The Growth of On-Site Health Clinics
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Highlights

On-site clinics offer employers immediate savings of 10% to 30% in their total healthcare costs. This represents a $7 to $20 billion total cost savings for the estimated 1,200 employers that operate onsite clinics.

- On-site clinics potentially serve over 10 million employees, their dependents, and retirees (approximately 4% of under 65s).
- Twenty four vendors currently manage approximately 2,200 clinics for 1,200 clients.
- Fuld estimates that the number of clinics could grow by 15% to 20% a year from 2,200 to 7,000 by 2015.
- Given their current growth-rate, on-site clinics could serve over 10% of the under 65s by 2015.1
- Employers are increasingly realizing they have to better manage both short- and long-term health issues to properly address the issue of total health costs (direct plus indirect health costs).
- On-site clinics help to address short-term health costs, while new integrated wellness and disease management programs have evolved through “value-based” health programs to address longer-term health costs.
- Long-term health issues are often attributable to a lack of compliance. These longer-term programs focus on individual employees and encourage adherence to medication regimens and routines.
- Employers are increasingly looking to on-site clinics to help with these longer-term health programs, rather than just addressing immediate occupational health and safety issues.
- These longer-term programs offer new opportunities for pharmaceutical firms to market the value of their products by helping employers minimize expensive disease progression costs.
- Since these programs occur at the employer’s expense, they should be very attractive to pharmaceutical firms.
- On-site clinics and the companies that manage them offer a very efficient channel to link into these programs, which today is virtually untapped by the pharmaceutical market.
- Issues related to the growth of workplace-centric healthcare support, for example, patient confidentiality and privacy (including genetic testing for possible workplace and other health risks, and illicit substance monitoring), require additional study and discussion.

1 The implications of a protracted recession introduce uncertainties that may either accelerate the growth of worksite-based healthcare resources if insurance costs accelerate or slow the growth of on-site healthcare resources available for employees: It is possible that many employees will turn to state and federal resources, Medicaid and Medicare, respectively.
Definitions: New types of clinics

On-Site Clinics: Health clinics located on an employer’s campus and dedicated to serving employees. These clinics are typically used by 60% of on-campus employees, 25% of employees’ dependents, and 20% of retirees. On-Site Clinics are frequently staffed by a registered nurse (RN) or physician assistant (PA) that can address occupational health and safety issues, administer travel and flu vaccinations, conduct new employee drug screenings, provide health and wellness education, and refer employees to in-network doctors and specialists. Clinics on larger campuses can employ full- or part-time physicians (that provide full primary care coverage). Large campus clinics can also maintain on-site pharmacies and fitness centers (Fuld estimates that the approximately 2,200 clinics operating today could grow to 7,000 by 2015).

Off-Site Clinics: Similar to on-site clinics, this new and untested concept is designed to serve employees from multiple smaller employer sites, such as might be found in a business park.

In-Store Clinics: Health clinics located in retail settings, such as retail pharmacies or mass merchandisers, like Wal-Mart. They are staffed only by RNs and PAs and provide a limited set of services, such as diagnosis and treatment of eye, nose, sinus, throat and bladder infections, minor injuries and skin infections. There are approximately 1,500 In-Store Clinics currently operating in the United States. Operators are ambitiously planning to expand the number of clinics to 7,500 by 2015.

Background: The reaction to escalating health costs

The national healthcare cost crisis is not a new phenomenon, nor is the effort by employers to lessen the financial burden of providing healthcare coverage to their employees. As the graph below indicates, healthcare costs continue to rise dramatically as a significant proportion of the average worker’s total annual compensation – 15% for a single employee and 40% for a married employee. Consequently, it is not surprising to see that the health plan market’s employer sector

The cost-based focus has created a slew of new high deductible plans, often called Consumer Driven Health Plans (CDHPs). With these, employees are required to pay the first tranche of their annual healthcare coverage themselves, either out of a tax free sum provided by their employer, or by themselves. Health plan coverage commences only after this “high deductible” has been exhausted.

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2 Realizing the Potential of Onsite Health Centers, Watson Wyatt, 2008

3 CMS data shows that total inflation adjusted annual cost of healthcare per population has increased by 44% from 1990 to 2007
The immediate problem with these plans is that they lead directly to poor drug compliance; a number of studies indicate that there is a direct correlation between the size of out-of-pocket drug expenditures and the level of noncompliance. These plans also actively encourage pill-splitting through their web-sites, again cutting back on drug usage. As a result, it is very likely that CDHPs will not cut long-term healthcare costs, but will cause them to increase even faster than they would have done with traditional HMO or PPO plans. CDHPs are not a great solution for the employee, the economy or the drug market, only for the employer that is looking to cut costs or offer the lowest level of health coverage.

The value-based focus has led to very different types of solutions. Two separate offerings have emerged (which have the potential of merging into one combined solution):

- Value-based health plans
- On-site clinics

With value-based health plans, the employer undertakes an analysis of its total healthcare costs, direct and indirect. Direct costs are those incurred through the firm’s health plan, while indirect costs have to be estimated through surveys and cover both absenteeism (cost of employees not being at work) and presenteeism (employees being at work, but unproductive due to some ailment). This total is then broken down by disease to identify the highest cost diseases for the firm.

With this information in hand, the employer invests in programs to manage each of its highest cost diseases through a specialized disease management firm. A corollary has emerged as this concept has evolved: the sooner that these diseases are diagnosed results in a greater likelihood that long-term disease management costs can be minimized.

Consequently, wellness services have been integrated into these programs. In addition, it has been found that maximizing compliance of specific drugs for specific high cost diseases significantly reduces longer-term expensive costs and so these programs balance maximizing the short term cost of high drug compliance with the long-term cost of expensive specialist and hospital visits, as well as the loss of time at work and productivity from ill employees.

For the pharmaceutical industry these “value-based health plans” are extremely attractive which results in large employers investing in sophisticated programs to maximize the compliance of drugs by giving them preferential formulary positioning that minimize co-pays. Such value-based plans also actively monitor employees to maximize compliance. Interestingly, these types of plans do not seem to favor generics over brand drugs. They are focused on compliance and there is little or no penalty if the employee prefers a brand to a generic drug. The resulting improvement in drug compliance is good for the employee by cutting the likelihood of longer term disease; good for the employer by reducing the risk of expensive trips to the emergency room (ER); and, subsequently good for the economy. It is also good for the drug manufacturer thanks to the higher use of drugs through compliance programs paid for by employers.

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4 The Effects of Copayments on Medication Adherence During the First Two Years of Prescription Drug Treatment. Ronald C. Kessler, PhD; Christopher Ron Cantrell, PhD; Patricia Berghund, MBA; Michael C. Sokol, MD, MS, Journal of Occupational and Environmental Medicine, June 2007

5 The cost of different doses of a specific medication is often very similar. So a 20 mg pill is the same of nearly the same as a 10 mg pill. It is, therefore, possible to purchase the larger dose and cut it in half to get two 10 mg doses and save 50% of the price. For example, one of the largest providers of CDHPs, Definity Healthcare a United Healthcare company, helps members of CDHPs by advising them through e-mail that there may be cheaper alternatives to preferred branded drugs, such generics. They also advice members about mail-order and pill-splitting options http://www.definityhealth.com/marketing/newsroom/hubmagazine /DrivingReprint.pdf
On-Site Clinics: How this channel is growing

The alternative to investing in large and complex value-based health programs is on-site clinics. With these clinics offering near-immediate positive return on investment, interest in them has increased significantly in recent years. Figures of 10% to 30% cost savings are mentioned for firms investing in on-site clinics. However, it is also recognized that over half of the firms with these clinics have not yet implemented systems that allow them to properly measure savings, attesting to just how recent is the interest in this market.

The key savings from on-site clinics result from minimizing employees’ time away from the workplace and expensive visits to the ER, while maximizing productivity and referrals to in-network specialists for conditions that the RN cannot handle. For example, the cost of visiting a specialist is generally 2.5 times that of a primary care visit. Three out of ten patients are usually referred to a specialist. Alternatively, on-site clinics generally only refer 1-in-10 patients to specialists.

Interest in on-site clinics is demonstrated by the growth in firms offering these services. The total number of new on-site clinic vendors that have entered the market in the last eight years is greater than the total number of startups in the four previous decades.

Today, there are some 25 vendors offering these services. Two of the largest were acquired by Walgreens in 2007, I-trax and Whole Health Management, and integrated into the new Walgreens Health and Wellness Division, along with its new in-store clinics. As a result, Walgreens has catapulted itself into the top on-site clinic vendor slot accounting for nearly 20% market share. In addition, Blue Cross of North East Pennsylvania’s health management firm, AllOne Health Group, recently acquired the on-site clinic vendor Health Resources.

If larger channel players were to acquire these on-site vendors, this sector could grow even faster as new capital is injected into these acquisitions. On-site clinic vendors that Fuld has interviewed have nearly all talked about very strong current interest in their services and growth rates of at least 20% a year in orders for new clinics. In 2007, the CEO of IMC HealthCare said that during the last two years the market for these clinics has “just gone ballistic” with inquiries jumping from 53 in 2005 to 275 in 2006.

So how big is the on-site clinic market today? Fuld estimates that there are some 1,200 firms currently operating on-site clinics. Many of these are Fortune 500 companies with multiple campuses and multiple clinics, resulting in an estimate of 2,200 on-site clinics. The vast majority of these firms with on-site clinics have over 2,500 employers and most clinics are on campuses with at least 1,000 employees. Increasingly, vendors are offering viable clinic models that can work on far smaller campuses, down to 200 to 300 employees. The models for these smaller campuses are based on the RN visiting for a limited number of hours each week. One vendor tried a minimum of 4 hours a week, but found that this was too disruptive for the RNs and so has increased the minimum to one full day a week. This has pushed up the minimum campus size from 100 to 200 employees. If on-site clinics were to gain total penetration of all firms with a minimum of 200 employees.

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7 Realizing the Potential of Onsite Health Centers, Watson Wyatt, 2008
8 On-Site Health Clinics, Knowledge Source, Inc, 2008
9 On-Site Saving, Human Resource Online, February 1, 2007
10 It is unclear how many firms have built and run their own clinics rather than using third party vendors, and a potentially low estimate of 300 has been included in the Fuld total of 2,200.
employees, they would serve over 60,000 firms with well over 100,000 clinics, potentially serving over half the country’s total workforce. It is unlikely that we would ever see the level of deployment of on-site clinics, but this does give a perspective on just how important the employee sector is to the overall healthcare market.

The diagram below illustrates the range of services offered by the simpler RN-staffed clinics. Pre-2000, these clinics were focused on occupational health and safety. Since 2000, they are aimed at increasing productivity and reducing costs for the campus. Hence, links to wellness program and associated risk assessment programs and disease education is included in the diagram in dotted boxes.

A major issue with many on-site clinics and associated health management programs is the lack of integration into the employers overall health and productivity programs as well as claims and data management. This is constraining firms from maximizing the value of these clinics and is a concern of many employers. This needs to be rectified for the true value of these programs to be recognized.

For campuses of the larger employers, clinic models can be very sophisticated, as is illustrated
below. In addition to RNs and PAs, they include full time physicians, pharmacies, labs and fitness facilities. They are increasingly offering access to, or partnership with, value-based health plans. Since these programs need to have regular contact with employees to enroll and monitor employees’ health, on-site clinics are the ideal solution to help drive these programs rather than the kiosks that some disease management firms offer to set up on employer campuses.

The clinic can help drive both the wellness and disease management components of these programs, while the vendor running the disease management programs will run the risk assessments, the incentive programs and the coaching, as well as providing access to on-line health portals. According to a 2007/08 Watson Wyatt survey of 84 firms with on-site clinics having at least 1,000 employees, 70% of firms that have installed clinics after 2000 are focused on using them to reduce medical costs, compared to only 49% of firms that had installed them prior to 2000. In addition, only 26% of firms that have post-2000 clinics see them helping with occupational health and safety compare with 54% firms that have had clinics prior to 2000. These figures illustrate the shift that has taken place since 2000 and that the driving force behind on-site clinics is now value, not traditional occupational health and safety.

The Future

To date, the two value-based services – on-site clinics and value-based health plans - have tended to evolve separately. For many employers, it would be logical to integrate the two. The same Watson Wyatt survey indicated that 50% of the firms surveyed maintain disease management programs, but only 40% of these link these programs into the clinics. Forty four percent of firms that have opened clinics since 2000 (compared to only 23% of firms that invested in them prior to 2000) are likely to provide pharmacy benefits through their clinics. Again, this is a significant difference and indicates a growing realization that better management of drug usage can drive cost savings.11

To set up and run value-based health programs, there has to be an on-campus presence. Vendors selling these programs will often set up their own kiosks on the client’s campus to enroll employees and monitor them. A far simpler solution would be to use the facilities of an on-site clinic. Some on-site vendors acknowledge this solution: The

11 Realizing the Potential of Onsite Health Centers, Watson Wyatt, 2008
VP of Sales and Marketing at the on-site clinic vendor, Comprehensive Health Services, told Fuld “Employers are concerned about the economics of a clinic. If the clinics are not driven by value-based plans then there is no difference between them and the clinic down the street. The value equation is essential to measure ROI. Almost all on-site clinic businesses are value-based and you have to have a value-based offer in this business.”

Although vendors of clinics and disease management programs are keen to talk about the positive benefits of value-based programs, there is still uncertainty over exactly how many disease areas these programs deliver strong returns on investments. As a result, some employers have gone down the road of implementing CDHPs rather than value-based plans together with onsite clinics. Additionally, not all on-site vendors (or all wellness and disease management vendors), acknowledge the integrated value-based plans/on-site clinics model. Some are only interested in providing their traditional offering and some are just focused on handling current growth. So in this rush to implement on-site clinics, it is too early to say that the obvious companion health plan for the employer will be the value-based plan.

If the value-based plan were to become the plan type of choice for the larger employer with onsite clinics, for the pharmaceutical market this could mean that a limited number of on-site vendors could become a new channel to access thousands of employers and millions of employees and their dependents covered by these value-based plans. It is unlikely that the pharmaceutical firm will want to detail directly to the on-site clinics as most will be only handling minor occupational ailments. By partnering with the small number of vendors managing these clinics, the pharmaceutical firms could potentially influence the design of the value-based health plans.

Today, this is not happening. Fuld has asked a number of these clinic vendors if they are talking with the pharmaceutical market and they have answered “no.” This does not mean that vendors will not work with pharmaceutical companies in the future.

The way that it might occur is for pharmaceutical firms to provide Phase IV trial or study data to the vendor for diseases that their clients, the employers, want to manage and reduce costs. The major high cost diseases for employers range across a wide number of indications, such as allergies, asthma, depression, diabetes, heart disease and migraine. There are probably many others that also impact employer total health costs such as insomnia and restless legs syndrome. Employers and vendors need good longitudinal data on specific diseases showing that maximizing compliance on medications leads to positive return when investing in these integrated programs. Pharmaceutical firms often have this data, or at least know how to collect it.

The one firm that currently is doing its share in the US market is GSK. The company has built an entire web-site around value-based health plans (www.centervbhm.com) giving access to studies,
news and podcasts on value-based health. GSK also conducted a study on its own employees that measured the impact of maximizing compliance with diabetes medications. The study showed that “each additional $1 spent of medication yielded a 3:1 return in lower medical costs.”

For the pharmaceutical firm the question is one of priorities. Is this emerging market of interest today which can be developed as a new and valuable channel, or is it too early because either it is still undergoing major growth, or still has to prove its true long-term value. To gauge how large it might become, if the current number of clinics is projected out at growth rates of 15% to 20% a year, by 2015, there could be 7,000 on-site clinics or some three to four times the number today. If we use the average levels of utilization talked about for the clinic today of 60% of all campus employees, plus many of their dependents, the proportion of the total population under 65 that could use these clinics could grow from 4% today to 13% by 2015!

This is a significant proportion of the total provider market.

The more on-site clinics are deployed by vendors that understand the concept of improving productivity, reducing both short and long term costs and delivering value, the more likely that these services will be deployed to firms other than the large Fortune 500. So, on-site clinics could become the catalyst for value-based health plans to become a serious alternative to traditional HMO and PPOs, as well as CDHPs, and be profitable for firms with as few as 300 to 500 employee campuses, not just 1,000 plus employee campuses.

It would seem that on-site clinics are already proving their value, especially for manufacturers where there is a reasonable likelihood of at-work injury and high salary environments where there is a clear financial incentive to maximize employee time in the office. The model of small clinics managed by RNs or PAs does seem to work for medium sized firms and a clinic model with physicians and other related services for the larger firm. Some vendors are talking about offsite clinics, such as in business parks. There is also the recent development of in-store clinics and the vendors of these clinics can very easily move into on-site offerings since they have already invested in the technology infrastructure, the knowledge where to hire, how to manage RN and PA staff and how to work with local health plans and family doctors.

If the trend to value-based employer health services continues, pharmaceutical firms need to understand how to support it and work within it. Today, it is too early to tell if this trend will become mainstream, or if it will wither on the vine.

One way or another, this is a market that needs to be watched.

Questions to Consider:

These are critical questions that the drug channel and pharmaceutical companies, in particular, should consider with respect to on-site clinics and value-based health plans to better understand how important on-site clinics may become:

• Will the trend to use on-site clinics to drive down the total health costs (direct and indirect) for large employers become a major trend across the whole employer segment of managed care?

• Will this trend drive the implementation of value-based health plans not only in the self-funded employer segment of the market, but also across the commercial health plan market resulting in major health plans like United, WellPoint, Aetna and CIGNA offering these types of plans to smaller employers?

• Will other major channel players, such as Walgreens, invest in on-site clinic vendors?

• Will major pharmaceutical firms openly collaborate with on-site vendors?

• Will on-site clinic vendors work with pharmaceutical firms to identify drug programs that will drive down long-term health costs and become an intermediate between their clients, employers, and the pharmaceutical market?

• Will Federal or state government support employer-funded initiatives?

• Will major employers with value-based health plans and on-site clinics, such as GE and Pitney

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12 GSK Shares Results of Internal Analysis, Urges Other Employers to Embrace Value-Based Benefit Design, GSK, August 28, 2007
Bowes, work with the new Administration to support the further implementation of these services across the employer healthcare market?

**On-Site Clinic Lexicon:**
The definitions below are commonly used terms and concepts used in the emerging on-site clinics marketplace.

- **Occupational health** – respiratory, skin, hearing, vision and other illnesses resulting from the workplace, as well as cuts, sprains and repetitive motion disorders

- **Urgent care** – mobile health services that go to wherever employees that are having critical health issues, such as onsite injuries

- **Pre-employment screening** – evaluation of new hires for drug, alcohol abuse and disabilities

- **Wellness issues** – weight, diet, smoking, and fitness

- **Disease management** – aimed at a limited number of high cost diseases seen in employees, such as asthma, hay fever, COPD, chronic pain, depression, diabetes, heart failure, coronary arterial disease and cancer

- **Specialty referrals** – recommended hospital or physician referrals by on-site clinic staff to the employer health plan in-network services

- **Health risk assessments** – third party evaluations of individual employees based on their health records and family health records following signatures of HIPAA release forms

- **Incentive programs** – third party programs funded by employers that give employees cash, reductions in annual health premiums or points which can be redeemed for retail goods based on the individuals meeting agreed health improvement milestones

- **Coaching** – telephone health specialists that assist employees comply with their health improvement programs when they are having issues meeting milestones

- **Indirect health costs** – absenteeism (time off work and often estimated through HR and workers compensation records) and presenteeism (unproductive time at work and often estimated through third party surveys)

- **Direct health costs** – health benefits that the employer pays directly on behalf of the employee (obtained from the firms’ health plan manager)

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For more information on Fuld & Company and its research and consulting services, contact Mike Ratcliffe at +1 (617) 492-5900 or mratcliffe@fuld.com.

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