

Narrow Provider Networks for Employer Plans

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At a Glance

The authors conducted in-depth qualitative research to examine questions around provider networks in employer health plans, particularly the development of so-called “narrow networks,” which have grown in the individual market exchanges under the Patient Protection and Affordable Care Act of 2010 (ACA). These narrow networks are characterized by offering considerably fewer health providers than is typical in the group market, and they are formed primarily based on price discounting.

The research includes the review of peer-reviewed journals, news sources, and public policy reports; structured interviews with a convenience sample of human resource benefit directors at 11 large employers; and field research by health-policy experts in a dozen states.

This *Issue Brief* describes the research in more detail and analyzes the reported facts and viewpoints. The major findings are:

- Narrow provider-networks are receiving renewed attention, following their increasing prominence in the ACA’s individual (nongroup) marketplace exchanges, which are highly price-competitive.
- So far, this renewed interest in narrow networks has not translated strongly to employers. For example, in 2016, only 7 percent of employers with health plans offered a narrow network. Also, in 2014, employers ranked narrow networks the least effective among several strategies to manage health insurance costs.
- Reasons employers give for their subdued interest include absence of a track record showing sustained (year-over-year) savings; concern about antagonizing workers; spotty availability of narrow networks, especially in rural areas; greater interest currently in other cost-savings strategies; and reluctance to adopt substantial changes in benefit structures until the future of the ACA’s so-called “Cadillac tax” is resolved.
- There are signs that employers’ interest in narrow networks may grow in the near future. More than one-third of employers with health plans that have 5,000 or more workers now offer some type of alternative network, including tiered or “high-performance” networks. Field reports indicate increasing adoption of narrow networks by both large and small employers, particularly in urban markets around the country.
- Where narrow networks are offered, their adoption could be increased by giving workers stronger financial incentives to consider them. Offering workers a fixed (“defined”) contribution that does not vary by choice of plan is one way to confer such incentives, and private exchanges are a way to offer workers a broader range of choice. Currently, however, neither defined contributions nor private exchanges are widely used by employers.

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Introduction

A frequently noted effect of the insurance market reforms enacted by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) was the emergence of much narrower provider networks than were previously common. According to various reports, the average plan sold through the ACA's exchanges in 2015 had one-third fewer providers than commercial plans (Avalere, July 2015); two-fifths of the provider networks in plans offered through the exchanges in 2014 included fewer than 25 percent of the area's physicians (Polsky 2015); and one-sixth had fewer than 30 percent of area hospitals (Bauman 2015).

Many observers view narrow networks as the result of increased price competition among insurers brought about by the ACA (AcademyHealth 2015; Avalere, October 2015; Corlette et al., May 2014; Shigekawa & Udow-Phillips 2013). Previously, insurers competed in large part based on their ability to “medically underwrite” subscribers by setting premiums and coverage terms based on their expected medical claims. For individuals and small groups (with 50 or fewer members), the ACA eliminated medical underwriting by requiring insurers to cover all applicants using community rating, and it required coverage of a standard set of “essential health benefits.” The ACA also created an online marketplace exchange structure that facilitates consumer shopping based on price. And although many enrollees in individual insurance plans received substantial subsidies, they were still highly price-conscious because they were required to pay the full differential in premium cost beyond the subsidized price of the second-lowest priced “silver” plan in the market.

These core elements of the ACA reflect much of what health policy analysts have long referred to as “managed competition” (Fronstin & Ross 2009). First articulated by Stanford economist Alain Enthoven almost four decades ago (Enthoven 1978), managed competition seeks to structure health care markets so that competition between insurers drives greater value in the delivery of health services. As Enthoven saw it, this would be done in just (about) the way

the ACA unfolded—through market rules and standardized plan designs that force insurers to compete on price and consumer value, and through rating rules that make consumers fully sensitized to the cost differences between plans. Enthoven predicted that this market structure would give rise to health plans competing based on differentiated networks of providers. The narrow networks that immediately formed on the ACA's new insurance exchanges appear to be at least the beginning embodiment of Enthoven's managed-care vision.

Some consumer advocates criticize narrow networks for providing insufficient access, especially for patients with higher-cost chronic illnesses, and they claim that insurers structure these networks strategically to discourage enrollment by higher-cost patients (see Pearson et al., 2015; Dorner et al., 2015). However, state and federal regulators are increasing their scrutiny of network adequacy, and insurers that strategically avoid higher-risk enrollees could be penalized (to some extent) by the ACA's risk-adjustment mechanism (AcademyHealth 2015). Accordingly, many public policy analysts view the emergence of narrow networks as a positive sign that the ACA's market reforms stimulated forms of competition that can benefit consumers (Haeder et al., 2015; Howard 2014).

However, for commercial health insurance, these narrow networks emerged primarily in the individual (nongroup) market through the ACA's new “marketplace” exchanges. Network narrowing has also been notable in the Medicare Advantage market over the past couple of years (Jacobson et al., 2016). Much less attention has been paid to network narrowing in the employer-funded group market.

Conventionally, provider networks in the group market have been quite broad, often including virtually all hospitals and a very large percentage (well over three quarters) of relevant physicians. Health maintenance organizations (HMOs) are seen as a form of narrow networks, and they have a strong foothold in some markets. But in many markets, HMO networks have also greatly expanded, coming to resemble preferred

provider organization (PPO) networks in their breadth (Draper et al., 2002).

Carriers have tended to form such large networks because this has been what their biggest customers (large employers) preferred, in order to meet the needs of large and often widely dispersed workforces (Nichols et al., 2004). Although some purchasers might have preferred smaller networks, there has not been a sufficiently critical mass of these purchasers to warrant the extra effort of large-scale development of alternative networks.

This market dynamic changed under the ACA, at least for the individual market. Through substantial subsidies and various market reforms, the ACA greatly expanded the nongroup market, and in response, carriers developed narrower networks in order to be more price competitive for these new enrollees.

But what about the group market? Having formed new networks for the newly expanded individual market, insurers could be in a position to easily offer those same networks to employers. Or, where narrow networks previously existed, perhaps their popularity in the newly reformed individual market could make them more acceptable to group purchasers. If so, reform of the individual market could have important spill-over effects on the group market.

To explore these possibilities, this study used in-depth qualitative research, consisting of the following elements:

- Extensive search of publicly available literature, in peer-reviewed journals, news sources, and public policy reports;
- Structured interviews with a convenience sample of human resource benefit directors at 11 large employers; and
- Field research by health policy experts retained by the first author in a dozen states (California, Illinois, Iowa, Kentucky, Massachusetts, Michigan, New Jersey, New York, Ohio, Texas, Virginia, and Washington).¹

The benefit directors in the structured interviews were employed by EBRI-member companies with covered lives ranging from approximately 10,000 to over 1 million, with a median size of about 50,000 covered employees. Interviews were conducted by the two authors, following an interview guide. States for the field research component were selected from the ACA Implementation Research Network, formed by the Rockefeller Institute for Government at the State University of New York (SUNY) (<http://www.rockinst.org/ACA/>) and managed in part by the Brookings Institution. In each field-study state, a local health-policy expert conducted a literature review and interviewed a range of key informants to explore a prescribed set of study questions. Overall, 106 people were interviewed, consisting of 57 insurance brokers or benefits consultants, 15 representatives of insurance companies, 26 employers, and 8 other market observers or participants.

Key Definitions

For clarification, the following terms are defined as they are most often used (recognizing that usage by others can vary):

- “Narrow network” is the type of network that has become more prominent in the ACA’s individual market exchanges, with considerably fewer providers than has been typical in the group market and in which providers are included based primarily on price discounting.
 - “Considerably fewer providers” usually entails at least a third fewer, but perhaps two-thirds fewer, among hospitals and specialists, but possibly also among primary care physicians. (Thus, not included are situations where a single hospital or specialist practice is dropped from a network because it is especially expensive, even though others legitimately can describe that as a form of narrowing.)
 - “Based primarily on price” emphasizes that quality criteria are not necessarily entirely absent; as with any provider
- “Alternative network” is a focused network that is not based primarily on price discounting. Instead, these are networks that lay some claim to being “high performance,” based on a mix of cost and quality criteria. Leading examples include networks formed by, or based on, a prestigious health system or an accountable care organization (ACO). Also, when forming a high performance network, insurers can use cost criteria in a way that focuses on overall “value,” meaning that measures of practice patterns and/or health outcomes are considered rather than simply fee-for-service price discounting.
 - “Tiered networks” are structures often used to form alternative networks. Unlike conventional narrow networks, for which non-participating providers are entirely out of network, tiered-network structures give patients a choice (and a financial incentive at the point of service) of whether to seek care from the most preferred providers (Fronstin 2003). However, tiered networks do not typically require a choice of network size or composition at the point of enrollment, so this analysis regards them as distinctly different from the prototype narrow networks that have emerged under the ACA.
- “Centers of excellence” are particular facilities contracted to provide specialized services for specified high-cost services, such as organ transplants, certain surgeries (orthopedic, bariatric), or complex cancer treatments. Sometimes employers require enrollees to use these designated providers, but more commonly their use is optional (although often incentivized through reduced cost sharing). Therefore, centers of excellence do not represent the type of full-scale network option presented at the point of enrollment, which is the focus of this report.

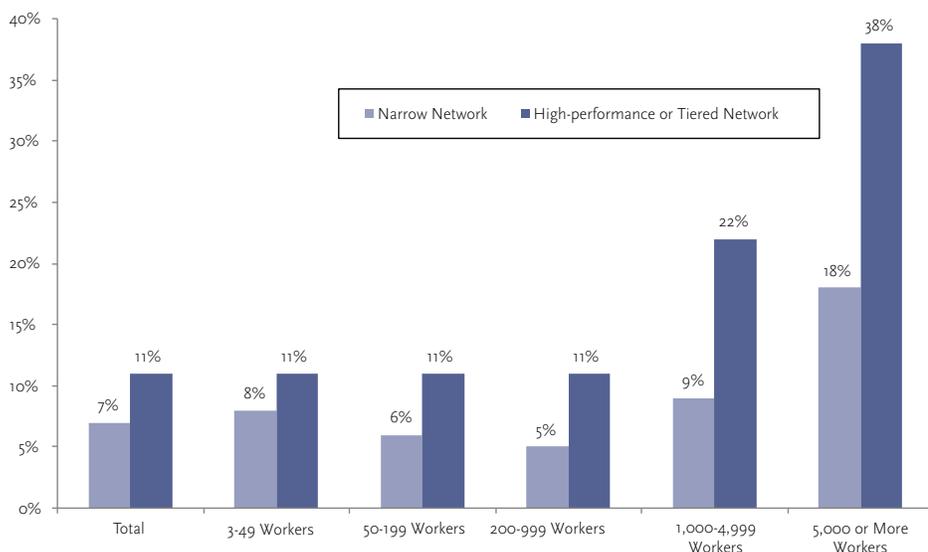
Current Interest Muted

Based on information from multiple different sources, the dominant impression is that narrow networks are much less prevalent in the employer market than in the individual market—but employers’ interest is growing in these and other forms of alternative provider networks.

According to a leading national survey by the Kaiser Family Foundation/Health Research and Education Trust (Kaiser/HRET), in 2016 only 7 percent of employers with health plans offered a narrow network (Figure 1). In 2014, the same researchers reported that employers ranked narrow networks the least effective among several strategies to contain health insurance costs, with only a third saying they believed that narrow networks are effective (Figure 2). Other employer surveys, some based more on convenience samples, have reported similar findings. For example, Mercer (2015) reported that 15 percent of large employers nationally (those with more than 500 workers) used “high performance” networks to some extent; Willis Towers Watson (2016) reported that 13 percent of the larger employers responding to its survey offered high performance or narrow networks; and Segal Consulting (2015) reported that 7 percent of the multi-employer plans offered narrow networks, based on its client survey. The employers in the latter two surveys also ranked narrow networks lowest among several cost-control strategies.

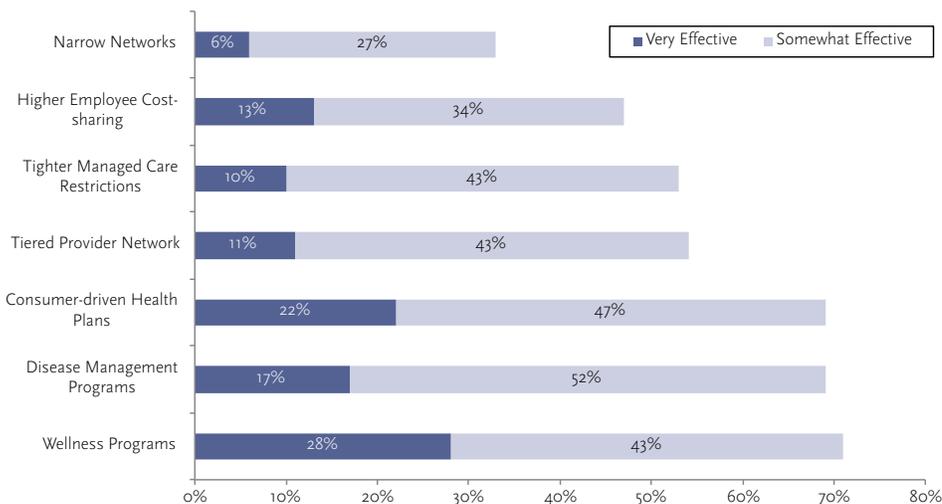
These national-level observations have been echoed in the state-focused field reports done by others (Corlette et al., Sept. 2014) and as part of this study. For instance, the Virginia field researcher for this study, reported that narrow networks accounted for only a “very small part of employer-sponsored insurance,” and while employers have some interest in them it is “outweighed by other factors.” In California, “next-generation narrow networks [beyond the established Kaiser Permanente plans] ... have only made a minor dent in the small and large group markets”; carriers have offered some nar-

Figure 1: **Percentage of Firms With Health Plans Offering a Narrow Network, High-performance Network or Tiered Network, by Firm Size, 2016**



Source: Figures 14.3 and 14.5 in Kaiser/HRET Survey of Employer-sponsored Health Benefits, 2016.

Figure 2: **Firms' Opinions on the Effectiveness of Various Strategies to Manage Health Insurance Costs, 2014**



Source: Figure 14.1 Kaiser/HRET Survey of Employer-sponsored Health Benefits, 2014

row networks to groups, but there has been only “anemic takeup.” Similarly, in Ohio, narrow networks “have not gained traction across either small or large employer groups”; in Michigan, narrow networks are a “nascent market” in which “these models do not have significant adoption” yet; and in Iowa, narrow networks “have not proven to be a popular or perhaps even viable option in the group market thus far.”

Key Reasons for Muted Interest

There are several explanations for this subdued interest (see also Hoo & Lansky 2016). Perhaps foremost, based on interviews with benefit managers for this study, employers are still “skeptical about true sustainable savings” absent “good data” showing that narrow networks can reduce “trend” (year-over-year) sufficient to “bend the cost curve”—rather than simply delivering a one-time discount. And employers want to see such perfor-

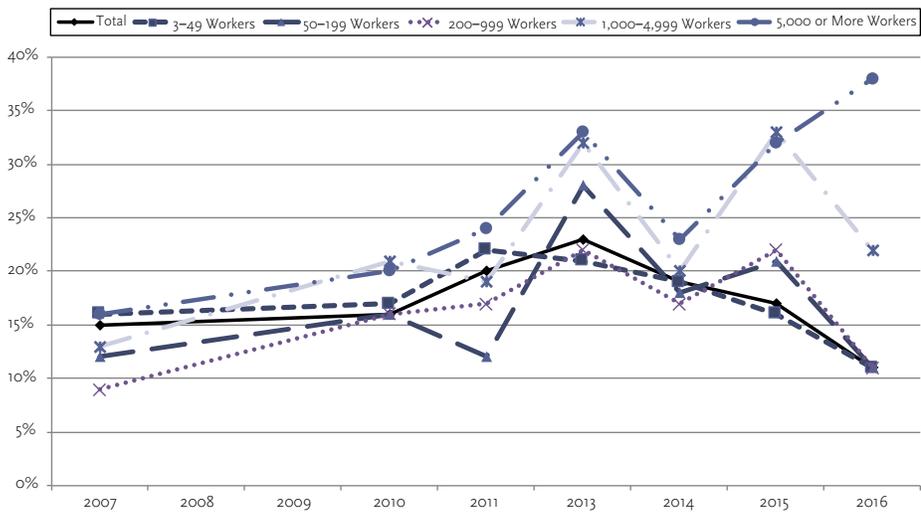
mance before asking employees to accept a benefit change that might be unpopular.

Several factors appear to mute the potential savings for larger employers. For example, when they have offered alternative networks, larger employers have tended to use a “tiered” PPO format that offers incentives to use the more select providers as an option at the point of service, rather than requiring workers to choose their network structure when they enroll. Also, larger employers are more likely to adopt “high performance” network structures that, as described above, incorporate criteria of quality and overall value, rather than adopt conventional narrow networks based principally on fee-for-service unit price discounting.

For example, the Kaiser Family Foundation (Kaiser/HRET 2016) reports that for larger firms (over 200 workers), from 11 percent to 38 percent (depending on firm size) offer a “high-performance” or “tiered” network, compared with only 5 percent to 18 percent offering a “narrow network” (Figure 1). According to this national survey, narrow networks are offered by a substantial percentage (18 percent) of only the largest firms—those over 5,000—and, for that size, “high-performance” or “tiered” networks still remain twice as common (38 percent) as conventional “narrow” networks. Furthermore, the percentage of employers with 5,000 or more employees that have been offering a high-performance or tiered network has grown from 16 percent as recently as 2007 (Figure 3).

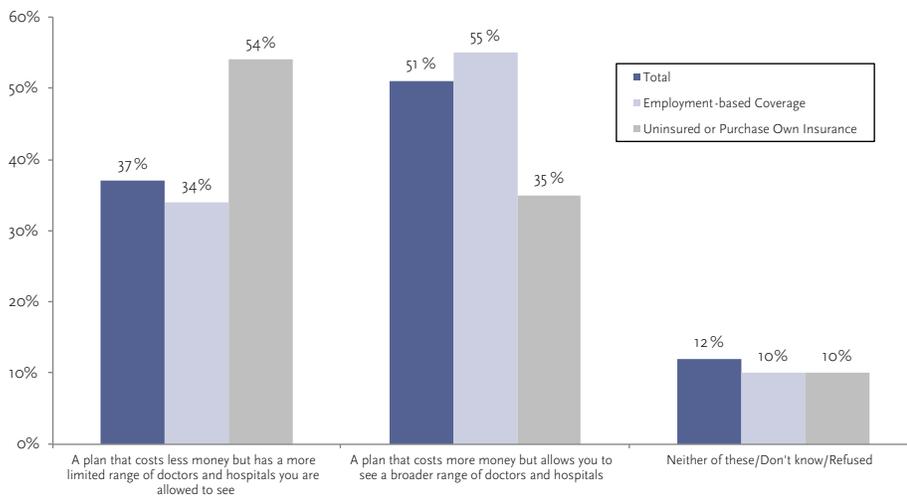
Elaborating on these observations, several field researchers reported that alternative networks in the employer market consist primarily of networks “built around a particular provider system” as a way to capture more volume, but “with very little evidence of price discounting.” Or informants pointed to networks that excluded only a single or a few especially high-cost providers, producing only a small savings overall. Thus, when asked how much

Figure 3: Percentage of Firms Offering a High-performance Network or Tiered Network, by Firm Size, 2007-2016



Source: Figures 14.5 and 14.6 in Kaiser/HRET Survey of Employer-sponsored Health Benefits, 2016.

Figure 4: Preferences for Narrow vs. Broad Network Plans, by Insurance Status



Source: Hamel et al., 2014.

less their alternative network cost, several employers cited savings of less than 10 percent, which may not be sufficient to either motivate adoption or drive substantial enrollment.

Also, it is likely that, without greater savings, many employers are reluctant to make a major change in the current structure of their health benefits that might be adversely viewed by their employees. For example, several of the employers in this research said that requiring workers to choose between much more affordable coverage or the broad network to

which they are accustomed would require a “cultural” or “philosophical” change in the firm’s historical approach to benefits. Other benefits managers said that narrow networks are not as well suited for the group market as they were for the ACA’s individual market because people who are currently comfortable with the coverage they have are “reluctant to switch,” whereas many enrollees in the individual market were previously uninsured. Consistent with that insight, a national survey (Hamel et al., 2014) found that “those who are either uninsured or currently purchase their own individual coverage—a group

that is most likely to be in a position to take advantage of new coverage options under the ACA—are [50 percent] more likely [than those with employer coverage] to prefer less costly, narrow-network plans over more expensive plans with broader networks” (Figure 4).

Employers’ reluctance to adopt narrow networks is reinforced by uncertainty over whether particular hospitals and physicians will remain part of new networks year after year. Larger employers typically conduct a “disruption analysis” before considering a change in networks, to determine how many workers might have to change their current providers. With established broad networks, there is some confidence that most current providers will remain available in future years, but there is less confidence with newer and more selective networks. Several large-firm benefits managers interviewed for this study emphasized that they do not want to implement a major change and then “pull it two years later” because they “really don’t like this kind of disruption,” or “volatility.” Some of them spoke of difficult transitions to other new benefit structures recently, such as high-deductible plans with health savings accounts, and said that they were reluctant to undergo similar disruption again without convincing reasons.

Adding to employers’ reluctance to make major benefit changes now is uncertainty over the possible effect of the ACA’s “Cadillac Tax”—a 40 percent excise tax on the excess portion of higher-cost employment-based health benefits (Blakely 2016). Originally, this tax was due to take effect in 2018, but, due to its unpopularity, Congress postponed the tax at least two years, and there is much speculation that the tax eventually may be repealed or substantially altered. This major uncertainty has caused many employers to postpone making changes in benefits.

For example, a leading national survey (Kaiser/HRET 2016) reported that, among firms that have analyzed how the Cadillac Tax might affect them, almost

one-third (31 percent) have reconsidered or postponed making changes in health benefits due to this delayed effective date. Similarly, one HR manager interviewed for this study explained “the specter of the Cadillac Tax that was over our heads ... would have required radical surgery on many employer-sponsored health plans, sure to be very disruptive.” Thus, “why take on an interim measure that was likely to be disruptive when the entire plan structure may have needed to be revisited in a year or two anyway?”

Possible Negative Reactions

Not surprisingly, underlying many of these sentiments is employers’ concern about workers’ reactions to a substantial narrowing of provider networks. Many employers fear that workers will see network narrowing as being based primarily on cost considerations, even when employers or carriers include quality criteria, and they worry that workers will blame the employer (rather than the insurer) for making this change, which will work against the employer’s need to offer good benefits to attract “the labor force we need.” Also, according to some benefits managers, “There’s a perception that doctors in narrow networks aren’t as good,” and therefore that workers will distrust the employer for “steering them to someone who is cheaper,” since narrow networks “come across mainly” as a cost control rather than a quality-based idea. Several benefits managers emphasized that “we need a better term” than narrow networks as a “communication tool”; otherwise, the idea is “hard to sell.”

Some have suggested that a way to reduce negative reactions from workers is to offer narrow networks as an option, alongside conventional broad networks, rather than as a full replacement for existing plans. Doing that requires offering some significant incentives for selecting the narrower network, which, several informants noted, can “eat into” the employer’s potential savings. Offering a narrow network choice also adds complexity to benefit design and

selection. Simply conveying the relevant information was seen as a challenge by several HR professionals interviewed for this study. They felt that information tools were not sufficiently well developed to present workers a more complex range of options, and they were concerned about not wanting to “overwhelm” workers with “too much choice,” which can “cause people to freeze.”

This is one reason that some companies said they prefer to present network options at the point of treatment, in a tiered network format, rather than making employees choose a network at enrollment, because people are more inclined to evaluate the trade-offs when the need for treatment arises. Others mentioned a desire to keep the benefits structure simple because people who understand the structure are more inclined “to use and navigate it.”

Adding to this concern over complexity is the fact that alternative networks are just one of several innovations that employers interviewed for this study are considering or have adopted, such as wellness programs, disease management, value-based insurance design, reference pricing, centers of excellence, and savings/spending accounts. At some point, the complexity “becomes unbearable to manage” when additional programs and options are added on top of those that already exist. Also, several of these are much higher on the list of options, and for various reasons many employers may prefer to focus on some of these innovations to see how well they work before deciding whether to try narrower networks.

Benefits Design Issues

Designing enrollment incentives can pose specific challenges based on the way that particular employers currently structure their contributions and benefits. One benefits manager noted that, if an employee’s premium contribution is already low, there may not be “enough leverage to play with” in terms of further reducing the

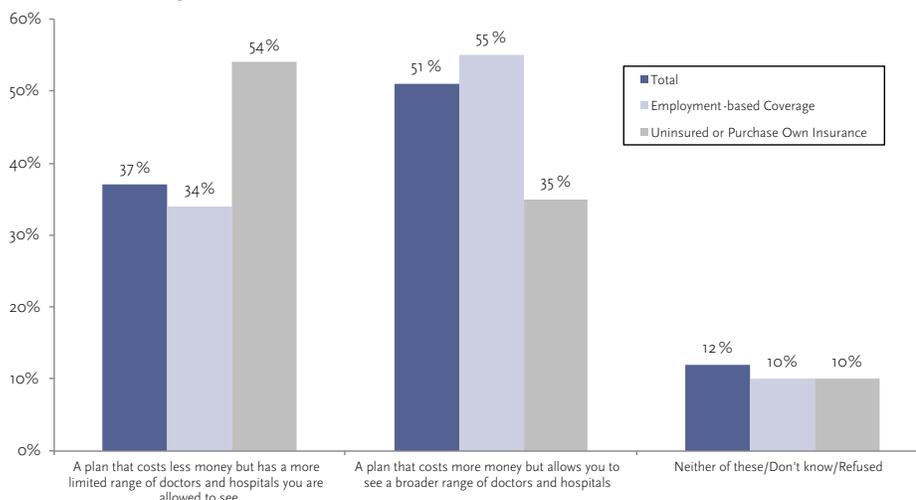
worker’s contribution enough to induce selection of a narrow network. If that is the case, the only other option is to have lower patient cost-sharing under the narrow network plan, but that may require either increasing cost sharing in the standard plan, which can cause backlash, or reducing cost sharing for those who switch into the narrow network plan.

Finally, many sources noted that the narrow or alternative networks that currently exist are geographically limited, because they exist mainly in urban areas that have a sufficient number of competing hospitals (or hospital systems) and key-specialist groups to permit selective contracting with just some of them. Thus, narrow networks are not yet feasible in many cities where providers have consolidated, and, according to many observers, they are “not viable” at all in rural areas. For instance, the Illinois field report for this study reported that narrow networks exist mainly in the Chicago area, where there is “a vibrant” provider market that “offers lots of different provider options,” but hardly at all elsewhere in the state.

The lack of broad geographic coverage means that narrow or alternative networks are less suitable for larger and even medium-sized employers whose workers live in different locations. Although it is possible, as some employers do, to offer these networks to only part of a workforce, one benefits manager said that “wouldn’t be fair” to the entire workforce, and another, at a multistate employer, noted that it would become “highly complicated” to “break coverage into lots of little local networks,” saying “I can’t imagine having to manage all of that.”

Another current innovation that some employers are considering is contracting with particular “centers of excellence” for specified types of planned, high-cost care, such as orthopedic surgery, bariatric (“stomach stapling”) surgery, organ transplants, or cancer treatment. According to one benefit consulting firm (Willis Towers

Figure 5: Percentage of Small Employers That Would Use a Narrow Network, by Premium Savings



Source: Hamel et al., 2014.

Watson 2016), employers' use of centers of excellence is "growing dramatically," possibly reaching almost three quarters of large employers by 2018.

Several informants viewed centers of excellence as a way to move in the direction of network narrowing, at least incrementally. Others saw centers of excellence as a distinct idea. Sometimes using a center of excellence is mandatory for workers, but more often employees are given an incentive to seek care from the contracted provider. Either way, the use of a center of excellence arises at the point of treatment rather than being presented as a network option when subscribers enroll. In that way, centers of excellence are more akin to the tiered approach described above.

Future Interest Increasing

Signs of Growing Interest

Despite employers' relatively subdued interest in narrow networks, there are noticeable signs of increasing interest, and some indications that interest may increase in future years. For example, responding to employer interest, several of the major national carriers (e.g., United, Aetna, Cigna) are offering employers narrow or alternative networks, covering at least several dozen metropolitan areas, as do many state-based Blue Cross and Blue Shield plans.

Many of the large employers interviewed

for this study were at least considering the possibility of adopting or expanding their use of narrow or alternative networks in future years. Also, other employer surveys have indicated growing future interest (Willis Towers Watson 2016; Cheney 2014; Willis Towers Watson and National Business Group on Health 2015). An optimistic analysis based on interviews with executives at eight major carriers (Eggbeer & Morris 2013) concluded:

[T]he interest among employers in plans with a high performance network option has grown substantially in the past five years....The resurgence of narrow and high performance networks, in combination with tiered benefit plans and payment reform, is reshaping the commercial insurance market... It is not too far a leap to predict that in the future, if current trends continue, we are going to have a market where we have high deductible open access plans for those who can afford them, and tightly managed competing narrow networks for most of us and not much in between.

Although not going nearly that far, one key informant for this study expressed the thought that, once uncertainty over the ACA's Cadillac tax is resolved, more employers will start "thinking long-term and may be more receptive to a broader range of select network approaches." Also, several state-based reports for this study reflected growing

interest among employers:

- In Illinois, narrow networks were reported as being "increasingly popular."
- In New York, "there has been a dramatic growth in the offer and take up of plans with narrow networks," mainly by small employers.
- In Massachusetts, a statutory requirement that most insurers offer an alternative network priced at least 14 percent below their standard network has produced a 19 percent enrollment growth in these plans over a period of two years, to reach 400,000 people in 2014 (Center for Health Information and Analysis, 2016).

Small vs. Large Employers

As with other recent health system developments, interest in narrow networks might initially emerge more strongly among smaller employers, because large employers have "more institutional inertia" (according to one observer), perhaps because they tend to be more deliberate in analyzing multiple competing factors before initiating change. For instance, small employers were among the early movers from indemnity to managed care coverage in the latter part of last century, and then again early in this century with the increase in deductibles.

For narrow networks, one national survey (Kaiser/HRET 2016) reports that employers with more than 5,000 workers offer "narrow networks" more than twice as often as do smaller employers. This same survey, as well as a national survey done by Mercer (2015), reports that larger employers are twice as likely as smaller employers to offer "high-performance" or tiered networks.

Regarding the future, views differed somewhat on which part of the market is more likely to see narrow networks grow. Because small employers are much less likely to offer a choice of plans, and the move to narrow networks is easier if workers are given a choice, some observers said that interest will emerge first with larger employers. But more often the opposite

was expressed (Hoo & Lansky 2016)—that interest in narrow networks as a way to reduce premium increases is much stronger and more visible among smaller employers, without regard to whether such networks are considered to be “high performance.”

More interest among small employers was the conclusion reached in 5 of the 12 field study states (Illinois, Kentucky, New Jersey, New York, and Virginia), with only one state (Massachusetts) reporting the opposite (and the remainder not noting a difference). Also, one survey of small employers (Gabel et al., 2013) reported that a premium discount of 10-20 percent might be sufficient to attract a majority of small firms to narrow networks (Figure 5). Generally consistent with that, another study (Atwood and Lo Sasso 2016) found that, in one (unnamed) metropolitan area, half of small firm workers chose a modestly narrower network (that excluded academic medical centers) when it was 18 percent less costly than the full network, or 9 percent less after accounting for other coverage differences.

Achievable Savings

The extent of cost savings is also the primary motivator for larger employers and for individual workers. Several observers felt that savings of 25 percent or more would be needed to motivate a broader adoption of narrow networks by employers or individuals. Consistent with that, one national survey (Hamel et al., 2014) reported that “when those who initially prefer a more expensive plan with a broader network are told that they could save up to 25 percent on their health care costs, the share continuing to prefer the more expensive option drops from 51 percent to 37 percent among the public overall.”

Savings of this magnitude may be achievable in the group market, as well as in the individual market, at least in some locations. In Massachusetts, a very high-cost state, the field researcher reported that some narrow networks in the group market were priced 30–40 percent less

than standard networks. A 40 percent savings was also reported for the narrow network offered to Massachusetts government workers (Gruber & McKnight 2014). However, a study of the first year in the ACA’s individual market exchange reported that, in 2014, premiums for “extra small” network plans were only 13 percent less than those for “extra large” networks, and the savings were smaller or not statistically significant for less extreme differences in network size (Polsky et al. 2016).

Defined Contribution and Private Exchanges

One development that some analysts believe could greatly spur adoption of narrower provider networks is to give workers much stronger financial incentives to select a narrow network option (Fronstin Dec. 2012). Modest savings in total premiums could translate to more substantial savings in the portion of the premium employees contribute—depending on how the overall premium savings are shared with employees. In Massachusetts, 17 percent of government workers were motivated to choose a narrow network when offered a 25 percent reduction in their premium contributions, a savings that ranged from \$268 to \$764 per year depending on the worker’s family composition and previous plan (Gruber & McKnight 2014). On the other hand, one of the large employers interviewed for this study reported very low takeup of a narrow network option where the incentive was simply a deductible that was \$500 less. That benefits manager said that what is needed is a substantially larger incentive that shows up immediately in the workers’ paychecks, rather than an incentive gained only if treatment costs exceed a certain amount later in the year.

There are different ways to give workers stronger financial incentives to select narrower networks. The most explicit way is a “defined contribution” or “voucher” or “flat dollar” approach to an employer’s contribution (see Nichols 2002; Fronstin 2001) under which the employer contributes a set amount that does not vary at all based on the plan that a worker

selects, so that workers bear the full cost of selecting plans that are more expensive. Most employers do not structure benefit options this way (Kaiser/HRET 2016). Instead, they usually set their contributions in ways that share with workers only a portion of the cost or savings differentials among the choices offered.

Private insurance exchanges, patterned broadly on the ACA’s marketplace exchanges, have emerged in recent years as one vehicle that employers might use to adopt a defined contribution approach to offering narrower networks (Fronstin July 2012). For instance, Atwood and LoSasso’s (2016) analysis of narrow networks is based on a private exchange structure used by 963 small firms in one metropolitan area. In another example, one of the multistate employers interviewed for this study has plans to introduce narrow networks in two dozen of its national locations, using a private exchange.

One advantage of private exchanges noted by benefit managers at two large firms that do not offer narrow networks, is that an exchange structure presents the selection of an alternative network as a choice that workers make from options presented by the exchange operator, rather than as a constraint that workers view as being imposed by the employer. Thus workers might be less inclined to resent an employer that uses a private exchange to offer narrow networks, because in that context each worker is evaluating and making the trade-off among contributions, network breadth, and other variables.

Despite these potential advantages, there has been much less employer adoption of private exchanges than many analysts had predicted (Accenture 2015; Kaiser/HRET 2016; Pacific Resources 2016). The primary reason given is that sustained cost savings from exchange structures have not yet been shown sufficient to warrant the additional fees and transitional costs entailed with shifting to these additional intermediaries (Hall 2015). Also, larger employers can be reluctant to reduce their

control over the design and structure of the health benefits they offer.

Finally, several informants indicated that employers' interest in narrow networks is largely independent of private exchanges. Indeed, employers that have adopted narrow or alternative networks typically have not done so using private exchanges, and private exchanges do not universally offer such networks, nor do they tend to emphasize network innovations as one of their principal features. Although some analysts interviewed for this study commented that it "stands to reason" that narrow networks would be more attractive if offered through a defined contribution approach using an exchange structure, and that the market may be moving in that direction, such logic has not yet gained momentum to any great extent.

The ACA's Influence

Where narrow networks have emerged in the group market, this study inquired whether, and to what extent, this development has related to the formation of narrow networks in the individual market. Conceivably, the ACA's creation of a new market dynamic for individual insurance that made narrow networks much more attractive than before also catalyzed network formation in a manner that could have spilled over to the group market. Put another way, prior to the ACA, "it was just not worth it for the insurance companies to go to the trouble of creating narrow network plans" (Tolbert 2016) because larger employers favored broad networks; but, once a critical mass of individual purchasers emerged to whom narrow networks were marketable, it might have become more feasible to also offer such networks in the group market.

This study observed some, but only limited, confirmation of this "spillover" thesis. Some sources noted that, following enactment of the ACA, particular carriers developed narrow networks primarily for the individual market that they also planned to, or were considering, offering in the group market. In their view, these carriers used the nongroup market to

"test out" new networks, which are now "much more in vogue" due to the ACA, and then carriers decided when to "turn them on" for the employer market; thus, their "strategy is to demonstrate the value of this approach so as to market it more broadly in the future." Field researchers for this study gave several specific examples of this spillover from the individual to the group market happening in Illinois, Iowa, Kentucky, and Washington (see also Eggbeer & Morris 2013). Others were less confident in where particular narrow networks emerged first—whether from the group market "chicken" or the individual market "egg" (or is it vice versa?)—but still they noted that the narrow networks that carriers offered in these two market segments have "some," "substantial" or "mirrored" overlap.

Accordingly, some of the sources for this study said that, "absolutely," the emergence of narrow networks in the group market was "related to" the ACA's reform of the nongroup market. Similarly, in Michigan, Shigekawa and Udow-Phillips (2013) concluded that "the ACA has been a catalyst for greater development of an array of health plan products ... consumers seem willing to consider products that include fewer providers in exchange for lower premiums." Most observers, however, did not see a direct connection between the ACA's individual market and the group market's increasing interest in smaller networks. Instead, they noted, as described by Burns (2012), that many carriers had developed alternative networks prior to the ACA in response to employers' apparent interest in new means of cost control during the weak economy that followed the 2008 recession.

Even if alternative networks in the group market do not have a direct connection with the ACA's individual market reforms, many sources noted that the ACA more broadly spurred employer interest in these networks (Gruessner 2016). It did so not so much by its reform of the individual market, but instead by other provisions, such as the employer mandate and the Cadillac tax that affected the employer

market, causing employers to reassess previous approaches and explore new strategies for their health benefits. Also, the ACA (in the words of one informed source) gave employers "cover" to make changes they wanted to do anyway and "blame" it on the government. Whether through direct insurance market reforms, or through broader changes in the health policy "landscape of the ACA," there was widespread agreement that the ACA "definitely precipitated," "spurred on," or "accelerated" a trend toward alternative networks in the group market. Even if that movement had begun previously, it "picked up steam" under the ACA, which "threw fuel on the fire."

Conclusion

Stanford economist Alain Enthoven's original vision of managed competition was that consumer choice in the insurance market would drive consumer value in medical care, through delivery system competition (Enthoven 1978). The ACA brought glimmers of this vision to the individual market, but it remains largely unrealized in the employer-based group market. Perhaps the vision is not realistic, or perhaps its fulfillment remains a matter of time. Findings from this research are not definitive and support both the skeptical and optimistic views.

The prominence of narrow networks in the ACA's nongroup exchange market spurred increasing attention by employers to alternative network structures. However, several barriers stand in the way of greater numbers of employers adopting or offering narrow networks. Employers have a variety of options available for managing the costs and value of health benefits, and they are reluctant to adopt ones that constitute a major change without clear evidence of employee acceptability and sustainable savings. The idea of narrow networks has existed for several decades, but the actual formation of such networks in substantial numbers is still too new to provide that track record, and many locations still lack such networks, especially non-urban areas.

A key component of reluctance among larger employers is how employee contributions and choices are structured. Enthoven's full vision of managed competition calls for employers to make defined contributions through insurance exchanges (whether public or private) that allow workers to choose from any credible option in the market, but requires workers to bear the full costs of options that exceed the employer's fixed contributions. Most larger employers prefer different, more conventional structures for choosing and contributing to health benefits.

These existing barriers may soon start to erode, however. The ACA's market reforms spurred the development of many more narrow networks than previously existed, and many of these networks formed principally for the individual market are also being offered, at least in some form, in the employer group market. Moreover, once uncertainty about the Cadillac tax is resolved one way or the other, employers may be motivated by ever-increasing health care costs to consider whatever additional changes are still untried that have at least the potential to bend the cost curve without sacrificing essential quality.

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Endnote

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