer model places a greater emphasis on “stay well” care. Web Golinkin, CEO of RediClinic (a subsidiary of InterFit), estimates that his clinics now provide about 75 percent get-well and 25 percent stay-well services, with some seasonal fluctuation due to flu shots and school physicals.⁹ “We’d like to get to more stay-well,” he says. “We believe that convenience and affordability are just as important to consumers in prevention as they are in treatment, and that consumer interest in preventive services will grow over time.”

In addition, although the clinics started out mainly in suburban enclaves, they are now appearing in less affluent communities where under-insured and uninsured consumers are willing to pay cash for clinic care, not only because it is convenient, but also because they have limited access to health care elsewhere.

Licensure and Regulation

Licensure regulations for retail clinics and those who practice within them vary from state to state. In many states, clinics are licensed as physician practices, and are regulated by the state's Medical Board.

In California, the clinics must be a medical corporation owned by a physician, in accordance with the state's Corporate Practice of Medicine Guidelines.* Physicians and nurse practitioners working in the clinic must also have appropriate state licensure.

Most clinic companies operate multiple sites within a state. Licensure regulations specific to sites also vary. For example, in Arizona each site must be licensed, whereas in most other states, the clinic is licensed at the corporate level and the license covers multiple sites. Some states require an in-state supervising physician, while others permit a supervising physician to be at a corporate office out of state.

A separate license from the federal government is required to accept Medicare patients and payment and some clinics apply for this licensure.

*Medical Board of California, Corporate Practice of Medicine Guidelines:

www.medbd.ca.gov/Corporate_Practice.htm

Regulatory Trends

Regulation of retail clinics varies from state to state. The clinics are typically staffed with nurse practitioners (NPs) who have different degrees of autonomy in each state. In states such as Minnesota (where clinics have the largest presence), NPs can perform a range of functions with no physician on site. In other states, the physician must be physically present for some or all of the time. Each state has different requirements for credentialing and licensing, as well as for physician oversight. These issues may expand, limit—or even prohibit—in-store clinics and the specific services they can provide on a state-by-state basis (see sidebar). Regulatory requirements for the extent of the physician's involvement make a significant difference in clinics' labor costs, so that in some states, although it is technically possible to operate licensed retail clinics, legal practice parameters would make it unprofitable. Warns RediClinic CEO Golinkin, "If clinics are going to realize their full potential to provide people with easier access to high-quality, routine health care at affordable and transparent prices, some of the regulatory barriers in some states will have to be torn down."

Federal support for consumer-driven health care makes clinics more attractive by giving consumers incentives to reduce their health care spending. In particular, the Medicare Modernization Act of 2003 offers consumers tax incentives for high-deductible insurance plans coupled with health care spending accounts to encourage Americans to manage their health care expenditures most cost efficiently and mitigate out-of-pocket costs.¹⁰

Nurse Practitioners

According to the American College of Nurse Practitioners, 23 states allow nurse practitioners to treat patients on their own without a physician and 28 states (including California) require documented physician involvement. Laws in these states vary and are changing, but may regulate collaboration, supervision, and authorization.

California's doctrine precluding the corporate practice of medicine and the state's requirement for standardized procedures and limitations on the dispensing of drugs highlight challenges to NPs practicing independently in retail settings or elsewhere.

In California, a nurse practitioner's basic scope of practice is covered by the Nursing Practice Act in the Business & Professions Code. Generally, standardized procedures must be developed and approved by the NP, the supervising MD, and the facility administrator before an NP can perform anything that might be considered "practice of medicine" (including diagnosis of mental or physical conditions, the use of drugs in or upon human beings, and severing or penetrating tissue of human beings). Standardized procedure guidelines are described in the California Code of Regulation. NPs and other health care professionals are also bound by various state and federal health and safety regulations, labor laws, and business licensing requirements.

Nurse practitioners might be employed by different entities (physician practice, hospital, clinic, etc.). In California, NPs do not have the authority to provide fully independent primary care; rather they must practice under "standardized procedures" that are developed among the NP, the supervising MD, and the institution/agency where the care is provided. Many of the requirements seem to be open to interpretation. For example, according to the Board of Registered Nursing, "The mileage between the nurse practitioner and the supervising physician is not specifically addressed in the NPA [Nursing Practice Act]. However, the physician should be within a geographical distance, which enables her/him to effectively supervise the nurse practitioner in the performance of the standardized procedure functions." The standardized procedures may detail supervisory and signatory requirements.

The dispensing, or "furnishing," of drugs or devices by NPs must be done under the supervision of a physician. For furnishing purposes, the physician may supervise a maximum of four NPs at any given time and must be available by telephone when the patient is being examined by the NP. To dispense or order drugs, NPs are also required to have a special certificate from the Board of Registered Nursing and a Drug Enforcement Administration number.

Table 1: Retailers and Clinic Companies

Clinic Operator/ Headquarters	Locations and Expansion Plans	Retailers	The Consumer Pitch	Notes
Aurora Quick Care Milwaukee, WI	<ul style="list-style-type: none"> • 11 Quick Care clinics in Aurora Pharmacy locations • Considering additional locations 	Aurora Pharmacy, Piggly Wiggly	<i>No appointment. No waiting. No hassle.</i>	The first major clinic operator with a not-for-profit parent company. Opened March 2004. www.aurorahealthcare.com
Family Express Care South Euclid, OH	<ul style="list-style-type: none"> • 1 location in OH (closed) • No plans to expand 	Giant Eagle	<i>Convenient Care When Your Doctor's Not There!</i>	Opened February 2005. Closed 2006. No website
HealthRite Atlantic City, NJ	<ul style="list-style-type: none"> • Opening first clinics in grocery stores Aug 2006; plans for 8 clinics in NJ 	Shoprite grocery stores	<i>Health Care Rite When You Need It</i>	Part of the AtlantiCare health system that includes hospitals, nursing homes, urgent care, primary care physician network and health insurance programs. Smaller footprint clinics 160sq ft designed to resemble a doctors' office with exam table. Offers franchise arrangements for other hospitals at a 4% fee.
MediMin Phoenix, AZ	<ul style="list-style-type: none"> • 3 locations in AZ • 2 more in 2006 	Bashas'	<i>Time, Sensitive Care</i>	www.medimin.net
MedPoint Express South Bend, IN	<ul style="list-style-type: none"> • 3 locations in IN • 2 more Wal-Mart clinics planned 	Wal-Mart	<i>Get Well Soon</i>	Affiliate of Memorial Health System, Inc. www.medpointexpress.com
MinuteClinic Minneapolis, MN	<ul style="list-style-type: none"> • 86 locations in IN, GA, MD, MN, NC, OH, TN, WA • Projected to grow to 300 clinics by the end of 2006 	CVS, Target, Supervalu's Cub Foods, Bartell	<i>You're Sick. We're Quick!</i>	Formerly known as QuickMedx. The first mover and current leader in national retail clinic market share. Backed by Bain Capital. CEO Michael Howe is former CEO of Arby's. On July 13, 2006, MinuteClinic announced that it will be acquired by CVS. www.minuteclinic.com
QuickHealth San Francisco, CA	<ul style="list-style-type: none"> • 3 locations 	Farmacia Remedios, Longs	<i>We make quality medical care affordable and convenient.</i>	Formerly known as QwikHealth. Founder Dave Mandelkern co-founded Docent. www.quickhealth.com

Source: Individual company Web sites, Scott & Co. research.

Clinic Operator/ Headquarters	Locations and Expansion Plans	Retailers	The Consumer Pitch	Notes
Quick Quality Care Tampa, FL	<ul style="list-style-type: none"> • 3 locations in FL • Plans to expand both in Wal-Mart and other retail locations 	Wal-Mart	<i>Professional Healthcare Without the Wait</i>	Clinics are set up for diagnostic imaging (including x-rays) but not yet offering these tests. www.qqcare.com
RediClinic Houston, TX	<ul style="list-style-type: none"> • 11 locations in AR, NY, OK, TX • Plans to open 75 more clinics in 2006, mostly in Wal-Marts. 	HEB, Wal-Mart, Duane Reade	<i>Get well. Stay well... Fast!</i>	Division of Interfit Health (Revolution Health Group). General Manager Sandra Kinsey was formerly head of marketing for Wal-Mart's pharmacies. www.rediclinic.com
SmartCare Greenwood Village, CO	<ul style="list-style-type: none"> • Opening first clinic the first week of August in Charleston, SC. Plans to open as many as 1,050 centers in 3 to 5 years. 	Kerr Drug (in North and South Carolina) Wal-Mart (in Nevada, Arizona, and Colorado)	<i>Convenient health care for everyday needs.</i>	CEO Lawrence Hay was the founder of HomeSync www.smartcarecenters.com
Take Care Health Systems Conshohocken, PA	<ul style="list-style-type: none"> • 16 locations in KS, MO, OR • Plans to open 200 clinics in next 12 months and 1,400 clinics by the end of 2008. Contract in place with Brooks Eckerd Pharmacy. Walgreens is planning to open more than 20 this summer and Osco (Albertson's Inc.) locations are expected to close and staff to move to the new facilities. 	Brooks Eckerd Pharmacy, Rite Aid, Osco, and Sav-on Drugs	<i>Professional care. Always there.</i>	Just secured \$77 million in financing (led by Beeken Petty). Chairman of the Board Hal Rosenbluth was the founder of a large travel company that he sold to American Express. www.takecarehealth.com
The Little Clinic Louisville, KY	<ul style="list-style-type: none"> • 8 locations in IL, IN, KY • 3 clinics will open in FL in 2006 and as many as 500 nationwide in 5 years 	Kroger	<i>Convenient neighborhood medical care.</i>	Formerly known as Fast Care. www.thelittleclinic.com
Wellness Express San Ramon, CA	<ul style="list-style-type: none"> • 3 locations in CA • 12 clinics total by end of 2006 	Longs Drugs	<i>Prompt & professional medical care.</i>	First clinic operator in California affiliated with a national chain. www.wellnessexpressclinic.com

The California Situation

California lags behind the national curve in adoption of the retail clinic model. In terms of national retail chains, as of June 2006 there are only three in-store clinics operating in the state, all Wellness Express clinics located in Longs Drug Stores in Northern California (in Campbell, Davis, and Sunnyvale). Longs has already opened and closed in-store clinics in two additional locations after finding that they were not profitable. There are also some local chains, such as Farmacia Remedios in the San Francisco Bay Area, that are successfully running in-store clinics.

While clinic companies and retailers are attracted by the size of the market, regulations for oversight of nurse practitioners limit clinics' potential profits and scalability. In most states, the clinic companies directly recruit, train, and staff nurse practitioners.

Web Golinkin, CEO of RediClinic, says, "California is a market that we're extremely interested in, but very cautious about from a regulatory standpoint, mainly because the corporate practice of medicine statutes would prevent us from employing mid-level health care professionals directly. This would make it substantially more expensive and complicated to operate RediClinics in California as compared to most other states."

The retail "hosts" of the clinics echo this view. Ameer Chande, vice president of health care strategy for Wal-Mart, shares, "We will open where our operators indicate they want to go. Given that the landscape is wide open today, we all can choose from many states. A key issue for some of our operators is their ability to hire nurse practitioners. States can influence operators, and indirectly us as hosts, to locate

in certain states by ensuring that there is a good supply of nurse practitioners and that the oversight requirements on these nurses is appropriate and cost effective."¹¹

One reason California is an attractive market is its large uninsured and underinsured populations, who often have difficulty getting their health care needs met. But clinic operators are still not clear on how to attract and serve this demographic segment profitably. At the three Wellness Express (Longs Drug) clinics in California, approximately 70 to 80 percent of visitors have insurance (many with HMO plans); these consumers are simply willing to pay out of pocket for convenience. Even at \$40 on average per visit, the clinics are prohibitively expensive for many of the state's poorest residents, and the clinic operators cannot lower their prices and remain profitable.¹²

Another opportunity in California is the large Latino market. Farmacia Remedios, a small pharmacy chain in the San Francisco Bay Area, has had success catering mostly to Spanish-speaking, lower-income urban customers. Its in-store medical clinics, run by Quick Health, are staffed full-time with Spanish-speaking physicians who offer comprehensive care and prescriptions.¹³ Ben Singer, the company's co-founder, says that this model works well because it isn't a behavior change for his customers. "In Latin America the first point of care is the pharmacy. You go and you say, 'I have a toothache,' the pharmacist says 'okay, this will help you, and if it doesn't go away in two days see a dentist.' Here in the United States it's the other way around: You see the doctor, then the pharmacy. When our customers arrive, they're greeted in their usual environment by a staff member who speaks their language, so in a way they feel back at home."

Quick Health operates on a different model than other retail clinics—while it is located in a retail setting, it's staffed by physicians and designed not just for convenience, but to provide basic primary care to the uninsured. Quick Health

plans to open six to eight additional physician-staffed clinics by the end of 2006, some in other Farmacia Remedios locations and others in partnership with Longs Drugs and another California retailer.

The AtlantiCare Model

Another variation on the theme is offered by AtlantiCare—southeastern New Jersey's largest health care system—which has recently added six clinics in ShopRite, New Jersey's largest grocery chain, and plans to have nine by the end of 2006. Don Parker is president and CEO of Atlantic Care Health Services and George Lynn, former board chair of the American Hospital Association, is its chairman. The clinics will carry the slogan "HealthCare Rite When You Need It."

The first store clinic will open in August 2006. Rather than a kiosk environment, the clinic space is designed to feel and look like a doctor's office with an exam room and a nurse practitioner with a tablet for check in (albeit at 160 square feet a fairly small one).

AtlantiCare's goal is to employ HealthRite as part of what it describes as "a daily interaction" with consumers about their health care and overall wellness. In addition to several hospitals and clinics, the company owns and operates day care facilities, nursing homes, and fitness centers as well as an insurance company, for a total of 57 locations within a two-county area. "We have a consumer-directed health care plan," explains Parker. "We see HealthRite as an extension of our community presence and our health care offering and also a way to connect health, wellness, and food."

Services will be provided by nurse practitioners with physician oversight at an average price of \$49. The clinics accept insurance with the AtlantiCare health plans (and cash payments for those without insurance) with a \$5 or \$10 co-payment—the same as they would to visit their physician. The company is also negotiating with other insurers about covering care provided at the HealthRite clinics.

The clinics will be equipped with an electronic medical record (EMR) system, which the company plans to have connected to the entire AtlantiCare system—hospitals and other care locations—within 18 months.

Parker acknowledges that the new clinics will compete with AtlantiCare's existing primary care networks. However he sees that as a plus. "We believe that we need to create access and create new models for care." The idea is to integrate the clinics into the AtlantiCare system and offer solo or small-office practitioners the option to use them for weekend and evening coverage, among other things.

II. Converging Trends in Retail and Health Care

CONSUMER-DRIVEN HEALTH CARE IS AT THE heart of the retail clinic trend. In the conventional payer-provider system, five out of six dollars spent on health care are not spent directly by the patient.¹⁴ This is changing as premiums, deductibles, and copayments rise. In addition, economic incentives such as FSAs and HSAs are designed to help consumers manage these rising out-of-pocket expenses, while forcing them to become more cost-conscious in shopping for health care services.

Retail-based companies are ready to cater to this new kind of health care consumer by offering what they believe their shoppers want: convenient basic medical care at a fair price, stated in advance. If successful, this could change the way many people receive routine, non-urgent medical care, with significant implications for insurers and health care providers. Other trends in health care—such as standards and infrastructure for electronic medical records, and technological advancements that make testing and diagnostic work compact and portable—could dovetail with new retail-based care.

The Retailer Perspective

Due to intense competition and consolidation in the retail industry, grocery and drugstore retailers operate with razor-thin margins—typically less than 5 percent and sometimes as low as 1 percent. This forces them to focus heavily on the productivity of their assets by looking for ways to intensify the profits from existing geographies, stores, inventory turns, customers, and brands.

Retailers make money primarily by re-selling goods, a business with several proven strategies. Some retailers negotiate with suppliers for distinctive products at lower prices (Costco, WalMart); some create their own private label exclusive brands (Trader Joe's); some have a membership model (Sam's Club and Costco); some create better shopping experiences (Whole Foods); some offer an array of in-store services (Starbucks at Safeway); and some motivate their employees to offer superior service (Wegman's). All, however, face cutthroat economics. Because margins are tight, retailers rely on alternative revenue

sources such as slotting fees (fees for shelf space or position), sponsorship of marketing programs, and cooperative advertising (payments from manufacturers for discount coupons and mentions in their flyers).

All retailers attempt to allocate space to extract the most profit possible per square foot and create a specific shopping environment. For average-sized grocery stores, there is a gross sales performance range of \$450 to \$600 per square foot per year.¹⁶ Grocery retailers commonly lease space to banks at \$100 to \$120 per square foot, and to specialty services such as branded coffee or juice shops at \$250 to \$350 or more per square foot. These leases are usually for much smaller spaces than clinics, and often include a revenue share that is not possible with clinics due to federal anti-kickback laws pertaining to the health care industry. When retailers consider new uses of space, such as medical clinics, they factor in a margin of about 15 percent to account for fixed costs and sales margins of 3 to 7 percent (see sidebar).

Three kinds of retail stores now host medical clinics: discounters or mass merchandisers (such as Wal-Mart) who see clinics as a front-of-store

consumer service; grocers who see clinics as a way to increase store visits and “basket” size; and pharmacies who see clinics as a way to increase prescription spending. Obviously, while they might have slightly different priorities, all retailers hope that a combination of these benefits will ultimately result in higher profits.

When the clinics are housed in mass merchandise stores, there is usually an in-store pharmacy as well. The retailer hopes customers shop while waiting to be seen at the clinic, fill their prescriptions at the pharmacy, buy OTC medication, or otherwise expand their “basket” as a result of their clinic visits. MinuteClinic, arguably the pioneer of the trend, sees 25 to 30 people per day in its clinics. Roughly 70 percent of these become new pharmacy customers, 38 percent will buy an OTC product during that visit, and 80 percent will make a general merchandise purchase.¹⁷ Surveys have also shown that 95 percent of customers diagnosed at Target’s in-store clinics get their prescriptions filled at the same store.¹⁸ Interestingly, 90 percent of clinic customers came to the store for the care, not necessarily to shop, but ended up buying something anyway.

Table 2: How Retailers Make Money¹⁵

Revenue	Example
Retail Sales	Pet food and private label items are high margin; paper products are a loss leader
Slotting Fees	Consumer Packaged Goods (CPG) companies pay for shelf space—more if it’s an end-of-aisle display
Co-Promotion	Inclusion in weekly circular and in-store marketing collateral
Sponsorship	Suppliers subsidize special events, in-store promotions, sampling programs
Lease Income/ Revenue Share	Banks, video rentals, coffee shops, clinics

Source: Scott & Co.

Crunching the Numbers: The Economic Deal with Retailers

Given some representative economics, a 600-square foot clinic space might lease for \$50 to \$70 per square foot, or \$30,000 to \$42,000 per year. Retailers would expect that space to represent income of about \$49,500 (gross sales of \$550 per square foot at a 15 percent margin).¹⁹ In this example, this would mean that the retailer believes it can make up for a margin loss of at least \$7,500 on a clinic's lease income.

To make up that \$7,500 retailers can sell more goods, attract new sponsorship dollars, and/or increase the rent the clinic companies pay. The first option, increasing merchandise sales, is tough. Retailers would need to sell \$150,000 of goods at their usual 5 percent margins—or or close to \$3,000 per week—to generate the foregone income. A successful clinic might generate 20 to 25 clinic visits a day, or about 150 visits per week, so each consumer would need to spend an *incremental* \$20 per visit. Given that the average basket size is less than \$20 across grocery and drug retailers, this increase in spending is a lot to expect.

Prescriptions are higher margin, so clinics would only need to drive about \$60,000 to \$65,000 in incremental pharmacy sales for the retailer to hit its revenue targets. This translates to incremental sales of \$10 per visit, which is still a challenge.

Sponsorship is another way to make up for foregone revenue. In recent years, retailers and CPG companies like Procter & Gamble have shifted their focus—and marketing spending—to in-store promotions and advertising. According to investment bank Veronis Suhler Stevenson Partners LLC, U.S. companies will spend around \$18.6 billion on in-store marketing advertising this year, up from \$17.6 billion last year.²⁰ Retailers and consumer packaged goods firms know that 70 percent or more of all retail purchase decisions are made at the shelf, and sponsorship in the grocery or drugstore is now a critical communication tool. For example, pharmaceutical companies sponsor clinics and in-store health events, using in-store displays, inserts in store circulars, samples, coupons, and loyalty programs to increase sales of OTC products. Clinics represent an interesting new vehicle for samples, coupons, and product recommendations by health care providers.

A third approach by the retailer is to increase rent to \$100 per square foot so that there is no need to make up lost margins. This is already happening in some stores, but at \$100 a square foot, the clinic operator is assuming significantly more risk. An increase in fixed costs of about \$20,000 to \$30,000 means they need to attract about 5 to 10 incremental customers per day.

Retailers are still testing to see how clinics will deliver profits for them. For example, HEB is the largest food and drug retailer in Texas. It hosts seven RediClinics, each one located in a different demographic and socioeconomic market. Local

customization is minimal, but the company plans to test different models to see what resonates with consumers. Similarly, Wal-Mart is working with 11 different clinic companies to evaluate contrasting business and care delivery models.

The Retail “Host” Perspective

Health care benefits for employees are the second largest expense item for employers after wages, and the fastest growing cost. For the largest retail chains, health care costs can literally make the difference between profit and loss and overall valuation. Tellingly, the retailers’ same store sales “comp” target of 2 to 4 percent is similar to the rise in their health care benefit costs. A recent study by McKinsey & Co. projects that by 2008 the average Fortune 500 company will be spending as much annually on health benefits as it earns in profits.²¹ If employers (retailers or other employers) can use in-store clinics to provide basic, inexpensive health care for employees, it will be worth it even if there are limited revenues gained from the clinics. The key issues are direct costs, absenteeism, and employees coming to work sick.

The Clinic Company Perspective

There are three basic payment models for in-store clinics based on the payments for services: 100 percent consumer pay, insurer reimbursed, or mixed, with a consumer copayment.²² The clinics and payers are experimenting because it isn’t clear what works; one of the first in-store clinics operated by MinuteClinic in a Target store has had 150,000 patient visits in five years, but is not yet profitable. In 2004, MinuteClinic had revenues of under \$4 million, up from \$2.5 million in 2003.²³

The economics of a clinic company are challenging. They have high fixed costs (labor and insurance,²⁴ IT, rent, and corporate overhead comprise 85 percent of the cost structure) and minimal variable expenses (lab tests, supplies). While there is a range of costs based on the clinics’ space and services, on average a 450-square foot clinic has fixed costs of \$600,000. Each visit generates an average of \$52, so a clinic needs about 11,500 visits a year—220 per week or more than 30 per day—to break even. The bottom line is that clinics need to see two to three people every hour.

The Payer Perspective

The first in-store clinics asked consumers to pay 100 percent of the cost of their visits, so insurers were not involved in the equation. However, in-store clinics quickly came to seem like a good idea for the insurance companies. As attracted as they were by the potential cost savings, however, many insurers were also nervous that clinics would increase their subscribers’ total health care visits, rather than acting as a cheaper substitute for care they would have received elsewhere. Once the initial usage patterns indicated that the clinics did not appear to increase overall demand for medical services, the insurers were sufficiently encouraged to begin covering retail clinic services.²⁵

One reason the clinic operators didn’t initially accept insurance was because the claims process is extremely inefficient and expensive for the provider. Billings-related expenses account for about 30 percent of the operating costs of a physician’s practice (this includes staffing, documentation, IT, delays in accounts receivable, and unpaid claims).²⁶ The economics of in-store clinics cannot support such overhead. In 2004, MinuteClinic in Minneapolis began to work with Blue Cross and Blue Shield plans to find an approach that made sense for the retail clinic model. The plans would have to change their paper and people-intensive process (including multiple claims rejections and negotiated fees) to a radically simplified system: 100 percent payment for 100 percent of claims within 10 to 14 days. Despite its usual adherence to a conventional claims process, the insurer agreed to a trial that used periodic random claim audits instead of individual reviews. The system remains in place and is a model for other clinic operators and insurers.

About 40 percent of clinics now accept insurance, although this varies by location.²⁷ Some insurers have completely eliminated copayments for in-store clinics in order to encourage their subscribers to use the lower-cost services and preventive care. This represents a sea change for insurers—they have had to adjust their IT systems, payment processes, auditing protocols, relationships with other health care providers, and fundamental business models. If all insurance companies followed this approach, it would mean that clinics would operate on a radically different (and more favorable) economic basis than other care kinds of care providers. It could also give consumers a significant incentive to use the clinics—a total reversal of the clinics’ original premium-for-convenience concept.

Consumer Attitudes

In the era of consumer-driven health care, the consumer can decide how, when, and where to seek health care services from a wide range of options. Retail-based businesses are ready for this. They are intensely consumer-centric, continually probing what shoppers want and using a battery of metrics and tests to evaluate whether their marketing approach—the blend of product, price, place, and promotion—is working. Most conventional health care providers simply don’t think this way about their patients. In the retail world, the lifecycle for product innovation/concept renewal is between two and six years, compared with an average of seventeen years for medical innovations.²⁸

Not much is known yet about consumer attitudes toward clinics, given how few are in operation and how often the care models have changed. It is obvious that retail clinics will require significant behavior changes for consumers. They will have to accept care in a different location, from a different type of provider, with a different payment process, and even though the clinics are obviously convenient, that

might not be enough to incite change. Take an example from financial services: The first ATM was installed outside a bank in 1967; there were widespread installations in the early 1980s; and the machines gained broad acceptance and usage in the early-1990s. So consumers proved willing to adopt a more convenient alternative to bank tellers—after about twenty years.²⁹

For a limited range of conditions, retail clinics will be a new choice for consumers who might otherwise go to primary care or urgent care providers. These consumers will consider how much treatment costs at one provider or another, how long it takes, and how effective it is.

Retailers often rely on rapid testing and market research to evaluate consumer attitudes to new product concepts. This includes online surveys to gauge consumer interest, test new products, and understand which features to emphasize in marketing communications. While far from comprehensive studies, these surveys and focus groups can give retailers a sense of consumer readiness for a new service, an indication of price sensitivity, and a better understanding of how consumer spending decisions are made.

One such rapid-response survey asked consumers where they would seek treatment for a sore throat, assuming their regular doctor was not immediately available. Respondents’ first choice was urgent care clinics, their second choice was to wait for their family doctor and their third—with a response rate of approximately 20 to 25 percent—was the emergency room (30 percent for those without a family doctor).³⁰ Suspected strep throat is the most common complaint at retail clinics, accounting for one-third of all visits.³¹ Strep throat is a bacterial infection that can be accurately and easily diagnosed from a throat culture that is evaluated in the clinic or sent to a lab. Treatment usually involves a prescription for oral antibiotics. Figure 1 compares the cost to treat a strep-throat patient at different

delivery sites. While it is cheaper for the insurance company to deliver service through the retail clinic, it can be three to four times more expensive for the consumer—assuming that consumers don't put a dollar value on their time.

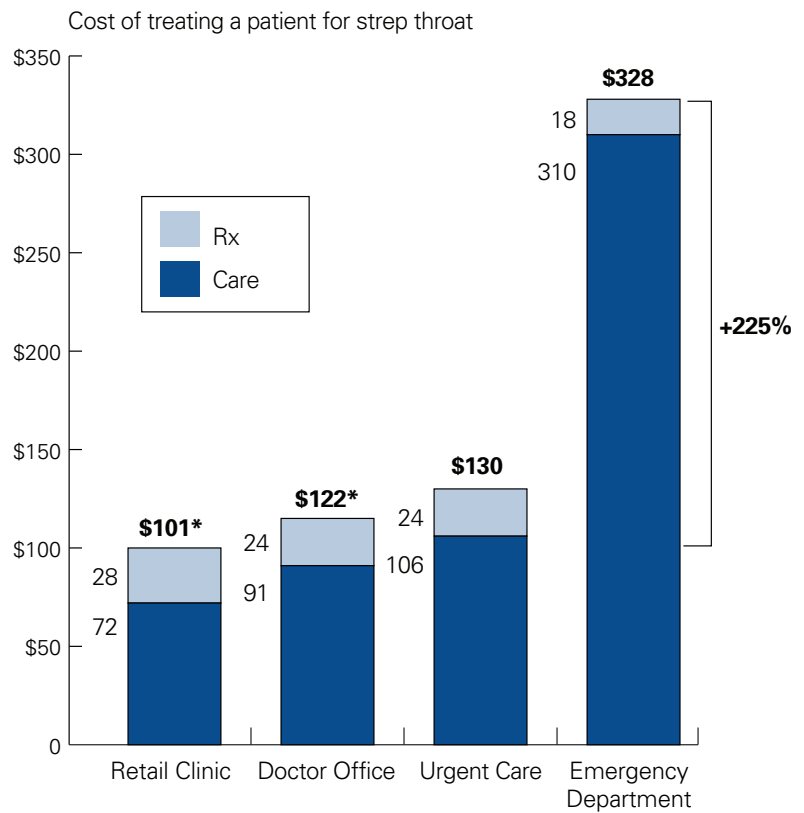
There are some early indications that consumers are willing to try retail clinics. However, large majorities also have concerns about them. A report published by Harris Interactive indicated that only 7 percent of adults had actually used the clinics, but among those, 92 percent were satisfied with the convenience and 89 percent were satisfied with the quality of care they received.³² But three-quarters of those surveyed were worried that serious medical problems might not be accurately diagnosed at a retail clinic.

Consumers have readily taken advantage of workplace clinics, flu shot clinics at drugstores, and screening clinics outside of their primary care physicians' offices. The aforementioned rapid response survey showed that consumers with restricted access to quality health care were more likely to try retail clinics: low-income respondents (49 percent), Latinos (51 percent), those with poor or limited insurance (54 percent), the uninsured (56 percent), and those without a family doctor (60 percent).

Both low- (under \$50,000) and high-income (\$100,000 and above) respondents were more likely to use the clinics than middle-income ones. Latino and low-income consumers were the most likely with 71 percent indicating they would probably try them.

Safeway recently conducted an employee survey³³ and found strong interest in a retail clinic located on its main campus, with 47 percent of

Figure 1: Cost of Care Comparison



Source: Health Partners, 2005

employees indicating they were likely to use such a clinic (increasing to 66 percent if it were free). The respondents saw clinics as a convenient supplement to their regular physician, with 77 percent of employees requesting that a record of their visit to be sent to their own doctor.

The Safeway survey also found that 42 percent of their employees would be willing to try a clinic, while a third said that they “might / might not use the clinic” and 42 percent agreed that receiving care from a nurse practitioner was acceptable.³⁴

Technology Trends Supporting Retail Clinics

Affordable, compact diagnostic devices and evidence-based clinical software are keys to the viability of retail clinics. The FDA continues to approve tests with CLIA waivers.³⁵ These tests enable rapid, accurate testing of blood pressure, glucose, and cholesterol, as well as common conditions such as strep throat, UTI, and pregnancy. Meanwhile, miniaturization of medical devices means that these clinics can have sophisticated equipment such as an ultrasound machine that is smaller than a laptop at affordable prices.

Several of the major retail clinic operators use proprietary software systems to control the quality and scope of care and support their clinicians' decisions with evidence-based medicine. Patient information is entered into a computer program where it is sorted and matched to a knowledge base. The program provides a decision tree that supports specific assessments or recommendations and ensures that any conditions outside of a narrow scope of treatment are immediately referred elsewhere.

Investor Trends

Another key driver for clinics' rollout is the availability of capital. There is an appetite in the investment community for innovation in health care delivery. Clinic companies are attracting a lot of attention because of their revenue and margin potential, and because there are few other options for entrepreneurial investment in health care services. In fact, in 2005 only 3 percent of health care venture capital funding in the United States went to services.³⁶ Take Care Health Systems recently received \$77 million in venture funding from Petty, O'Keefe & Company; RediClinic was funded by Revolution LLC (backed by AOL founder Steve Case), which bought a minority interest in RediClinic's parent Interfit; MinuteClinic is backed by Bain Capital Ventures; and SmartCare just received an undisclosed amount to back its expansion.³⁷ These investments demonstrate that if the clinics prove viable and have committed retailers behind them, then the clinic companies will be able to attract sufficient capital for rapid expansion.

III. Retail Clinics and the Health Care Delivery System

GIVEN THE MANY CHOICES CONSUMERS HAVE to treat acute episodic ailments, how will the retail clinics compete against or integrate with urgent care clinics, hospital emergency rooms, and primary care physician practices?

Retail-based clinic companies are very careful to distinguish their services from emergency care and primary care providers. They train their staff to refer away any unusual or potentially complicated cases and randomly audit their practitioners on a regular basis to be sure that these standards are being followed.³⁸ When there is some potential overlap of services, the clinics proceed with caution, even if it means foregoing revenues. For example, all three Quick Quality Care locations in Florida Wal-Marts have fully outfitted x-ray rooms with lead-lined walls but are not yet using the equipment because, according to CEO Jack Tawil, “we want to be clear that we’re not an urgent care center.”³⁹

Primary care physicians, whose practices overlap substantially with retail clinics, have been vocal about the downsides of this new site of care. They have expressed concerns about quality and continuity of care, especially in handling patients with serious or chronic conditions (see sidebar). People with chronic conditions are theoretically attractive to retailers and clinic companies—they are potentially very profitable repeat customers—but critics are quick to point out that clinics are not set up to function as a “medical home” for patients with chronic disease.

In response to these concerns, the clinic operators have been firm about their limited scope of practice. For instance, all of them offer treatment for seasonal allergies but most do not treat asthma. Most do not treat chronic conditions such as diabetes. The clinics also form strong referral relationships with doctors in their communities before they open. Sometimes the referral process even works the other way. Michael Howe, CEO of MinuteClinic, says, “In established markets, when physicians understand the model they refer patients to MinuteClinic. For example, on weekends when patients call in, the doctor can say if it’s within the MinuteClinic [scope of practice], so our clinics allow primary care physicians to provide their patients with a better experience... and it frees them up to focus on high-risk or chronic conditions...”⁴⁰

In terms of integrating patient information with other providers, all the clinic companies interviewed indicate that they keep centralized electronic medical records that are accessible from any of their locations. These records include a brief medical history taken at the time of service, prescriptions, and test results. If requested, the clinics will print a copy of the record from each visit for the consumer, but they do not electronically transfer the medical records to the PCP or referred physician. Each of the clinic companies indicates that they have invested in software to enable the collection and storage of data for patient records in compliance with state and federal regulations. In terms of electronically sharing records, MinuteClinic medical director Woody Woodburn says, “we’re ready to push out data, we’re just waiting for national standards for interoperability.”⁴¹ AtlantiCare plans to integrate its EMR across its retail clinics, hospitals, urgent care, and primary care locations within 12 to 18 months.

For consumers with insurance, retail clinics can cost more out of pocket than typical copayments for care at other sites. Even clinics that accept insurance usually charge \$20-25 for a visit (insurers simply discount the standard “menu price” of care by some amount), compared with \$10 to \$25 copayments for physician office visits and \$20 to \$100 copayments at the ER. Clinics that don’t accept insurance cost much more out of pocket and the charges may or may not be reimbursable if submitted to the insurer. Until this payment disincentive is resolved, clinics will continue to appeal mainly to high-income consumers who are willing to pay more for convenience, and uninsured consumers who either have no cheaper alternative or cannot afford the wait times or missed work that a visit to a clinic or ER typically entail.

The American Academy of Family Physicians (AAFP) recently published guidelines for “desired attributes of retail health clinics”:

- A well-defined and limited scope of clinical services;
- Clinical services and treatment plans that are evidence-based and quality improvement-oriented;
- Formal connections with physician practices in the community, preferably with family medicine practices, to provide continuity of care. Other health professionals should operate only in accordance with state and local regulations and should be part of a care team operating under physician supervision;
- Codified systems for referring patients to physicians when patients’ symptoms exceed the clinics’ scope of services;
- Use of electronic health record systems—preferably, systems that are compatible with the continuity-of-care record supported by the AAFP—that can communicate patients’ information with the family physicians’ offices.

Source: *AAFP News Now*, “AAFP Defines Ideal Retail Health Clinics,” 1/3/06

IV. Key Issues and Early Conclusions

WHETHER RETAIL CLINICS ARE A FLASH IN THE pan or become a permanent part of the health care landscape, their emergence and the reaction of consumers and providers to them raises a series of interesting issues.

How will changes in benefit design influence consumers' willingness to use retail clinics? As the cost of health care continues to rise, employers and governments will continue to shift some of that burden onto employees and will structure incentives for them to seek cheaper care. In the past few years, employers offered reduced copayments for generic prescriptions along with significantly higher copayments for brand name drugs, and consumers responded by opting for generics more frequently. Insurers have already begun to offer a similar financial incentive to use a retail clinic versus the more expensive family doctor, urgent care, or emergency room options. Given the rising number of employers offering high-deductible health plans, this paradigm of consumer financial incentives and disincentives has already started to change the way Americans select and receive health care. Will rising out-of-pocket costs provide an incentive for treatment of minor ailments in this lower-cost setting?

Will the clinics be profitable, and if so, how? The clinic companies profiled in this report and the others emerging operate under very different business models. The industry is in its infancy, and experimentation with locations, partnerships, and strategies for profitability will continue. Retail clinic “hosts” (the retailers in which the clinics are located) are also looking for new profit centers, and will continue to experiment as they seek to benefit from the presence of on-site clinics. Will retail clinic companies and retail hosts develop mutually beneficial business models? What lessons will retail and health care learn from one another along the way? Retail experts believe that, for the retail hosts, providing access to health care is not a goal in and of itself, because retailers' primary commitment is to their customers, their employees, and their shareholders. Will they be able to satisfy their shareholders while pursuing this new line of business?

How will the provider community respond?

The American Academy of Family Physicians, American Academy of Nurse Practitioners, and American Medical Association have all gone on record with opinions about retail clinics. Physician groups urge close physician oversight of non-physician providers working in the retail clinic setting, and nurse practitioners point to the needs of uninsured and under-insured Americans and the potential of retail clinics to offer access. As the clinics become more widespread and more patients and providers have experiences with them—positive and negative—will providers embrace retail clinics as a cost-effective, appropriate adjunct to a primary care provider? Or will physicians and others in the industry reject the clinics?

How will policymakers and regulators respond?

Most states regulate retail clinics as physician practices. If clinic expansions play out according to clinic companies' projections, they will undoubtedly attract more regulatory attention. How will quality standards for this category of provider be set and monitored? Will regulators embrace the clinics as an extension of access into the health care system and a more convenient patient care proposition? Or will they create barriers to their proliferation? Will scrutiny of this care delivery setting prompt more scrutiny of other settings?

Will retail clinics push change in the health care system?

The emergence of retail clinics has caused physician organizations to offer guidance to their members to consider cutting wait times, offering more convenient office hours, and moving toward price transparency. Will retail clinics prompt convenience and quality improvements in the “mainstream” health care system? Will these clinics be embraced as a positive alternative to physicians' offices for those services that physicians are “overtrained” to provide and not well compensated for, or will they be seen as

second-tier medicine? Will retail clinics produce insights for the broader industry on how to lower the cost of care?

Will retail clinics move into “stay well” care, chronic care and alternative therapies?

While surveys to date indicate that patients with chronic conditions are not as positively predisposed to retail clinics as others, will some clinic companies develop compelling chronic care services? Many clinics already offer immunizations, screenings and physicals, nutrition counseling, and other “stay well” services. Will this broadening of the service scope continue, and if so, in what directions? In 2005 total visits to complementary and alternative medicine providers exceeded those to physicians, and consumers spent more than \$27 billion out of pocket.⁴² Will retail clinics move in the direction of offering these types of services?

How will clinics connect to the health care delivery system?

The companies profiled in this report connect with the mainstream health care delivery system in a variety of ways, from referring patients to primary care physicians to providing copies of visit records. Response from provider organizations has so far been mixed, with some expressing enthusiasm and others caution. Will the industry evolve so that retail clinics form mutually beneficial partnerships with hospitals, community clinics and physicians offices, or will they remain outside the mainstream?

What kinds of experiences will consumers have?

Retail clinics are a market phenomenon—people elect to use them and generally pay out of pocket. As more Americans use the clinics we can expect them to “vote with their feet.” People are frustrated with the current system, and most surveyed to date are open to trying clinics but worried that they might be misdiagnosed.⁴³ How will the American public weigh in as they begin to experience care in the retail clinic setting?

Endnotes

1. Harris Interactive poll for *The Wall Street Journal*, 2005. Available at http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2005vol4_iss21.pdf.
2. “QuickMedx, Inc.” Harvard Business School Case 603-049.
3. “Broom-ready” refers to clearing and cleaning the space and potentially installing HVAC, electrical, and plumbing upgrades depending on the clinic concept and the contract between retailer and clinic company.
4. Solantic is a major provider in Florida with clinics in two Super Wal-Marts and ten other locations. All Solantic clinics are staffed with on-site physicians.
5. National Salary Survey of Nurse Practitioners. <http://nurse-practitioners.advanceweb.com/common/editorial/editorial.aspx?CC=65201>
6. Solantic corporate Web site: www.solantic.com.
7. “Wal-Mart to Expand Employee Health Insurance Plan and In-Store Clinic Use,” *New York Times*, February 24, 2006.
8. Congress passed Clinical Laboratory Improvement Amendments (CLIA) in 1988 to establish quality standards for laboratory testing and in 1992 published guidelines for waived tests: simple laboratory examinations and procedures that are cleared by the Food and Drug Administration (FDA) for home use; employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or pose no reasonable risk of harm to the patient if the test is performed incorrectly.
9. Interview with Web Golinkin, CEO of RediClinic, March 24, 2006.
10. During a recent *Wall Street Journal* interview, President Bush expressed his desire for Congress to determine “how to expand HSAs to make them achieve an objective, which is to have a patient-doctor relationship that will have market forces within the decision-making process and the pricing of medicine.” *The Wall Street Journal Online*, Transcript of Bush Interview, 1/26/2006. HSAs are an analog to the shift from corporate pensions in the 1980s to consumer owned 401(k) retirement plans. HSAs are a key part of the new “ownership society” where consumers will be expected and incented to save for their health care and spend their own money wisely.
11. Interview with Ben Singer, founder of Farmacia Remidios, April 17, 2006.
12. Interview with Roger Bickford, Project Manager for Wellness Express, June 8, 2006.
13. Interview with Ben Singer, founder of Farmacia Remidios, April 17, 2006.
14. “Making Health Care Markets Work,” by Glenn Hubbard, *Columbia Ideas at Work*, Columbia University, April 25, 2006.
15. The revenue mix varies significantly by retailer.
16. Most grocery stores measure 50,000 to 75,000 square feet and super centers 100,000 to 130,000 square feet.
17. “A crowded market emerges to fill growth prescription,” *Drug Store News*, 10/22/2005.
18. “Target’s In-Store Clinics Offer Quick Health Care,” *Baltimore Sun*, 8/8/2005.
19. Usual grocery and drugstore gross margins are 3 to 7 percent, but 15 percent margins take into account “real shelf space” and fixed costs, so this figure is used as a hurdle for internal returns.
20. “Using in-store advertising to win the First Moment of Truth (FMOT),” *WireSpring*, 10/10/2005, referencing *The Wall Street Journal*, 9/21/2005.
21. “How to Control Health Benefit Costs,” by Lynn Dorsey Bleil, James Kalamas, and Rayman K. Mathoda, *McKinsey Quarterly*, v. 1 2004.
22. There may be a fourth model emerging: nonprofit or subsidized clinics, such as Alegen in Omaha. Although the model is simple and promising, it has not been in place long enough or in enough locations to give any sense of its viability.
23. “Gone in 60 Seconds,” *Fortune*, 6/6/2005.
24. Labor is a significant expense, accounting for about 65 percent of the total costs of the clinic. Of this, easily 10 to 25 percent is for physician oversight. Costs can be reduced with the amount of off-site physician oversight. Source: Interviews with MinuteClinic, RediClinic.
25. From confidential report on Blues and MinuteClinic; Health Partners, 2005.
26. Dr. Robert Berry, Congressional testimony before the Joint Economic Committee, April 20, 2004.
27. “Md. Requires More Health-Care Spending for Wal-Mart,” *Morning Edition* on NPR, January 13, 2006.
28. IOM 2003; Ballas 2001.

29. *ATM Marketplace*, "A Man and His Machine," April 1, 2005.
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32. "Many Americans Open to Care at Retail-Based Health Clinics," *Wall Street Journal*, 10/26/2005. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2005vol4_iss21.pdf
33. Safeway HR survey August 2005.
34. Results are from a Scott & Co. online survey of over 400 California residents. One-third of respondents were Latino and one-third of all respondents were low-income (under \$50,000). The survey described retail clinics and asked respondents about their likelihood to visit them. It also included a conjoint analysis of factors in deciding on a site of care, care provider, price, time to get appointment, and total time for care. This survey simulates a retailers approach to determining the potential success of a clinic or other new product or service concepts.
35. Congress passed Clinical Laboratory Improvement Amendments (CLIA) in 1988 to establish quality standards for laboratory testing and in 1992 published guidelines for waived tests: simple laboratory examinations and procedures that are cleared by the Food and Drug Administration (FDA) for home use; employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or pose no reasonable risk of harm to the patient if the test is performed incorrectly.
36. Venture Source, 2005 Dow Jones, Inc.
37. "Get a Checkup in Aisle 3," *Time*, 3/20/2006 and *VentureWire*, 4/5/2006.
38. Interview with Woody Woodburn, chief medical officer of MinuteClinic, June 4, 2006.
39. Interview with Jack Tawil, chairman and CEO of Quick Quality Care, June 8, 2006.
40. Interview with Michael Howe, CEO of Minute Clinic, April 22, 2006.
41. Woodburn, 2006.
42. National Academies of Medicine CAM report, 2005.
43. See Note 1.