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Federal Trade Commission Investigation on Health Care Competition  
Project No. P131207

### On Retail Clinics

Disclaimer: *"I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University."*

#### Executive summary

This analysis addresses how retail clinics, which provide limited medical services in retail stores, could help reduce the gap in healthcare distribution and be beneficial in medically underserved areas. Currently, retail clinics contribute to increasing the gap in healthcare distribution instead of bridging it. The following review draws upon existing literature and provides the reader with options states and municipalities could implement in order to tackle the identified problem.

#### Evidence

This analysis relies first on press releases and articles in order to better understand the evolving context of retail clinics. This material relayed a preliminary idea of the information visible to the wider public: mainly the voiced opposition from the physicians' associations regarding quality of care. Then, a search through Google Scholar yielded more evidence-based results. The following keywords were used: "retail clinics", "integration retail clinics", "geographic disparities retail clinics" and "existing policies retail clinics". This process and research was iterative, from the most general to the most specific. From this process, the decision to focus on the geographical disparities in receiving care from retail clinics arose. Indeed, this aspect differed significantly between the public discourse and opinion and the research results within the expert community.

#### Background

Retail clinics constitute a reality that can no longer be considered as "passing trend"<sup>1</sup>. The overall share of visits to retail clinics remains low in comparison of the entire medical system: there were about 6 million visits to retail clinics, compared to the 117 million to emergency departments and 577 million to physician offices<sup>2</sup>. However, between 2007 and 2009, the

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<sup>1</sup> Takach, M., & Witgert, K. (2009). Analysis of State Regulations and Policies Governing the Operation and Licensure of Retail Clinics.

number of visits to retail clinics has quadrupled<sup>2</sup> and specialists do not seem to predict a halt in this constant rise.

The resulting question is: what can explain this continuous growth over a decade? Retail clinics are less costly and more convenient: they constitute an alternative to expensive out-of-pocket payments. Takach and Witgert agree on the fact that “low costs for both consumers and payers is a large part of what makes retail clinics attractive.”<sup>1</sup> Other advantages pointed out are the price transparency as well as the lack of abundant regulation since this has been such a niche market. Most articles on retail clinics seem to recognize their importance in the changing healthcare market since their first appearance in 2000, especially towards improving accessibility and cost of care. However, an issue brief from California Healthcare Foundation identified five main issues: “patient safety and quality of care, access for the underserved, care fragmentation, conflict interest as well as corporate ownership and organizational issues”<sup>1</sup>. These concerns have led the states with the highest amount of retail clinics to draft and pass in some cases legislation towards better regulation. These regulations mainly address the ‘patient safety and quality of care’ issue through licensing, reviewing advertising materials, increased physician oversight and restricting the number of clinics directed by a single physician<sup>1</sup>.

The FTC has already positioned itself against too restricting regulations in open letters to Massachusetts in 2007, Illinois in 2008 and Kentucky in 2010<sup>3</sup>. However, other states have established more regulation than recommended by the FTC. With the major change brought by the voting of the Affordable Care Act into the law and the expected increase in insured individuals, retail clinics are likely to become a necessary and important part of care. Therefore it is necessary to reflect on their evolution, their likely increase as well as the possible ways in which they can contribute to mend the gaps in healthcare distribution in order to reach better equity throughout the United States.

## Problem

When considering the matter in more details, the geographical and income considerations seem to be an inherent component and characteristic of these clinics’ development and implementation. Two studies by Pollack paint a rather contrasted picture. The first study by Rudavsky, Pollack and Mehrotra was an in-depth analysis of the operating retail clinics in the summer 2008 and led to the following conclusions<sup>4</sup>:

1. “42 operators ran 982 clinics in 33 states. 44 percent of those

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<sup>2</sup> Mehrotra, A., & Lave, J. R. (2012). Visits to retail clinics grew fourfold from 2007 to 2009, although their share of overall outpatient visits remains low. *Health Affairs*, 31(9), 2123-2129.

<sup>3</sup> Letters from the FTC provided in: <http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx>

<sup>4</sup> Rudavsky, R., Pollack, C. E., & Mehrotra, A. (2009). The geographic distribution, ownership, prices, and scope of practice at retail clinics. *Annals of internal medicine*, 151(5), 315-320.

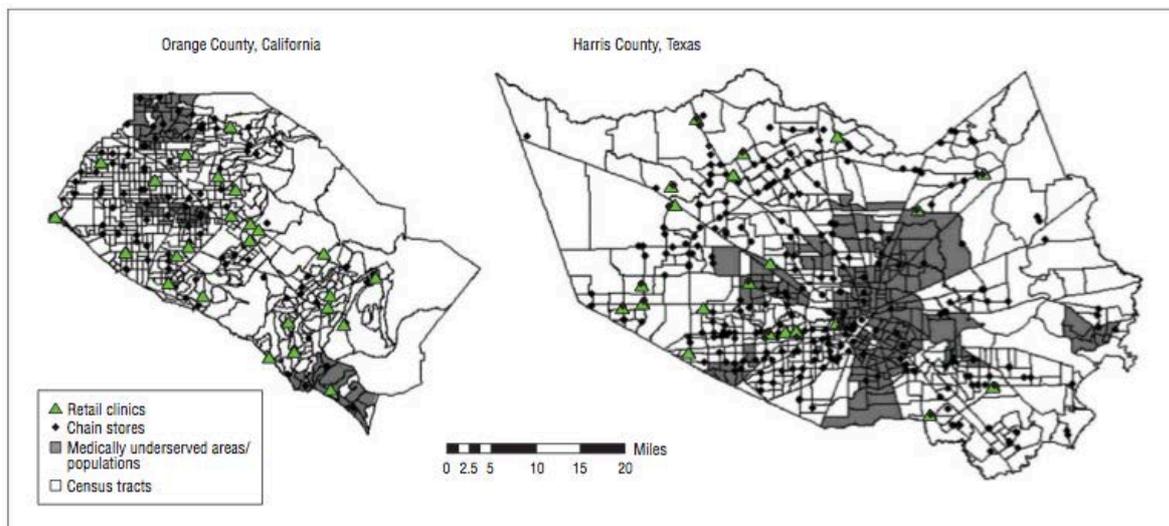
clinics are located in five states: Florida, California, Texas, Minnesota and Illinois.

2. 97 percent of clinics accepted private insurance and 93 percent accepted Medicare fee-for-service.
3. Seven percent of the operators are for-profit retail chains and they are in charge of 73 percent of the clinics.
4. 10.6 percent of the total U.S. population (13.4 percent if we only consider urban settings) lives within a 5-minute driving distance of a retail clinic. These numbers go up to 28.7 percent (and 35.8 percent for urban areas) if we increase the condition to a 10-minute driving distance."<sup>4</sup>

The authors hinted that the disparities within states were probably due to differences in legislation, whether regarding scope-of-practice or licensing. Another study by Pollack and Armstrong, more specifically related to the underserved population, concludes that "within counties with at least one retail clinic, census tracts with retail clinics had a lower black population percentage, lower poverty rates, and higher median incomes and were less likely to be medically underserved areas compared with census tracts without retail clinics"<sup>5</sup>. This is clearly apparent in their mapping of retail clinics in the two counties with the highest number of retail clinics, which I included in this analysis for illustration and reference.

Therefore, if those retail clinics - meant to reduce the widening gap in healthcare delivery - actually contribute to this inequity increase then it is a trend that should be addressed. In other words:

*How to better acknowledge and respond to the geographical and income disparities considerations in retail clinics implementation?*



**Figure 2.** The locations of retail clinics, chain stores, and medically underserved areas/populations.

Source: Pollack C. E., & Armstrong K. The geographic accessibility of retail clinics for underserved populations. *Archives of internal medicine*, 169(10), 945-949.

<sup>5</sup> Pollack, C. E., & Armstrong, K. (2009). The geographic accessibility of retail clinics for underserved populations. *Archives of internal medicine*, 169(10), 945-949.

## **Policy options to address the problem and criteria for selection**

In order to respond to the raised concern and help retail clinics be an opportunity to care for underserved communities, some action should be taken either on a state or federal level. Since retail clinics have passed their testing phase, the development phase should now be closely monitored so that they do not create deeper disparities in health distribution. The following options, with little interferences or restrictions in terms of policy, would help ensure that they develop in the right direction.

### *1. Push for more evaluation through evidence-based research and audits.*

The example set by Pollack and Armstrong, in the specific analysis of retail clinics detailed above, is a task that each state should take on and monitor more closely. An increased monitoring of these clinics will help better understand the market, its expectations and areas of improvement. Effective policy starts with accurate research. For example, randomized control trials could be developed and implemented in order to determine which initiatives work best and if the difference in the outcomes is significant.

Currently, the studies asked for by Indiana, New Hampshire and North Carolina are linked to commissions created to determine if further legislation and regulations are required<sup>6</sup>. These states are not conducting needs assessments within communities or trying to discover if a specific intervention developed to target one of the five issues identified above is effective. There is a need for better evaluation in order to determine if the policies implemented are helpful and convincing.

### *2. Push for more regulation to target lower SES and rural communities.*

The second option is to implement regulation in order to target the lack of communication between primary care physicians and the retail clinics. Indeed, this increased communication between caregivers can help in the creation of an action plan to better address the care distribution within medically underserved areas. An important aspect that can help retail clinics be more accessible to the lower income families is to make sure that they accept insurance from Medicaid and amendments could help ensure this is the case in every clinic.

An example of this option's implementation is Texas: the regulations concerning physician overview differ if the retail clinics are located in underserved areas. In those areas, physician's physical presence is less than the 20 percent of time usually required and they do not need to review 10 percent of the charts<sup>7</sup> (the exact numbers were not included in the article). A majority of the existing regulation across the country seems to be targeting and restricting retail clinics activities in order to ensure patient safety instead of helping expanding care in regions where primary care is already low or quasi-inexistent.

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<sup>6</sup> Retail Health Clinics: State Legislation and Laws. Last updated Sept 2012. Retrieved from: <http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx>

<sup>7</sup> Takach, M., & Witgert, K. (2009). Analysis of State Regulations and Policies Governing the Operation and Licensure of Retail Clinics.

### 3. *Push for incentives and subsidies*<sup>8</sup>

The last option is a reaction to the second one: incentives and subsidies may generate better results than regulation. It is important to make those medically underserved areas attractive. Finding incentives targeting retail clinics, tax credits for example, would help these for-profit companies invest in those forgotten places and prompt better care for medically underserved population.

Similar action already exists for physicians: their incentive packages include loan repayment, visa waivers and flexible work options. And it is easy to imagine an expansion of these measures tailored to clinics.

#### **Recommendation**

Although these options could emanate from a federal agency or each individual state, the latter would contribute to the empowerment of municipalities and avoid downstream impacts if the solution chosen wasn't appropriate with the local culture.

In my opinion, the first option would generate better results: going in a direction without being sure of the outcomes is not appropriate from a policy standpoint. Moreover, I believe that policymaking requires data in order to make informed decisions. In the short term, states could develop a needs assessment conducted in medically underserved areas and a randomized control trial to determine whether regulation or incentives yield better results. This would be the best alternative as there isn't enough data on the potential benefits of retail clinics in medically underserved areas. The results of this more focused research will help shape the next steps. Indeed, we have to make sure that retail clinics are accepted, from the consumer point of view. A detailed analysis conducted by the RAND Health Division expressed skepticism about the use of retail clinics in urban underserved areas because of the existing high lack of trust<sup>9</sup>. The authors specify that it would be necessary for retail clinics to communicate with the prevailing community health centers in order to better integrate in these medically challenged areas.

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<sup>8</sup> Pollack, C. E., & Armstrong, K. (2009). The geographic accessibility of retail clinics for underserved populations. *Archives of internal medicine*, 169(10), 945-949.

<sup>9</sup> Weinick R.M., Pollack, C. E., Fisher M.P., Gillen E.M. & Mehrotra, A. (2010). Policy implications of the use of retail clinics. *Rand Corporation*.