

Health Care Reform and Real Estate



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Health Care Reform



Four main areas –

1. Improvement in insurance coverage
2. How to pay for it
3. Reduction in costs
4. Long term care

Then miscellaneous items

Basic Concept



- Up to 133% of Federal Poverty level the government (state and federal) provides the insurance
- Between 133% and 400% the government and private pay provides insurance
- After 400% employers and individuals must provide insurance
- Insurance companies generate many more customers and, consequently, must accept regulation
- We don't know how to curtail costs so we are going to experiment
- Many interesting miscellaneous provisions that have significant impact

Improved Insurance Coverage



1. Immediate changes (effective within 6 months)

- a) Expands dependent coverage under parents plan to age 26
- b) Children cannot be denied insurance for pre-existing conditions
- c) Prohibits lifetime dollar limits on coverage (annual limits prohibited beginning 2014)
- d) Insurers cannot rescind coverage except for fraud
- e) Eliminates extensive waiting periods for coverage
- f) Tax credits for small employers (under 25) for providing qualified insurance
- g) Provides \$5 billion for high risk federal plan to cover uninsurable until Exchanges are operational in 2014
- h) Medicare enrollees who are in Part D “donut hole” receive \$250 rebate; “donut hole” drugs discounted by 50% beginning in 2011
- i) Establishes minimum percentages for amount of premium dollars spent on clinical care and quality activities (2011)

Improved Insurance Coverage



2. Insurance Reform

a) Individual Mandate (2014)

- 1) US citizens and legal residents are required to have health insurance
- 2) Failure results in a penalty of greater of \$695 per year (\$2085 maximum per family) or 2.5% of income (phased in from 2014 to 2016)
- 3) Exceptions for religious reasons and for low income (if the lowest available premium is more than 8% of annual income)
- 4) Refundable and advanceable premium credits to individuals and families with incomes between 133% and 400% of FPL (available to citizens and legal immigrants)
- 5) Premium subsidies increase annually by the excess of the premium growth over income growth
- 6) Federal cost sharing subsidies through tax credits

Improved Insurance Coverage



2. Insurance Reform

b) Employer Mandate (2014)

- 1) Employers with more than 50 full-time employees must provide coverage
- 2) Failure results in a penalty of \$2000 per full-time employee, excluding the first 30 employees
- 3) Any employer with 50 employees that offers coverage, but has an employee receiving a premium tax credit will pay the lesser of \$3000 for each employee for each employee receiving a premium credit or \$2000 per full-time employee
- 4) Employers with more than 200 employees must automatically enroll employees into employee plans
- 5) Tax credits up to 35% of premium for small employers (fewer than 50 employees)

Improved Insurance Coverage



2. Insurance Reform

- c) State Exchanges (2014) funded by fed until 2015
- d) State insurance exchanges approve insurance plans for purchases by citizens, legal immigrants and businesses up to 100 employees
 - 1) Four benefit categories plus a catastrophic plan in each exchange
 - 1) Bronze 60% of costs up to the HSA maximum (\$5950/person)
 - 2) Silver 70% of costs with HSA limits
 - 3) Gold 80% of costs with HSA limits
 - 4) Platinum 90% of costs with HSA limits
 - 2) Regulations of plans include required provider networks, required marketing restrictions, state licenses, accredited for quality and others
 - 3) Regulation of exchanges requiring call centers, uniform enrollment and reporting

Improved Insurance Coverage



2. Insurance Reform

e) Qualified Plans – certified by exchanges

- 1) Provides essential health care services
- 2) May include primary care medical home as part of the plan (concierge care)
- 3) May rate premiums only on geographical area, age, family composition and tobacco use
- 4) No preexisting conditions
- 5) States and the Feds will oversee rate increases that are effective in 2010 on. Excessive increases may result in exclusion from participation in the exchanges.
- 6) Cap on administrative expenses and profit of 20% of premium for individual and small group coverage and 15% for large groups
- 7) Simplified health insurance administration with single set of operating rules for eligibility and claims status 2014
- 8) coverage without cost-sharing for certain preventive services

Grandfathered Plans



- Defined as any group health plan that was in effect on March 23, 2010.
- Exceptions:
 - For plan years beginning after September 23, 2010:
 - Pre-existing conditions. Pre-existing condition exclusions have to be removed from group health plans *for children under the age 19*. Not for everyone. That comes later.
 - Dependent coverage. Group health plans must provide coverage for adult dependent children up to age 26 only if the child is not eligible to enroll in other employer-provided coverage (other than in a grandfathered plan).
 - Rescissions. Plans will not be able to cancel coverage after someone has submitted medical claims. Rescission would still be permitted if an individual committed fraud or made an intentional misrepresentation of a material fact.
 - Coverage limits. Group health plans must removed lifetime maximum limits on coverage of essential benefits and the eliminate of certain annual limits.

Improved Access



- Expansion of FQHC's 11 billion over 5 years
- Medicare/Medicaid reforms
 - Government subsidies for Medicare enrollees in the Part D “donut hole”
 - Medicaid primary care reimbursement increased to Medicare rate for 2013 and 2014
 - Medicare bonus of 5% in urban areas and 10% in rural areas for primary care through 2016
 - Provides free annual wellness visit and waives cost sharing requirements for preventative services 2011
 - Reduces costs of drugs while in the donut hole

Improved Access



- Workforce reform
 - 1.5 billion mandatory spending to improve health care professional availability in underserved areas
 - Strengthens grant programs for primary care
 - Redistribute unused residency programs to institutions that will train primary care doctors
 - Financial assistance to nurse training and students
 - Promotes public health professional programs and increases financial assistance to these professionals

Paying for Reform



- Tax on individuals without insurance from \$695 up to 2.5% of income in 2014 (phased in over two years)
- Employer penalties
- Increase by 3.8% tax on unearned income on higher income taxpayers in 2013
- Increase by .9% the tax for Medicare Part A on earning over \$200,000 in 2013
- Eliminate HRA or health FSA coverage for over the counter drugs not prescribed by a doctor in 2011
- Increase the tax on distributions from HSAs not used for medical expenses to 20% in 2011
- Increase taxes on HSAs and FSAs

Paying for Reform



- Limit contributions to FSA to \$2500 a year in 2013
- Increase limit on medical expense deduction to 7.5% of income in 2013 except for seniors until 2016
- Excise tax on insurers with health plans that exceed \$10,200 per person and \$27,500 per family. Tax is 40% of the value of the plan that exceeds the thresholds.
- 2.3% excise tax on taxable medical devices in 2013

Paying for Reform



- Impose annual fee on Pharmaceutical Companies starting at \$2.8 billion in 2012
- Impose annual fee on health insurance sector starting at \$8 billion in 2014
- Impose a 2.3% excise tax on taxable medical devices 2013
- Limit the deductibility of employee compensation to \$500,000 per individual 2010
- Tax of 10% on indoor tanning facilities 2010

Cost Containment



- Accountable Care Organizations (ACOs)
 - Accountable Care Organizations share in cost savings to Medicare program 2012
 - Collaborations between doctors, hospitals and other providers that will be clinically and financially accountable for care
 - Payment methods
 - Fee for service plus shared savings
 - Partial capitation plus shared savings
 - Other
 - Must have a formal legal structure
 - Must have sufficient primary care to provide services to patient population
 - Must meet state licensing requirements

Cost Containment



▪ Independent Payment Advisory Board (IPAB)

- A Medpac with clout
- 15 members appointed by Administration and confirmed by the Senate
- The legislation sets an overall target for Medicare spending
- The IPAB will develop proposals to reduce costs
- The HHS secretary is obligated to implement changes unless legislation is passed rejecting the changes.
- Effective in 2014 as to Medicare only, but its application to plans approved by exchanges seems logical.
- IPAB is prohibited from submitting proposals that would ration care, increase revenues, or change benefits, eligibility, or Medicare beneficiary cost-sharing (including Parts A and B premiums)

Cost Containment



- **Medicare Pilot Programs**
 - Episode payment systems (bundling, capitation, quality payments)
 - Family medical home
 - Fund Collaborative Care Programs to integrate delivery systems
 - Access to comprehensive health risk assessment and prevention plan 18 months of enactment

Where Will the Money Be Spent?



- Integration and consolidation of providers
- Expanding public health clinics
- Health care training and education
- Facilities for newly insured, both in-patient and out-patient
- Expansion of physician facility sites

Affect of Health Care Reform on Real Estate



- The “\$64 Million” Question
 - Rule of Thumb: 2.0 sq. ft./new patient in system (32 million patients = 64 million sq. ft.)
 - Headlines:
 - “Health Care Reform Fires Up Investors”
 - “Health Care Reform: Boon for Commercial Real Estate”
 - “Experts Predict Demand for Medical Space Will Be Resuscitated”
 - “Healthcare Reform to Boost Healthcare Real Estate Industry”

Drivers for Real Estate



- More Customers
 - More people with access to health care system (i.e. more patients)
- More Money
 - More dollars to help pay for such access
- More Jobs
 - More health care providers to serve increase in patients
- Supply/Demand
 - Not enough facilities today to serve increased demand (both patients and providers)

Drivers for Real Estate (cont.)



- Location, Location, Location
 - Provider Integration/Consolidation
 - Lower profit margins/higher patient volume: consolidate space and share resources
 - Go where the patients are: stand alone outpatient sites, neighborhood medical office space
 - Hospitals
 - Potential reversal of inpatient/outpatient ratio (less demand for full-service hospital campuses)
 - Less reliance on ER treatment and space (fewer uninsured)

Drivers for Real Estate (cont.)



- Hospitals (cont.)
 - Go where the patients are: expansion of ancillary outpatient facilities, satellite hospital campuses, and neighborhood medical space
 - Reduction in physician-owned hospitals
- Public Health Clinics
 - Expansion of space needs in underserviced areas

Potential Countervailing Forces



- Low supply of health care providers
- Lower reimbursements will drive some providers/hospitals out of business
- Potential of increased health insurance costs could curtail hiring by employers

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