



## **Foresight Seminars on Health and Innovation**

### **Medicare Futures: Generational perspectives and new medical technologies**

#### **May 31, 2002 Meeting Overview**

Extrapolating today's reality leads people to anticipate that there will be 77 million Baby Boomers demanding ever-more expensive therapies and making the program unsustainable—but maybe not. The crisis for Medicare is driven by both demographics and technology. A deeper look into demographic cohorts and medical innovation reveals potential for a more desirable future. The IAF Foresight Seminar offered policy makers forecasts on the drivers that will change Medicare and policy options to improve the program in a fiscally and socially responsible manner.

One key to change in Medicare is the realization that demographic cohorts vary from generation to generation. Thus the generation that most recently defined old age will give way to a very different group that can change the demand for healthcare services. Next generation elders may look for something different, especially in their end of life experience. They also may not expect the government to play as great a role in paying for healthcare.

Innovation in technology can also supply a new economics for care near the end of life. Better medicines, diagnostics and knowledge could replace expensive and ineffective treatments that are now widely used. For example, large expenditures on hospital care in the last months of life might be displaced if disease management, prevention and hospice fulfill their promise. Science can alter the supply side of the medical equation with cost-saving technology, while the turning of generations alters demand. The May 31 Foresight Seminar on Medicare Futures presented these alternative perspectives to policy makers to help them find and evaluate new options and political opportunities over the coming decade.

#### **Two guest experts made presentations (available online at [www.altfutures.com](http://www.altfutures.com)) and took questions from the audience:**

**Neil Howe:** Best-selling author and national speaker, is a renowned authority on generations in America. Along with co-author William Strauss, Howe has written four books, all best sellers widely used by businesses, colleges, government agencies, and political leaders of both parties. He has drafted several Social Security reform plans and testified on entitlements many times before Congress. He has written extensively on budget policy and aging and on attitudes toward economic growth, social progress, and stewardship. His articles have appeared in *The Atlantic*, *The Washington Post*, *The New York Times*, *American Demographics*, *USA Weekend*, and other national publications.

**Joshua Cohen:** Dr. Joshua Cohen joined the Tufts Center for the Study of Drug Development in September 1999. He utilizes his background in economics to focus on public health policy issues related to a Medicare prescription drug benefit, pharmacy benefit management (PBM), disease management, and prescription (Rx) to over-the-counter (OTC) switches. His current research examines the role of both disease managers and PBMs in administering a Medicare prescription drug benefit, as well as a decision analysis of potential Rx-to-OTC switches.

## Seminar Summary

*The two guest experts argued that while the aging of the “Baby Boomers” will certainly put new stresses on the US Medicare system, the aging of this critical demographic group is also creating new opportunities to reshape healthcare so it can meet the health needs of the next generation of elders. The following summary is a synthesis and condensation of their remarks:*

Two main opportunities to improve the Medicare system will arise from changes in the **supply** of available treatments, and in the **demand** for treatment among individuals. One opportunity is to capitalize on **politics** that recognize generational change in demand for Medicare services. The second is to make **policy** changes to improve Medicare services based on supply side trends.

### Supply

Commonly, economists project that the future supply of healthcare options will be shaped by the “hard technologies” of healthcare innovation. Important trends in this area include:

- Increased spending on pharmaceutical R&D is likely to lead to the discovery and invention of new therapies for previously untreated diseases. For example, new drugs in the development pipeline for Alzheimer’s disease will be a key technology for the Medicare population.
- New treatments may also extend longevity, which will attract many elders but will not necessarily reduce the high cost of care at the end of life that burdens Medicare.
- Quality-of-life enhancements will offer to improve various types of performance (cognitive, sexual and physical). Many of these products will raise difficult coverage decisions because the line between treatment and enhancement is not always clear.

Another critical area that can determine future supply are the “soft technologies” of health system innovations that can deliver better treatment outcomes for lower costs. Disease management programs, for example, have the potential to shift much of managed care from the acute care treatment model to a more cost effective chronic care model.

- When Medicare was enacted in 1965, hospital stays were much more important, accounting for 87 percent of Medicare benefit payments. Today that percentage is down to 41 percent. This transformation reflects the increasing importance of prescription drugs and the delivery of healthcare by physicians, outpatient centers, and nurses, though hospital care is still contributing 20 percent to the growth of Medicare.
- 15 percent of the Medicare population with chronic illness account for 75 percent of total Medicare expenditures. The costs of these patients are exacerbated by Medicare’s lack of coordination of care across specialties, the lack of a drug benefit, and the adverse effects of inappropriate treatment and patient non-compliance.
- Disease management for prevention and cost containment is currently a small industry largely confined to managed-care enrollees, but it is growing dramatically. It is growing particularly in disease categories that are especially relevant to Medicare: diabetes, cardiovascular and renal disease.

## Demand

From the Generational perspective, there are no age-based stereotypical behaviors that correspond to a particular stage of life. Instead, behaviors and attitudes are constantly being shaped and modified by each generational cohort that moves through any given age bracket. In other words, each generation redefines the expected behavior of each phase of life based on their generational characteristics. Generational change dynamics in our elderly population can help to describe the factors that make big changes in Medicare policy possible.

- The **GI Generation** was the generation that won WWII, and went on to push for building new public institutions. The new “senior citizens” that emerged on the political scene during 1960’s/early 1970’s were GI Generation elders. They transformed the possibilities of senior politics, drove the growth of organizations like the AARP and the National Council of Senior Citizens (NCSC), and created a very constructive environment for entitlements. Under the GI’s we have seen the creation of Medicare, Medicaid, and the expansion of social security. They now comprise the oldest cohort of elders.
- The **Silent Generation** currently comprises younger retirees, who feel more guilt and ambivalence about the effects of senior programs on the federal budget. One reflection of their decreased sense of entitlement is that according to AARP and other polling organizations, the GI Generation term “senior citizen” is beginning to fall into disuse with younger retirees.
- The **Baby Boomers** will be the next cohort to enter the retirement age-brackets, and they will bring their own generational preferences to policy debates. However, the Boomers are not united and will not organize politically to defend an entitlement for themselves. This may help explain why the 1990’s has been the first decade since the 1920’s when per capita federal spending on children has grown faster than for any other age bracket. The Boomers also bring with them a more holistic notion of healthcare, which is more sympathetic to the practices of alternative medicine and is empowering patients in their relationships with doctors.
- **Generation X** tends to be skeptical about the long-term viability of government entitlement programs and has a tendency to stay on the sidelines of political debates. They have low rates of voter turnout, low rates of participation in party politics, and do not make a fuss when benefits to their generation are cut in the political process – such as in the case of welfare reform.

## Politics

The shifting generational attitudes towards healthcare will play a crucial role in shaping the political feasibility of future Medicare reforms. Government entitlements for elders are widely regarded as a “third rail of politics.” The last major reform effort taught politicians a lesson that may no longer hold true. The 1988 Medicare Catastrophic Coverage Act was passed and then later repealed due to a mobilized cohort of elders, who then had a high rate of political participation and tended to vote as a block. However, the political dynamics of past public attitudes may be shifting as the GI Generation elders are increasingly replaced by Silents and then the Baby Boomers.

National voting rates among elders should start to decline over the next decade as the last of the Silent generation will have entered the 65+ age bracket. This decline will continue as the Baby Boomers begin to move into that age bracket as well. Elder interest in national politics will decline under the Boomers, who will instead focus their energies on being more influential in the wider culture and in local politics.

Since Boomers tend to respond to crises rather than systematically plan, the next wave of healthcare reform might very well be in the aftermath of a major healthcare crisis. The process of Medicare reform in the early 21<sup>st</sup> century may be more like the crisis of the 1930's leading to Social Security than the deliberate policy discussions that created Medicare in 1965. The next reform could bring a Boomer-led renewal of the healthcare system for elders that will need to reflect their unique generational preferences for medical treatment:

- *Empowering the Individual*  
The Boomer attitude towards health will be to empower people to have a genuine relationship towards their health, however the individual decides to pursue it. However, as a part of this focus on the individual there will be certain things that you should be prohibited from doing, as well as certain things that you should be required to do.
- *Healthcare for the Good of the Public Health*  
Boomers may also feel much more comfortable making health decisions based on what is good for public health in general. Rather than lifestyle decisions being determined between a patient and a doctor, Boomers may become increasingly comfortable with being required to make lifestyle adjustments. We have already seen this Boomer tendency in anti-smoking and anti-alcohol campaigns, but as they move into old age this impulse may shift the focus of healthcare choices from what the individual wants towards making choices that are good for the entire community.
- *Variety of Healthcare Options*  
While the current healthcare system emphasizes a standardized approach to care, Boomers are going to be much different, and will instead have a much greater tolerance of greater variation in relationships between individuals and the healthcare system. Some will gravitate towards alternative medicine; some will want the traditional fee-for-service approach, while others might opt for an HMO-type plan. As long as the choices available allow people to select their options in a way congruent with personal self-expression, the Boomers may even be willing to accept more tiering of medicine by income level.
- *Medicare as a Subsidy, Not an Entitlement*  
Boomers may have the willingness to reject the current “maximum entitlement” mentality towards Medicare as a form of insurance/entitlement to instead adopt a view that the public provides a health/floor of protection. Advances in genomics research are increasingly eroding the underpinnings of risk assessment in health insurance, which will contribute to this shift. Boomers may have an increasing willingness to view Medicare as a transfer and benefit – not as an entitlement – and could be willing to redefine Medicare as a government subsidy to certain types of medical plans that will be available to only certain types of people.

## Policy

While the aging of the Boomers will change both the demands and the expectations for healthcare, it may take a decade before they start to exert a strong influence in healthcare entitlement policy debates. In the meantime, the demands on the Medicare system are expanding – particularly for a prescription drug benefit - and the costs of the Medicare program keep rising. Medicare currently accounts for 20 percent of US healthcare spending (250 billion), which is about 13 percent of the federal budget. By 2030 the Medicare program alone could account for up to 20 percent of federal budget expenditures if demand does not change. The need to find policy solutions that can effectively provide quality health care at an affordable price is becoming an increasingly pressing issue. There are several policy approaches that could reform Medicare through affordable improvements:

- ***Decreasing Hospitalization With Increased Use of Prescription Drugs***  
Drug costs have contributed to the increasing costs of Medicare. However, for the therapeutic categories with high spending growth rates, recent increases have been due more to increased volume of utilization than to increases in prices. Much of the increase in spending on prescription is spending on more drugs, not more expensive drugs, and is decreasing other costs such as hospital expenditures.

Independent Disease Managers are optimistic about the prospects of generating net cost savings in health care by increasing spending on prescription drugs. By taking the proper medications in an appropriate fashion, patients may be able to decrease their chances of hospitalization, and decrease the costs that acute care can place on the Medicare system.

- ***Adoption of Pharmacy Benefit Managers (PBMs)***  
Pharmacy Benefit Managers (PBMs) are another possibility for containing the costs of rising Medicare drug expenditures. PBMs would allow Medicare to directly negotiate drug rebates with pharmaceutical manufacturers. While this would decrease the costs of drug benefits, there are several problems to overcome. One is that the general secrecy surrounding the details of the PBM agreements may clash with Medicare's desire for transparent interactions with its partners. A second hurdle is that PBMs use differential cost sharing to manage their drug formularies, an approach that may come into conflict with the traditional concept of Medicare being a non-discriminatory universal entitlement.

However, PBMs do offer other means to reduce healthcare costs by improving quality. Many PBMs have advanced technology systems in place that can provide patient education for primary prevention and the early detection of disease. This is very important, and is not currently being done in Medicare. Currently, many chronic care patients operate from within the acute-care model, and go directly to the hospital for care when a crisis arises. Moving them towards a chronic care model for management by using a PBM approach to care could reduce unnecessary admissions or re-admissions to the ER.

- ***Moving Towards the Disease Management Paradigm***  
Medicare Prescription drug benefits and pharmacy discounts are only one piece of the puzzle. If pharmaceutical care management is the goal, then items such as pharmacy claims analysis, integration of pharmacy and medical claims, age-appropriate dosing and drug interaction programs should all be added to the system. This higher level of data integration could help to optimize the level of care, minimize

the harms from drug interactions and mis-prescriptions, and flag patients that are non-compliant with their drug therapies.

Disease Management currently occurs largely in managed care organizations, and not with the Medicare population. Disease managers see the commercial population is much more lucrative than the Medicare population, given reimbursement rates. One reason for this is that Congress currently focuses on how to pay managed care organizations as little as possible for Medicare Plus Choice. Changing the financial incentives for the disease management of the Medicare population could open up wider opportunities to both optimize healthcare and decrease costs for the Medicare population.

With healthcare demand and costs forecast to rise in the short-term, the issue of rationing medical care will become increasingly important. While European healthcare systems have adopted more explicit healthcare rationing practices, it is unlikely that the US will control costs in the Medicare system by rationing direct access to medical services. US health consumers are unwilling to get on a waiting list to see a specialist, or wait years for a drug to be approved by a government formulary. American healthcare consumers have shown a willingness to trade off the universal access of the European healthcare systems for increased responsiveness to patient demands for care. If this attitude towards healthcare persists, elders may be more likely to accept a rationing system that limits coverage of costly and marginally beneficial treatments, rather than one that limits the responsiveness of the healthcare system. If medical rationing comes to Medicare, it could resemble the Oregon State Medicaid plan, in which all the rationing decisions are out in the open for everyone to see.