On-Site and Ne

Reshaping Access to Primary Care

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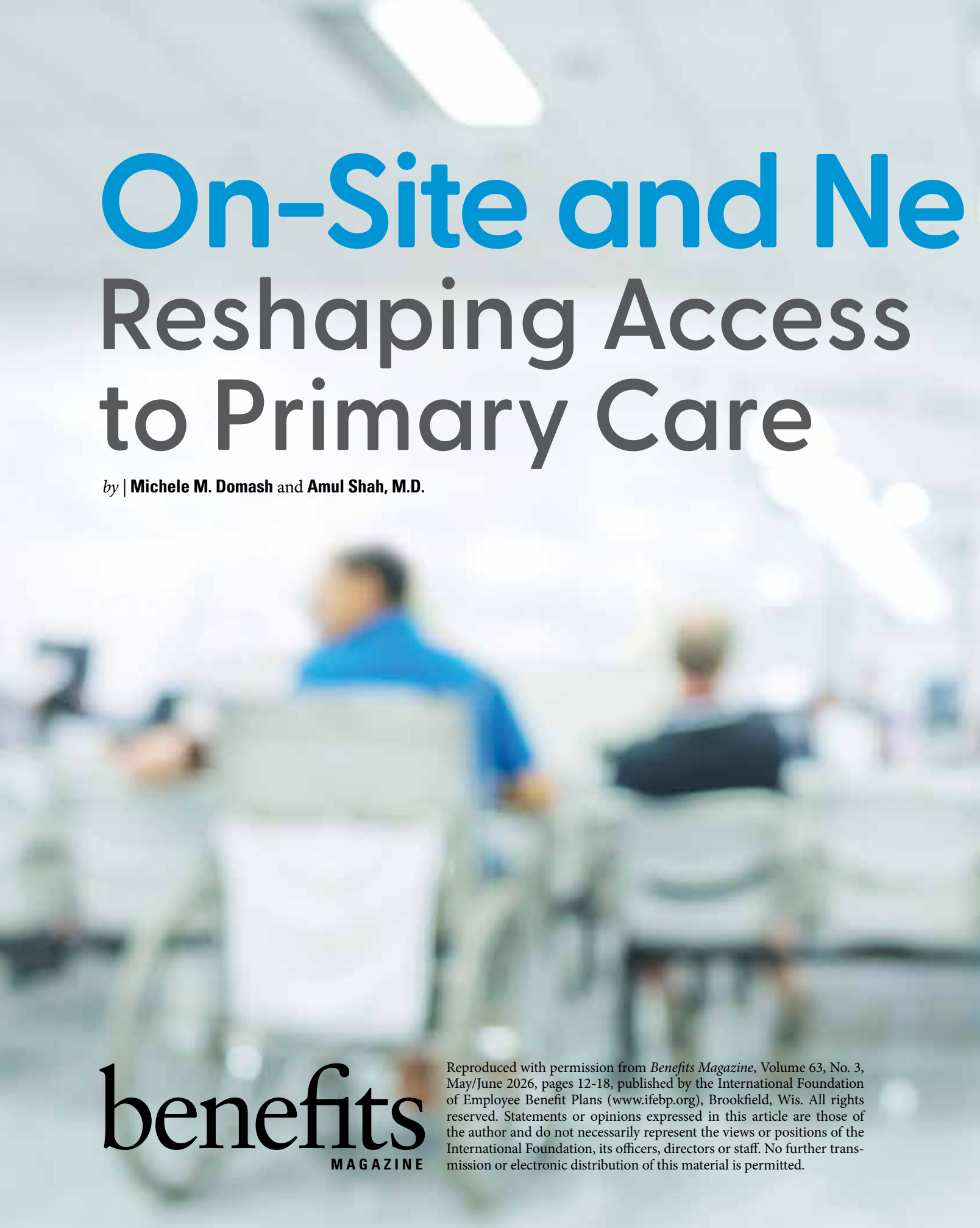

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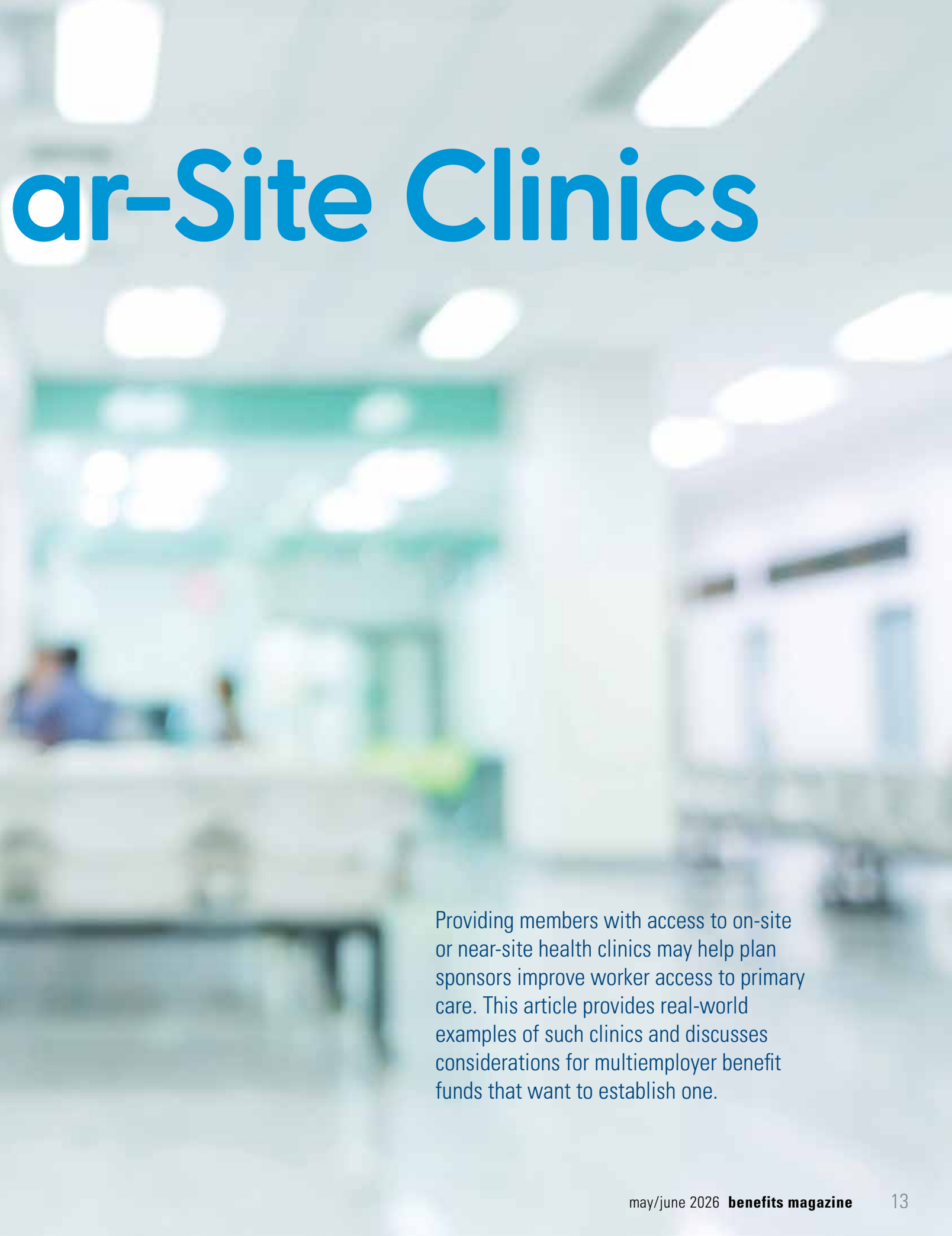

Providing members with access to on-site or near-site health clinics may help plan sponsors improve worker access to primary care. This article provides real-world examples of such clinics and discusses considerations for multiemployer benefit funds that want to establish one.

The number of on-site and near-site clinics and wellness centers has grown significantly in the past decade for participants covered by group health plans.

These clinics have been established by private sector single employer plans; multiemployer or Taft-Hartley plans for union members; and public sector plans for the federal government, states and municipalities. This article will focus on clinics established by multiemployer health funds.

On-site and near-site clinics may offer a more sustainable solution to primary care access issues and result in a coordinated approach to health care, with the potential benefits of better health outcomes, improved patient experience and reduced health care costs, according to a recent survey of employers and clinics.[1]

A Better Primary Care Solution for Patients and Physicians?

Plan sponsors have long emphasized the importance of primary care by encouraging health plan participants to choose a designated primary care physician and tracking employees' primary care visits as an indicator of health trends.

However, access to primary care in the United States is limited and often depends on where a patient lives. The number of people in the U.S. living in areas with shortages of primary care providers increased about 21% in 2025 to 92.3 million, up from 76.3 million the previous year, according to the Health Resources and Services Administration (HRSA).[2]

In addition to access challenges, the quality of primary care visits has become an issue. Primary care physicians need to see between 2,000 and 2,900 patients a year (or 20 to 30 patients per day) to break even, though this may vary widely from practice to practice.[3,4,5]

In an interview, David Jacobson, D.M.D., chief executive officer of the New York Hotel Trades Council & Hotel Association of New York City Inc. Employee Benefit Funds, said that the general problem is that the health care system has little communication, and providers are charged with increasing revenues in addition to focusing on care.

On-site and near-site clinics are one solution that multiemployer funds are pursuing to address these challenges.

takeaways

- On-site and near-site health clinics are increasingly used by single employer, multiemployer and public sector health plans to improve access to primary care for plan participants.
- Compared with traditional primary care delivery, many of these clinics offer longer visits, faster access and more coordinated services, which can improve patient experience and health outcomes.
- Multiemployer plans may choose from a few different clinic models—plan sponsor–owned and –operated, vendor-operated and shared clinics.
- Clinics tend to generate the greatest value when they reduce emergency room use, hospital admissions and fragmented care. A monetary return on investment may take a few years to emerge.

Clinic Models

The following are examples of typical on-site and near-site clinic models.

Clinics Owned and Operated by Plan Sponsors

In this model, the plan owns and operates the clinic. These clinics are typically reserved for large plans. The plan must identify the location with optimal access for members and decide whether to build or rent. Building costs depend on whether the clinic is new construction or an existing space being retrofitted, the location, and the number of rooms and services offered. Physical clinic space requires cash outlays for construction, materials, permits and customization to meet clinical requirements, varying widely from $100,000 to millions of dollars, although the costs are usually amortized. Plans can also consider renting commercial space.

Vendor-Operated Clinics

Many plan sponsors lack the size or the clinical and health provider expertise to successfully operate their own clinic and instead choose to contract with a vendor specializing in clinic management.

The selected vendor provides services to run the clinic, including hiring providers (doctors, nurses, others); setting up scheduling and medical record software; handling supplies, equipment and maintenance; managing compliance with privacy and professional regulations; and ensuring the right levels of commercial and other insurance.

The plan may own or rent the physical space and would pay the vendor for the clinicians; ongoing supplies, including prescriptions; and other operating costs.

Responding to a Need: Three Examples

The following are three examples of on-site/near-site clinics operated by multiemployer benefit funds.

1. New York Hotel Trades Council & Hotel Association of New York City, Inc. Employee Benefit Funds

Model: The funds own and operate four near-site health centers for their 90,000 members.

Services available: Health center services include primary care, such as family practice and pediatrics; specialty care, such as cardiology, endocrinology, gastroenterology, nephrology, and obstetrics and gynecology (OB/GYN); and others, such as a pharmacy, a laboratory, radiology, physical therapy and dental services.

Additional Details

Almost half of the funds' health care claims costs are attributable to the clinics. In other models, wellness centers or clinics might account for less than 10% of health care claims costs. The wide range of services offered by the clinics is likely one reason for the difference. One of the sites—the Brooklyn Health Center—welcomes members and their families in a concierge-style setting with minimal wait times. The five-story center is designed to serve as a one-stop hub for outpatient services.

The clinics operate in an expensive region, but the funds have managed to attract and retain a full staff of highly qualified providers. The primary care model of clinics attracts physicians and providers who share the same mission and want to deliver intensive primary care rather than acute "drive-through" care. They typically receive a salary and benefits, and they can focus on patient care without the pressure of managing a large panel of patients to meet financial targets. The clinic model aligns incentives around the patient and supports a more traditional doctor–patient relationship, which many providers and patients find appealing.

2. Mid-America Carpenters Regional Council Health Fund, Kansas City, Missouri

Model: On-site, vendor-operated, union-built health center

Services available: Well-appointed contemporary center, with primary care, vision care, behavioral health counseling, chiropractic care and physical therapy.

Additional Details

Members are not charged copays for services, and many with chronic conditions are returning because of easy access to trusted providers. Once the health center opened in December 2024, members quickly adopted this method of care, allowing it to reach capacity quickly and increasing primary care utilization by 30% year over year before and after the clinic launch.

3. Bricklayers Allied Craftworkers (BAC) Union, Fenton, Missouri

Model: Vendor-operated, on-site primary care clinic

Services Available: Services include wellness and preventive care, including wellness physicals, screenings, and immunizations; chronic condition counseling and management for conditions such as diabetes and hypertension; and acute care for injuries and illnesses.

Additional Details

The clinic operates in the BAC Local 1 union hall in Fenton. The International Health Fund, which is the multiemployer fund that provides health benefits to union members, contracts with a vendor to operate the clinic. Visits to the clinic increased by 64% from 2022 to 2025, and return visits more than doubled during that time.

The fund and the local union hold campaigns—such as health fairs, biometric screenings, family days, school backpack giveaways and more—to encourage members and their families to choose the clinic for their primary care and other services. Members with high blood pressure receive a free blood pressure cuff and clinic staff instruction on how to use it and how often to check their readings. Follow-up visits make up the largest share of appointments, and more members are choosing the clinic as their primary care provider.

According to John Crowe, M.D., who staffs the clinic, the clinic's unique attributes include enhanced access to care without appointment delays or long waits, removal of copays and other unanticipated fees for member benefits, a trusting patient–provider relationship, and the ability to build a culture of care and long-term wellness.

Vendors may use a fixed fee method or a more transparent method referred to as *costs plus*, which is the actual costs that the vendor incurs plus an agreed-upon percentage to cover administration and clinic oversight.

Once the clinic is established, plan sponsors could face financial drawbacks if it cannot operate at capacity.

Shared Clinic Model

Some plan sponsors may choose to participate in a shared clinic model in which multiple plans or employers share clinic services.

The investment and evaluation are simpler for the plan sponsor under this model. The plan pays access fees for its members to use the shared clinics, and the primary plan sponsor selects the clinic vendor partner and handles all operational and compliance requirements. The focus shifts to the cost of access and likely utilization. Ensuring that members in the primary clinic model continue to have the same quality of care when granting access to other patients from other plans can be a concern for the primary plan sponsor and vice versa.

Comparing On-Site/Near-Site Clinics With Traditional Primary Care

Health plans that offer on-site or near-site clinics are typically seeking to remove barriers and improve access to primary care. Tables I and II compare traditional primary care with care provided by on-site/near-site clinics.

In addition to the services mentioned in the tables, on-site and near-site clinics often hold member events to provide information and services such as health screenings and massage

TABLE I

Comparing the Patient Experience

Factors Involved in Primary Care	Primary Care Physician From a Group Health Plan	Primary Care From an On-Site/Near-Site Clinic in a Group Health Plan
Average patient panel per physician	2,000-2,900 patients*, †, ‡	1,200-1,600 patients per physician (or 12-16 patients per day)
Before an appointment	Scheduling the first visit may take months or longer; the average time for a family medicine appointment is 23.5 days, and for new patient visits, 31 days.**	Visits can be the same day or same week due to lower patient volume. Sixty-eight percent report same-day access.††
When patients arrive	Wait time can be 30-45 minutes. A reported average is 22 minutes, including waiting in the exam room. ‡‡	Clinics emphasize the lack of wait time. Some do not even offer waiting rooms.
At the visit	Typically, the physician has access to patient notes, and the patient usually does not.	Clinics may offer a more inviting approach, with the patient and physician reviewing the records together.
Duration of visit	Ten to 15 minutes	Annual physicals are scheduled for 30-45 minutes or more.
Prescriptions	The physician writes a prescription, and the patient picks it up.	Many clinics ensure that patients leave with an initial dose of the prescription.
Quality of provider services	The average Net Promoter Score is 58 in the health care industry.***	Net Promoter Scores are reported to be above 90, with 100 being the perfect score.

*SigmaMD blog, "How Many Patients Does a Primary Care Doctor See in a Day?"

†Justin Porter, Cynthia Boyd, M. Reza Skandari, Neda Laiteerapong, "Revisiting the Time Needed to Provide Adult Primary Care," *Journal of General Internal Medicine*, July 1, 2022.

‡Kurt B. Angstman et al., "Family Medicine Panel Size with Care Teams: Impact on Quality," *Journal of the American Board of Family Medicine*, July-August 2016.

**AMN Healthcare Press Release, "New Survey Shows Physician Appointment Wait Times Surge: 19% Since 2022, 48% Since 2004," May 27, 2025.

††Alliant Insurance Services in collaboration with the National Association for Workplace Health Care (NAWHC), *NAWHC 2025 Worksite Health Centers Survey Report*.

‡‡PatientPoint blog, "What's the average wait time for patients?"

***Ian Luck, "NPS Healthcare Guide: 25 Healthcare NPS Benchmarks & Industry Guide."

therapy. More than half of employer-sponsored health centers indicate they will increase services or staff, and 28% will add health centers in other locations, according to the National Association for Workplace Health Care (NAWHC) survey.[6]

When Are On-Site/Near-Site Clinics of Value? (Determining ROI)

Finding the Right Fit

On-site/near-site clinics may not be a fit for every plan. Plans that might find this approach worth pursuing for the first time or further expand services for their employers include those with the following characteristics.

- Inadequate primary care coverage, with provider density and visit rates per 1,000 members falling below healthy ranges
- High and persistent member emergency room (ER) visits (e.g., more than 250 ER visits per 1,000 covered members)
- High incidence of hospital admissions
- Member complaints about an inability to find an in-network provider on a timely basis
- Members simply not seeking care at all
- A high density of members and their families who live in a concentrated region. Smaller plans or widely dispersed workforces may be a better fit for a shared services model of care.
- A community ethos, fostering a sense of belonging to the industry, the organization and the extended workforce family

These clinics may not be a fit for plans with the following characteristics.

- Good primary care coverage, with provider density and visit rates per 1,000 members within or above normal ranges
- Low ER utilization, since this indicates that members are likely receiving adequate care from primary care providers and specialists
- Low rate of hospital admissions since some of the value of on-site/near-site clinics is from reducing the hospitalization rate
- A widely dispersed workforce without a high concentration of members and their families in a particular region. Plans would lack a central location for an on-site/near-site clinic.

TABLE II

Scope of Primary Care Services

Factors Involved in Primary Care	Primary Care Physician From a Group Health Plan	Primary Care From an On-Site/Near-Site Clinic in a Group Health Plan
Chronic care management and counseling	Limited time to address the full scope of chronic care management	The longer visit lets the physician discuss ways to mitigate common chronic conditions. Sixty percent of clinics offer care coordination services.*
Specialist referrals	Physicians deal with many insurance networks in the community.	Referrals may be customized to the plan's network. Some offer second opinion services.
Physical therapy and chiropractic care	Separate referrals and services	Larger clinics might offer these services.
Dental and vision care	Separate services	Some offer dental and vision care.

*Alliant Insurance Services in collaboration with the National Association for Workplace Health Care (NAWHC), *NAWHC 2025 Worksite Health Centers Survey Report.*

ROI Metrics

One industry survey reported a 2:1 return on investment (ROI) for more than half of the responding plan sponsors with clinics.[7] However, it may take plans a few years to realize a monetary ROI. Improvements in patients' health are often observed first.

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Key metrics for determining (ROI) include the following.

- Usage vs. capacity
- Savings from avoided hospital or ER admissions
- Improvements in population health
- Nonfinancial factors (e.g., a reduction in the number of locations a patient must visit for care). The more accessible the care, the more likely patients will follow through, Jacobson noted.

While these metrics are useful, the best evidence of whether clinics are working is when year-over-year plan costs level off or even decline. In addition, clinics that treat members with chronic conditions who need repeat visits tend to see a greater ROI.

Some funds can reinvest their savings in providing even more care, Jacobson explained.

For example, the New York Hotel Workers' clinic purchased a state-of-the-art CT scanner for its new center. On-site CT scan services will allow the health center's clinical staff to coordinate directly with the radiology team to perform on-site tests, including cardiac CT imaging to assess coronary artery blockage as well as low-dose chest scans for lung cancer screening. The clinic expects that the scanner will allow its medical team to detect abnormalities early, ultimately translating into better outcomes, less hospital time and perhaps less costly treatment.

Conclusion

On-site and near-site clinics have the potential to address primary care access challenges for multiemployer fund members. Funds can consider multiple models and should evaluate factors such as where members live and how they access care when determining whether a clinic is worth pursuing.

bios

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Endnotes

1. Alliant Insurance Services in collaboration with the National Association for Workplace Health Care (NAWHC), *NAWHC 2025 Worksite Health Centers Survey Report*.

2. Health Resources and Services Administration's Bureau of Health Workforce, *First Quarter of Fiscal Year 2026 Designated Health Professional Shortage Areas Quarterly Summary*, January 14, 2026, reflecting data as of Dec. 31, 2025.

3. SigmaMD blog, "How Many Patients Does a Primary Care Doctor See in a Day?"

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7. Ibid.

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