



## Issue Brief

# Checking Up on Retail-Based Health Clinics: Is the Boom Ending?

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**ABSTRACT:** Retail store-based health clinics, which provide basic preventive services and diagnose and treat simple health ailments, have proliferated rapidly in recent years. Younger families and people that have difficulty accessing health care services—including the uninsured and minorities—are among the groups most likely to use these clinics. Still, in 2007, only 1.2 percent of U.S. families reported they had visited a retail clinic during the past 12 months, and only 2.3 percent of families reported ever having visited one, according to the Health Tracking Household Survey conducted by the Center for Studying Health System Change. The boom in retail clinics, moreover, appears to be slowing. Continued fall-off in the growth of retail clinics would likely disproportionately affect underserved Americans who lack affordable alternatives for primary care.

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### BACKGROUND

Retail-based health clinics—located inside pharmacies, supermarkets, and big-box retailers—are walk-in clinics that provide basic preventive services, such as vaccinations, and diagnose and treat a limited set of simple health ailments, such as strep throat or ear infections. Usually these clinics offer extended evening and weekend business hours, employ lower-cost clinicians (typically nurse practitioners), charge relatively low, fixed prices, and display those prices prominently so that consumers know ahead of time how much each service will cost.<sup>1</sup> Proliferating rapidly during the past few years, the number of retail clinics grew from only 60 at the beginning of 2006 to approximately 1,100 clinics by mid-2008.<sup>2</sup>

For consumers with insurance coverage and a regular physician, in-store clinics may simply be a more convenient way to receive care for common ailments or simple preventive services than a customary physician visit. Under most health plans, the patient's copayment is the same for a retail clinic visit as

to a physician's office. For the uninsured and those with high-deductible health plans who must shoulder the full cost of care out-of-pocket, however, clinics could represent a more affordable, accessible option than the alternatives, especially hospital emergency departments. In addition, for lower-income working people—many of whom have jobs with neither flexible work schedules nor paid time off—the quick service and evening/weekend hours offered by retail clinics may be more of a necessity than a convenience. Despite their consumer-friendly innovations, retail clinics have faced significant opposition from physician groups, which cite quality concerns such as questions about the continuity and coordination of care provided by clinics, the ability of clinic staff to accurately diagnose and appropriately treat the conditions presented to them, and the potential incentives for clinics to over-prescribe medications because of their co-location with pharmacies.

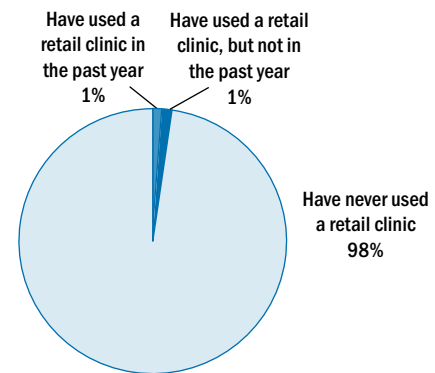
Retail clinics are often referred to as a “disruptive innovation” in health care because their model for addressing routine health needs—quick, convenient, appointment-free care available at relatively low prices during extended business hours—is more like a fast-food or quick-oil-change operation than a traditional health care setting. Indeed, for certain basic primary care services, retail clinics can change the way care is delivered by shifting the provider and point of care.

For all the attention retail clinics have received, there has been little national information to date regarding consumers' perspective on these clinics: how many American consumers use retail clinics overall, which consumers are most likely to use them, and why consumers choose them.<sup>3</sup> This study draws on new data from HSC's 2007 Health Tracking Household Survey, the only large, randomly sampled, nationally representative survey to date that examines the prevalence of consumers' use of retail clinics (for further detail, see “[About the Study](#)” on page 10).

## Retail Clinics: Overall Prevalence Still Low

In 2007, 1.2 percent of American families, or 1.7 million families, reported that they had visited retail clinics during the past 12 months (Figure 1). An additional 1.1 percent, or 1.6 million families, reported having visited retail clinics prior to the past 12 months. Altogether, 2.3 percent, or nearly 3.4 million families, have ever used a retail clinic.

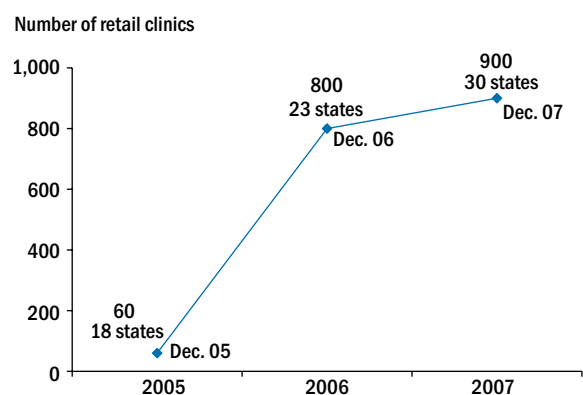
Figure 1. Use of Retail Health Clinics by American Families



Source: Center for Studying Health System Change 2007 Health Tracking Household Survey, April 2007–January 2008.

Although another 2007 survey found higher use of retail clinics,<sup>4</sup> the low nationwide prevalence reported here is perhaps not surprising given that these clinics are a relatively new phenomenon. At the end of 2005, only 60 clinics were in operation in the United States, distributed across 18 states. Although clinics have proliferated rapidly since then—there were about 900 clinics in 30 states by the end of 2007 (Figure 2)—they have gained a presence only in some markets within those states.<sup>5</sup>

Figure 2. Growth of Retail Clinics, Year End 2005–2007



Source: Interview with Mary Kate Scott, principal of Scott & Company, July 2008.

The HSC survey questions on retail clinic use first asked respondents whether their families had ever used retail clinics, then about whether they had used clinics within the past 12 months. In some markets where clinics had just recently opened, consumers would have had only limited opportunities to gain exposure to these clinics, much less use them. When prevalence is measured only across the population of the 18 states that had retail clinics in operation as of mid-2006, reported use is somewhat higher: 1.8 percent of families had visited clinics in the past year, and 3.5 percent of families had ever visited them.

### **Wide Variation in Clinic Penetration and State Regulations**

State regulations and clinic companies' assessments of market demand are among the key factors influencing clinic location. Some industry experts suggest, however, that there is a degree of happenstance involved in location decisions as well. For example, one of the primary innovators behind retail clinics—a cofounder of QuickMedx—was a Minnesota resident who developed the idea of convenience clinics when he encountered problems obtaining a prompt strep throat test for his son.<sup>6</sup> In 2000, this innovator launched the first pilot clinics, QuickMedx (which later became MinuteClinic), inside the stores of a local grocery chain in the Minneapolis-St. Paul area where he lived. An industry expert has suggested that if the first clinic innovator had happened to live in another state, then it would have been that other state—not Minnesota—experiencing the earliest clinic growth and the highest clinic utilization—state regulations and business environment permitting.<sup>7</sup>

State regulations governing retail clinics vary widely. Ten states allow nurse practitioners to treat patients without physician involvement, while other states require varying degrees of physician collaboration or supervision.<sup>8</sup> It might be expected that the states allowing the most nurse-practitioner autonomy would be the states with the greatest retail-clinic penetration, but this is not the case: Minnesota ranks only midway among all states, and Florida ranks 49th out

of 50 states, in limiting the degree of nurse practitioner autonomy allowed.<sup>9</sup> Yet, Minnesota has high rates of clinic use, and Florida has more retail clinics in operation than any other state.<sup>10</sup>

Several other factors influence where companies choose to open clinics. States vary in their licensure and ownership requirements for clinics. In some states, clinics are licensed as physician practices and are regulated by state medical boards. Some states require that clinic ownership be composed of physicians and/or state residents, thus limiting opportunities for outside investors seeking to launch new clinics.<sup>11</sup> A few states, instead of issuing a single license to a clinic corporation, require each clinic location to obtain its own license.<sup>12</sup>

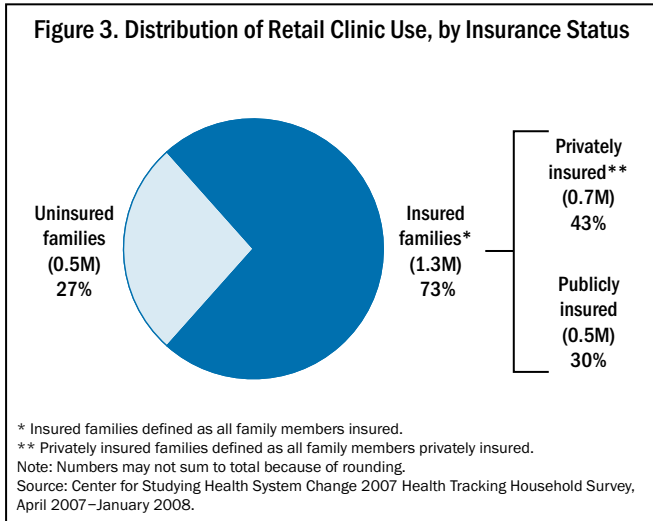
State regulations all interact with one another to affect the start-up and operating costs of retail clinics. Balanced against these cost considerations are assessments by clinic companies about the potential demand for clinic services in particular markets. Population density is a key consideration underlying clinic location decisions.<sup>13</sup> In addition, communities with primary care physician shortages and access problems may prove to be particularly attractive markets, because consumers lacking ready access to routine care may be more willing to try a clinic as an alternative care provider. Ultimately, experts suggest that these assessments of market demand play a more significant role than state regulations in clinic operators' location decisions.<sup>14</sup>

Minnesota stands out as a state with high use of retail clinics: 6.4 percent of the state population, or 191,000 Minnesota families, reported ever having used retail clinics, and 4.4 percent, or 132,000 families, reported using them during the past year.<sup>15</sup> High use of in-store clinics by Minnesota residents is consistent with the fact that clinics have a broader, more long-standing presence there than in other states.

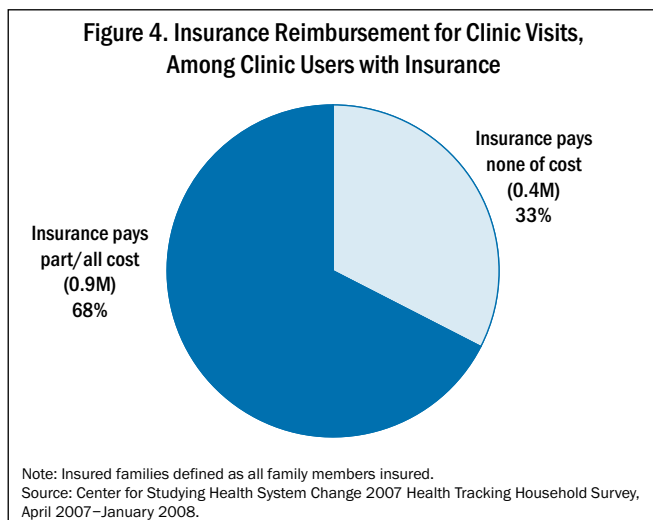
### **Insurance Coverage and Reimbursement**

Among all families that used retail clinics during the past year, uninsured families (defined as families with any member lacking health insurance) accounted for

27 percent of clinic users (Figure 3). These families used retail clinics at a much higher rate than their share of the population (17%, data not shown in figure).<sup>16</sup> The finding that uninsured consumers are more likely to use retail clinics is consistent with previous research.<sup>17</sup>



Among the 1.3 million families covered by insurance who used retail clinics during the past year, more than two of three reported that some or all of their clinic fees were reimbursed by insurance (Figure 4). Overall, among all families who used retail clinics in the past year, half reported that some or all of their clinic fees were reimbursed by insurance. Another national study recently estimated a higher proportion (67 percent) of clinic visits being reimbursed by insurance.<sup>18</sup>



When retail clinics first emerged in 2000, their services were provided strictly on a cash-pay basis. However, insurance coverage for clinic visits has become common in recent years. By 2007, all the major national private insurance carriers, as well as many smaller regional insurers, had begun providing coverage for clinic visits and were working with the large clinic companies to facilitate claims processing.<sup>19</sup> One study estimates that 85 percent of clinic sites now accept insurance.<sup>20</sup> A few large employers have even sought to encourage clinic use by their covered employees and dependents by offering lower copayments for clinic visits than for visits to physician offices, urgent care clinics, and hospital emergency departments.<sup>21</sup>

Public insurance coverage for clinic visits has lagged private coverage, but in 2007 several large clinic companies, including MinuteClinic and RediClinic, met the federal and state requirements necessary to receive Medicare and Medicaid reimbursement. The push to gain insurance reimbursement has not been universal among clinic companies, however. QuickHealth, for example, has chosen to remain cash-only, based on its assessment that most of its patient base is uninsured anyway.<sup>22</sup>

**DEMOGRAPHIC VARIATIONS IN USE OF CLINICS**

Families who reported not getting or delaying needed medical care at some point in the previous 12 months were almost 2.5 times as likely to have used retail clinics as families without such problems (1.9% vs. 0.8%, see [Table 1](#)). Also, younger families (those with a family respondent ages 18 to 34) were more than twice as likely as older families (those with a family respondent ages 50 to 64) to have used a retail clinic.

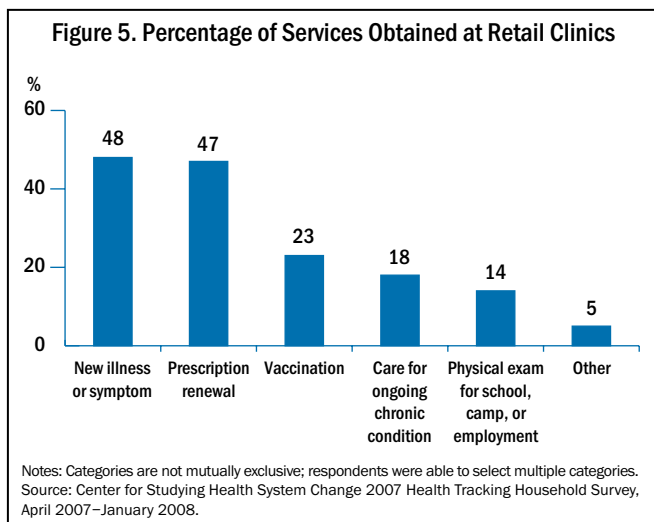
Beyond those two findings, there were no other statistically significant differences in retail clinic use across demographic subgroups. Some interesting patterns did emerge, however, suggesting that:

- Families with any member uninsured were more likely to use retail clinics than families covered by insurance.

- Minorities, especially Hispanic consumers, were more likely to use retail clinics than white consumers.
- Families with no usual source of medical care were more likely to use retail clinics than families with a usual source of care.
- Families with children were more likely to use retail clinics than single adults or couples.

### Most Common Clinic Services

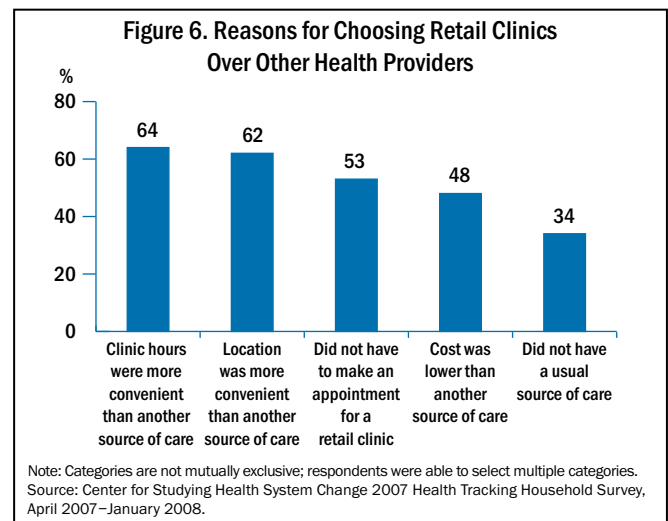
Nearly half (48%) of all consumers using retail clinics reported they had done so for diagnosis and treatment of a new illness or symptom (Figure 5). Almost as many (47%) said that their visit had included a prescription renewal. Other less common reasons cited by consumers were vaccinations, care for an ongoing chronic condition, and physical examinations.



Families with children were much more likely than childless couples or single adults to visit clinics for a new illness or symptom (67% vs. 36%). This is consistent with other research showing that otitis media (ear infection), pharyngitis (sore throat), and upper respiratory infection—common childhood ailments—were among the most frequent reasons for retail clinic visits.<sup>23</sup> In contrast, childless couples and single adults were much more likely than families with children to use clinic visits for prescription renewals (61% vs. 25%). No other statistically discernible differences across demographic subgroups were found.

### Reasons for Choosing Retail Clinics over Other Care Settings

Most consumers cited multiple reasons when asked why they had chosen retail clinics over other care settings, such as physician offices. Almost two of three respondents said that the clinic's convenient hours were a major factor in choosing it over another source of care (Figure 6). The convenience of the clinic's location and the ability to receive care without an appointment also were commonly cited as major reasons for choosing clinics. Seven of eight clinic users cited at least one of these three convenience factors as a major reason for choosing clinics, and one of three cited all three convenience factors as major reasons.

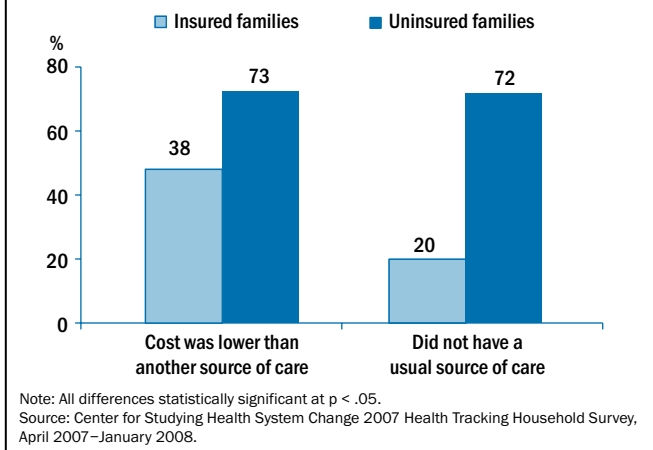


Nearly half of all clinic users cited the low cost of a clinic visit relative to other care settings, and one of three cited not having a usual source of medical care, as major reasons for choosing clinics over other care settings.

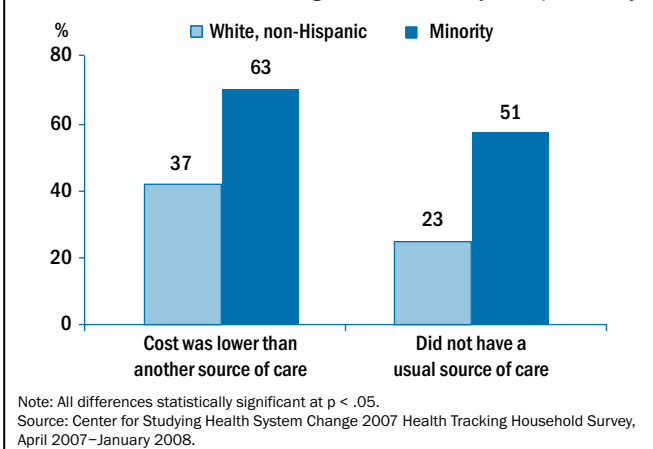
The likelihood of citing convenience factors (hours, location, no need for appointment) as major reasons for choosing retail clinics did not differ significantly across demographic subgroups. However, the likelihood of citing cost concerns and the lack of a usual source of care as major factors were much higher among uninsured and minority clinic users, compared with their insured and white counterparts, respectively (Figures 7 and 8). For example, uninsured clinic users were more than 3.5 times more likely than insured

clinic users to cite the lack of a usual source of care as a major reason for choosing clinics over other care settings.

**Figure 7. Percentage of Retail Clinic Users Citing Reasons Other than Convenience for Choosing Retail Clinics, by Insurance Status**



**Figure 8. Percentage of Retail Clinic Users Citing Reasons Other than Convenience for Choosing Retail Clinics, by Race/Ethnicity**



## Implications

Despite the hype about retail clinics being a disruptive innovation in health care, the nationwide proportion of families that has used retail clinics is still modest. As noted earlier, this finding is not surprising, given that clinics have a limited presence and are only available in some geographic markets within some states. Many consumers simply do not have access to in-store clinics in their communities.

From 2006, clinic growth had been rapid, and some forecasts suggested that perhaps 6,000 clinics would be in operation by 2012.<sup>24</sup> In recent months,

however, there have been signs that rapid clinic growth has begun to ebb. As of May 2008, clinic operators had shut down at least 70 clinics in 15 states, and the largest clinic operator announced it would scale back expansion plans for its MinuteClinic operations.<sup>25</sup>

Industry analysts noted that clinics have been more complicated and expensive to operate than many investors had expected. In particular, new clinics have had to spend heavily on marketing to build public awareness.<sup>26</sup> Some observers believe that local or regional health systems—already familiar presences within a community—are better positioned to attract patients to retail clinics without having to market as intensively. Some health systems, such as the Mayo Clinic, are launching their own retail clinics,<sup>27</sup> while other health systems are partnering with prominent retailers like Wal-Mart to introduce co-branded clinics.<sup>28</sup>

Another uncertainty for retail clinics is how conventional physician practices will react to competition from clinics. Some primary care practices have responded by extending office hours and facilitating same-day scheduling.<sup>29</sup> If such responses become widespread among physician practices, patients of these practices would find improved access to their regular providers and would then have weaker incentives to opt for retail clinics over their own doctors' offices for routine care.

Yet another potential impediment to clinic growth is the increasing scrutiny of regulators in several states related to retail clinics' scope of services, ownership, and hygiene and safety requirements. More stringent regulations would likely inhibit investment in clinics and slow their expansion.

Despite these uncertainties, there are some market developments that might be expected to contribute to retail clinics' continued growth. Expanding insurance coverage for clinic visits is likely to facilitate clinic use by insured consumers.<sup>30</sup> Mounting problems encountered by both insured and uninsured consumers in accessing medical care<sup>31</sup>—including problems obtaining timely appointments with doctors—may make retail clinics a more attractive alternative for basic care, regardless of insurance status. And, a growing

number of consumers are paying for health care out-of-pocket because they either lack insurance or face high deductibles. For such consumers, clinic services continue to be priced more affordably and transparently than other care settings.

While the use of retail clinics is still modest overall—suggesting that most consumers are unlikely to be significantly affected if the clinic boom fades—this study has shown that families with unmet need and delayed care tend to use retail clinics more than

the rest of the population. Also, minority families and families lacking insurance are much more likely to cite cost concerns and the lack of a usual source of care as major reasons for using clinics. As health care costs and the number of uninsured both continue to rise, these groups may increasingly turn to retail clinics for routine primary care. If the growth of retail clinics falters, underserved groups already facing access pressures may suffer from the loss of alternate sources of care more than the rest of the population.

## NOTES

<sup>1</sup> M. K. Scott, *Health Care in the Express Lane: The Emergence of Retail Clinics* (Report to the California Health Care Foundation, July 2006).

<sup>2</sup> There were 1,150 retail clinics open in July, according to an interview with Mary Kate Scott, principal of Scott & Company. Merchant Medicine, a private company that educates hospital systems and physician groups about retail clinics, listed 988 retail clinic locations on its Web site: <http://www.merchantmedicine.com/Home.cfm> (retrieved Aug. 7, 2008, from the “Convenience Care in the United States” graph). Healthcare 311, a company that provides basic information about nonemergency health care, advertises having records for over 1,200 retail health clinic locations (retrieved Aug. 7, 2008, from [www.healthcare311.com](http://www.healthcare311.com)).

<sup>3</sup> The following study is a large national study describing patient characteristics of and reasons for retail clinic visits: A. Mehrotra, M. C. Wang, J. R. Lave et al., “Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients’ Visits,” *Health Affairs*, Sept./Oct. 2008 27(5):1272–82. The study uses data obtained from eight retail clinic companies, among a total of 24 known retail clinic companies in the United States. The eight companies account for 74 percent of retail clinics in operation as of mid-2007.

<sup>4</sup> The Harris Interactive online survey of 2,441 adults estimated that 5 percent of households have ever visited retail clinics. Harris Interactive, *Most Adults Satisfied with Care at Retail-Based Health Clinics*, Health-Care Poll, Apr. 11, 2007 6(6).

<sup>5</sup> Interview with Mary Kate Scott, principal of Scott & Company, July 2008.

- 6 R. Bohmer and J. P. Groberg, "QuickMedx Inc.," *Harvard Business School Case Study 9-603-049* (Apr. 2, 2003); Scott, *Health Care in Express Lane: Emergence*, 2006.
- 7 Interview with Mary Kate Scott, principal of Scott & Company, July 2008.
- 8 S. Christian, C. Dower, and E. O'Neil, *Chart Overview of Nurse Practitioner Scopes of Practice in the United States* (San Francisco: Center for the Health Professions, 2007); L. J. Pearson, "The Pearson Report," *American Journal for Nurse Practitioners*, Feb. 2008 12(2).
- 9 N. R. Lugo, E. T. O'Grady, D. R. Hodnicki et al., "Ranking State NP Regulation: Practice Environment and Consumer Healthcare Choice," *American Journal for Nurse Practitioners*, Apr. 2007 11(4):8–24.
- 10 Healthcare311 and Merchant Medicine search of all retail clinics in Florida (retrieved on July 28, 2008). Although the two sources differed in their tallies of Florida retail clinics, with Healthcare 311 reporting 148 clinics and Merchant Medicine reporting 122, both sources found more clinics in Florida than any other state.
- 11 M. K. Scott, *Health Care in the Express Lane: Retail Clinics Go Mainstream* (Report to the California Health Care Foundation, Sept. 2007).
- 12 Ibid.
- 13 Interview with Tom Charland, President and CEO of Merchant Medicine, Aug. 2008.
- 14 Ibid.
- 15 Estimates of retail clinic use in other states are not reportable because of high relative standard errors.
- 16 Data available from authors. HSC 2007 Data Health Tracking Household Survey.
- 17 Mehrotra et al., "Retail Clinics, Primary Care," 2008.
- 18 Ibid.
- 19 Scott, *Health Care in Express Lane: Mainstream*, 2007.
- 20 M. Laws and M. K. Scott, "The Emergence of Retail-Based Clinics in the United States: Early Observations," *Health Affairs*, Sept./Oct. 2008 27(5):1293–98.
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- 25 D. Armstrong, "Health Clinics Inside Stores Likely to Slow Their Growth," *Wall Street Journal*, May 7, 2008.
- 26 Ibid.
- 27 S. Bagchi, "Mayo Clinic Enters Retail Care Business," *Health Care News*, Feb. 1, 2008, available at <http://www.heartland.org/policybot/results.html?articleid=22571>; J. Goldstein, "Some Health Systems Out to Beat Retailers at Clinic Game," *Wall Street Journal Health Blog* (May 16, 2007; last accessed July 14, 2008).
- 28 Armstrong, "Health Clinics Inside Stores," 2008.
- 29 J. Bachman, "What Do Retail Clinics Mean for Family Medicine?" *Family Practice Management*, May 2006 13(5):19–20.
- 30 Interview with Tom Charland, president and CEO of Merchant Medicine, Aug. 2008.
- 31 P. J. Cunningham and L. E. Felland, *Falling Behind: Americans' Access to Medical Care Deteriorates, 2003–2007*, Tracking Report No. 19 (Washington, D.C.: Center for Studying Health System Change, June 2008).



**Table 1. Prevalence of Retail Clinic Use, by Selected Family Characteristics**

|                                   | Percent of Families with<br>Retail Clinic Visit in Past Year | Number of Families with<br>Retail Clinic Visit in Past Year |
|-----------------------------------|--|---|
| <b>Insurance Status</b>           |  |   |
| Entire family insured (R)         | 1.1  | 1,266,996   |
| Any family member uninsured       | 1.9  | 464,768   |
| <b>Income</b>                     |  |   |
| Less than 200% poverty            | 1.1  | 422,243   |
| 200%–399% poverty                 | 1.4  | 520,102   |
| 400%–599% poverty                 | 1.3  | 287,287   |
| At least 600% poverty (R)         | 1.1  | 502,131   |
| <b>Race/Ethnicity</b>             |  |   |
| White, non-Hispanic (R)           | 1  | 1,053,119   |
| Minority                          | 1.6  | 678,644   |
| Black, non-Hispanic               | NR   | NR  |
| Hispanic                          | 1.9  | 268,486   |
| Other                             | NR   | NR  |
| <b>Usual Source of Care</b>       |  |   |
| Yes (R)                           | 1.1  | 1,297,391   |
| No                                | 1.5  | 434,372   |
| <b>Unmet Need or Delayed Care</b> |  |   |
| Yes (R)                           | 1.9  | 975,497   |
| No                                | 0.8*   | 756,267   |
| <b>Age</b>                        |  |   |
| 18–34 (R)                         | 2.3  | 651,259   |
| 35–49                             | 1.3  | 523,804   |
| 50–64                             | 1.1*   | 478,994   |
| 65 and older                      | NR   | NR  |
| <b>Family Structure</b>           |  |   |
| Families with children (R)        | 1.5  | 678,575   |
| Single adults and couples         | 1.1  | 1,053,189   |

NR: Not reportable due to high relative standard errors.

\* Significantly different from the reference group (R) at  $p < .05$ .

Source: Center for Studying Health System Change 2007 Health Tracking Household Survey, April 2007–January 2008.

### ABOUT THE STUDY

Data for this study were drawn from the Center for Studying Health System Change 2007 Health Tracking Household Survey, which was funded by the Robert Wood Johnson Foundation, and conducted between April 2007 and January 2008. The sample size for the nationally representative survey was approximately 18,000 people in 9,400 families. The response rate was 43 percent. Samples were drawn using random-digit dialing techniques, and interviews were conducted by telephone using computer-assisted telephone interviewing (CATI) methods.

Survey questions on retail clinics underwent cognitive testing prior to fielding of the survey. For each surveyed family, the primary family respondent was asked: “An in-store clinic is a medical clinic that is located inside a retail store like CVS, Walgreens, Target, or Wal-Mart. Have you (or [names of other family members]) ever had a medical visit at an in-store health clinic? Do not include pharmacies that only offer flu vaccinations once a year or eye care.” Respondents who answered yes were then asked: “Have you (or [names of other family members]) used an in-store health clinic in the past 12 months?” Respondents who answered yes to this question were then asked about services obtained during clinic visits, reasons for choosing clinics, and insurance reimbursement for clinic visits.

All estimates reported in this study are family-level, not person-level estimates, because respondents were not asked which family members received clinic services. The survey sample size of families with retail clinic visits in the past 12 months was 113 families. Estimates are not reported for cases in which the relative standard errors exceeded 30 percent.

#### ABOUT THE AUTHORS

**Ha T. Tu, M.P.A.**, is a senior health researcher at the Center for Studying Health System Change (HSC) in Washington, D.C. Ms. Tu has been extensively involved in the design, planning, and analysis of HSC's 2007 Health Tracking Household Survey, a large nationally representative survey funded by the Robert Wood Johnson Foundation. Her recent research has focused primarily on consumer topics in health care, including consumer health information seeking, shopping for health services, willingness to trade off provider choice for cost savings, and use of complementary and alternative medicine. Other areas of research interest include price and quality transparency, benefit design innovations, and financial burden for people with chronic conditions. She received her bachelor's degree from Wellesley College and her master's degree in public affairs from Princeton University.

**Genna R. Cohen** is a health research assistant at HSC. Since joining in 2007, Ms. Cohen has worked with senior researchers on a variety of projects, including studies of consumer health information seeking, health system emergency preparedness, coordination of patient care, and health information technology. She holds a bachelor of science degree in social policy, with a concentration in health policy, from Northwestern University.

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