Chapter 10
On-Site Clinics: A New Model of Health Coverage in Local Government

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ABSTRACT

With the continued rising cost of health insurance and the fiscal constraints as a result of the 2007-09 economic recession requiring local governments in the U.S. to make cuts in employees, services, and benefits, it appears that on-site health clinics are one method of reducing, or at least, slowing health care costs. This chapter analyzes the use and benefits of such clinics for local government managers that is a new, but potentially effective method of both controlling costs and improving employee health.

CHANGING TIMES CALL FOR NEW IDEAS

A hallmark of the U.S. healthcare system for the last 70 years has been employer-sponsored health coverage. Growing out of the need to provide benefits as a means of remaining competitive in both hiring and retaining employees, employers
often offered coverage with low deductibles, co-pays and low-cost prescriptions. Historically speaking, federal, state, and local governments were initially slow to respond to this influx of health insurance benefits that permeated U.S. industry in the post-World War II society. Although some of the larger municipal governments began offering coverage to employees in the 1950s, it wasn’t until the passage of the Federal Employees Health Benefits Program in 1960 that federal employees saw direct participation by their employers. By the end of the decade most state and local government employees had followed suit. Once implemented the benefit package for public employees often served as a key recruitment tool, since public sector pay seldom matched private sector wages (Cox, 2011, p. 2; Falk, 2012, p. 8; Kaiser Family Foundation, 2012).

As cautious as they were in providing employer-sponsored health care, governments have been equally slow to address the rapid escalation in health costs over the last two decades. They have preferred to absorb rising costs while the private sector increasingly shifted these costs to employees. (Kavanaugh, p. 2, 2011; Claxton, Rae, Panchal, Damico, Lundy, Bostick, Kenward, & Whitmore, 2012). Saddled with high cost plans and low deductibles, governmental agencies throughout the country watched their health costs soar, a trend escalated by this so-called “Cadillac coverage,” insurance that costs as much as 20 percent more in the public than in the private sector (Barro, pp. 2-5, 2011). Adding to the rise in costs were the mandates included in the 2010 Patient Protection and Affordable Care Act that require preventive coverage with no co-pays, coverage of employees’ children up to age 26, and prohibitions on coverage limits for essential services. These and other requirements have further increased costs to both fully-insured and self-insured health plans. Such high-cost, low-deductible, and rich benefit plans take up an increasingly higher share of governmental budgets at a time when, in many areas, local government revenue is declining (Gross, Huh, Sylvester, & Zahradnik, 2012). One report estimates that health benefits offered by state and local governments reflect more than five percent of annual expenditures (Barro, p. 1).

The economic recession that began in 2007 forced local governments, in particular, to make reductions-in-force and cuts in services and benefits. A number of these governmental units came face-to-face with the fact that continued health care benefits to which government employees were accustomed were no longer sustainable. The growing public expectation for effective and efficient government that operates like the private sector, rising costs of health care, and reduced revenue became a triple threat to local governments. One approach that appears to be gaining in popularity in getting a handle on health costs has been the implementation of on- or near-site health care clinics, perhaps best described as a modern version of the “company doctor.”
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