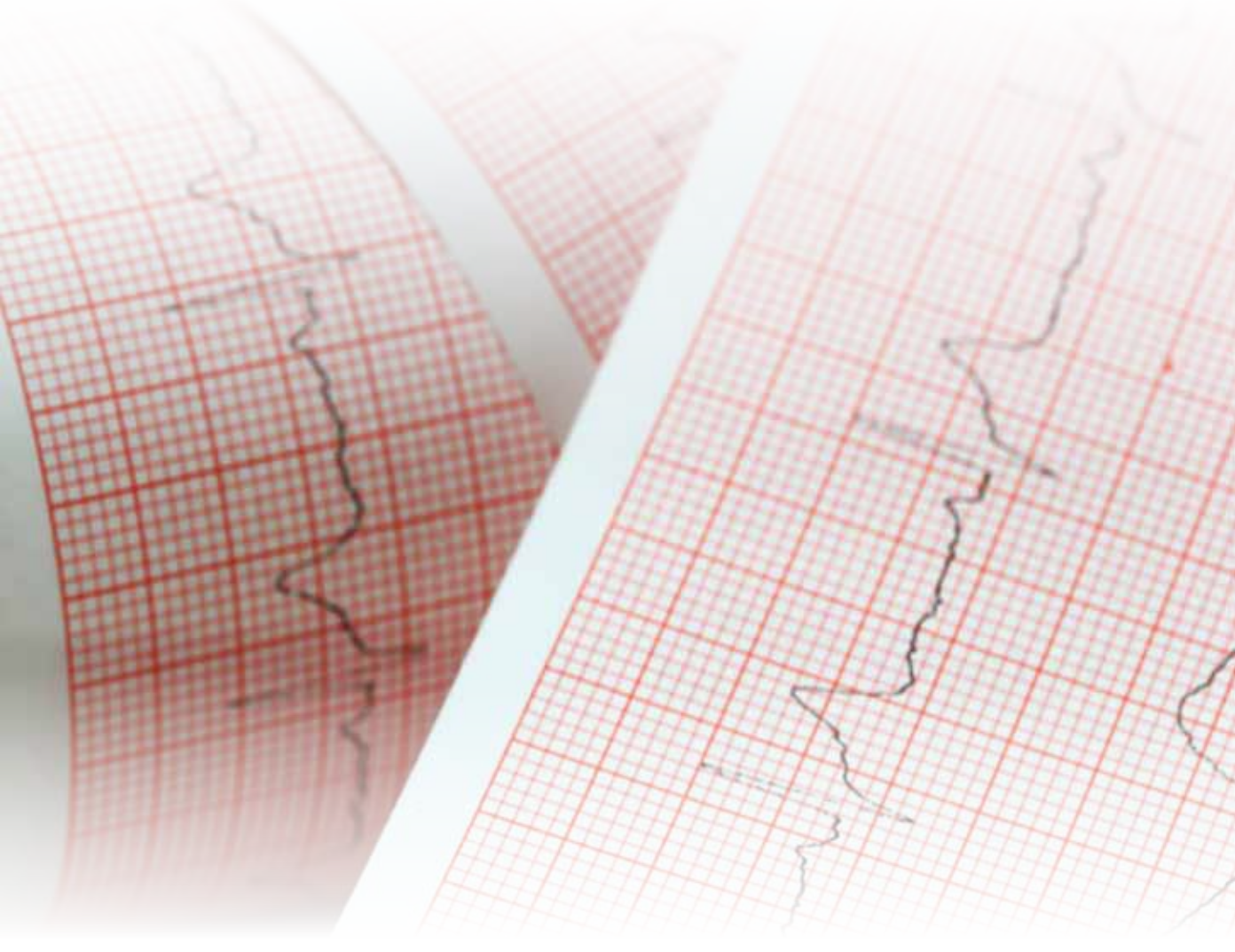
The Outlook for Health Care

Gary Shilling



Urban Land Institute

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About the Urban Land Institute

The Urban Land Institute is a 501(c)(3) nonprofit research and education organization supported by its members. Founded in 1936, the Institute now has nearly 30,000 members worldwide representing the entire spectrum of land use and real estate development disciplines, working in private enterprise and public service. As the preeminent, multidisciplinary real estate forum, ULI facilitates the open exchange of ideas, information, and experience among local, national, and international industry leaders and policy makers dedicated to creating better places.

The mission of the Urban Land Institute is to provide leadership in the responsible use of land and in creating and sustaining thriving communities worldwide. ULI is committed to bringing together leaders from across the fields of real estate and land use policy to exchange best practices and serve community needs by

- Fostering collaboration within and beyond ULI's membership through mentoring, dialogue, and problem solving;
- Exploring issues of urbanization, conservation, regeneration, land use, capital formation, and sustainable development;
- Advancing land use policies and design practices that respect the uniqueness of both built and natural environments;
- Sharing knowledge through education, applied research, publishing, and electronic media; and
- Sustaining a diverse global network of local practice and advisory efforts that address current and future challenges.

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Seavest operates through long-term, discretionary investment funds. These funds are structured to meet the needs of health systems and the developers serving these organizations while providing superior returns to the firm's investors. Seavest's established industry relationships, combined with its strong capital position, allows the firm to access a full range of opportunities to invest in medical office buildings and other outpatient projects.

With an extensive history of investing in medical office properties, Seavest offers market expertise and investment performance grounded by the principles of stability, loyalty, openness and mutual success.

About the Author

Dr. A. Gary Shilling is an economic consultant and investment adviser, as well as a longtime columnist for *Forbes* magazine. He is president of A. Gary Shilling & Co. Inc. and publishes *A. Gary Shilling's INSIGHT*, a monthly report of economic forecasts and investment strategy. He is a member of the Nihon Keizai Shimbun Board of Economists, a columnist for the *Christian Science Monitor,* and is on *Investment Advisor* magazine's panel of investment strategists. He appears frequently on business shows on radio and television.

He graduated magna cum laude and Phi Beta Kappa from Amherst College with an AB in physics, and earned his MA and PhD degrees in economics at Stanford University.

Dr. Shilling's best-selling eighth book, *The Age of Deleveraging: Investment Strategies for a Decade of Slow Growth and Deflation,* was published by John Wiley & Sons in late 2010.

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Dear Reader:

ULI, through the generous support of Seavest Inc., is delighted to present *The Outlook for Health Care* by Gary Shilling of A. Gary Shilling & Co., Inc., Economic Consultants. This paper has been prepared for the ULI Policy and Practice Forum "Anchor Institutions as Catalysts of Urban Investment" and marks a rising dialogue across ULI—including the recent formation of the ULI Healthcare and Life Sciences Council—that recognizes the strategic importance of health care investments in local economic development.

Across the United States, health care institutions are a growing economic force in their communities. This trend is being fueled by the increasing need for health care services from an aging population and a soon-to-be-expanding insured segment mandated by the Patient Protection and Affordable Care Act. Adding to this trend, the technology of medicine is rapidly moving many procedures from an inpatient to an ambulatory setting and making new treatments available where previously none had existed. Operating in this dynamic environment, health care providers are finding themselves in an increasingly competitive industry where costs and access to patients are key factors in delivering services.

These changes can be—and will be—felt in communities across the country where health care anchors are often one of the leading employers in local markets. Innovative land use strategies are being fostered that emphasize the urban development opportunities created by investments in health care institutions. Whether Boston, Cleveland, Columbus, Houston, Kansas City, Orlando, Philadelphia, San Francisco, Seattle—or Las Vegas—local communities are exploring how to capitalize on the long-term, legacy investments that health care represents.

The result is likely to be the development or adaptive use of existing facilities to serve the needs of this growing population. Medical office buildings equipped with the latest technology for surgery, imaging, cancer treatment, and other treatments will grow in importance. These facilities will exist on hospital campuses, but just as important, be located within existing communities throughout the United States. Convenience, access, and cost will be the driving factors as health care providers build out their networks.

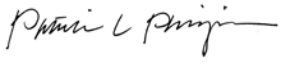
At a moment when the commercial and residential real estate markets continue to work through cycles of correction, we must not lose sight of the fundamental drivers that create value in urban communities. Access to high-quality education is widely acknowledged as one key driver of land value across metropolitan areas. With this paper, ULI seeks to commence a corresponding dialogue around health care delivery networks. These networks, which are formed by a combination of public, private, and nonprofit uses, constitute one of the most elemental uses of land within our communities.

This paper suggests the trend in health care will continue and strengthen. The land use implications of this trend extend well beyond the direct investments in medical facilities themselves to a host of affordable and workforce housing markets as well as the retail and hospitality sectors. In turn, these evolving land use frameworks lead to transportation and infrastructure challenges.

This paper underscores the need for a strategic conversation between land use professionals and health care industry leaders that explicitly recognizes that as the delivery of health care is transformed, so are our cities and neighborhoods. As with many other land use challenges faced by communities across the country, community leaders can make deliberate choices on how to meet future demand.

We look forward to engaging you in this dialogue at ULI!

Sincerely,



Patrick L. Phillips
Chief Executive Officer, ULI

Douglas Ray
President, Seavest Inc.

Executive Summary

The demand for medical services in the United States will mushroom over coming decades and, with it, the need for new and refurbished medical office buildings (MOBs) and related outpatient care facilities such as ambulatory care facilities, surgery centers, ambulatory surgical centers, medical imaging facilities, outpatient cancer care facilities, and wellness centers.

This increased demand is supported by a variety of long-term trends and drivers:

- *An aging population* drives increases in medical service demand. Those over 65 years of age have three times as many office visits per year as people under 45, and the oldest of the 78 million post–World War II baby boomers will reach 65 in 2012, the youngest in 2029. The government estimates that Medicare and Medicaid expenses will leap from 6.4 percent of gross domestic product (GDP) this year to 10.7 percent in 2029.
- *Technology advances* are driving patient demand for more medical services and the space in which to deliver them. Also, new and smarter MOBs are often required.
- *Thirty-two million more* Americans will be covered by health insurance under the new health care law, an 11 percent net addition by 2019. The Obama administration estimates that national health care expenses will rise from $2,632 billion in 2010 to $4,717 billion by 2019, only $46 billion, or 1 percent, higher than without the new law. However, history suggests the government may be underestimating the growth in health care outlays and the related need for new physical facilities. In 1967, the year after Medicare commenced, the House Ways and Means Committee forecast Medicare's cost at $12 billion in 1990. It turned out to be $110 billion—nine times as much.
- *Increased demand for medical services in the years ahead will create jobs* but not enough to absorb all the unemployed in an era of slow economic growth. Therefore, Washington may readily accept the creation of more health care jobs than anticipated by the new health care law, ranging from nursing home attendants to brain surgeons—and the MOBs they will occupy.
- *The new health care law does little to increase the supply of medical personnel and facilities,* but booming demand will result in the rapid growth of both, with the latter largely financed by private investments.
- *Cost control pressures* from government and employers will work to the advantage of big, profitable hospital systems with large campuses and expanding satellite facilities. Renewed growth in cheaper outpatient surgical and other facilities will also result from an emphasis on cost containment.
- *Hospital-employed physicians* will increasingly dominate the field as medical record-keeping requirements, cost containment pressures from government and insurers, constraints on government reimbursements, expensive new technology, lack of economies of scale and high practice management costs, and lower incomes relative to hospital-employed physicians weigh on small private practices. This situation will

create substantial demand for MOBs, replacing many small physician offices with much larger hospital-related facilities. Hospitals will also be better able to establish accountable care organizations (ACOs), authorized by the new law, which allow medical providers to share in cost savings from cost containment efforts.

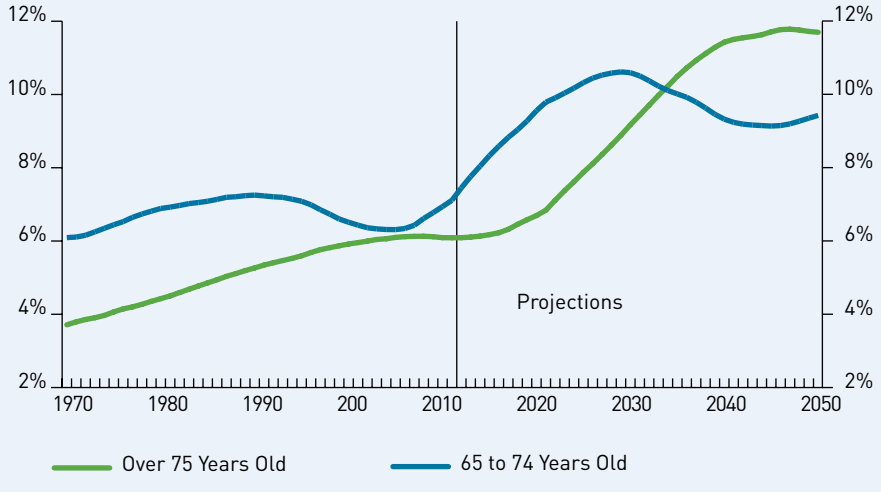
- *Undocumented immigrants* are excluded from health insurance under the new law, so the newly covered urban poor and the facilities needed to serve them will be most economically efficient in cities that have fewer undocumented immigrants.
- *MOB demand* is forecast to expand 19 percent by 2019, 11 percent of it because of the new law and the rest from population growth. The 64 million square feet required to meet the demand of the new law compare with 2010 construction of 7 million square feet. MOBs are much less volatile than other commercial and residential real estate, as shown by more stable vacancy and capitalization rates. MOBs will not be plagued in future years by continuing excess capacity, as is the case with residential real estate, malls, and office buildings.

Both demand and supply factors point to rapid growth in spending on medical services and MOBs for many years.

More Health Care for Seniors

The aging of the population is well known. The jump in those 65 to 74 years of age as a share of the population will peak in about 20 years but only because many of those people will join the 75-plus age group (figure 1). Also clear is that older people consume more medical care. Those over 65 were 12.5 percent of the population in 1998 but accounted for 24 percent of visits to physicians' offices. By 2008, the numbers were 12.7 percent and 27 percent, respectively. Furthermore, those people had 6.9 office visits on average in 2008, up from 6.1 in 1998, or almost three times the visits of those under 45

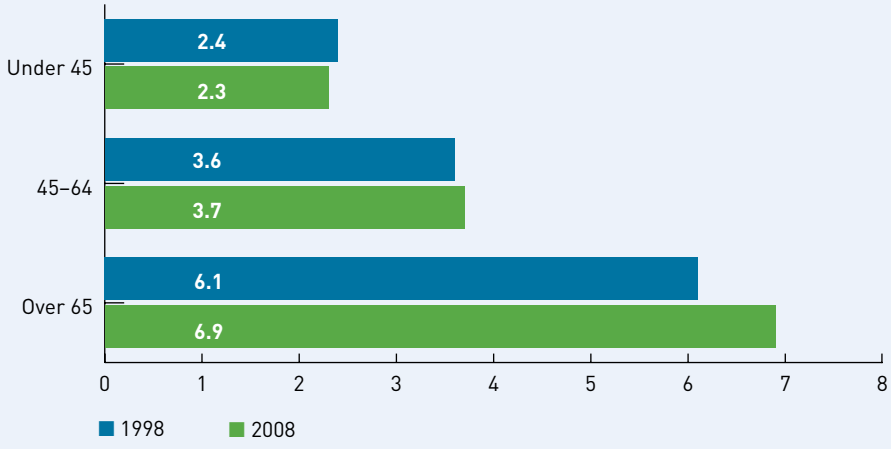
FIGURE 1: U.S. Elderly Population as a Share of the Total Population



Source: U.S. Census Bureau.

years of age (figure 2). Per capita health care costs for those over 65 in 2004 averaged $14,797, compared to $4,511 for Americans in the age groups from 19 to 64 (figure 3). About half the average outlay for seniors was by Medicare at $7,242, whereas all public spending for those 19 to 64 years of age was only $1,395 on average.

FIGURE 2: Annual Rate of Physician Office Visits by Age Group, 1998 versus 2008



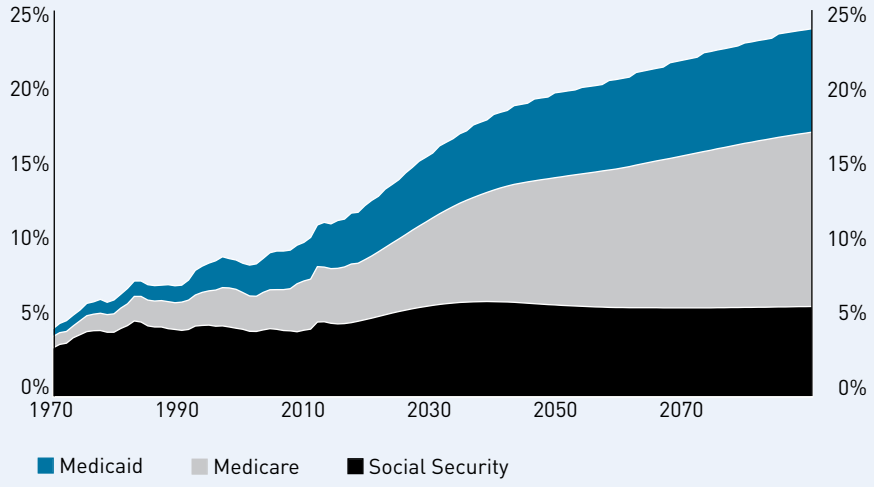
Source: U.S. Centers for Disease Control and Prevention.

FIGURE 3: Per Capita Health Care Costs by Age Groups

Age Group (Years)	Total	Total Private	Primary Health Insurance	Out of Pocket	Other Private	Total Public	Medicare	Medicaid	Other Public
Total	$5,276	$2,921	$1,898	$802	$221	$2,355	$1,032	$918	$405
0–18	$2,650	$1,558	$1,096	$338	$124	$1,092	$2	$819	$271
19–44	$3,370	$2,269	$1,559	$520	$190	$1,100	$87	$662	$351
45–54	$5,210	$3,760	$2,570	$899	$290	$1,451	$310	$737	$403
55–64	$7,787	$5,371	$3,784	$1,225	$363	$2,415	$706	$1,026	$683
65–74	$10,778	$3,851	$2,174	$1,437	$241	$6,927	$5,242	$1,112	$573
75–84	$16,389	$5,066	$2,428	$2,281	$358	$11,323	$8,675	$2,058	$590
85+	$25,691	$8,304	$2,817	$4,886	$601	$17,387	$10,993	$5,424	$970
0–18	$2,650	$1,558	$1,096	$338	$124	$1,092	$2	$819	$271
19–64	$4,511	$3,117	$2,154	$722	$241	$1,395	$239	$738	$417
65+	$14,797	$4,888	$2,351	$2,205	$331	$9,909	$7,242	$2,034	$633

Source: Centers for Medicare and Medicaid Studies.

FIGURE 4: Social Security, Medicare, and Medicaid as a Percentage of GDP



Sources: Congressional Budget Office and Social Security Administration.

Even before the new health care law, the costs of supporting older and indigent people were projected to explode. Notice in figure 4 that Medicare and Medicaid outlays—not Social Security benefits—will push the total costs from about 10 percent of GDP at present to almost a quarter of total economic output late in this century. The government estimates that Social Security pension and disability recipients will increase from 51.7 million in 2009 to 67.4 million in 2018.

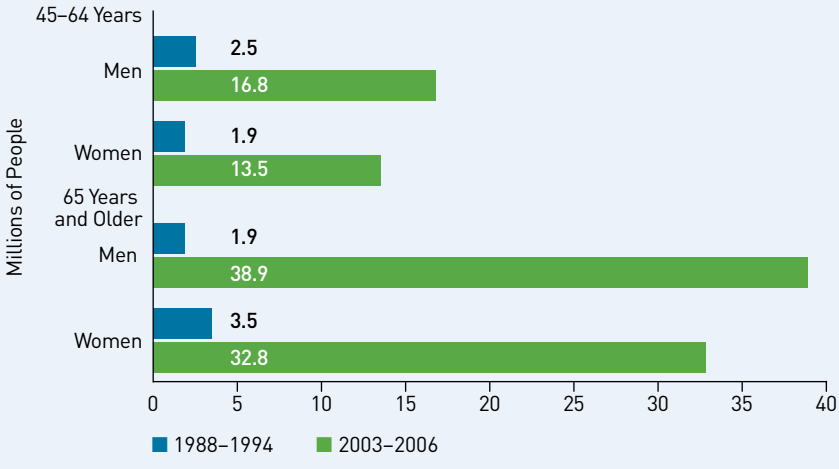
Technological Advances

Not only the aging population but also technological advances are increasing the demand for medical services. The current medical care delivery system is driven by two basic economic factors. First, the government and employer insurance plans pay for most medical costs. In 2004, only $802 of the total average per capita cost of $5,276 was paid out of pocket by patients (see figure 3). Second, each individual tends to rationalize that his or her life is at stake in medical treatments. With these two economic realities, the newest and best of medical services is none too good for their users.

In addition, most medical care, from a visit to a physician to a brain operation, is paid on a fee-for-service basis, so providers have an incentive to provide more services. In an October 26, 2010, article, the *Wall Street Journal* found by mining government data that a number of physicians are prone to administering sophisticated and expensive tests to Medicare patients that federal authorities say are frequently abused. One New York City osteopath gave 29 of these tests to 89 percent of her patients and was paid more than $2 million by Medicare in 2008. Furthermore, Medicare, which spends more than $60 billion per year on physicians and other medical providers, accepts at least 90 percent of the

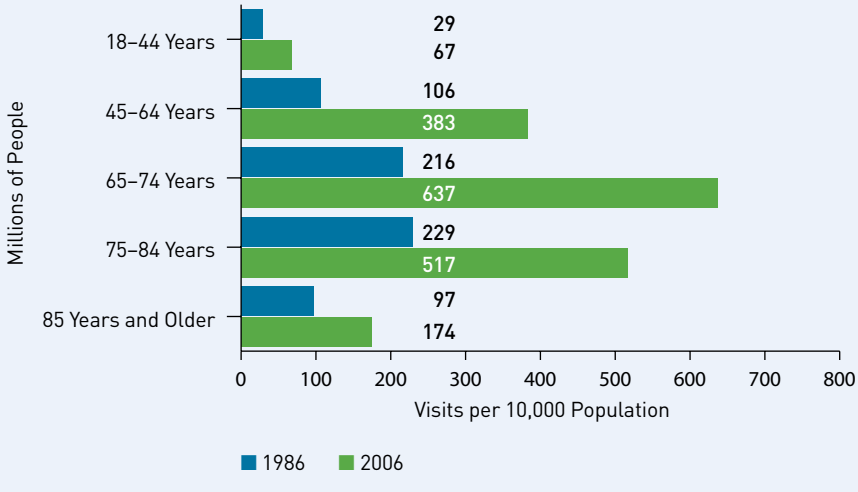
recommendations on medical fees from a panel of practitioners convened by the American Medical Association, according to an October 21, 2010, *Wall Street Journal* report. The use of statin and other patent drugs has exploded in recent years (figure 5). So have colonoscopies (figure 6), knee and hip replacements (figure 7), and MRI/CT/PET scans (figure 8). Advances in reproductive technology have also encouraged its use (figure 9). Laser eye surgery has created tremendous demand.

FIGURE 5: Adults 45 Years of Age and Older Reporting Prescription Drug Use in Past Month for Statin Drugs



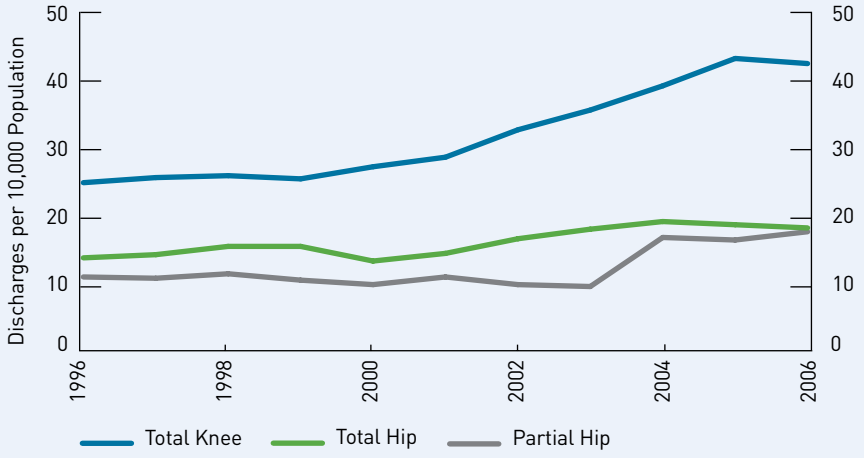
Source: U.S. Centers for Disease Control and Prevention.

FIGURE 6: Colonoscopy Procedures among Adults 18 Years of Age and Older



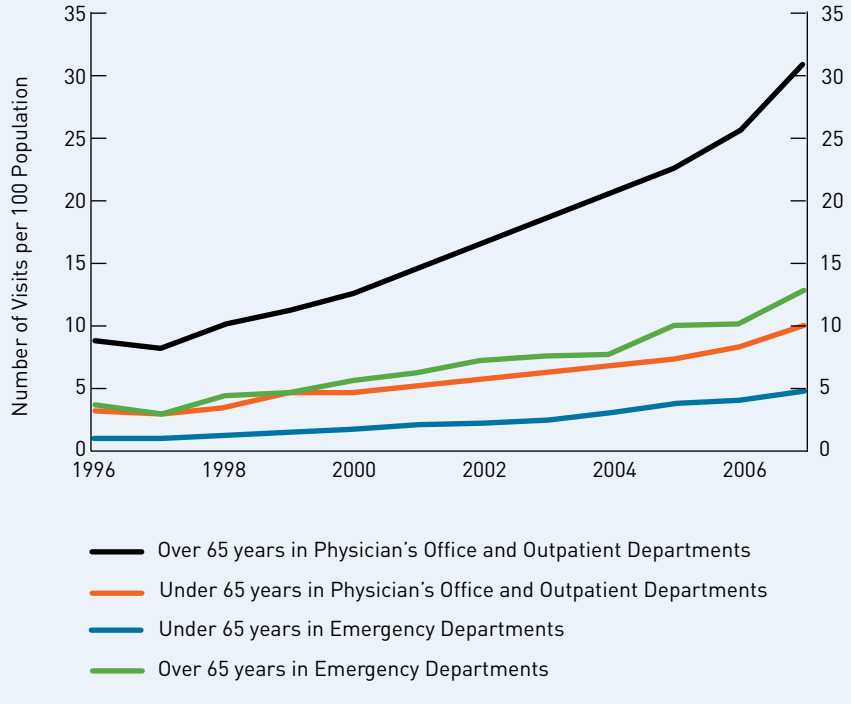
Source: U.S. Centers for Disease Control and Prevention.

FIGURE 7: **Hip and Knee Replacements in Nonfederal Short-Stay Hospitals: Adults 45 Years and Older**



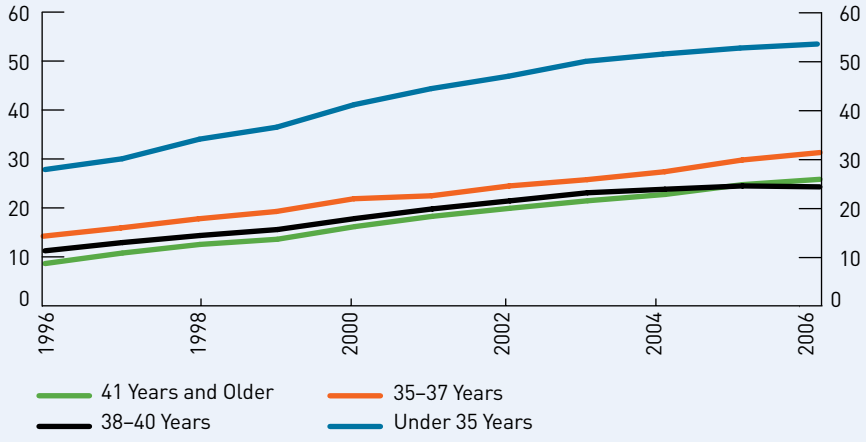
Source: U.S. Centers for Disease Control and Prevention.

FIGURE 8: **MRI/CT/PET Scans**



Source: U.S. Centers for Disease Control and Prevention.

FIGURE 9: **Assisted Reproductive Technology Cycles Initiated by Women**



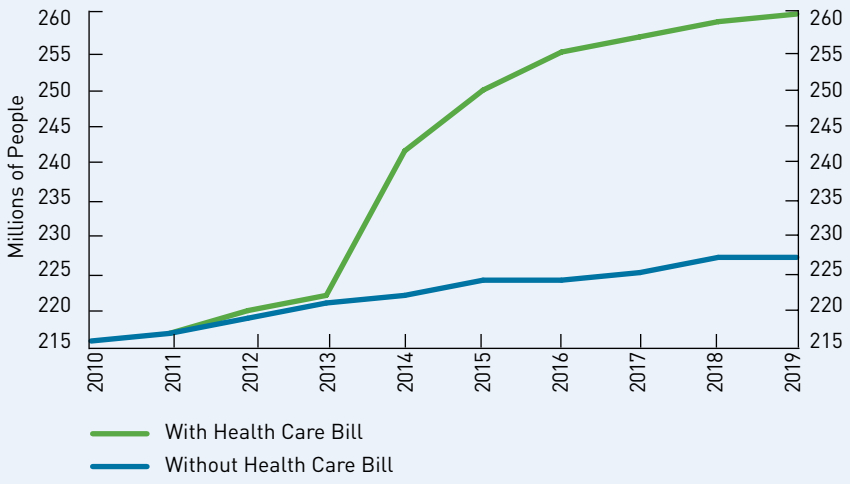
Source: U.S. Centers for Disease Control and Prevention.

32 Million More

Because almost all elderly people are already covered by Medicare, the new health care law will expand coverage principally for the nonelderly and lower-income people who tend not to be covered by employer-sponsored plans or Medicaid. By 2019, the new law is projected to reduce the ranks of the uninsured by 32 million (figure 10). Notice in figure 11 that by then, Medicaid is expected to pick up 16 million more covered individuals as a result of the new law and 24 million from the health insurance exchanges for the nonindigent mandated under the law. At the same time, employer coverage is expected to drop by 3 million and nongroup coverage by 5 million. In 2019, the number of nonelderly who lack medical insurance is projected to drop to 23 million from the 2010 figure of 50 million, and the percentage of legal residents covered will rise from 83 percent to 94 percent.

Many of the regulations to implement the new health care law remain to be worked out, and some provisions will not become effective until 2014. Furthermore, the newly elected Republican majority in the U.S. House of Representatives hopes, with the aid of sympathetic Democrats in the Senate, to repeal the law and start over. This outcome seems improbable, with the president likely to veto significant changes, but he has agreed to consider some alterations. Moreover, states—with 11 more Republican governors than before the November 2010 election—are calling for changes in the new law and are threatening to minimize their participation in the new law's expansion of Medicaid. They figure that even though Medicaid's enlargement will initially be paid for by the federal government, it will be too costly when states start sharing the burden in 2017. Despite the increased coverage for 32 million Americans, the Obama administration estimates that national health care costs by 2019 will be $4,716.5 billion, only $45.9 billion, or 1 percent, higher than without the new law (figure 12).

FIGURE 10: Insured Nonelderly Population with and without Health Care Bill



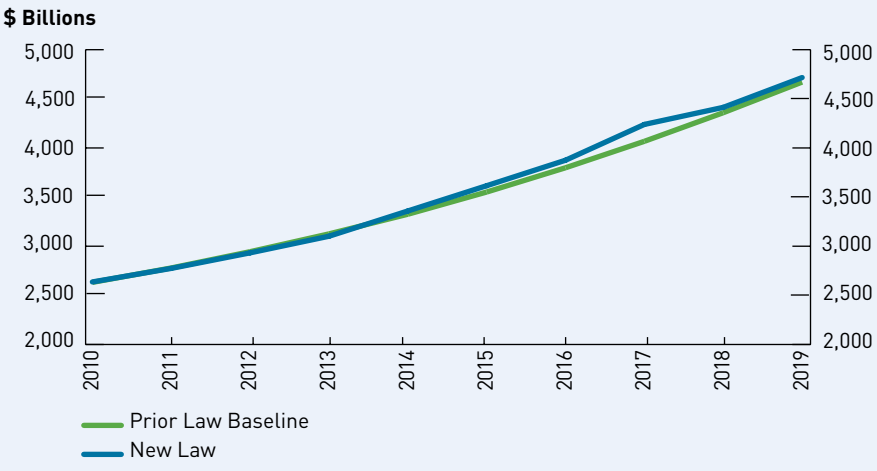
Source: Congressional Budget Office.

FIGURE 11: Changes in Health Insurance Coverage Caused by the New Law

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Change in Millions (+/–)										
Medicaid	*	–1	–2	–3	10	15	17	16	16	16
Employer	*	3	3	3	4	1	–3	–3	–3	–3
Nongroup	*	*	*	*	–2	–3	–5	–5	–5	–5
Exchanges	0	0	0	0	8	13	21	23	24	24
Uninsured	*	*	–1	–1	–19	–25	–30	–31	–31	–32
Postpolicy Uninsured Population										
Millions of Nonelderly People	50	50	50	50	31	26	21	21	22	23
Insured Share of Nonelderly Population										
Including All Residents	81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Unauthorized Immigrants	83%	83%	83%	83%	91%	93%	95%	95%	95%	94%

Sources: Congressional Budget Office and Joint Committee on Taxation.
Note: * = between 0.5 million and –0.5 million people.

FIGURE 12: **National Health Expenditures before and after Enactment of Patient Protection and Affordable Care Act**



Source: Centers for Medicare and Medicaid Services.

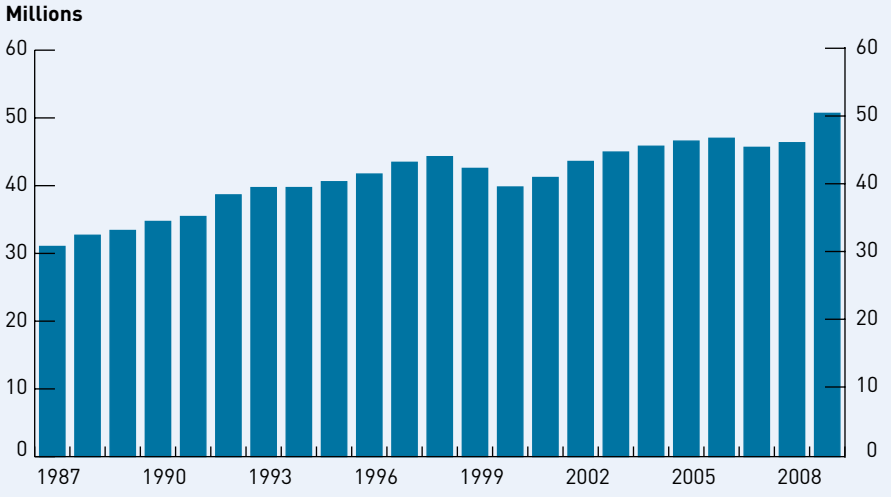
From 2002 to 2009, the four largest for-profit health insurers denied coverage to one in seven applicants, or 651,000, because of prior conditions. Under the new law, that denial is no longer allowed after 2014. Have the resulting higher medical costs been accounted for? In any event, history suggests that the costs of the new medical law will far, far exceed estimates. In 1967, the year after Medicare commenced, the House Ways and Means Committee forecast a $12 billion cost for the new program in 1990. Medicare outlays in 1990 proved to be $110 billion, or nine times as much!

The insurance exchanges established in 2014 by the new law are extremely attractive. A family of four with $90,000 in annual income and headed by a 45-year-old will receive a federal subsidy of 40 percent of their health insurance costs. With a $50,000 income, close to the median, the subsidy is 76 percent of cost. This economic framework will encourage many new businesses with well-paid employees not to offer health care insurance in favor of the exchanges. Also, many existing employers may save money by dropping their health plans, paying the $2,000 penalty per employee, and encouraging their employees to sign up with an exchange.

Effects of Slow Economic Growth

Furthermore, the number that would be newly covered by government programs could expand significantly beyond the official estimates if slow economic growth and high unemployment persist. With economic weakness, the number of uninsured Americans jumped by 4.4 million in 2009 to 50.7 million, or 16.7 percent of the population (figure 13). Those covered by employer-sponsored insurance dropped by 6.6 million to 169.7 million. Total private coverage fell by 6.5 million to 194.5 million, or 63.9 percent of the population, the lowest since 1987. Meanwhile, those under government health programs

FIGURE 13: Medically Uninsured People



Source: U.S. Census Bureau.

climbed by 5.8 million to 93.2 million, or 30.6 percent of the population, the highest since 1987, with Medicaid coverage jumping by 5.2 million to 47.8 million. The overall drop in coverage from 255.1 million in 2008 to 253.6 million in 2009 suggests that some of those who were dropped from employer-sponsored plans as they lost jobs have yet to be picked up on existing government programs, quite apart from those added by the new health care law.

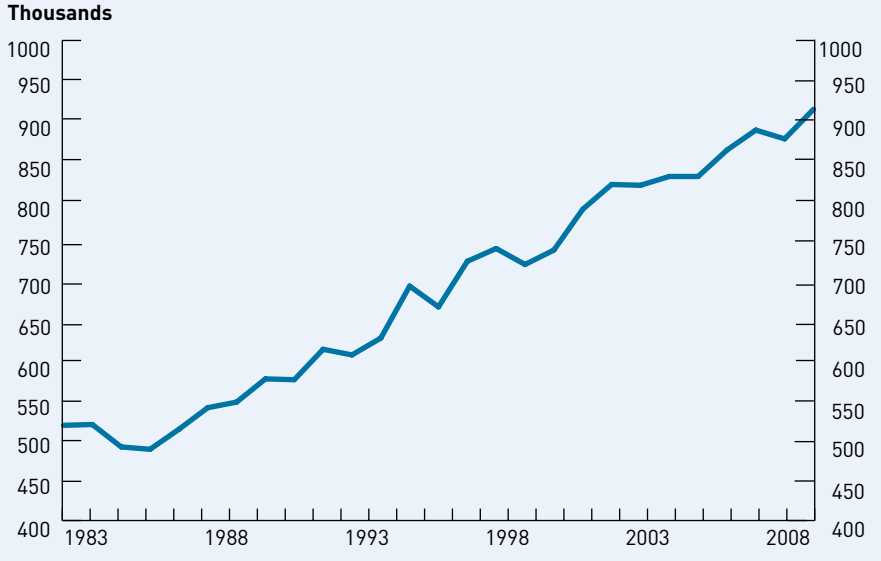
Interestingly, expansion of costs and employment in health care beyond that planned in the new law may be welcomed in Washington. With the slow growth that is expected in future years, chronic high unemployment will be a problem. The post–World War II data indicate that 3.3 percent annual real GDP growth is needed just to keep the unemployment rate stable, so the 2.0 percent rate that is forecast implies a rise in the unemployment rate of more than one percentage point, year after year. No government—left, right, or center—can withstand high and chronically rising joblessness, so immense pressure will exist on Washington for job creation. Health care is already a big sector of the economy, accounting for almost 13 percent of payroll employees, that can employ people throughout the skills spectrum, ranging from nursing home attendants to medical researchers to developers of new technologies to hospital administrators to brain surgeons.

Little Supply Increase

The costs of covering another 32 million individuals with health insurance are also questionable because the new law, like the earlier Medicare and Medicaid laws, does little to expand the supply of medical services and practitioners. It does include $168 million to train 500 new primary care physicians over the next five years, $30 million

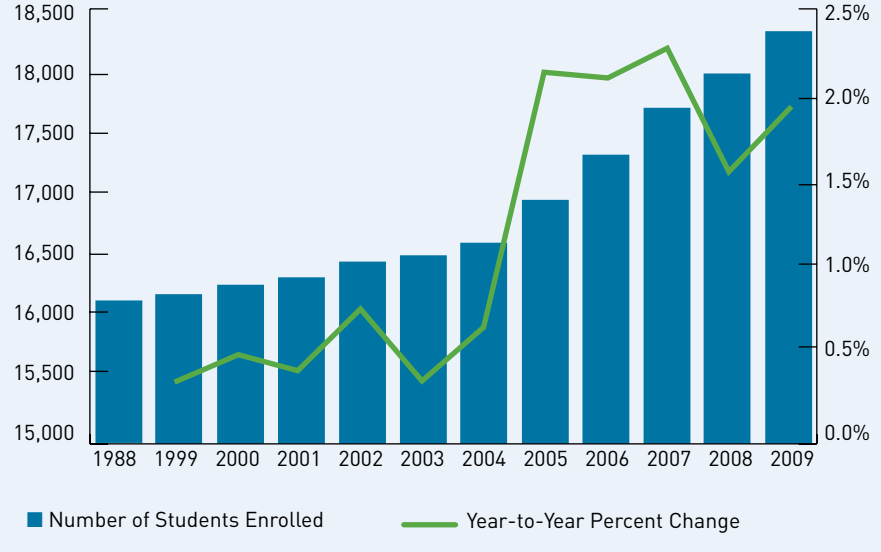
for 600 to attend and graduate from nursing school, and $32 million for 600 new physician assistants. But without these limited additions, the Department of Health and Human Services estimates a shortage of 21,000 primary care medical personnel. The Association of American Medical Colleges projects a shortage of 42,000 primary care

FIGURE 14: Doctors Employed in the United States



Source: U.S. Bureau of Labor Statistics.

FIGURE 15: U.S. Medical School First-Year Enrollment



Source: Association of American Medical Colleges.

physicians in 2020 and 47,000 in 2025. That is a lot of undersupply, considering that 914,000 doctors were employed in the United States in 2009 (figure 14).

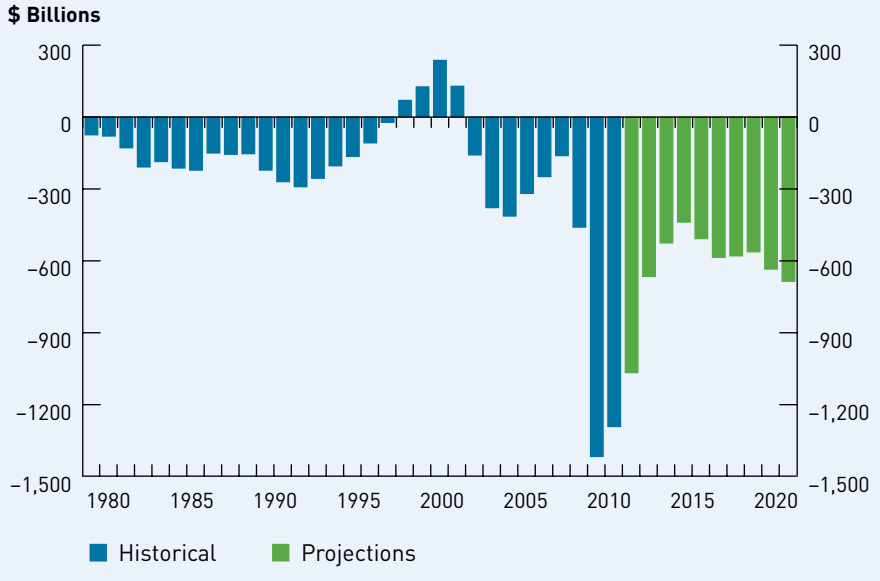
American medical school enrollment is growing slowly (figure 15) although two dozen medical schools have recently opened or plan to, the most since the 1960s and 1970s. In the 1980s and 1990s, only one new medical school started up. The new additions will add 18 percent to the existing 131 medical schools, and some existing schools are expanding enrollment (figure 15), sometimes with branch campuses.

Still, many aspiring American physicians are attending foreign medical schools, and U.S. hospitals are increasingly relying on foreign-trained and foreign-born physicians to fill residencies. The Association of American Medical Colleges estimates that 3,500 doctors will commence graduate training over the next ten years, or half the 7,000 foreign medical school graduates entering U.S. medical residencies annually.

Cost Control Pressures

Despite the Obama administration's hopes that the expansion of health care coverage will not increase the huge federal deficit meaningfully (figure 16), the high likelihood of substantial cost overruns will no doubt hype the red ink and increase the pressure for cost control. Consequently, Washington can be expected to lean on the private health care sector to hold down expenses. The new law requires that insurers spend at least 80 percent of the premiums they collect from individual and small business health plans on medical services (85 percent for large-company plans). That requirement limits the amount left over for administration and profits.

FIGURE 16: Federal Budget Balance



Source: U.S. Congressional Budget Office.

In September 2010, the administration denied rate increases and benefit cuts by 298 privately run Medicare Advantage plans. In contrast, last year no bids for rate and benefit changes were denied. As part of the health care law enacted in March 2010, the government in 2012 will start cutting $136 billion in payments to insurers who manage Medicare Advantage plans, and insurers wanted to prepare by trimming plan costs now. Drug companies were pressured by the administration to provide over $2 billion in drug discounts to Medicare beneficiaries in 2010. They will provide 50 percent price cuts to the 3.4 million who fall in the "doughnut hole" and spent $4.9 billion on drugs in 2009, largely because of the lack of Medicare coverage from the $2,830 cap on annual drug coverage on one end of the doughnut hole to $4,550 on the other side where it resumes. This $2 billion in discounts is part of the $80 billion the pharmaceutical industry promised to contribute to the expanded health care bill over ten years.

Pressure on Hospitals

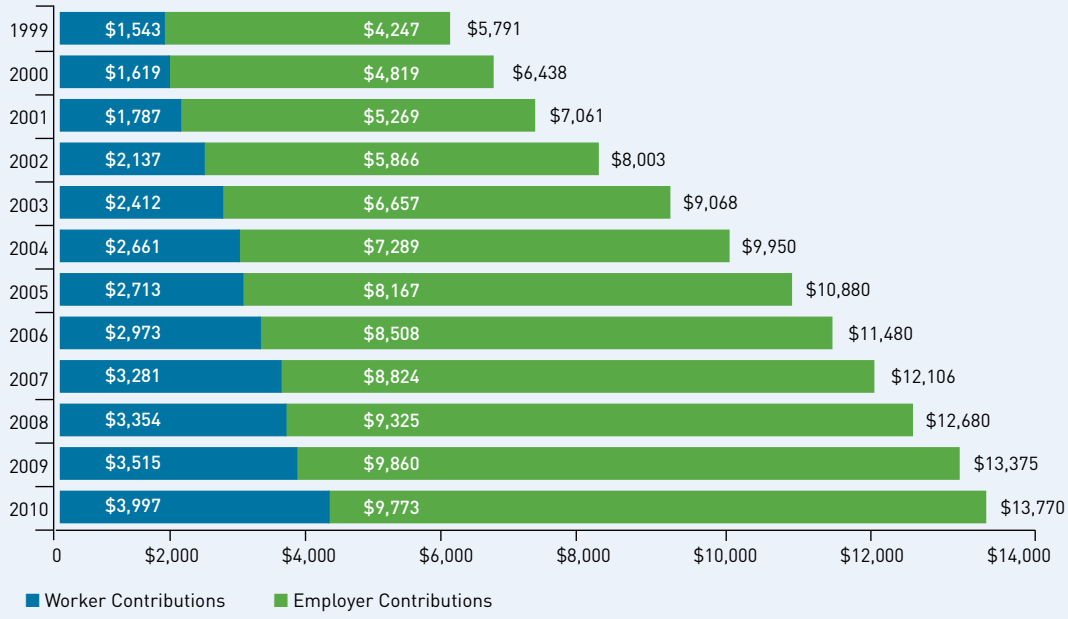
At the same time, large health insurers are pressuring hospitals in price negotiations with the active help of the employer plans they insure. To improve efficiency and cut costs, health insurers are narrowing provider networks. The larger, more efficient health care systems are clearly the most profitable (figure 17). Also to contain costs, more emphasis is being placed on managed care, prenegotiated rates with selected hospitals, and preventive medicine, a key goal of the new law.

FIGURE 17: Size and Profits of Large Health Systems

	Largest System	
Hospital Referral Region	**Percent of Region's Admissions**	**Percent of Region's Profits**
Houston	18	25
New York	22	58
Atlanta	12	15
Boston	23	56
East Long Island, New York	31	34
Philadelphia	20	34
Dallas	19	37
St. Louis	25	47
San Diego	24	40
Pittsburgh	29	54
Orange County, California	23	45
Minneapolis	26	14
Columbus, Ohio	28	52
Miami	19	41
Average among the 82 regions with at least 1 million people	28	35

Source: *New England Journal of Medicine.*

FIGURE 18: Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999–2000



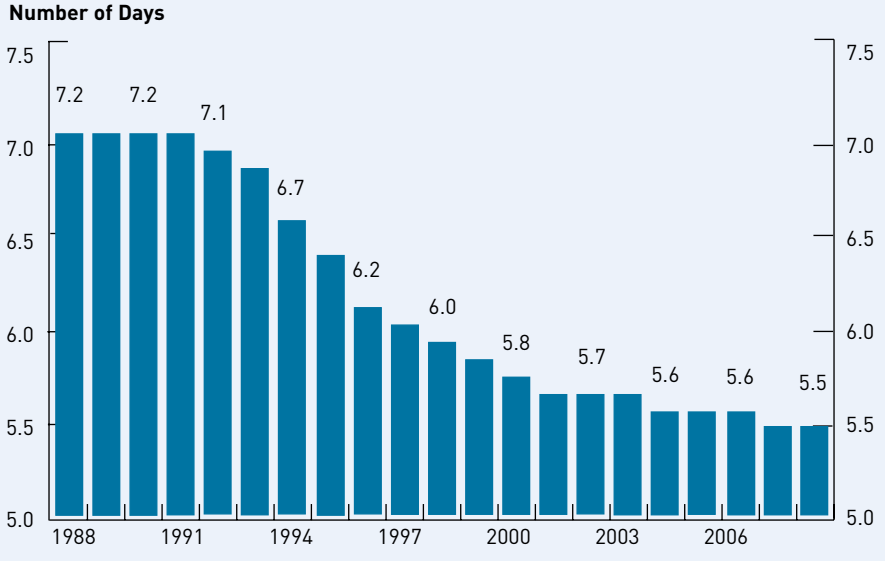
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

Employers also continue to act to offset their escalating employee health care costs by passing on to their employees increasing amounts and by giving them other incentives to control spending on medical services, such as medical savings accounts that allow employees to keep the money they do not spend on health care. Employees on average are paying $4,000 for family coverage in 2010, up 14 percent from 2009, but insurance premiums paid by employers rose only 3 percent, according to the Kaiser Family Foundation and the Health Research and Educational Trust (figure 18). Employers still pay 71 percent of the total cost of $13,770 per family, but the 29 percent paid by employees is up from 26 percent in 2005. As employers shift health care costs to employees through higher deductibles and steeper copays, employees react by using fewer medical services, which also retards the growth in insurance premiums.

Outpatients versus Inpatients

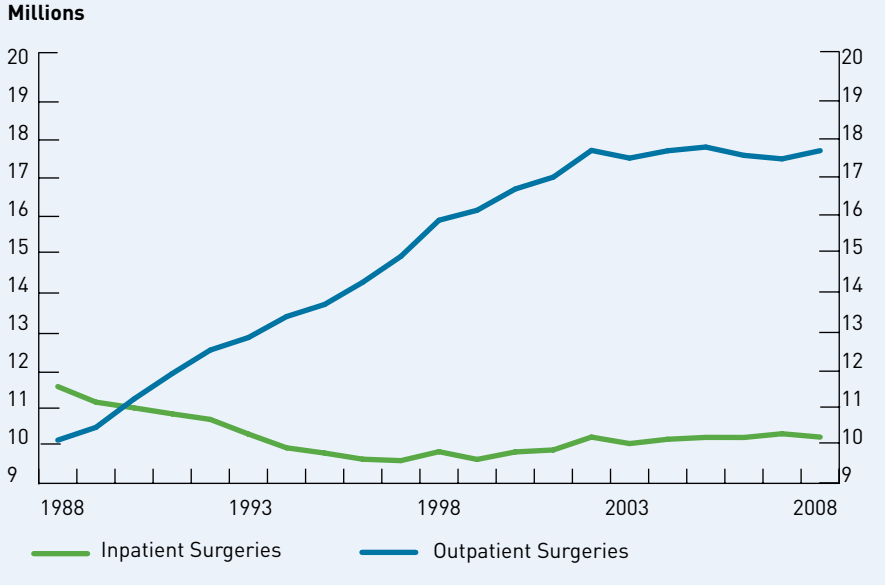
The past trends toward shorter patient stays in hospitals (figure 19) and more outpatient surgeries (figure 20) may get renewed emphasis from efforts to contain costs. The shift to outpatient surgeries also continues to be encouraged by technological advances that involve smaller incisions, improved anesthetics, less risk of infection, and faster recoveries. Laparoscopic procedures and colonoscopies are now routinely done on an outpatient basis. Orthopedic procedures such as shoulder and knee repairs as well as bone replacement are following, and spine surgeries are in the wings.

FIGURE 19: Average Length of Stay in Community Hospitals



Source: Avalere Health/American Hospital Association.

FIGURE 20: Inpatient and Outpatient Surgeries at U.S. Community Hospitals



Source: American Hospital Association.

Almost 65 percent of all surgeries today do not require overnight hospital stays, compared with 16 percent in 1980. Moreover, stays after major operations are now a few days rather than the many weeks that were the norm in previous decades. So patients are much more responsible for their own recoveries. The recovery risks can still be substantial even with smaller incisions and less blood loss in surgery. Medicare and health insurers have financially encouraged hospitals to move simpler procedures to outpatient facilities, and the number of freestanding surgery centers leaped from 240 in 1983 to more than 5,000 today.

Electronic Medical Records

Another development that is changing the economics of medical services delivery is the adoption of electronic records, encouraged by $27 billion paid by the federal government to health care providers starting in 2010. Only 20 percent of U.S. hospitals currently have electronic medical records. Starting in 2010, a 500-bed hospital will receive $6 million to switch to digital records, and if it does not act by 2017, it could lose up to $3.2 million a year in Medicare funding.

Most electronic medical records systems are going to include automatic notifications of patient visits that will make physician practices more efficient. Additionally, electronic medical records will systematize physician/patient follow-up so that patients are notified in a timely manner to make return visits to doctors.

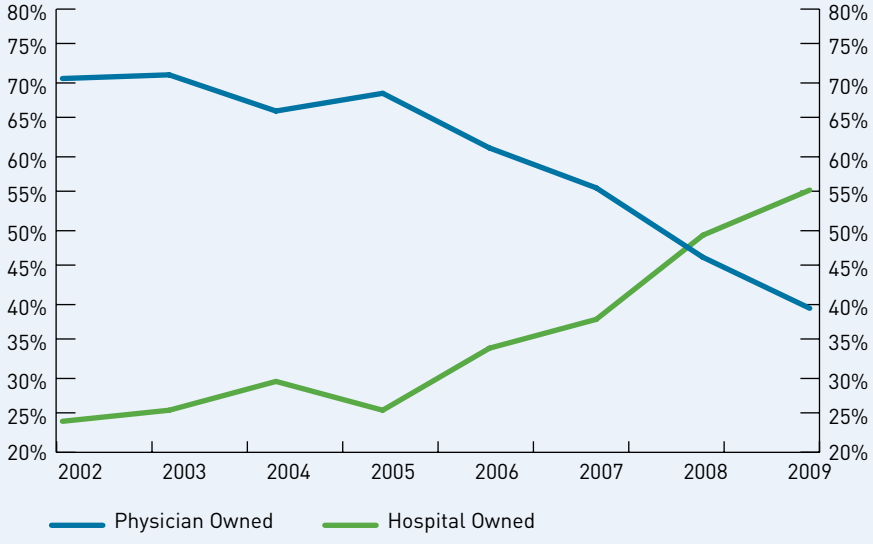
Physicians also are under government orders to upgrade software as the country shifts to new insurance billing codes. Only 20 percent of physicians have electronic records, and they too can qualify for part of the federal subsidy to switch to digital records. In 2015, they will be penalized by Medicare if they do not change. Insurers are assisting physicians in the transition because electronic records will link them more closely in reimbursements and patient care management aimed at improving the quality of service and reducing costs. Getting physicians to subscribe to these services is a challenge because many prefer to practice medicine rather than take the time and expense to establish and maintain patient medical records.

Insurers are pressing physicians to reduce costs in other ways. United Health Group is now reimbursing oncologists for the drugs they administer at cost and paying for their services separately. Historically, oncologists, who often administer drugs in their offices, bought the drugs and billed the insurers their cost plus a markup of about 15 percent. United Health says that drugs account for 65 percent of an oncologist's income, and the company hopes the new payment system will curb overuse, especially on terminally ill patients.

Hospital Employees

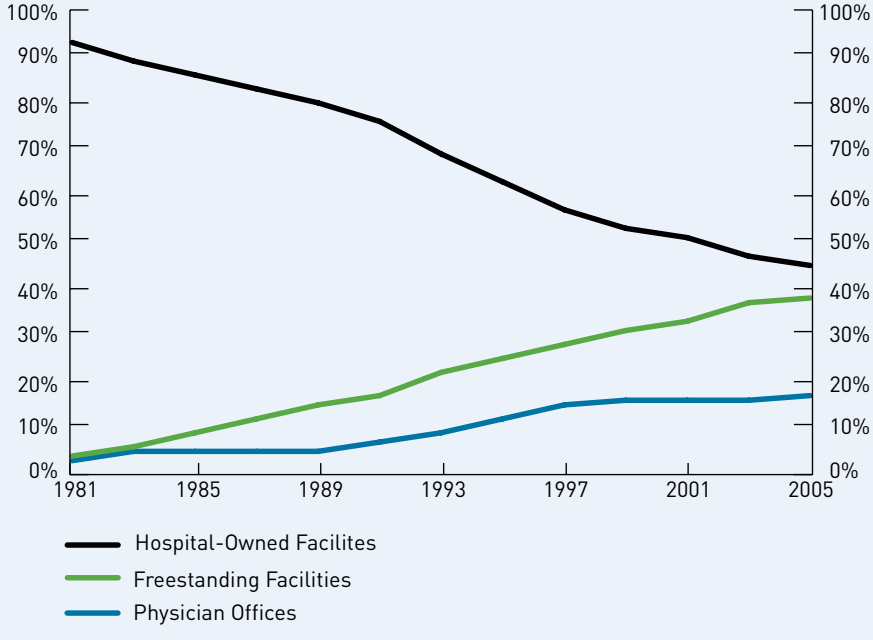
With all the nonmedical hassles of dealing with insurers, collecting out-of-pocket payments from patients, and acquiring and installing electronic record-keeping software and other new technology, many established physicians, not surprisingly, are selling their practices to hospitals while new doctors are becoming hospital employees from

FIGURE 21: Share of Medical Practices Owned by Physicians and Hospitals



Source: Medical Group Management Association.

FIGURE 22: Percent of Outpatient Surgeries by Facility Type



Source: American Hospital Association.

the start. In 2009, 55 percent of medical practices were owned by hospitals, up from 30 percent in 2005 (figure 21). The largest physician-recruiting firm, Merritt Hawkins, reports that 51 percent of its searches were conduced for hospitals in the 12 months ending in March 2010, up from 45 percent a year earlier and 19 percent five years ago. Meanwhile, its searches for physician groups and partnerships fell. CTSonline's physician survey reports that in 1996–1997, 37 percent of physicians were full owners of their practices while 38 percent had no ownership, but in 2004–2005, the numbers were 31 percent and 46 percent, respectively.

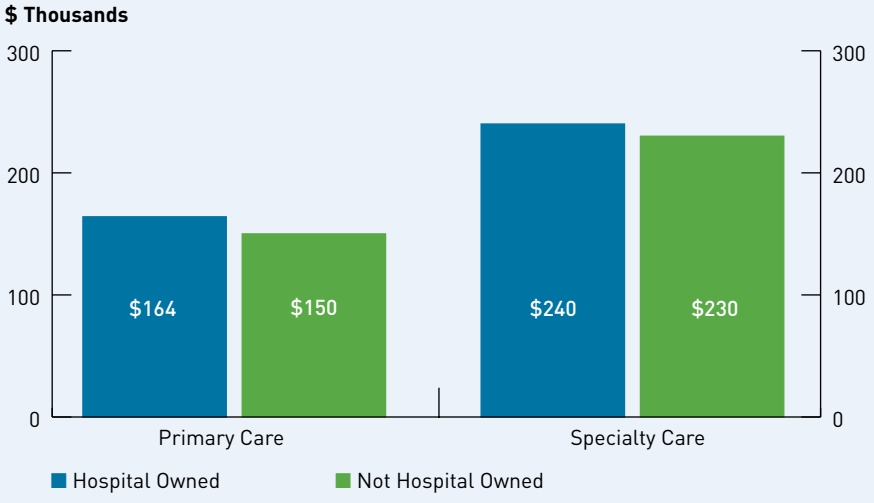
Furthermore, some procedures pay more if done in hospitals rather than in physicians' offices, adding to the former's income. Moreover, under anti-kickback laws, physicians cannot order MRI tests and other procedures from facilities in which they have ownership. Notice in figure 22 that the decline in the share of outpatient surgeries done in hospitals earlier benefited both operations in physicians' offices and freestanding facilities but lately is accruing almost entirely to the latter, which are often affiliated with hospitals.

Hospital Benefit

For their part, hospitals like to employ physicians who can generate steady streams of revenue rather than admit patients to an array of institutions. Also, they are getting ready for the ACO model encouraged by the new health care law, which allows hospitals to share in the savings generated by cost containment.

By economies of scale and better management, hospitals can increase the income of physicians. In 1996–1997, according to CTSonline's survey, 20 percent of solo or two-physician practices earned $200,000 to $300,000 pretax and net of expenses while 14

FIGURE 23: Median First-Year Guaranteed Compensation by Practice Ownership, 2009



Source: Medical Group Management Association.

percent of physicians based in hospitals had the same pay range. In contrast, in 2004–2005, nearly the same 22 percent of solo or two-physician practices made $200,000 to $300,000 whereas 29 percent of those employed by hospitals earned that amount.

In 2009, 49 percent of physicians hired out of residencies or fellowships joined hospital-owned practices. High and more certain pay without the hassle of starting a practice was no doubt a strong motivating factor (figure 23). Perhaps with physicians increasingly becoming hospital employees, the day may come when the close-in parking spaces at hospitals that now read "Doctors Only!" while patients are relegated to the outer darkness becomes the reverse.

Accountable Care Organizations

As discussed earlier, the current health care delivery system is extremely expensive and inefficient for three reasons. First, most medical costs are paid for by government and employers instead of patients, so they have little concern about costs. Second, because patients' lives can be at stake, they believe the best care must be obtained. And third, payment on a fee-for-service basis encourages both providers and users of medical services to increase the number of procedures. ACOs authorized by the new health care law aim at blunting the third of these incentives for excessive medical services and at the same time will encourage physicians to become hospital employees.

The ACO program, established within Medicare, will be launched in January 2012. The hope is to improve the quality of care while lowering costs below normal Medicare reimbursements by getting medical providers to cooperate and coordinate in the care of assigned groups of patients. If an ACO reduces costs for Medicare patients below a certain benchmark, the providers can receive a share of the saving. This possibility gives providers the incentive to avoid unnecessary tests and to otherwise curb costs. They could consult with patients by phone rather than encourage more expensive office visits. And office visits might be with nurse practitioners rather than physicians.

The costs of establishing and maintaining ACOs, reporting on quality and cost measures to the government, ensuring that practitioners are using procedures backed by the strongest evidence, creating cost-saving incentives, and accepting and distributing bonus payments all will be considerable. Large hospitals and multispecialty groups will be able to afford these expenses, but few small physician groups will be interested.

The Driver of Land Use Decisions

The aging of the American population, the increased demand for medical services spawned by technical advances in health care, the increase in new hospitals, the movement of physicians from private practice to hospital employment, and the new health care law will all propel demand for real estate that serves health care delivery networks. The 32 million individuals who will be covered under the new law will require 64 million square feet of additional space, according to *National Real Estate Investor*, which uses an industry multiplier of about two square feet per patient. This square foot figure will be about 11 percent higher in 2019 than without the new law and a 19 percent rise after

accounting for the medical demands caused by population growth in the interim. This increase compares with the roughly 7 million square feet of new space that Deloitte expects will be built in 2010. Note, however, that many of those people soon to be covered are already using health care space—namely, emergency room facilities.

Furthermore, geographic and service changes in medical care will add to the demand for MOBs. Hospitals are opening satellite facilities to accommodate patients in suburbs. Low-cost walk-in clinics are popping up in pharmacies like CVS and Walgreens, grocery stores, malls, and big-box retailers like Wal-Mart and Target. The new health care law's emphasis on preventive care coupled with lower reimbursement rates and more regulation will spawn high-volume facilities that have the efficiency to operate at lower margins. More physicians will probably abandon Medicare for concierge practices confined to affluent patients. More office space will be needed for growing support services such as insurance claim processing, medical billing, and record keeping.

Varying Market Implications by Region

The distribution of the 32 million newly insured will also influence the geographic demand for more MOBs. Many newly insured will be lower-income people in urban areas, so more facilities will be needed there. But, as noted earlier, many of them currently use emergency rooms for their primary health care, so it may be more a matter of reconfiguring facilities than creating net new space in some cases.

FIGURE 24: Percentage of Unauthorized Immigrants in Total Population, 2008

Total	4.0%	Kentucky	1.1%	Ohio	0.9%
Alabama	2.3%	Louisiana	1.6%	Oklahoma	1.5%
Alaska	<1.0%	Maine	<0.5%	Oregon	3.9%
Arizona	7.9%	Maryland	4.7%	Pennsylvania	1.1%
Arkansas	2.1%	Massachusetts	3.0%	Rhode Island	2.8%
California	7.3%	Michigan	1.1%	South Carolina	1.6%
Colorado	4.8%	Minnesota	2.2%	South Dakota	<1.0%
Connecticut	3.1%	Mississippi	1.3%	Tennessee	2.4%
Delaware	3.6%	Missouri	0.8%	Texas	6.0%
District of Columbia	5.0%	Montana	<0.5%	Utah	4.1%
Florida	5.7%	Nebraska	2.7%	Vermont	<1.0%
Georgia	4.9%	Nevada	8.8%	Virginia	4.0%
Hawaii	2.8%	New Hampshire	1.3%	Washington	2.7%
Idaho	2.3%	New Jersey	6.4%	West Virginia	<0.5%
Illinois	3.6%	New Mexico	4.0%	Wisconsin	1.6%
Indiana	1.9%	New York	4.8%	Wyoming	1.5%
Iowa	1.9%	North Carolina	3.8%		
Kansas	2.5%	North Dakota	<0.5%		

Source: Pew Hispanic Center.

Further complicating the new demand for MOBs is the fact that the new law does not cover undocumented immigrants, so they are not included in the additional 32 million Americans. The newly covered urban poor will probably be more numerous in cities with fewer undocumented immigrants, such as Cleveland, Detroit, and Minneapolis, than in those where undocumented immigrants are more numerous, such as New York, Los Angeles, or Phoenix. Data from the Pew Hispanic Center show that undocumented immigrants are a greater share of the population in Arizona, California, Colorado, Washington, D.C., Florida, Georgia, Nevada, New Jersey, New York, and Texas (figure 24). Figure 25 reveals that they are concentrated in low-paying jobs such as construction, trade, and leisure and hospitality. Figure 26 shows that their median income per household is 72 percent that of U.S.-born households, but because they have 146 percent more people per household, their median income per person is only 51 percent as large.

FIGURE 25: Unauthorized Immigrants' Share of Major Industrial Groups, 2008

Total, Civilian Labor Force	100.0%		
Agriculture, Forestry, Fishing, and Hunting	3.8%	Information	0.9%
Mining	0.2%	Financial Activities	2.7%
Construction	21.2%	Professional and Business Services	13.3%
Manufacturing	13.4%	Education and Health Services	6.1%
Wholesale and Retail Trade	11.5%	Leisure and Hospitality	16.7%
Transportation and Utilities	3.5%	Other Services	6.7%
		Public Administration	n.a.

Source: Pew Hispanic Center.

Note: n.a. = not applicable.

FIGURE 26: Household Income Statistics, 2008

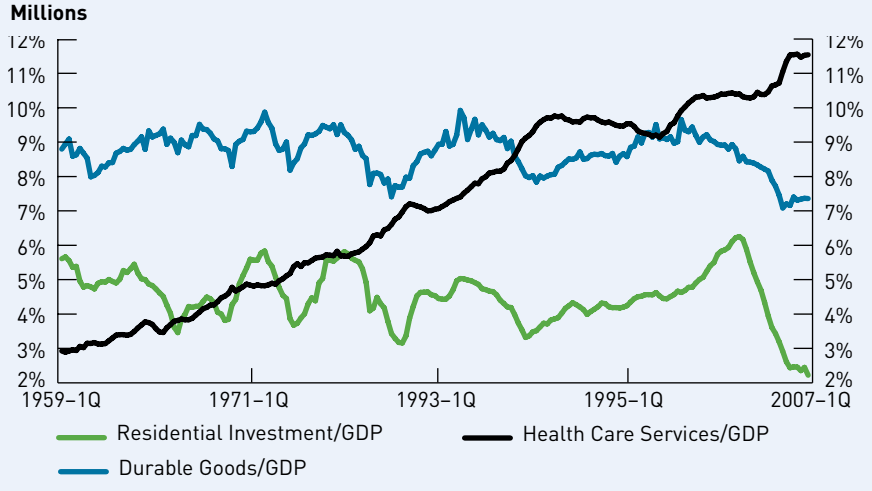
	Median Household Income	Mean Household Size	Median Income per Person	Mean Workers per Household	Median Income per Worker	Number of Households
U.S.-Born Households	50,000	2.39	23,000	1.23	35,300	98,456,000
Unauthorized-Immigrant Households	36,000	3.51	11,900	1.75	22,500	4,680,000
Percentage Unauthorized-Immigrant Households versus U.S.-Born Households	72%	146%	51%	143%	64%	**Share** 4%

Source: Pew Hispanic Center.

Market Stability for Health Care–Related Real Estate

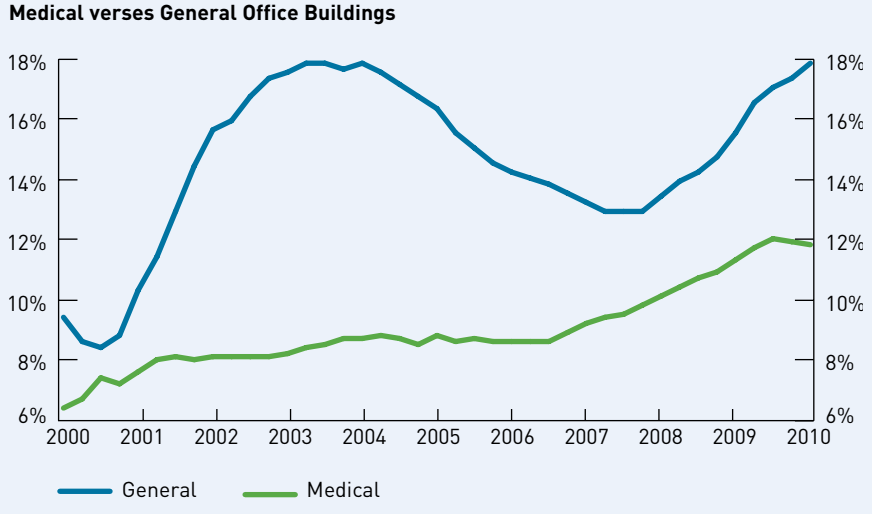
Medical care will continue to grow rapidly and steadily for two basic reasons—it is an essential human service, and it is heavily supported by the government. Thus, it is quite different from the volatile and trendless housing or consumer durable goods sectors in relation to GDP (figure 27). Similarly, the MOB sector is quite different from other

FIGURE 27: Health Care, Durable Goods, and Residential Investment as a Share of GDP



Source: Bureau of Economic Anaylsis.

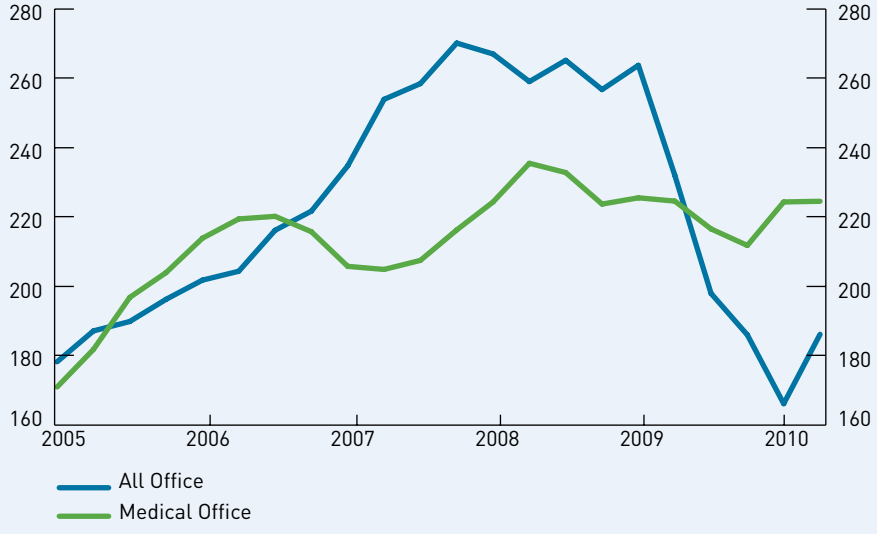
FIGURE 28: Office Vacancy Rates



Sources: Co-Star and Grubb & Ellis.

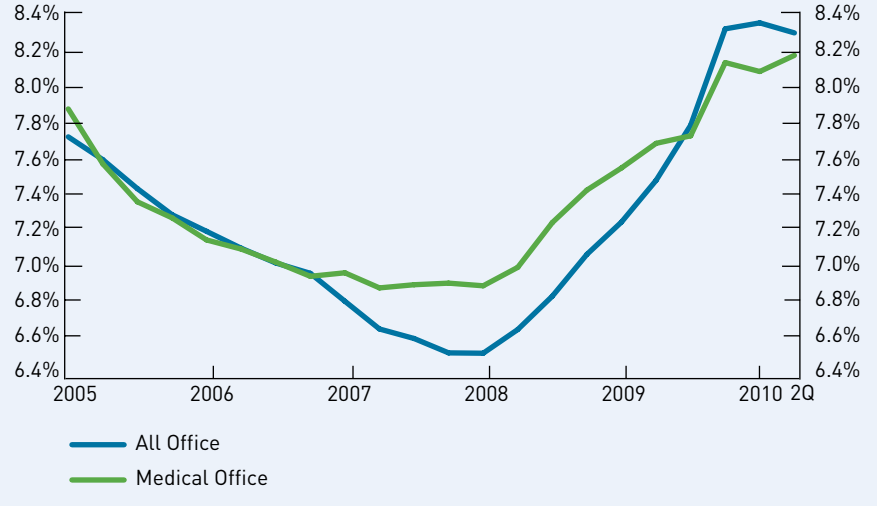
commercial real estate sectors because of its past stability and rapid growth, which no doubt will speed up. Notice the stability of MOB vacancy rates compared to those of general office buildings (figure 28) and prices per square foot (figure 29). Similarly, cap rates are less volatile (figure 30). However, medical office transaction volume tends to be low (figure 31).

FIGURE 29: Average Sales Price per Square Foot



Source: Real Capital Analytics.

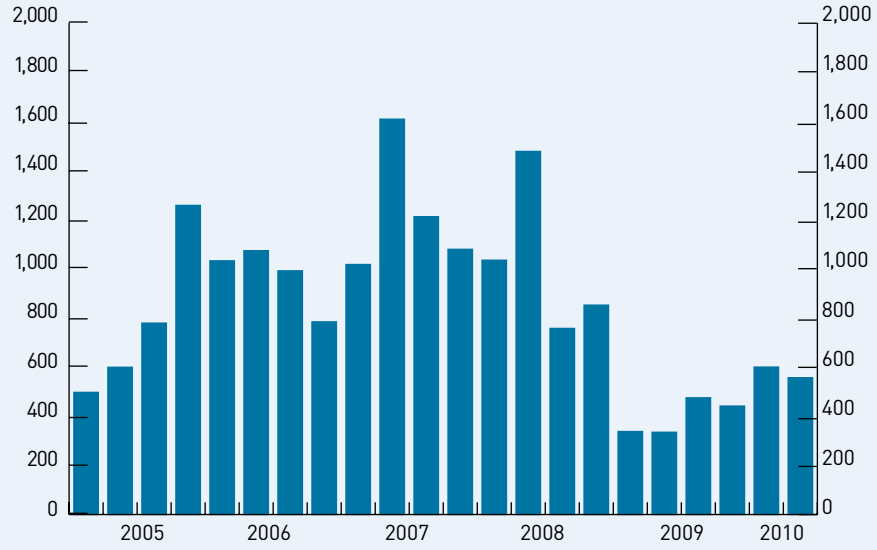
FIGURE 30: Cap Rates



Source: Real Capital Analytics.

FIGURE 31: Medical Office Transactions

Quarterly Data; $ Millions



Source: Real Capital Analytics.

Conclusion

Health care's essential market character and robust government support will be stabilizing factors for associated real estate markets and may protect these markets from deflation in future years. A contributing factor for stability will be that, like most property, health care–related real estate will offer an excellent hedge against inflation. Regional markets will see differentiated trends because of the demand factors associated with the composition of local sociodemographics as well as the evolving market of health care suppliers.

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