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The Berkeley Forum – A Roadmap for Improving Healthcare in California

Abstract: The ACA’s passage was followed by great uncertainty about how the healthcare landscape would transform. During this tumultuous period, a unique group of California’s private sector health systems, medical groups and health plans, alongside public sector leaders, came together to help shape a more effective healthcare system. The Berkeley Forum, facilitated by the School of Public Health at the University of California-Berkeley, provided an opportunity for healthcare leaders to engage with peers and stakeholders in an intimate, collaborative manner, and address what they viewed as the largest threat – uncontrolled healthcare spending, detached from quality and outcomes. The group issued a report, endorsed by each of the private sector participants, containing far-reaching recommendations. The report’s central tenant is the “Forum Vision”, a rapid shift towards paying providers using risk-adjusted global budgets rather than fee-for-service, coupled with greater use of integrated systems that coordinate care across settings, providers and time. Implementation of the Forum Vision along with six other initiatives, such as increased physical activity and palliative care access, could reduce healthcare spending by \$110 billion in the coming 10 years. Today, these high-level leaders continue to provide a unified voice to promote better health and higher-quality, affordable care for Californians.

Keywords: accountable care organizations; cost curve; global budgets; healthcare; integrated care; multi-stakeholder collaborative.

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1 Introduction

The fall of 2011 was characterized by a great deal of uncertainty about healthcare. The Affordable Care Act (ACA) was the most significant piece of healthcare legislation signed into law since Medicare and Medicaid in 1965. Yet it was not clear whether or how it would be implemented. The law was winding its way towards the Supreme Court and Republican presidential primary candidates vowed to repeal the ACA immediately if elected. It was in this environment that the *Berkeley Forum for Improving California's Healthcare Delivery System*, a collaboration among the CEOs of the largest organizations across California's healthcare industry, along with public sector healthcare leaders, emerged.

Aside from the legal and political battles challenging the ACA's ultimate existence, the ACA itself was uncharted territory for healthcare stakeholders across the board. How many people would take up coverage via the healthcare exchanges and what would the emerging risk pool look like? How would the system absorb so many new patients? Would the problem of cost shifting to the privately insured worsen with increased Medicaid enrollment, or be mitigated due to fewer uninsured patients?

To what extent would Accountable Care Organizations (ACOs) take off across the country, how would they impact healthcare quality and costs, and, perhaps most importantly for providers, payers and the public sector – how would they address rapidly increasing healthcare costs as more people entered the system? Given the ACA's focus on coverage expansion and insurance market reform, what would happen to “affordability”?

Political compromises woven into the Affordable Care Act codified state, rather than federal, responsibility for various areas, including the reimbursement structure for Medicaid, if and how to design a state health insurance exchange, and whether to create a state-run high-risk insurance pool (Espinosa 2010). Since passage of the ACA, regulations have provided flexibility to the states with regard to benefit design and selecting benchmark essential health benefit plans for the insurance exchanges (National Conference of State Legislatures 2013). Most significantly, the June 2012 Supreme Court ruling placed the decision on a key element of the ACA – the expansion of Medicaid to all eligible low income adults – in state hands. Thus, aside from events at the federal level, there was significant uncertainty and key decisions to be made by each state.

As such, states have taken very differing paths to ACA implementation. As of January 2014, 17 states had elected to run their own exchanges, seven selected a state-federal partnership, and the rest deferred to a federal exchange (Hansard 2013); (Kaiser Family Foundation 2013). Currently, half of the states have chosen to expand Medicaid, 19 have chosen not to expand, and six are still debating the issue

(Kaiser Family Foundation 2010). The vast variation among state efforts led the Robert Wood Johnson Foundation to fund ongoing analyses of ACA implementation across ten states. Oregon has focused on developing Coordinated Care Organizations (CCOs), globally-budgeted, local organizations responsible for the full medical, behavioral and dental needs of the Medicaid population (Coughlin et al. 2012).

Even with a Republican governor who opposed the ACA, New Mexico chose Medicaid expansion and a state-run exchange. It has focused on revamping its Medicaid program to emphasize the use of medical homes, comprehensive managed care plans encompassing behavioral and long-term care, and consumer incentives for healthy behaviors (Coughlin and Corlette 2012). Vermont is simultaneously moving the ACA forward alongside a much more ambitious single-payer plan for 2017, assuming financing issues can be resolved (Health 2013). Finally, having essentially implemented the predecessor of the ACA independently in 2006, Massachusetts has focused much of its recent attention on legislation and regulation dealing with cost containment.

Given the tumultuous healthcare landscape in the fall of 2011, Dean Stephen Shortell and Professor Richard Scheffler from the School of Public Health at the University of California-Berkeley recognized a window of opportunity to convene a unique group. They asked various leaders whether they would be interested in devoting time and resources to a multi-stakeholder collaboration to create a new vision for California's healthcare system and discuss strategies for achievement.

Without exception, the CEOs committed themselves to the process. The Berkeley Forum held its first meeting in February 2012, with the participation of the leaders of the largest health plans (Anthem Blue Cross, Blue Shield of California, Health Net), health systems (Cedars-Sinai Medical Center, Dignity Health, Kaiser Permanente, MemorialCare Health System, Sharp HealthCare, Sutter Health); medical groups (HealthCare Partners, Monarch HealthCare); and the public sector [California Secretary of Health and Human Services, California Insurance Commissioner, and Regional Director of the Centers for Medicare & Medicaid Services (CMS)]. A year later, in February 2013, the Berkeley Forum issued a major report "*A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives.*"

Forum staff assembled a highly influential, numerically manageable group of the largest organizations across California's healthcare industry. While not directly involved, trade associations, such as the California Hospital Association, California Association of Health Plans, California Medical Association and the California Association of Nurse Practitioners, were consulted, as were the Pacific Business Group on Health, Integrated Healthcare Association, and the California HealthCare Foundation. California's safety net organizations, which were undergoing major changes with regard to organization, financing and state-county relationships, were also consulted (Misczynski 2011).

Private sector participants funded the project with the understanding that the analysis would be independent and objective. As a university effort, neutrality and academic rigor were key to the process. To ensure that the dialogue remained policy-oriented and far from discussions of strategy or pricing that would invoke antitrust concerns, Forum meetings included an independent attorney.

2 Motivations Underlying Participation in the Berkeley Forum

There were varying motivations as to why each CEO agreed to devote time and resources to the Forum. The main impetus was the great uncertainty about the future of healthcare and potential upheaval occurring in the market place. The scope of change and the implementation challenges of the ACA were of particular significance in California. California has a very diverse population, with over double the national rates of Asian and Latino residents, greater income disparity and higher rates of uninsured than the national average (Scheffler et al. 2013). The number of uninsured Californians is greater than the entire population of each of 39 states (Kaiser Family Foundation 2011).

Nonetheless, California has been one of the most proactive states in terms of ACA implementation. It was the first state to legislatively authorize the creation of the American Health Benefits Exchange, Covered California, which has arguably been designed more systematically and conscientiously than the federal exchange and other state exchanges. California seized ACA options to expand Medi-Cal early via the “Bridge to Reform” waiver, granting coverage to an additional half a million low income Californians well before full ACA implementation, and to pursue an insurance program for those with high-risk pre-existing conditions (California HealthCare Foundation 2013); (Nighohossian et al. 2013).

California’s ambitious ACA implementation is aligned with the state’s historical efforts to legislate universal coverage, its Democratic-controlled legislature, the cost of treating the uninsured, and the expected economic benefits. A simulation by the Bay Area Council Economic Institute suggests almost 100,000 additional jobs would have been added and the state economy increased by \$4.4 billion in 2010 had the ACA been in effect (Haveman and Weinberg 2012). The uncertainty of the ACA’s future and its impact on the healthcare industry led participants to seize the Forum as an opportunity to find solutions in turbulent times. Forum leaders wanted to discuss shared challenges, understand their counterparts’ perspective on the changes, and gain additional insights to address the challenges.

For some, fear of missing out encouraged participation. Once several key leaders signed on, others were eager to be part of the dialogue. The organizations represented by the Forum participants interact regularly as suppliers, customers, and competitors. They have fierce negotiations over provider-health plan contracting and battle over market share.

Such organizations often blame each other for the challenges and dissatisfaction with healthcare. Insurers are criticized for their contracting practices, administrative burdens and cream skimming of the healthiest patients. Large health systems and physician groups are criticized for price variations, lack of price transparency, and bargaining leverage. A major source of contention with the California Health and Human Services Agency is the low Medi-Cal payment rates to physicians and hospitals, which may lead to a “cost shift” to private payers and access challenges for Medicaid patients. In 2012, California was the third-lowest state in terms of Medicaid payment rates relative to Medicare for physician services and the second-lowest state in terms of rates of physicians accepting new Medicaid patients (California Budget Project 2013).

The Forum involved a step back from daily concerns. It offered leaders an opportunity to establish stronger relationships among business partners, and understand and influence the perspectives of peers in a non-threatening environment.

Participants also felt a desire to positively affect the direction of healthcare in the state. Many of the leaders have been pillars of their organizations’ success, and the Forum challenged them to develop a broader perspective regarding the future of state healthcare. The group expressed concern about the rising burden of chronic diseases, socioeconomic determinants of health, and unhealthy lifestyles and environments in the state.

The most pressing concern was the growing share of the economy devoted to healthcare and the subsequent burden on premiums and government budgets. California remains below the national average in terms of healthcare expenditures as a share of the state economy, but healthcare has grown from 12.1% of Gross State Product to 15.1% between 1991 and 2009 (see Figure 1).

Forum participants wanted to provide an active voice on the issue, fearing that if industry cannot “self-regulate” with regard to healthcare spending, more government regulation may ensue. For example, to address budget deficits exacerbated by growing Medi-Cal spending, California imposed a 10% reimbursement cut for many providers in 2011. This law, upheld in court, went into effect in September 2013 and could worsen access challenges for patients and cost-shifting to private payers (Gorn 2014). Massachusetts faced similar challenges; healthcare spending per capita that is 36% higher than the national average recently led to legislation setting overall spending goals, hospital and physician price monitoring and premium rate regulation (Nighohossian et al. 2013); (Patrick et al. 2009).

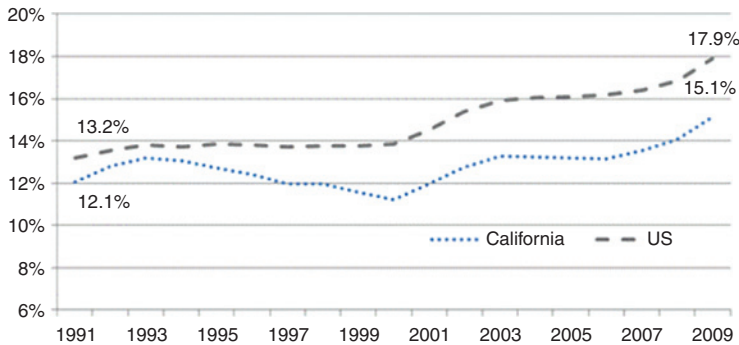


Figure 1: California and U.S. Healthcare Spending as a Percentage of Gross Domestic Product, 1991–2009.

Sources: Berkeley Forum (2013b); Centers for Medicare & Medicaid Services (2013).

Forum participants were apprehensive about certain market approaches to cost containment, such as the use of reference pricing to encourage consumers to obtain elective procedures in lower-cost hospitals. There was concern that reference pricing could lead to greater price distortion for other procedures or reduced funding for research and graduate medical education occurring at higher-priced institutions. High-deductible plans, which have grown in popularity among employers, often place an undue financial burden on consumers to cover their high deductible, which may result in prioritizing short-term savings over long-term health. Given that quickly rising healthcare spending is a top concern for government, employers, and individuals, the Forum leaders hoped to influence the conversation and resulting policies.

When the Forum convened, there was skepticism about the possibility of achieving anything. The collaboration faced various obstacles, including the need for cooperation among competitors, potential reputational, corporate or political risks to the organizations involved, and existing mistrust and misperceptions among participants. The Forum navigated these intricacies via a common understanding of problems in the healthcare system, a process of shared education and discussion, and ultimately, a coalescing around goals and recommendations underpinning “*A New Vision for California’s Healthcare System*” (Kania and Kramer 2013).

3 A Deep Dive into Healthcare Spending in the State

The Forum quickly pinpointed healthcare affordability as the key challenge and discussed affordability in the context of increasing the return-on-investment –

such as health outcomes, quality, and patient satisfaction – of healthcare spending. As shown in Figure 1 above, healthcare spending as a share of the economy in the state remained stable in the 1990s. However, relative spending on healthcare increased rapidly in the initial years of the 21st century, with per capita healthcare spending growth above 6%. Healthcare spending growth dropped significantly in 2008 and 2009 (the most recently available state data), as did economic growth rates due to the recession. By 2009, California spent 15.1% of its Gross State Product (GSP) on healthcare.

The latest national figures indicate a recent slowdown in annual healthcare spending growth to the lowest levels in decades, and total U.S. healthcare spending as a share of GDP held relatively steady between 2009 and 2012. A major debate has ensued regarding the extent to which economic factors or structural changes in the healthcare system are responsible for the tapering in spending. Research articles published in 2013 by the Kaiser Family Foundation and Cutler and Sahni estimate that 37%–77% of the slowdown in spending growth can be attributed to the recession and macroeconomic factors. The remaining portion may be caused by systematic changes such as higher cost sharing by patients, increased provider efficiency and lower than expected spending on imaging and pharmaceuticals (Holahan and McMorro 2013). An analysis by researchers at the Congressional Budget Office concludes that neither slower growth in provider payments nor the recession accounted for much of the slowdown in Medicare fee-for-service spending during recent years. Rather, the researchers suggest that changes in provider behavior may have promoted lower quantity, intensity, and overall cost of care (Levine and Buntin 2013).

Berkeley Forum Staff developed projections to educate participants about the trajectory of healthcare expenditures and economic growth in the state. Because the causes and sustainability of the recent healthcare slowdown is greatly uncertain, our forecasts take a similar approach to CMS's, which generally assumes a return to higher growth later in the decade. The Forum estimates that although healthcare spending as a percent of GSP stays relatively constant between 2010 and 2013, it will begin increasing again in 2014. By 2022, we estimate that California's healthcare spending as a percent of Gross State Product will be 17.1% (see Figure 2).

An examination of total employer-sponsored insurance (ESI) premiums, which include both employer and employee premium contributions,¹ shows even faster growth than overall healthcare spending. Unfortunately, median

¹ Economists generally view the employer contribution to premiums as part of the overall employee compensation. Increased employer contributions to premiums could come in lieu of higher wages; we thus consider both the employer and employee contribution to premiums for our analysis.

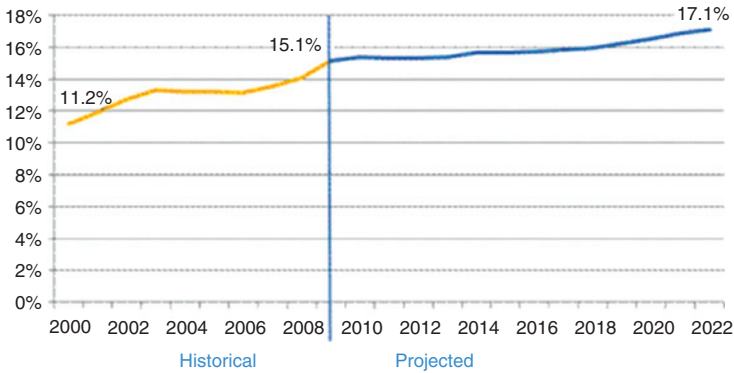


Figure 2: California’s Cost Curve: Historical (2000–2009) and Projected (2010 – 2022) Health-care Expenditures as a Percent of Gross State Product.

Source: “Berkeley Forum Healthcare Expenditures Projections Model,” Berkeley Forum (2013a).

household income growth in California has been even more sluggish than the overall economy’s growth. Thus, California households have been particularly hurt in terms of health insurance affordability. In 2005, total ESI premiums represented 9.3% and 16.1% of household income for single coverage and family coverage, respectively.² By 2011, those figures had increased to 13.5% and 23.8%, respectively (see Figure 3). From 2005 to 2022, we project that California households will have almost doubled their relative household spending on premiums.

The greatest uncertainty with regards to the ACA’s impact on premiums does not concern employer-sponsored insurance, but rather, individual market insurance, which will mostly be purchased through Covered California. Following the establishment of Covered California, the essential benefits package regulation, and new rating and guaranteed issue requirements in 2014, California’s individual market is experiencing dramatic changes. Average premiums for those purchasing insurance as individuals and families increased with the ACA’s implementation in 2014, due to the changing risk pool, more expansive benefits, and new taxes. The premium increases are less than those initially projected, and vary across California’s 19 geographical regions (Mathews and Radnofsky 2013). Even with the overall premium increases, the majority of Californians purchasing insurance in Covered California are expected to pay less for coverage due to their eligibility for generous federal subsidies (O’ Connor 2013).

² Considers income for single- and family-led households under 65 years of age.

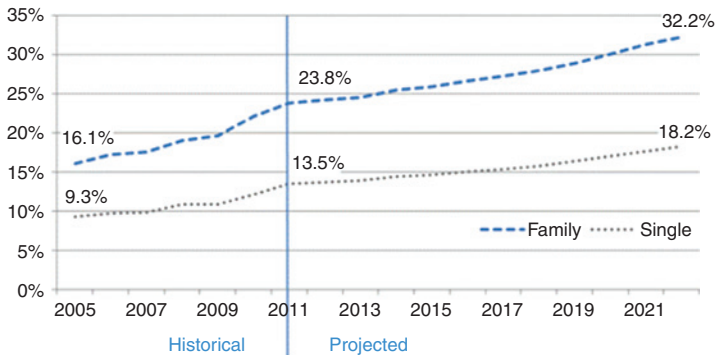


Figure 3: Historical (2005–2011) and Projected (2012–2022) Employer-Sponsored Health Insurance Premiums for Single and Family Coverage as a Percent of Median Household Income in California.

Notes: 1) Premiums include both employer and employee contributions.

Source: “Berkeley Forum Healthcare Premiums Projections Model”; Berkeley Forum (2013a).

4 Leveraging the Characteristics of California’s Healthcare System Towards a New Vision

After identifying affordability as the main area of concern for the group, the Forum engaged in a more robust understanding of the California healthcare system. Participants were particularly interested in the factors that lead California to have per capita healthcare spending well below the national average. The objective was to understand if there were characteristics of California’s current system that could be leveraged to improve healthcare value and affordability.

Healthcare unit costs and prices in California are much higher than the US average. However, California’s utilization is particularly low, even after accounting for the state’s higher uninsured rate, younger population and higher rates of Asians and Latinos, all groups that tend to be low utilizers. For example, Californians have only 76% the adjusted rate of inpatient discharges as residents in the rest of the US (See Figure 4).

At least some of California’s lower utilization is likely due to healthcare system characteristics. The presence of Kaiser Permanente in California, which provides coverage and medical care to about a third of California’s commercially insured under-65 population, has greatly influenced healthcare in the state. Kaiser developed the integrated care model, with coordination and financial alignment among providers, medical records that transcend care settings, and innovative use of technology and non-physician providers. Kaiser’s reliance on globally budgeted

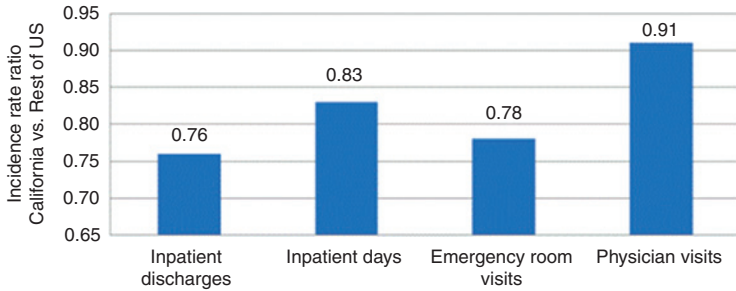


Figure 4: Utilization Rates of Various Healthcare Services in California vs. Rest of the US, 2005–2009.

Notes: 1) All results above are significant ($p < 0.05$) between California and the rest of the US. 2) Results are based on negative-binomial regression models, which control for gender, age, race/ethnicity, income, insurance status, number of key medical conditions and body mass index. 3) The sample size for each model was 155,776.

Source: Berkeley Forum analysis using MEPS-Household Component, 2005–2009.³

hospitals and salaried physicians, with careful quality evaluation and use of evidence-based medicine, has largely severed the fee-for-service paradigm.

Kaiser has had a significant competitive effect on other providers and payers in the state, driving expansion of non-Kaiser managed care offerings, formation of large physician groups, increased integration among health systems and development of Accountable Care Organizations. Figure 5 below shows that 44% of

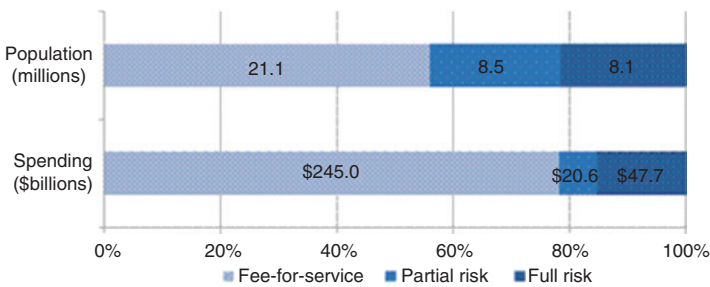


Figure 5: Analysis of Payment Systems in California, by Population and Spending, 2012.

Source: Berkeley Forum (2013b).

³ All analyses involving the Medical Expenditure Panel Survey in this article were conducted while Brent Fulton was a Special Sworn Status researcher of the U.S. Census Bureau at the Center for Economic Studies. Research results and conclusions expressed are those of the co-authors and do not necessarily reflect the views of the Census Bureau. These results have been screened to insure that no confidential data are revealed.

all Californians are enrolled in managed care today, in either partial- or full-risk systems. Nonetheless, fee-for service permeates even in California, as we estimate that about 78% of spending, or \$245 billion annually, is still paid on a fee-for-service basis. A large part of this spending is due to Medicare fee-for-service and Medicare-Medicaid dual eligibles, both groups that have high expenditures per capita.

In contemplating where California's healthcare system is today and where it is headed, Forum participants articulated their view on the need for fundamental change in the care system towards integrated care and aligned financial incentives. The discussion led the group to collectively develop something broader and more far-reaching than any one intervention or program – the Forum Vision.

The Forum Vision calls for a major transition towards integrated care systems and risk-adjusted global budgets, with payments linked to quality measures. Integration ensures that care is coordinated among settings, conditions, providers and time, and is a significant shift from the fragmented care many Californians receive today. Risk-adjusted global budgets ensure that physicians and hospitals have an incentive to provide effective and efficient healthcare to their patients by aligning their incentives away from payment for each service provided, and towards a holistic view of populations and budgets.

While financial arrangements such as shared savings and episodic payments are helpful intermediate goals, the Forum took a stance that risk-adjusted global payments are the end-goal. Global budgets consider patients and populations comprehensively, place responsibly in the hands of providers whom patients trust, and avoid frequent inter-provider squabbles between hospitals and physicians. Thus, global risk-adjusted budgets can be more effective in promoting value and reducing administrative burdens. The Forum endorsed reducing the share of expenditures paid for under fee-for-service from the current 78% to 50%, and doubling the share of the state's population, from 29% to 60%, receiving care from highly or fully integrated care systems by 2022.

In the Forum Vision, we found the sweet spot among the participants. We developed far-reaching recommendations endorsed by various segments of the private healthcare market. The Forum went beyond the recommendations of policymakers or other groups who have promoted a move away from fee-for-service and towards risk-sharing schemes that are less comprehensive than global budgets.

Following achievement of this major consensus statement, we evaluated specific initiatives in the context of their impact under a scenario where the Forum Vision came to fruition. In the process of selecting initiatives to study, we steered away from those in which there were vastly differing perspectives, such as reference pricing for hospitals, as well as initiatives that did not seem feasible to attain across the various stakeholders, such as administrative simplification. We also did not include initiatives that specifically targeted other

key healthcare stakeholders not present, such as biotech and medical device companies.

In addition to increased use of global budgets and integrated care, six other initiatives analyzed included greater uses of patient centered medical homes and palliative care, increased physical activity, expanded use of nurse practitioners and physician assistants in primary care, and reduction in healthcare acquired infections and pre-term births. If we saw significant increase in adoption of these initiatives, as would be anticipated under the Forum Vision, California could save \$110 billion over the coming 10 years (Figure 6). This represents a savings of 2.5% of all healthcare spending during this time period, or over \$800 per household, per year for the next decade.

In January 2013, the Commonwealth Fund released an important analysis suggesting that total U.S. healthcare spending could be reduced by 4.8% over the coming 10 years via a sweeping range of initiatives. The Commonwealth Fund suggested delivery system reforms such as patient centered medical homes and payment reform away from fee-for-service that are well aligned with Forum recommendations. The Commonwealth Fund analysis considered consumer-targeted initiatives, such as cost transparency, new Medicare “essential benefit” plans that facilitate a move away from private “first-dollar” Medigap plans, and value-based purchasing incentives. Finally, the Commonwealth Fund analyzed system-wide efforts such as reducing administrative burdens and reforming medical malpractice policies.

The Forum’s lower estimates relative to the Commonwealth Fund (2.5% vs. 4.8%, respectively) are a result of the more narrow range of initiatives considered

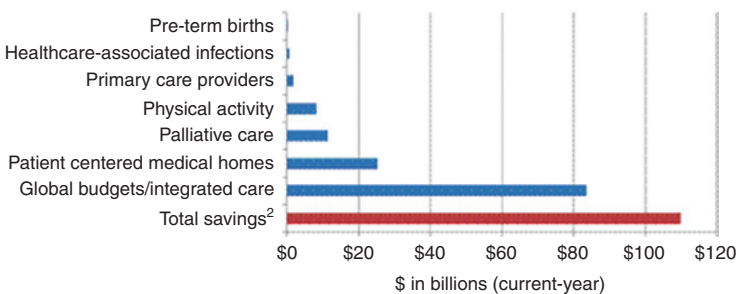


Figure 6: Total Estimated Healthcare System Savings From Seven Initiatives Implemented Under the Forum Vision, 2013–2022.

Notes: 1) Total projected healthcare spending between 2013 and 2022 is \$4.4 trillion in current-year dollars. 2) “Total savings” adjusts for estimated overlap in savings from the individual initiatives being implemented concurrently.

Source: Scheffler et al. (2013).

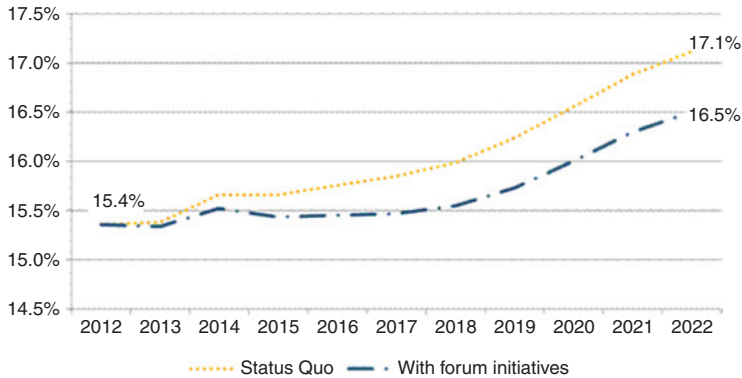


Figure 7: California Cost Curve: Projected Healthcare Expenditures as a Share of Gross State Product Under the Status Quo and With Forum Initiatives, 2012–2022.

Source: Scheffler et al. (2013).

by the Forum, the more conservative modeling approach, and because California has less room for improvement with regards to utilization-targeted initiatives as compared to the rest of the country. Overall, the Forum’s specific initiatives could help bend the cost curve, bringing the state to 16.5% of Gross State Product spent on healthcare in 2022 vs. the anticipated 17.1% under the status quo (see Figure 7).

The Forum Report highlighted two initiatives that had unanimous support from the participants: the need for increased physical activity to improve the health of Californians, and the expansion of palliative care to ensure high quality patient and family-responsive care for seriously ill patients. Increasing prevalence and earlier onset of chronic disease, combined with emerging research on the widespread positive health impact of physical activity, led this intervention to move to the forefront.

The Forum highlighted palliative care because of research showing the large discrepancy between the care patients say they want to receive and what they actually get, and the high concentration of spending on patients in their last months of life. Greater levels of physical activity and increased access to palliative care could be instrumental in improving health status and healthcare quality, respectively, for Californians, leading to significant reductions in healthcare spending growth.

5 Conclusion

Forum participants met in a time of great uncertainty about if and how the Affordable Care Act would be implemented, how the state of California would

engage, and how the healthcare landscape would unfold. The group was constructed of the largest private sector health systems, medical groups and health plans in the state, along with public sector healthcare leaders. Forum participants looked for opportunities to positively shape the future of health and healthcare in California. They were aware that if the industry does not tackle healthcare affordability and quality issues itself, the potential for painful alternative responses are real – including continuous decreases in employer-sponsored coverage, massive shift to high-deductible health plans, and new government regulations.

A large part of the value for Forum participants was engaging in dialogue with each other and better understanding the perspectives and views of their peers. The Forum discussed the proliferation of larger, integrated care systems and managed care in California, which have contributed to California's relatively low utilization and healthcare spending. Nonetheless, California has gone from spending 12.1% of Gross State Product on healthcare in 2001 to 15.1% in 2009, and Forum projections estimate healthcare spending will increase to 17.1% of the state economy in 2022.

Seven delivery system and financing changes recommended by the Forum could save \$110 billion over the coming 10 years and reduce that figure to 16.5% of Gross State Product in 2022. Much of these savings come from a concerted move towards the Forum Vision of integrated care systems and risk-adjusted global budgets, with payments linked to quality measures. The Forum Vision calls for a fundamental change in the payment system to financially incentivize provision of high quality, cost-effective care coordinated across conditions, providers, settings and time.

The Forum emphasized the importance of improving healthy lifestyles and environments for Californians. The participants endorsed Governor Jerry Brown's December 2012 *"Let's Get Healthy California"* (LGHCA) report, which aims to make California the healthiest state by the end of the decade. The Governor's report was the result of input from a task force and a wide range of stakeholders, most of which were not involved in the Forum. Nonetheless, there was significant overlap between the Forum Report recommendations and five of LGHCA's six priority areas, encompassing healthy childhoods, living well, end-of-life care, healthcare system redesign and healthcare affordability.

The LGHCA report outlined a series of key indicators for monitoring healthcare in the state. Many such indicators align with Forum priorities, including those on obesity rates, chronic disease management, palliative care and hospice access, care coordination, and healthcare acquired infection rates, among others. Recognizing the importance of healthcare affordability to the overall health of Californians, LGHCA also emphasized the need to monitor cost growth and

insurance premiums relative to household incomes. The release of the LGHCA and Forum reports within months of each other helped reinforce the key priorities and recommendations for improving California's healthcare system.

The endorsement of the Forum Report by each of the private sector participants demonstrated the Forum's united public front. The Forum showed broad alignment on how to improve the healthcare system, which could be viewed as a response to the current cost containment approach of large employers. In recent years, California employers have moved away from traditional Health Maintenance Organization (HMO) offerings and towards more selective narrow networks, high cost sharing and self-funded Preferred Provider Organization (PPO) plans.

Some of the most pointed questions regarding the Forum report came from those affiliated with employer groups, who feel that the HMO model has failed to contain costs. Another major challenge to the Forum Vision is the concern that integrated care organizations may become large enough to exercise their market power against payers, which would adversely impact prices. These debates, and ensuing policy ramifications, will continue for some time. Nonetheless, the Forum participants succeeded in providing a strong, analytically rigorous defense of "provider-side" solutions such as integrated care and risk-based global budgets, in addition to direct consumer-oriented cost approaches.

The Forum Vision goes even further than much of the current policy paradigms, moving beyond ACOs, bundled payments and medical homes by calling for risk-adjusted global budgets. The biggest limitation of the Forum Report is that it lacks specific commitments from participants to implement change and measure progress. Even without a specific commitment, the Forum's ultimate recommendations are far-reaching and bolstered by the consensus among and endorsement from the leaders of the top healthcare organizations in California.

Two years after the Forum came together, the landscape has changed. The Supreme Court upheld the key tenets of the Affordable Care Act, and Barack Obama was reelected. The Affordable Care Act is being implemented, with various modifications and new guidance issued by CMS regularly. There are some major bumps along the way, namely the problematic roll-out of the federal healthcare exchange website, the cancellation of insurance plans that did not meet new standards, the delay of the employer mandate by 1 year, and the decision by numerous states not to expand Medicaid or operate their own exchanges.

Nonetheless, California is charging ahead. About 830,000 Californians had bought a private health plan as of mid-February 2014 (Terhune and Karlamangla 2014) and Medi-Cal expansion is well underway. About 915,000 Californians are enrolled in 67 ACOs (Cattaneo & Stroud Inc. 2013); more than any other state in the country. The focus for healthcare organizations now is to position themselves effectively in an ACA world and execute on strategy.

The Forum's needs during this ambiguous time period have thus morphed slightly – away from interacting regularly and representing a united voice in a rapidly changing world. The next meeting of the Forum will involve many of the same participants, with the addition of the University of California medical centers and the University of Southern California Medical Center.

The Forum now is focused on leveraging the Forum Report and encouraging stakeholders and policymakers to endorse the Forum Vision. The Forum continues to monitor healthcare spending, the growth in integrated care, and the move away from fee for service. The group has developed a taxonomy to characterize ACOs and is creating measures to assess the impact of ACOs on cost and quality. The Forum is making progress on palliative care by working with the California HealthCare Foundation to develop an expanded benefit for end-of-life care. The Forum is also collaborating with the Integrated Healthcare Association (IHA) and various work groups stemming from Governor Brown's *Let's Get Healthy California Report* in preparing the State's Innovation Model (CalSIM) proposal for CMS funding.

In brief, the focus is now on implementing the broad, progressive Forum Vision recommendations. However, many questions remain. These include: what specific policy changes can encourage rapid adoption of integrated care and risk-adjusted global budgets? How can organizations be held accountable for moving in such a direction? How do we promote this direction against the growing winds of opposing forces, primarily from employers concerned about potential price increases? How do we develop smart networks and cost-sharing mechanisms that encourage consumer involvement in healthcare? And how do we truly leverage the two key aspects of California's healthcare system – integrated care and aligned financial incentives – to achieve greater value for the investments we are making?

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