

Insider

Volume 22 | Number 1 | January 2012

U.S. Supreme Court and Health Care Reform: A Momentous Decision Ahead

By Sharon Cohen and Kathleen Rosenow

On December 19, the Supreme Court announced it would spend three days in late March hearing the challenges to the 2010 health care reform law. If the court finds the mandate unconstitutional, the next order of judicial business will be ruling on its severability from the rest of the Patient Protection and Affordable Care Act (PPACA). Also at issue are the constitutionality of the Medicaid expansion provisions and whether the Anti-Injunction Act (AIA) bars courts from reviewing the individual mandate until it goes into action.

The Supreme Court is responding to petitions filed by a business group, the Obama administration and 26 states. It has allotted more than five hours for oral arguments on these issues — far more than the typical one hour.

Both the individual mandate and Medicaid expansion are slated to take effect in 2014. The court's decisions will determine whether everyone must comply with the mandate. The decisions are expected in June — when the presidential election campaign will be in full swing.

Anti-Injunction Act review

On March 26, the Supreme Court will review whether the AIA bars challenges to the individual mandate. At issue is whether violations of the individual mandate trigger a “penalty” or a “tax.” Under the AIA, taxes can be challenged only after being assessed and paid,

meaning that courts should not consider legal challenges to the mandate until someone pays the applicable taxes in 2015.

If violations of the individual mandate are found to trigger a tax, the court will not rule on the other issues. Opponents of the individual mandate would have to wait until 2015 to challenge its constitutionality and severability.

Individual mandate and severability review

Under the mandate, individuals must purchase health care insurance or face a penalty. Business groups, individuals and several states have challenged the mandate's constitutionality, claiming that Congress overstepped its powers. On March 27, the Supreme Court will consider two questions:

1. Does the individual mandate violate the Commerce Clause?

While the Commerce Clause gives Congress authority to “regulate commerce among the states,” opponents argue that failing to buy health insurance is not an act of interstate commerce. The government, meanwhile, maintains that the Commerce Clause empowers Congress to require people to buy health insurance or face penalties. Everyone will need health care services sooner or later, and, in aggregate, being unable to pay for care affects interstate commerce, according to the government.

2. Does the mandate violate other enumerated powers under the Constitution, including the power of taxation?

The PPACA also amended the Internal Revenue Code to impose a sanction on taxpayers who do not comply with the individual mandate (which the PPACA labels a “penalty” rather than a “tax”). The government

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Insider is a monthly newsletter developed and produced by Towers Watson Corporate Research and Innovation.

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argues that the individual mandate is a valid exercise of its power of taxation under the Constitution because it regulates, discourages or deters certain activities. A ruling by the 11th U.S. Circuit Court of Appeals, however, found that the plain statutory language of the law and the legislative history overwhelmingly established the individual mandate as a penalty — and thus not a valid exercise of Congress's power to tax.

On March 28, the Supreme Court will consider whether the individual mandate is severable from the rest of the law. Opponents of the individual mandate also argue that the mandate cannot be separated from the rest of the law, so that striking down the individual mandate must invalidate the entire law. The administration, however, claims that most of the PPACA's provisions are separate from the mandate and so should stand even if the Supreme Court declares the mandate unconstitutional. The 11th Circuit Court found the individual mandate unconstitutional but severable from the rest of the PPACA. The federal appellate courts have split on these issues (see *Figure 1*, next page).

If the Supreme Court upholds the constitutionality of the individual mandate, implementation of the PPACA will continue as planned. If the court finds the mandate unconstitutional but severable, employers and insurers will have to comply with market mandates and reforms, and the other provisions will take effect as scheduled. If the court finds the individual mandate both unconstitutional and not severable, it will undo the whole of health care reform (see "The Economic Significance of the Individual Mandate in the Health Care Reform Law" on page 4).

Review of Medicaid expansion

Medicaid is a joint federal and state program that funds medical care for the poor. The states contribute funds and typically have discretion in designing and implementing their own programs. The PPACA makes Medicaid available to individuals and families whose incomes fall below certain thresholds,¹ which would result in far more enrollees than ever before. Some employers would see greater numbers of Medicaid enrollees as well. Under health care reform, states that fail to comply with the federal requirements will lose all federal Medicaid funding.

The Supreme Court will hear arguments on March 28. Opponents argue that threatening to withhold federal Medicaid funding from noncompliant states exceeds congressional authority. The appellate judges in the 11th Circuit acknowledged that coercive federal funding requirements violate the Constitution's fundamental federalism principles (the 10th Amendment) but did not find a violation. The government maintains that states are free to participate or not and to provide their own alternatives to Medicaid. If the Supreme Court finds the Medicaid expansion unconstitutional, the ruling could significantly affect other federal programs and spending requirements.

Looking ahead

The Supreme Court today is generally split between four liberal and four conservative justices, with Justice Anthony Kennedy typically holding the swing vote. Individual ideologies and the historic nature of the case are likely to play a role.

Rejecting the individual mandate and its severability from the rest of the PPACA would strike a severe blow to the reforms. Throwing another wrench into the works, many Americans are beginning to benefit from some of the provisions in the PPACA, which could make unraveling those more difficult politically.

¹ The PPACA specifies 133% of the federal poverty level (FPL), but a later modification to the law includes a five-percentage-point deduction from the FPL, effectively making Medicaid available to those individuals with household income up to 138% of the FPL.

Figure 1. Status of current litigation

Case	Description
National Federation of Independent Business v. Sebelius, Sec. of HHS, et al.	Supreme Court granted writ of certiorari: ¹ “The question presented is whether the PPACA must be invalidated in its entirety because it is nonseverable from the individual mandate that exceeds Congress’ limited and enumerated powers under the Constitution.”
Dept. of HHS, et al. v. Florida, et al.	Supreme Court granted writ of certiorari on Question 1: “Whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision.” The court also asked for a briefing on whether the AIA bars the suit brought by challenging the minimum coverage provision of PPACA.
Florida, et al. v. Dept. of HHS, et al.	Supreme Court granted writ of certiorari on Question 1 of the petition: “Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress’s spending power that this Court recognized in <i>South Dakota v. Dole</i> , 483 U.S. 203 (1987), no longer apply?” Court also granted writ of certiorari on Question 3 of the petition: “Does the Affordable Care Act’s mandate that virtually every individual obtain health insurance exceed Congress’s enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act?”
Case (opinion date)	Description
Seven-Sky v. Holder (11/8/2011)	District of Columbia Circuit Court of Appeals upheld the individual mandate as a valid exercise of legislative power by Congress under the Commerce Clause.
Virginia ex rel. Cuccinelli v. Sebelius (9/8/2011)	4th Circuit Court of Appeals held that plaintiffs lacked standing.
Liberty University Inc. v. Geithner (9/8/2011)	4th Circuit Court of Appeals found a lack of subject-matter jurisdiction.
State of Florida, et al. v. HHS (8/12/2011)	11th Circuit Court of Appeals held that the individual mandate provision violates the Commerce Clause, but the court upheld the remaining PPACA provisions.
Baldwin v. Sebelius (8/12/2011)	9th Circuit Court of Appeals affirmed lower court ruling that plaintiffs lacked standing.
New Jersey Physicians Inc. v. Obama (8/3/2011)	3rd Circuit Court of Appeals affirmed lower court ruling that plaintiffs lacked standing.
Thomas More Law Center, et al. v. Obama, et al. (6/29/2011)	6th Circuit Court of Appeals ruled that the individual mandate is a valid exercise of legislative power by Congress under the Commerce Clause.
Butler vs. Obama (9/30/2011)	District Court in New York dismissed lawsuit because plaintiff lacked standing.
Goudy-Bachman v. HHS (9/13/2011)	District Court in Pennsylvania ruled the individual mandate provision exceeds Congress’s authority under the Commerce Clause.
Bryant v. Holder (8/29/2011)	District Court in Mississippi overturned earlier opinion and ruled plaintiffs have standing to challenge the individual mandate.
U.S. Citizens Association v. Sebelius (7/1/2011)	District Court in Ohio dismissed case challenging the constitutionality of the individual mandate based on 6th Circuit Court of Appeals’ ruling.
Calvey v. Obama (4/26/2011)	District Court in Oklahoma held plaintiffs have standing to challenge the individual mandate.
Kinder, et al. v. Department of Treasury, et al. (4/26/2011)	District Court in Missouri dismissed lawsuit because of the court’s lack of subject matter jurisdiction and the plaintiffs’ lack of standing.
Purpura, et al. v. Sebelius, et al. (4/21/2011)	District Court of New Jersey dismissed lawsuit because plaintiffs lacked standing.
Physician Hospitals of America v. Sebelius (3/31/2011)	District Court in Texas concluded that Congress did not act unconstitutionally in enacting the PPACA.
Peterson v. Obama (3/30/2011)	District Court of New Hampshire dismissed lawsuit as plaintiff lacked standing to question the constitutionality of the individual mandate.
Mead, et al. v. Holder, et al. (2/22/2011)	U.S. District Court for the District of Columbia ruled that the individual mandate does not violate the Constitution.

“If the court finds the individual mandate both unconstitutional and not severable, it will undo the whole of health care reform.”

Source: Towers Watson.

¹ Certiorari is generally a writ issued by the U.S. Supreme Court to a lower court stating it will review the lower court’s judgment for legal error (reversible error) and review where no appeal is available as a matter of right.

The Economic Significance of the Individual Mandate in the Health Care Reform Law

By Mark J. Warshawsky

The U.S. Supreme Court has agreed to hear arguments on the constitutionality of the 2010 health care reform law. The court will decide whether the individual mandate in the Patient Protection and Affordable Care Act (PPACA) is constitutional and — if not — whether it can be severed from the rest of the law. The court will also determine whether requiring states to choose between expanding Medicaid coverage and forfeiting their federal Medicaid funding is unduly coercive.

The arguments are scheduled for March 26 to 28, and the court will likely make its decisions in June. The decisions will be momentous, both legally and politically (see “U.S. Supreme Court and Health Care Reform: A Momentous Decision Ahead” on page 1). While many analysts and commentators have predicted the court’s direction, this article, by contrast, is more conjectural.

If the Supreme Court strikes down the individual mandate but finds it is severable from the rest of the PPACA — as did the 11th U.S. Circuit Court of Appeals — would the PPACA remain viable economically? Or is the individual mandate essential for reforms to function successfully? This article reviews the architecture of the new law, summarizes three economic studies that examine these questions empirically and gives some “outside-the-model” considerations of this pivotal issue.

Basic architecture of health care reform

The architects of reform set out to increase the number of nonelderly people covered by health insurance and to make coverage more comprehensive, reliable and affordable to individuals. To those ends, the design reforms the insurance market, offers clearly differentiated coverage choices, subsidizes coverage, assigns coverage responsibilities (including the individual

mandate) and expands Medicaid eligibility. Advocates of the reform still expect the law to reduce total health care spending sufficiently to finance the broader coverage, although achievement of this goal is doubtful.¹

Beginning in 2014, every health insurer in the individual or small group market must accept all individuals and small employers that apply for coverage. Insurers may restrict enrollment to open enrollment periods, which the law limits to 90 days, and health plans may not impose annual or lifetime caps on benefits.

Premium rates

In determining premium rates, insurers may consider only three personal factors: age, geography and individual versus family coverage. Across age bands, the highest premium rate for adults may not exceed three times the lowest premium rate. Insurers may not impose pre-existing condition exclusions, nor may they discriminate based on health-status-related factors such as medical condition and genetic information. The reform calls for establishing an annual process to review “unreasonable increases” in health insurance premiums at both the federal and state levels.

State exchanges

State health benefit exchanges must be open for business by 2014, offering coverage options for individuals and (initially, just small) employers. If a state does not launch its own exchange, the federal government will do so.

The essential health benefits package offered by an exchange must include specific categories of benefits, meet cost-sharing standards and provide certain levels of coverage. In the individual and small group markets, the scope of benefits must be equivalent to benefits under a “typical employer plan.” Standardizing benefits and prohibiting annual and lifetime limitations will have the effect of bringing up benefit generosity on the low end (for example, effectively eliminating “mini-med” plans).

An exchange’s least generous plan — a “bronze” plan — must pay a minimum of 60% of allowed charges. The exchanges also must offer more

“If the Supreme Court strikes down the individual mandate but finds it is severable from the rest of the PPACA, would the PPACA remain viable economically?”

¹ See Mark Warshawsky, Towers Watson, “Bending the Cost Curve: Will Health Care Reform Rein in Health Care Spending?” *Insider*, October 2010.

generous plans: “Silver” plans must pay at least 70% of covered charges, “gold” plans must pay 80%, and “platinum” must pay 90%.²

Total cost sharing in 2014 may not exceed the applicable out-of-pocket limits for high-deductible plans qualified under health savings accounts. After 2014, the limits will be indexed to the growth in average per capita premiums.

Tax credits

Individuals and families who do not qualify for Medicare or Medicaid and lack access to an affordable employer plan can receive a refundable health insurance premium tax credit for insurance purchased through an exchange. Generally, taxpayers whose household income is between 100% and 400% of the federal poverty line can qualify for a credit. This credit, or subsidy, operates on a sliding scale, requiring taxpayers at 100% of poverty to spend only 2% of their income on health insurance premiums (measured as the second-lowest-cost silver plan) but taxpayers at 400% of poverty to pay 9.5% of income. These individuals and families are also eligible for cost-sharing reductions, again on a sliding scale, with additional reductions for those below 250% of poverty.

Shared responsibility payments

Beginning in 2014, nearly everyone must have health insurance coverage or pay a “shared responsibility” payment. There are exceptions, including low-income individuals who are exempt

from filing federal income tax returns and those who would have to pay (net of subsidies) more than 8% of their income. This monthly penalty applies to both taxpayers and dependents, with the taxpayer paying for his or her dependents. The law sets out an intricate formula for calculating this shared responsibility payment, which generally is capped at the national average of the annual cost of an exchange-based, bronze-level health plan, adjusted for family size.

The shared responsibility payment is the greater of a “flat dollar” or “percentage of income” amount. The flat-dollar amount is assessed for each individual, spouse and dependent who lacks coverage. The amount is phased in over three years: \$95 in 2014; \$325 for 2015; and \$695 in 2016 and thereafter, indexed to inflation. (The amount is halved for individuals 18 or younger.) The law caps the annual family payment at three times the flat-dollar amount, regardless of family size or coverage gaps. The percentage of income amount is determined by first subtracting the taxpayer’s exemptions and standard deductions from household income and then multiplying that amount by the applicable percentage. The applicable percentage is phased in over three years: 1% for 2014, 2% for 2015 and 2.5% thereafter.

Enrollment and penalties in employer plans

By 2014, employers that offer health plans and have more than 200 employees must automatically enroll all new full-time employees and continue coverage for current employees. Employees may opt out of coverage.

“Beginning in 2014, nearly everyone must have health insurance coverage or pay a ‘shared responsibility’ payment.”

² Catastrophic plans may be offered only to those who are under age 30 or impoverished.

Benefits Advisory and Compliance Update

Revised Form 5300 Not Required for Cycle A

Although the Internal Revenue Service (IRS) released a revised Form 5300 earlier this year, the agency recently announced that plan sponsors filing Cycle A determination letter requests may use either version of the form. The Cycle A deadline is January 31, 2012, and plan sponsors had been concerned about whether they could update their software in time. As such, plan sponsors can continue to work on their Cycle A filings (using the old form) while software providers update their programs for future filings.

The new form will be required for all plan sponsors beginning February 1, 2012. Plan sponsors will have to submit more information, some of which may take additional time to collect, including the following:

- The date amendments were signed and when each became effective
- Additional information about the sponsor’s other plans, such as each plan’s vesting schedule and verification of a pending or current determination letter for each
- Any pending issues under an IRS or Department of Labor correction program
- Whether the plan has been involved in a merger and, if so, a statement indicating the merger date and whether the other plan was qualified at the time of the merger

Your local Benefits Advisory and Compliance consultant can provide more information on the new Form 5300 requirements and assist Cycle A filers in completing their upcoming determination letter requests.

For employers with 50 or more employees that do not offer a health plan, if at least one full-time employee receives a premium tax credit, the annual penalty will be \$2,000 per full-time employee. Even for employers that offer an affordable health plan, if at least one full-time employee receives a premium tax credit, the penalty is generally \$3,000 per employee receiving a credit.

Expanded Medicaid benefits

Beginning in 2014, states must provide Medicaid benefits to all those between ages 19 and 65 whose household income is up to 133% (effectively 138%) of the federal poverty level.³ Tax-exempt hospitals must adopt and widely publicize a written financial assistance policy. They cannot bill patients who qualify for assistance more than they generally bill insured patients or take “extraordinary” collection actions.

Role of the individual mandate

All these provisions represent a complex structure that, in essence, compels individuals to have health insurance and thereby enables the government to require insurers to disregard health status, limit pricing flexibility and standardize benefit offerings. Without the individual mandate, there could be a premium spiral, in which younger and healthier people forgo insurance, leaving health plans with sicker, higher-cost participants. Insurers, in turn, would increase premiums, prompting still more people to go without coverage, snowballing until premiums were very high and coverage dropped drastically. If insurers remained subject to all coverage and pricing requirements during the spiral, they might go bankrupt or withdraw from the market.⁴

Similarly, standardizing benefits and prohibiting annual and lifetime benefit limits are accomplished in part through the forcing mechanism of the minimum coverage requirements in the individual mandate.

Empirical evidence from three studies

At least three studies have estimated the impact of removing the individual mandate from the health reform structure: (1) the Congressional Budget Office (CBO), (2) Jonathan Gruber, an MIT professor, and (3) John Sheils and Randall Haught, senior analysts at the Lewin Group, a health care policy, research and consulting firm.⁵

³ The statutory language in the PPACA says 133% of the federal poverty level, but a subsection added later included a five-percentage-point deduction from the federal poverty level in the calculation of income, effectively making the threshold 138%.

⁴ See empirical analyses in Appendix of “Brief for Amici Curiae Economists in Support of Petitioners Regarding Severability,” January 6, 2012, Nos. 11-393 and 11-400 in the Supreme Court of the United States.

⁵ See CBO, “Effects of Eliminating the Individual Mandate to Obtain Health Insurance,” June 16, 2010, and Statement of Douglas W. Elmendorf, “CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010” before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011; Jonathan Gruber, “Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer with Higher Premiums,” Center for American Progress, April 8, 2010, and “Health Care Reform Without the Individual Mandate: Replacing the Individual Mandate Would Significantly Erode Coverage Gains and Raise Premiums for Health Care Consumers,” Center for American Progress, February 2011; and John F. Sheils and Randall Haught, “Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted,” *Health Affairs*, November 2011, 30:11, and “Modeling Health Reform Without the Mandate to Have Coverage,” Lewin Group Staff Working Paper No. 14, September 29, 2011.

CBO study

Eliminating the individual mandate would increase the number of uninsured by about 16 million people — from 23 million nonelderly residents estimated under current reform law to 39 million in 2019, according to CBO estimates. Absent any health care reform, the CBO projects that 54 million people would lack health insurance in 2019. Repealing the mandate would result in roughly 5 million fewer participants in employer plans, 5 million fewer individual subscribers and 6 million fewer enrollees in Medicaid or the Children’s Health Insurance Program.

The CBO also estimates that eliminating the mandate would accelerate adverse selection — in which healthy people decline to purchase insurance — thereby increasing premiums by an estimated 15% to 20% relative to the current health reform law. Medicaid enrollees would also have higher expected health spending, on average.

Gruber study

Gruber, an intellectual father of federal health care reform and its predecessor in Massachusetts, has developed impact estimates akin to the CBO’s — but more severe — using his own similar model. Gruber estimates that eliminating the mandate would increase the number of uninsured by 22 million to 24 million, compared to current reform law, mainly by reducing the rolls of those covered by employer plans by 15 million. He also estimates that, without the mandate, the cost of the average individual premium would rise by 27% to 40%, while government spending would be only 20% to 30% less, severely reducing the bang of increasing coverage for the buck of subsidies and Medicaid spending. In fact, Gruber concludes that “[w]ithout the individual mandate, the entire structure of reform would fail.”

The models used by both the CBO and Gruber employ estimates of a price elasticity of health insurance coverage — the estimated percentage change in coverage divided by the percentage change in price, as found in the professional literature. The model removes the individual mandate by eliminating its associated penalties. Its removal decreases the cost of being uninsured, which sets off an iterative cycle of reduced demand for coverage, increased adverse selection and higher insurance costs until a new market equilibrium is reached. The analyses

“Gruber concludes that [w]ithout the individual mandate, the entire structure of reform would fail.”

also presume that the mandate will succeed beyond its financial incentives owing to an emerging social stigma associated with being uninsured along with supporting conventions, which seems to have occurred in Massachusetts.

As additional support for his estimates, Gruber cites the actual impact on price of community rating and guaranteed issue requirements in the individual and small-group markets in the 1990s experience of several Northeastern states. In that case, the reforms pushed policy prices higher by as much as 40%, and the number of insurers in the market dropped.

Lewin Group study

The analysts at the Lewin Group take a more benign view of the mandate's elimination. Using various data sources, the Lewin model simulates employers' decisions to offer coverage and identifies those individuals eligible for Medicaid and subsidies. Sheils and Haught then adapt a model of consumer risk aversion to estimate the difference in "utility" between having health insurance (calculating a separate value for each standard benefit package offered in the exchanges) and going without. If the difference is positive, the consumer decides to get health coverage; if negative, he forgoes it. The estimate hinges on estimating consumer risk aversion (as opposed to using estimates of price elasticity, as in the other two studies), as well as on net coverage costs (with or without a penalty) and the net costs and variability of health spending.

Sheils and Haught estimate that eliminating the individual mandate would increase nongroup premiums by 12.6%. Individual coverage would fall from an estimated 30.7 million to 26.2 million people — a drop of 4.5 million. They also project 2.1 million fewer participants in employer plans (as some employers and employees drop coverage, but others buy it in response to the higher nongroup premiums) and 1.2 million fewer Medicaid enrollees. Overall, they estimate the number of people without health insurance at 28.5 million without the mandate compared with 20.7 million with the mandate — an additional 7.8 million without health insurance.

The Lewin analysts attribute their rosier projection to two factors: the self-adjusting nature of subsidies and the exchanges' limited enrollment periods (about six weeks a year). Because many of those currently without health insurance are eligible for subsidies and the PPACA ties the subsidies to the cost of the second-least-expensive silver plan, the price increases caused by losing the individual mandate will automatically trigger higher subsidies

to keep consumer spending within PPACA limits. This mechanism, according to Sheils and Haught, will buoy the demand for insurance coverage even without the mandate. Moreover, they believe the limited open enrollment period will prompt people to purchase insurance without waiting for a health need to arise, even without underwriting limitations on coverage.⁶

Other considerations

These studies provide careful and comprehensive estimates and projections for coverage and insurance policy prices under the new health care law, with and without an individual mandate. Nevertheless, some of the estimates seem more sensible than others. In particular, the expansion of Medicaid coverage depends on more than potential recipients' actions. Hospitals and clinics with uninsured patients who might be eligible for Medicaid will do their best to get Medicaid coverage for such patients, with or without an individual mandate.

On the other hand, it is much more difficult to predict the behavior of those who are uninsured but ineligible for Medicaid. After all, some will not be eligible for subsidies, and for others the subsidies will be relatively small. More important, many currently do without health insurance by choice, perhaps because they are risk-tolerant, in excellent health or planning to rely on charity care if they get sick. Estimates of price elasticity and risk aversion based on the general population might not be particularly relevant to predicting the behavior of these uninsured individuals and households. The penalty is probably significant enough to matter in the coverage decision of many of these people, and social conventions would also play a role.

Therefore, it is reasonable to presume that, without a mandate and associated penalty and for those receiving no or relatively little subsidy, both individual and employer-sponsored coverage will decline substantially, more in line with the overall estimates of the CBO or Gruber. Moreover, the assertion by Sheils and Haught that a limited open enrollment period will prompt individuals to buy in ignores that at least some health care is elective or its timing can be controlled.

After the court's decision

In its briefs before the courts, the Obama administration has stated that if the individual mandate is declared unconstitutional, the guaranteed issue and community rating provisions should be removed from the law as well. Recall that

"It is reasonable to presume that, without a mandate and associated penalty and for those receiving no or relatively little subsidy, both individual and employer-sponsored coverage will decline."

⁶ Sheils and Haught address the implied criticism from Gruber arising from the experience of Northeastern states after their insurance market reforms by noting that, although nongroup premiums increased in these markets, coverage apparently did not decline much, albeit less comprehensive policies were likely purchased and the states continued to allow some limitations on coverage for pre-existing conditions.

the rest of the law includes the minimum coverage requirements, standardization of benefits, elimination of benefit limits, restrictions on health provider collection efforts and others. The 11th Circuit Court of Appeals found the individual mandate unconstitutional but severable, thus allowing the rest of the law to remain intact.

If the Supreme Court follows this lead, then the Obama administration will face the strong possibility that the provisions left standing will not increase health insurance coverage and lower prices for many health consumers. The blow to the functioning of reform will be even stronger if the court also strikes down the Medicaid expansion provisions as unduly coercive to the states.

Even if the Supreme Court declares the individual mandate unconstitutional and severs the guaranteed issue and community rating provisions, the remaining structure will be significantly weaker. Although it would be difficult politically to accomplish the inclusion of other constitutionally allowed enrollment mechanisms, they would no doubt be sought to keep the reform structure intact, given the considerable investment the administration has already made in implementation of the law and its political significance.⁷

One such mechanism could be an auto-enrollment option applying to all workers and employers, not

just workers at large companies (as under current law). While auto-enrollment options have worked well for 401(k) plans, the efficacy of such a mechanism for health insurance is more doubtful because health insurance is so expensive, and many of the uninsured lack access to employer plans. Another option would be imposing penalties for late enrollment, as in Medicare Parts B and D, but even a tough penalty — such as being barred from purchasing insurance for three years — might not convince the risk-tolerant or young to buy health insurance. Moreover, waiting periods could have life-and-death consequences, such as forcing someone with a rare and deadly form of cancer to go without life-saving medical treatment.

These mechanisms clearly could not replicate the individual mandate in ensuring coverage and preserving the structure of health care reform. Should the Supreme Court strike down the individual mandate and/or the Medicaid expansion but preserve the rest of the law, the administration's options will be limited. If the Obama administration goes ahead with a flawed implementation, the United States might well face a particularly grim health care future — a failing individual health insurance market, rising insurance prices, and possibly withdrawals or bankruptcies among insurers and health care providers.

⁷ See the second half of the 2011 paper by Jonathan Gruber, *op. cit.*

Benefits Advisory and Compliance Update

DOL Revises Requirements for Electronic Disclosure of DC Plan Expenses

The Department of Labor (DOL) recently issued guidance (Technical Release 2011-03R) on electronic disclosure of investment fees in defined contribution (DC) plans. The new guidance primarily affects sponsors that wish to combine participant benefit statements with fee disclosure.

There are now four alternative standards for electronic disclosure. Determining the alternatives available (or preferable) in a given situation is complex and depends on the type of information being disclosed.

Sponsors that distribute participant benefit statements electronically under current standards may continue doing so, while also including basic plan-related disclosures, such as administrative expenses and identification of investment options. Sponsors that want to include investment-related disclosures in their electronic benefit statements may need to comply with new conditions in some cases. Specifically, to include both types of disclosures in electronic benefit statements, sponsors will need to meet the requirements of either the longstanding DOL safe harbor for electronic disclosure or a new alternative described in the latest technical release, which permits, among other things, use of a continuous-access website.

Please contact your local Towers Watson Benefits Advisory and Compliance (BAC) consultant if you have any questions about how the different alternatives affect your plans for fee disclosure. Your BAC consultant can also help you determine how best to communicate new fee disclosures to plan participants and how to prepare for questions that might arise about the fees.

Retirement Planning In a Post-Crisis Economy

By Steve Nyce

Prolonged economic uncertainty and high unemployment have taken a heavy toll on U.S. workers. Few have escaped hits to their retirement savings or to their confidence in being able to retire comfortably. Unsurprisingly, many Americans have become more financially conservative, cutting back on spending and paying more attention to household finances and retirement planning and saving.

As the economic recovery proceeds — albeit in fits and starts — economic satisfaction levels and optimism about retirement are slowly rising as well. Nevertheless, fallout from the crisis lingers in the psyche of American workers, as many remain apprehensive about their economic future generally and about retirement in particular.

This article is the first in a three-part series based on the 2011 *Towers Watson Retirement Attitudes Survey* highlighting American workers' attitudes toward their household finances and retirement readiness. The second article will examine how the financial crisis has changed the trade-offs employees are willing to make to reduce their retirement and health care risks. The last article will look at the impact of retirement programs on attracting and retaining employees.

About the survey

The *Towers Watson Retirement Attitudes Survey* was conducted in June/July 2011 and includes responses from 9,218 full-time U.S. employees at nongovernmental organizations with 1,000+ employees. This is Towers Watson's fifth consecutive survey of U.S. employees' attitudes toward their health care and retirement benefits. The primary results reported in this article reflect a subset of questions about retirement and health care programs completed by 3,074 respondents. Comparable surveys fielded in February 2009 and May/June 2010 asked similar questions, and we use selective results from those surveys to track

trends in employee attitudes. All results are weighted by age, gender and household income to the national average of workers. Margins of error are +/- 1.2% for the total sample and +/- 1.7% for the benefits sample.

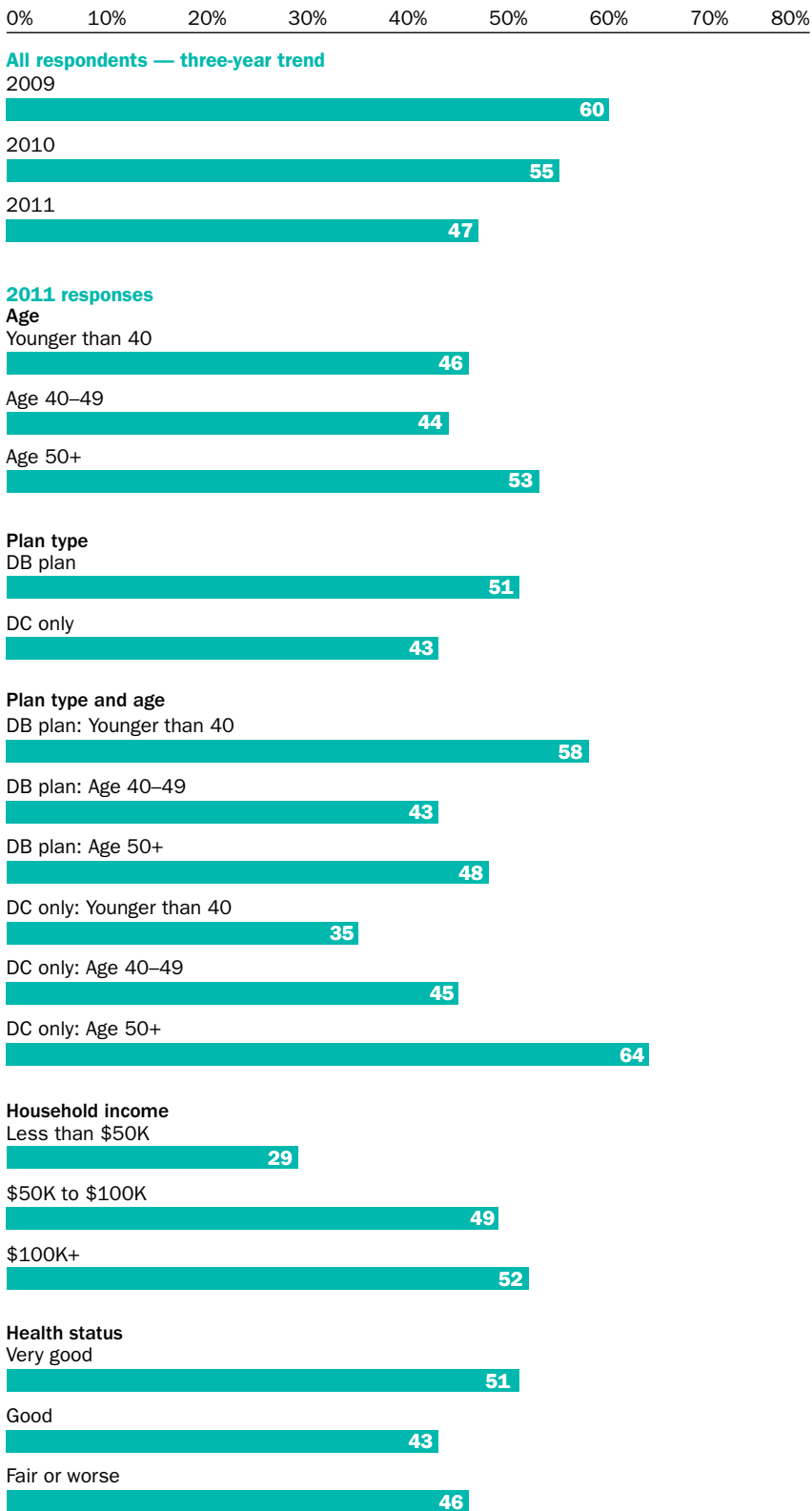
Respondents self-reported whether they participate in a defined benefit (DB) pension plan and/or a 401(k)/403(b) retirement savings plan. There were 1,662 respondents with only a defined contribution (DC) plan and 1,232 respondents with a DB plan. Nearly all responding DB plan participants also have a DC plan (92%). Roughly 80% of respondents with a DB plan are currently accruing benefits under their plan. Among those whose benefits are frozen, 70% are age 50 or older, and 85% have 10 or more years of service with their current employer. Younger employees with a DB plan were oversampled to improve confidence in comparisons of retirement attitudes by plan types and age groups. Margins of error for the age and plan type results are +/- 5% or less.

Survey highlights

- While employees' satisfaction with their overall finances improved, dissatisfaction remains widespread, especially among older workers, employees in poor health and those with only a DC plan.
- Employees with DB plans are more than twice as likely to feel "very confident" about the first 15 years of retirement and 2.5 times as likely to feel confident about 25 years of retirement.
- Many employees continue trying to pay off debt, reduce their spending, save more and think more carefully about their retirement saving targets.
- In 2011, only 37% of women felt comfortable making their own investment choices versus 62% of men. Younger DB plan participants are most comfortable making their own investment decisions.
- Despite the fact that health costs will represent a major expense for most retirees, 40% of employees do not consider these costs in estimating their retirement income needs.
- Older employees and employees in poor health are most likely to be delaying retirement — 46% of older workers are postponing retirement versus 34% of younger workers.

"Fallout from the crisis lingers in the psyche of American workers, as many remain apprehensive about their economic future generally and about retirement in particular."

Figure 1. I have experienced significant declines in my pension/retirement savings due to recent events in the economy and financial markets



Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
 Source: 2011 Towers Watson Retirement Attitudes Survey.

- The majority of workers delaying retirement expect to work an additional three years, and one-third plan on five additional years. Of workers who plan to retire later, 64% of those aged 50 and older cite keeping their health care coverage as the reason.

Fewer employees report significant declines in pension/retirement savings

From 2009 to 2011, the number of employees reporting a significant decline in their pension and retirement savings fell from 60% to 47% (Figure 1).

As shown in the 2011 responses, losses from the economic and financial turmoil are more likely to linger for workers nearing retirement than for mid-career and younger employees. Somewhat surprisingly, those with DB plans report steeper declines in their pension and retirement savings, but this generally reflects the perceptions of younger DB plan participants. The crises in the financial and housing markets continue to have a lasting impact on older workers with only a DC plan, whereas those nearing retirement with a DB plan are faring somewhat better. Financial market declines have tended to hit high-income workers hardest — those who generally have more retirement savings at risk.

“The crises in the financial and housing markets continue to have a lasting impact on older workers with only a DC plan, whereas those nearing retirement with a DB plan are faring somewhat better.”

Employee satisfaction with finances improves, especially among DB plan participants

As the economy and financial markets have slowly regained their footing, so has the percentage of employees satisfied with their financial situation. Satisfaction with household finances jumped from 26% to 41% between 2009 and 2011 (Figure 2). Higher satisfaction levels are strongly linked to DB plans — satisfaction rises by 20 percentage points for employees with DB plans versus six percentage points for those with only DC plans. But this is not a broad-based recovery, and satisfaction is concentrated among younger and mid-career workers. The sobering news is that three in five employees remain generally unsatisfied with their financial situation, and satisfaction is lowest among older workers (regardless of plan type), employees in poor health and those with only a DC plan.

Younger participants in DB plans were more likely than those with only DC plans to report both significant declines in their retirement savings and higher satisfaction with their finances. Many factors could account for this seeming inconsistency. For example, their greater satisfaction might derive from the cushioning effects of a DB plan, which have become more apparent as DC plans have suffered in comparison during the financial crisis. Moreover, as we discuss below, DB plan participants and particularly those younger than 40 tend to be more dialed into retirement issues and so may be tracking their financial gains and losses more closely. Between news media reports and chats with colleagues — the looking-around model of retirement planning — many DB plan participants have become more aware of just how fortunate they are, which may boost their satisfaction and confidence.

Retirement confidence improves but trails pre-crisis levels

Despite feeling more satisfied overall and confident about retirement, many employees continue to worry about whether their retirement savings will be sufficient, especially over the long haul. Roughly two-thirds of employees (68%) are “somewhat confident” or “very confident” their retirement resources will see them through the first 15 years, but confidence declines to 47% for 25 years (Figure 3).

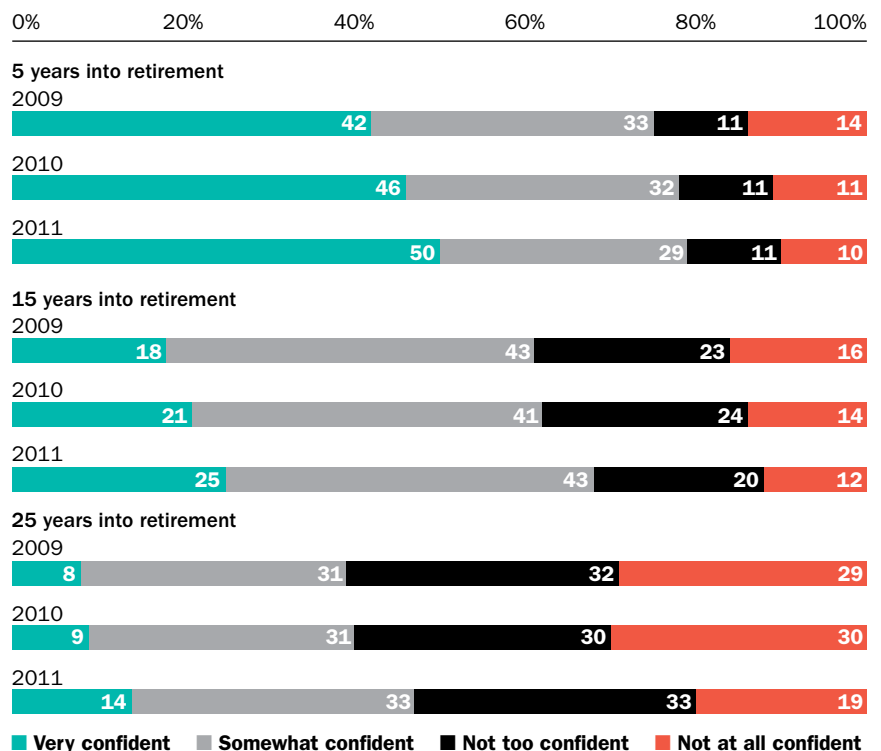
Improvements in retirement confidence largely accrue to DB plan participants, particularly as the retirement horizon lengthens, likely owing to the security of the lifetime annuity stream offered in

Figure 2. Thinking of all aspects of my finances, I am satisfied with my situation today

	Feb. 2009	June 2010	June 2011	Percentage point change: 2009 vs. 2011
All	26%	33%	41%	15
Age				
Younger than 40	28%	42%	47%	19
Age 40–49	22%	29%	39%	17
Age 50+	24%	32%	33%	9
Plan type				
DB plan	29%	40%	49%	20
DC only	25%	27%	31%	6
Plan type and age				
DB plan: Younger than 40	31%	58%	59%	28
DB plan: Age 40–49	27%	36%	51%	24
DB plan: Age 50+	30%	37%	34%	4
DC only: Younger than 40	29%	32%	36%	7
DC only: Age 40–49	19%	24%	22%	3
DC only: Age 50+	22%	26%	28%	6
Health status				
Very good	33%	43%	51%	18
Good	24%	27%	34%	10
Fair or worse	12%	18%	26%	14

Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
Source: 2011. Towers Watson Retirement Attitudes Survey.

Figure 3. Employees’ confidence in having enough resources to live comfortably in retirement



Source: 2011. Towers Watson Retirement Attitudes Survey.

Figure 4. Employees' confidence in having enough resources to live comfortably in retirement by plan type

Plan type	Years into retirement				Percentage point change: 2009 to 2011	
		2009	2010	2011		
DB plan	5 years	55%	57%	62%	7	
DC only		38%	40%	44%	6	
DB plan	15	26%	29%	39%	13	
DC only		14%	17%	18%	4	
DB plan	25	9%	14%	23%	14	
DC only		7%	6%	9%	2	

Note: Percentages indicate responses of "very confident."
Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 5. Older workers' (age 50 to 64) confidence in having enough resources for a comfortable retirement

	5 years				Percentage point change:	
	2007	2009	2010	2011	2007 to 2009	2009 to 2011
	Not at all confident	6%	10%	9%	8%	4
Not too confident	4%	10%	9%	11%	6	1
Somewhat confident	27%	35%	32%	29%	8	-6
Very confident	63%	44%	50%	52%	-19	8

	15 years				Percentage point change:	
	2007	2009	2010	2011	2007 to 2009	2009 to 2011
	Not at all confident	9%	15%	12%	10%	6
Not too confident	15%	21%	24%	23%	6	2
Somewhat confident	42%	46%	40%	41%	4	-5
Very confident	34%	18%	24%	27%	-16	9

Source: 2007 numbers based on T. Hill (2008), Watson Wyatt's 2007 U.S. Surveys of Older Employees' and Retirees' Attitudes Toward Lump Sum and Annuity Distributions From Retirement Plans.

Figure 6. Given recent financial events, which of the following actions have you taken or are considering taking in the next 12 months?

All employees	Actions taken			Actions considering in next 12 months
	Feb. 2009	June 2010	June 2011	
Pay off debt	33%	63%	53%	25%
Review my financial situation	41%	55%	49%	30%
Cut back on my daily spending	55%	54%	46%	28%
Review how much I need to save for retirement	20%	38%	34%	37%
Increase my monthly savings	19%	34%	29%	33%
Defer major expenditures	N/A	N/A	29%	23%
Obtain professional financial advice	N/A	N/A	19%	29%
Adopt a less risky investment strategy	13%	20%	16%	17%
Borrow/withdraw money from my retirement savings	9%	13%	15%	14%
Reduce my monthly savings	13%	10%	9%	7%
Adopt a more risky investment strategy	3%	9%	8%	13%

Source: 2011 Towers Watson Retirement Attitudes Survey.

many of these programs and/or the more generous retirement programs typically provided by DB plan sponsors. Either way, employees with a DB plan are more than twice as likely to feel "very confident" about the first 15 years of retirement and 2.5 times as likely to contemplate a 25-year retirement with confidence than workers with only a DC plan (Figure 4).

Figure 5 shows the trajectory of retirement confidence among older workers before and after the financial crisis. Restoration of retirement confidence has been slow, reflecting the weak recovery. Looking at both five-year and 15-year horizons, the percentage of older employees who are "very confident" about retirement remains roughly 20% below 2007 levels.

Employees still trying to get their financial houses in order

In 2009, workers cut back on their daily spending and re-examined their financial standing. A year later, many employees decided to pay off household debt and re-evaluate their retirement savings, and some chose to save more for retirement.

Employees today continue to budget and plan more conservatively (Figure 6). The survey results suggest that cost cutting and a sharpened focus on retirement security will continue over the next year. In fact, roughly a third of workers not already doing so are considering reviewing their retirement savings needs (37%) and/or increasing their monthly savings (33%). In the same vein, many more employees (29%) plan to seek professional financial advice.

"The percentage of older employees who are 'very confident' about retirement remains roughly 20% below 2007 levels."

Nearly half of survey respondents said they had significantly reduced their spending and deferred major expenditures over the last three years (Figure 7). This has been particularly true of younger employees (58%) and those new to their current job (66%), perhaps reflecting heightened job insecurity.

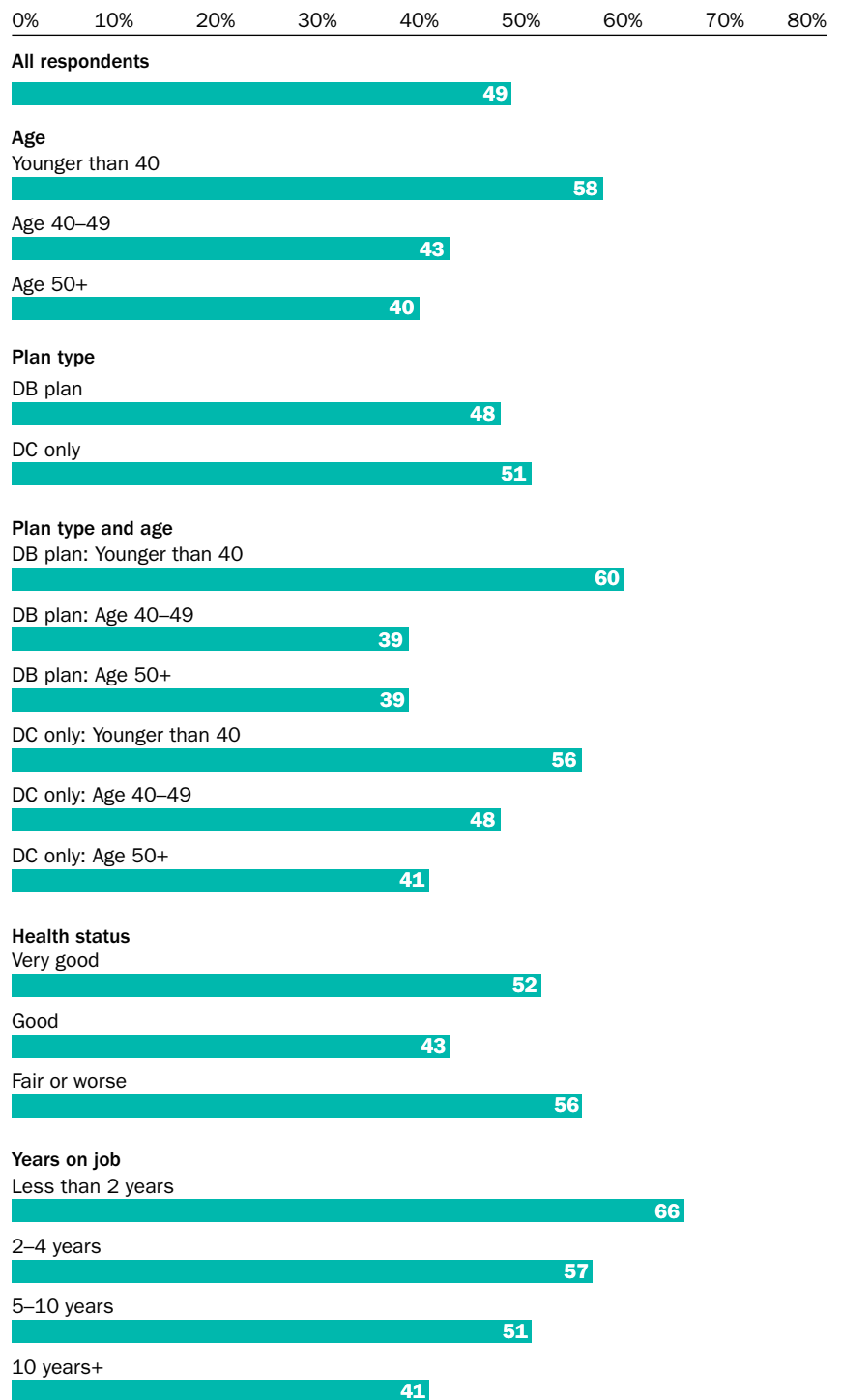
Saving more for retirement remains a priority

Workers of all ages are rethinking their preparations for retirement. In 2009, market declines prompted many workers to step up their retirement savings, although the higher savings rates fell as equity returns worked their way back up (Figure 8, next page). Perhaps due to the prolonged economic malaise since then, however, many employees appear to be reversing course. In 2011, the percentage of workers saying they need to save more for retirement is the same as it was in February 2009, when equity values were near their lowest point.

Mid-career and older workers with only a DC plan believe they will need to save much more to attain a comfortable level of retirement income compared with their counterparts with a DB plan. However, younger DB plan participants feel the greatest pressure to save more, perhaps due to recent hits to their retirement savings (see Figure 1). It may also reflect this group's fears about whether they will still have a DB plan when they're ready to retire, given pension curtailments over recent years.

“Mid-career and older workers with only a DC plan believe they will need to save much more to attain a comfortable level of retirement income compared with their counterparts with a DB plan.”

Figure 7. I have simplified my lifestyle over the last three years by spending less and deferring major expenditures



Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 8. Compared to what I thought three years ago, I will need to save much more in the future to achieve a comfortable level of income in retirement

	Feb. 2009	June 2010	June 2011	Percentage point change: 2009 vs. 2011
All	63%	57%	63%	0
Age				
Younger than 40	58%	54%	66%	8
Age 40–49	67%	61%	57%	–10
Age 50+	68%	55%	62%	–6
Plan type				
DB plan	59%	53%	61%	2
DC only	67%	60%	64%	–3
Plan type and age				
DB plan: Younger than 40	55%	56%	71%	16
DB plan: Age 40–49	59%	58%	50%	–9
DB plan: Age 50+	62%	50%	58%	–4
DC only: Younger than 40	60%	53%	62%	2
DC only: Age 40–49	74%	63%	65%	–9
DC only: Age 50+	75%	61%	70%	–5

Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
Source: 2011 Towers Watson Retirement Attitudes Survey.

More employees rethinking their retirement savings goals

The increasing attention to retirement is an encouraging development. Between 2010 and 2011, the percentage of young workers who had carefully reviewed their retirement plans increased by more than 40% (Figure 9). The budget crisis and media discussions of the ominous outlook for Social Security could be triggering second thoughts about reliance on government programs. Stepped-up attention to retirement might also reflect the growing prevalence of DC plans, which shift primary responsibility for retirement saving, investing and withdrawals from employers to employees.

While employees are more interested, many of them are not yet comfortable with being in charge of their retirement futures. Only half are comfortable making their own investment decisions (up from 47% last year). Moreover, of those relying entirely on a DC plan, only 42% are comfortable making their own investment decisions — down from 44% in 2010.

Figure 9. Extent to which active employees have reviewed their retirement plans and are comfortable making their own retirement investment decisions

	Reviewed my retirement plans in a lot of detail over the last year		Tried to calculate how much money I would need to save for a comfortable retirement		I am comfortable making my own retirement investment decisions	
	June 2010	June 2011	June 2010	June 2011	June 2010	June 2011
All	41%	47%	56%	58%	47%	52%
Gender						
Female	31%	34%	48%	45%	32%	37%
Male	47%	56%	60%	67%	57%	62%
Age groups						
Younger than 40	34%	48%	50%	58%	49%	55%
Age 40–49	36%	44%	54%	54%	43%	50%
Age 50+	47%	48%	59%	62%	49%	48%
Plan type						
DB plan	45%	54%	62%	67%	51%	60%
DC only	37%	38%	50%	48%	44%	42%
Plan type and age						
DB plan: Younger than 40	39%	59%	58%	70%	71%	72%
DB plan: Age 40–49	37%	50%	57%	66%	42%	58%
DB plan: Age 50+	51%	51%	65%	63%	50%	47%
DC only: Younger than 40	30%	38%	46%	48%	36%	41%
DC only: Age 40–49	36%	35%	52%	39%	44%	39%
DC only: Age 50+	41%	41%	50%	57%	49%	51%

Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
Source: 2011 Towers Watson Retirement Attitudes Survey.

Men are much more likely than women to have reviewed their retirement plans, to have calculated how much they needed to save and to be comfortable making retirement investment decisions. In 2011, only 37% of women felt comfortable making their own investment choices versus 62% of men.

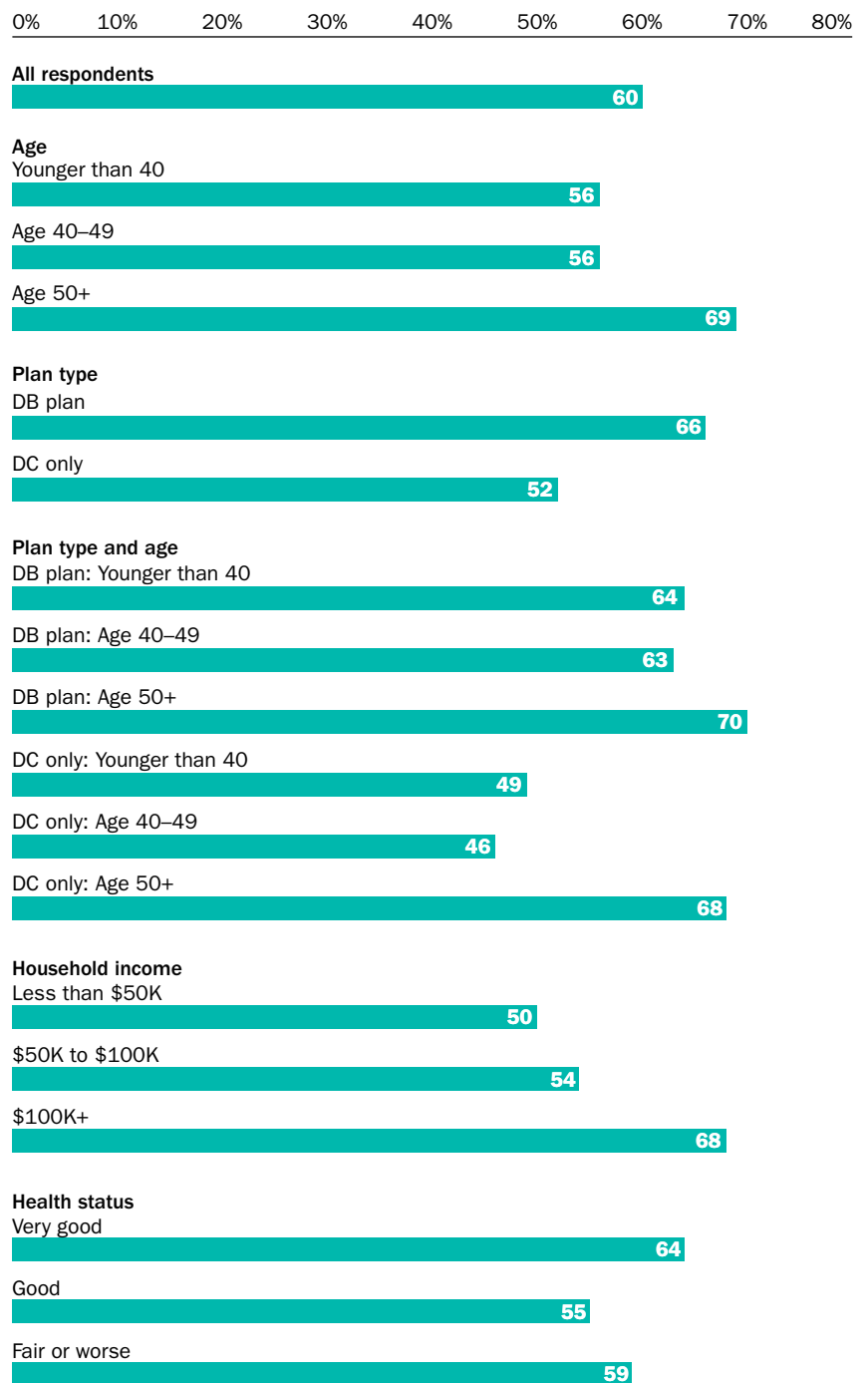
Surprisingly, younger DB plan participants are most comfortable making their own investment decisions. While this might reflect the overconfidence of youth, it could also arise from the bigger “risk allowance” conferred by the DB benefit. Participants in DB plans know that, even if their investment returns fall short, their DB plan provides a retirement security backstop.

Many employees are well aware of the effects of escalating health care costs on their retirement prospects (*Figure 10*). Not only will health care claim a significant share of future retirement income, rising health insurance and out-of-pocket health costs are squeezing workers’ paychecks now, leaving less for retirement savings.

Despite the central role health costs play in realistic retirement calculations, however, 40% of employees do not consider these costs in estimating their retirement income needs. Workers could benefit from more robust tools and better retirement education, especially as companies increasingly look to DC health care models as a way to manage the exploding cost of health care benefits.

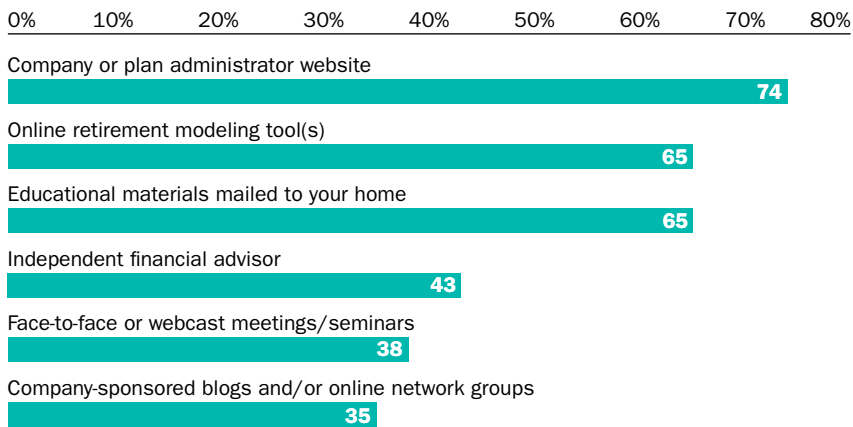
“Not only will health care claim a significant share of future retirement income, rising health insurance and out-of-pocket health costs are squeezing workers’ paychecks now.”

Figure 10. When planning for my retirement, I consider the cost of health care in estimating how much money I will need to save for a comfortable retirement



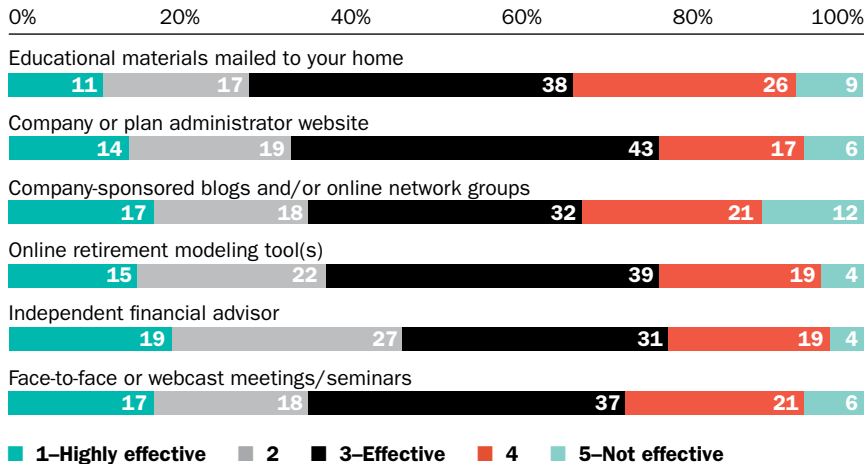
Note: Percentages indicate responses of “somewhat agree” or “strongly agree.”
Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 11. Which of the following educational materials/tools offered by your employer (or plan administrator) do you use to help you prepare for retirement?



Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 12. Please rate the effectiveness of the tools provided by your employer



Note: Includes respondents offered the tool by their employer/plan administrator.
Source: 2011 Towers Watson Retirement Attitudes Survey.

Customized retirement information and tools get highest marks

Many employers provide educational materials and tools to help employees prepare for retirement. Employees most often turn to company or plan administrator websites and online modeling tools to explore their options, and rely less on face-to-face meetings and company-sponsored blogs (Figure 11).

Employees value personalized and customized information — such as from an investment advisor or through online modeling tools — most highly and are less enthusiastic about generic mailings of educational materials (Figure 12). Employees report mixed experiences with online networking groups and face-to-face seminars. The explosion in social networking tools and gaming software and technologies suggests the emergence of new approaches to engaging employees and more effective retirement planning tools in the future.

“Employees most often turn to company or plan administrator websites and online modeling tools to explore their options.”

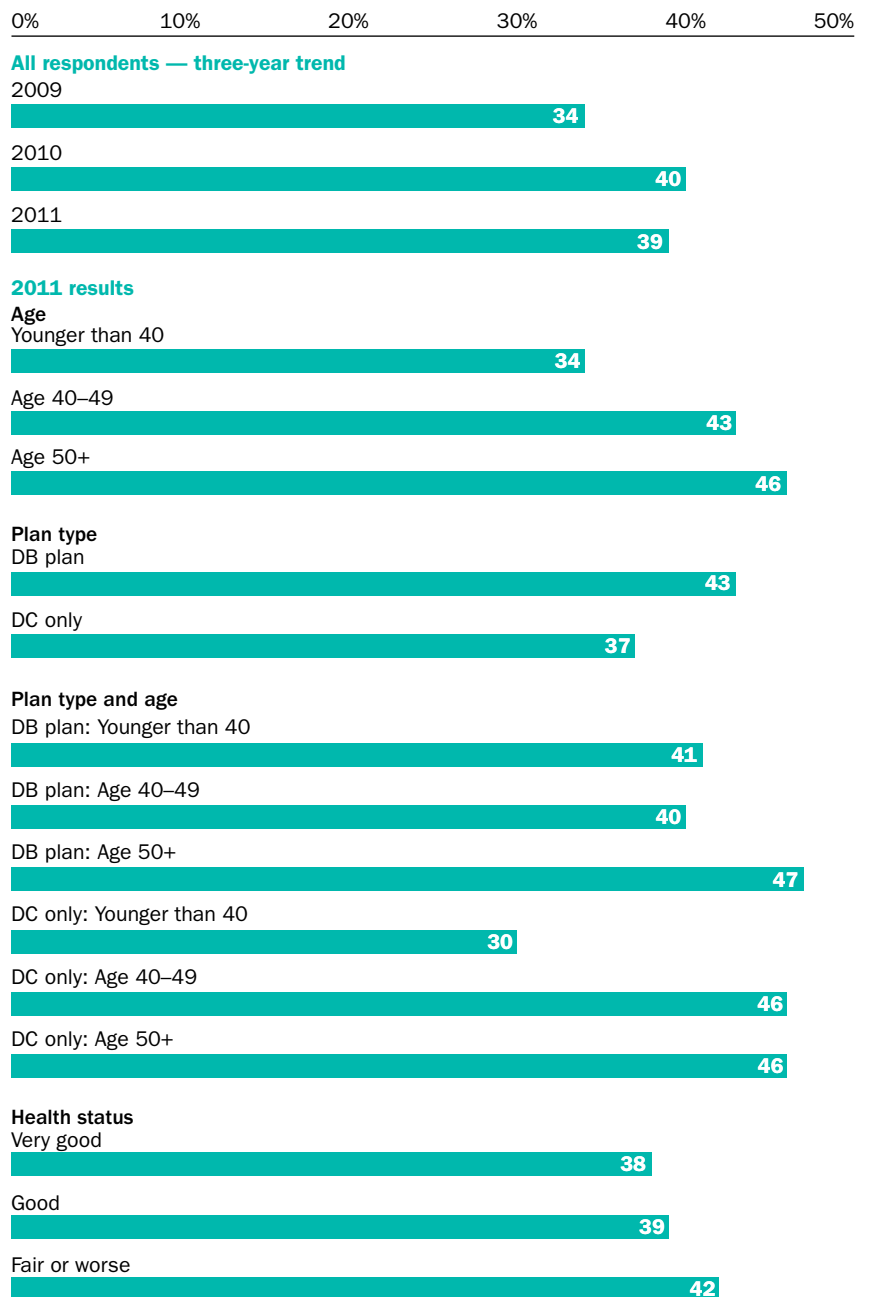
Many workers still plan to delay retirement

One of the most momentous effects of the economic crisis has been the number of employees deciding to delay retirement, which has remained relatively constant (Figure 13). The percentage of employees planning to retire later increased by six percentage points between 2009 and 2010, and declined by one percentage point over the last year. Older employees and employees in poor health are most likely to delay retirement — those with less time to recover lost savings or who can least afford to save more now. In fact, 46% of older workers are postponing retirement versus 34% of younger workers.

As reported earlier, satisfaction with household finances and retirement confidence are considerably higher for DB plan participants than for those with only a DC plan (see Figures 2 and 4). Yet DB plan participants in general are just as inclined as DC-only participants to retire later. In fact, younger employees with a DB plan are significantly more likely to say they plan to delay their retirement than younger employees with only a DC plan (41% versus 30%). This might reflect overall uncertainty about whether they can count on their DB plan in the future, given the fate of so many of these plans. And the high and increasing cost of health care may weigh heavily on all employees.

The majority of workers delaying retirement expect to work at least an additional three years, and one-third anticipate an extra five years on the job (Figure 14). These planned delays have held relatively steady over the last three years, but the delays are longer for those with only a DC plan.

Figure 13. Has the age at which you plan to retire from full-time employment changed over the last three years?



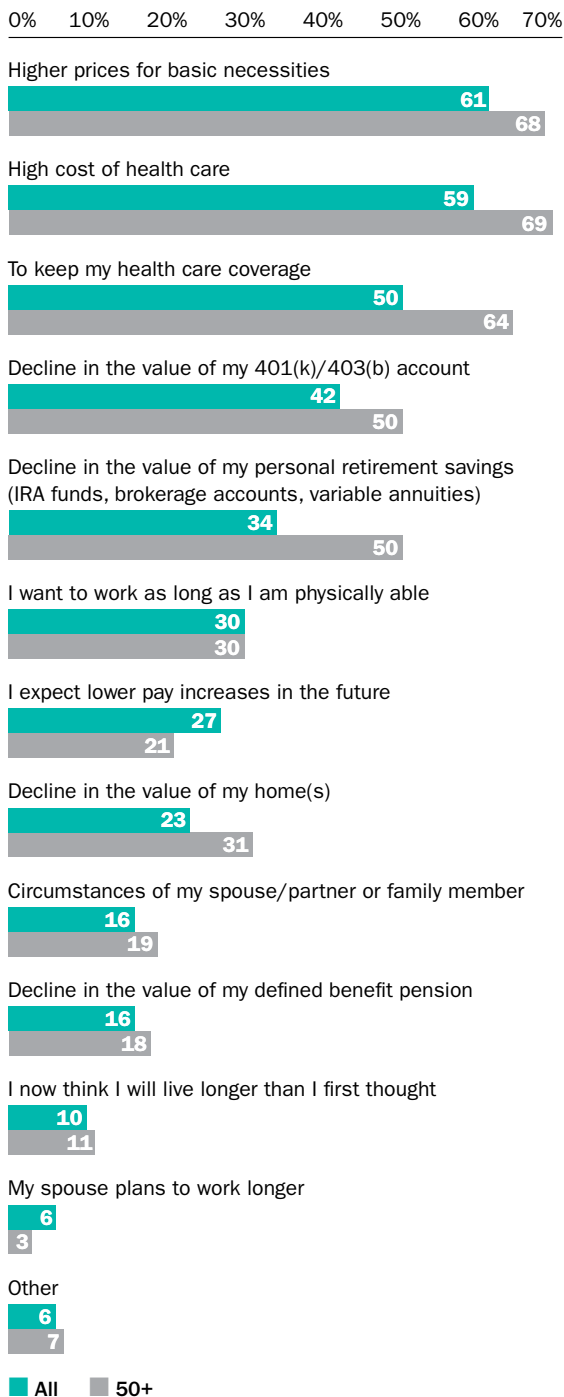
Note: Percentages indicate responses of "a little later" or "much later."
Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 14. Approximately how much later do you expect to work?

	All			In 2011 by plan type	
	Feb. 2009	June 2010	June 2011	DB plan	DC only
Less than 1 year	0%	1%	1%	2%	1%
1 year to less than 2 years	8%	8%	10%	10%	9%
2 years to less than 3 years	17%	23%	23%	28%	21%
3 years to less than 5 years	22%	27%	24%	22%	27%
5 years or more	41%	34%	36%	33%	36%
Don't know	11%	7%	7%	5%	7%

Note: Percentages based on respondents who plan to work "a little later" or "much later" due to the financial crisis.
Source: 2011 Towers Watson Retirement Attitudes Survey.

Figure 15. Which of the following are the most important reasons you expect to retire later?



Source: 2011 Towers Watson Retirement Attitudes Survey.

Rising health costs and retaining coverage are top reasons for retirement delays

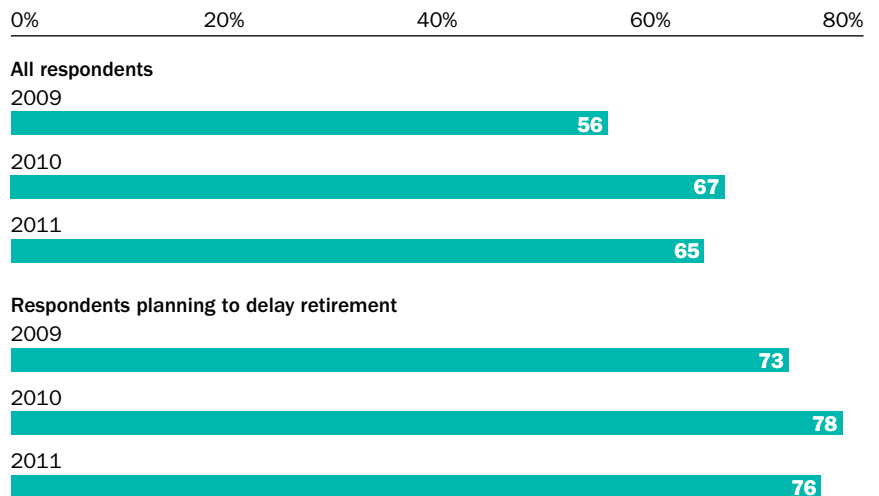
Survey respondents, especially older workers, most often blame the rising costs of necessities and health care for retirement delays. Of workers who plan to retire later, 64% of those aged 50 and older cite keeping their health care coverage as the reason (Figure 15). Indeed, 65% of all respondents and 76% of those delaying retirement are basing their retirement date on their eligibility for Medicare (Figure 16). The Patient Protection and Affordable Care Act and its health insurance exchanges — assuming they operate as planned — might weaken the link between health care coverage and retirement by making affordable care more attainable for older Americans.

Yet the financial crisis remains a driving force behind delayed retirements. Older workers' reasons for postponing retirement include losses to their retirement accounts, personal savings and home values.

Younger workers anticipate an earlier retirement

The age at which older and mid-career workers expect to retire remained relatively stable between 2009 and 2011 (Figure 17, next page). Younger workers, however, have been revising their expectations forward. In 2009, 32% of employees younger than 40 planned to retire before their 65th birthday. Today, 43% plan to retire before then — an increase of nearly 35%. Are younger workers' expectations realistic? Or does this reveal a knowledge gap that companies will want to take action to close?

Figure 16. I will likely work longer in order to keep my health care benefits before I'm eligible for Medicare



Notes: Respondents planning to delay retirement are those planning to work "a little later" or "much later" due to the financial crisis. Percentages indicate responses of "somewhat agree" or "strongly agree."
Source: 2011 Towers Watson Retirement Attitudes Survey.

“Sixty-five percent of all respondents and 76% of those delaying retirement are basing their retirement date on their eligibility for Medicare.”

Figure 17. At what age do you expect to retire from all full-time employment?

	Younger than 40			Age 40–49			Age 50+		
	Feb. 2009	June 2010	June 2011	Feb. 2009	June 2010	June 2011	Feb. 2009	June 2010	June 2011
Under age 65	32%	41%	43%	29%	33%	32%	29%	29%	29%
Younger than 55	6%	4%	5%	3%	3%	2%	0%	0%	2%
55–59	11%	13%	14%	10%	11%	11%	7%	6%	5%
60–61	7%	13%	13%	6%	7%	7%	7%	6%	6%
62–64	8%	11%	11%	10%	12%	11%	15%	17%	17%
Age 65	20%	18%	21%	15%	17%	20%	14%	16%	17%
Over age 65	31%	27%	24%	45%	40%	42%	50%	50%	48%
66–69	17%	18%	16%	24%	26%	25%	30%	35%	33%
70+	9%	8%	7%	17%	10%	15%	15%	12%	11%
Never retire	5%	1%	1%	4%	4%	3%	5%	3%	4%
Don't know	17%	15%	11%	10%	9%	6%	6%	5%	6%

Source: 2011 Towers Watson Retirement Attitudes Survey.

Conclusion

The financial crisis is having momentous and long-lasting effects on employee attitudes toward retirement. Although the economy might be on the mend, the recovery has been faltering and fragile. Employees are slowly rebuilding their lost savings, but doubts about the country's economic outlook linger.

More than three years after the crisis began, employees' confidence in their retirement resources remains below pre-crisis levels, especially among older workers who are closer to their desired retirement date. For many, poor health or concerns about the affordability of health care are further obstacles to financial security.

Although confidence is shaky across the board, DB pension plan participants — who are much less exposed than other workers to market risk — remain far more optimistic about their retirement prospects than do DC-plan-only participants. As the number of employers offering DB plans continues to dwindle, however, even these workers might well become less sanguine about their retirement prospects.

In terms of confidence, younger employees seem to have bounced back more quickly than older workers.

While younger employees generally have less savings to lose and more time to make them up, their optimism may be short-lived.

During the last few years, many American workers decided to save more, spend less, reduce their debt and think more realistically about retirement. While these actions might have been prompted by a deleterious economic crisis, employees' greater attention to retirement planning is a welcome development.

The effects of retirement delays by older Americans — a group sometimes called “hidden pensioners” — ripple throughout the economy, potentially shrinking career opportunities for younger employees and job seekers. Workers whose career progression is blocked might become frustrated, which could ultimately undermine their productivity. Even so, the reshaped employment landscape also offers new opportunities for recruitment and retention as more employees get serious about retirement planning. Employers might want to take advantage of this more engaged audience by highlighting the value of the retirement benefits they provide and considering emerging technologies for helping employees become more informed and proactive retirement planners.

“The reshaped employment landscape also offers new opportunities for recruitment and retention as more employees get serious about retirement planning.”

The Defined Contribution Plans Of *Fortune* 100 Companies for the 2010 Plan Year

By Vish Apte, Brendan McFarland and Erika Stoner

American workers increasingly rely on defined contribution (DC) plans, such as 401(k) plans, to save and invest for retirement. Thus, hits to workers' 401(k) savings together with the lingering fallout from the financial crisis have forced many employees to delay retirement. Given the prominent role 401(k) plans play in the financial security of millions of Americans and the widespread lack of retirement readiness, the design and operation of these plans warrant thorough evaluation and careful management.

This Towers Watson study¹ analyzes *Fortune* 100 companies'² accounting reports attached to Form 5500 filings for their largest DC plan covering salaried employees for the 2010 plan year.³ The analysis looks at eligibility and vesting rules, employee and employer contributions, and plan investments, as well as five-year trends in plan design and practices.

As the data are publicly available, the sample and data are well defined and consistent, with no apparent sample bias.

Analysis highlights

- Of *Fortune* 100 companies that offer only DC plans to new hires, 51% offered both matching and non-matching contributions, and 46% offered matching contributions only. Seventy-six percent of *Fortune* 100 companies with active defined benefit (DB) plans offered only matching contributions, and 21% offered both matching and non-matching contributions.
- Companies that offer only DC plans to new hires contributed an average 6.4% of pay, while

contributions from companies that sponsor both an active DB plan and a DC plan averaged 4.6% of pay. After freezing or closing their DB plan, many employers added a non-matching contribution to the DC plan design and contributed more to the DC plan.

- The majority of companies allowed participants to direct employer contributions as they saw fit, while a very small minority continued to provide employer contributions in company stock.
- Investment returns on DC plan assets averaged 12.5% during 2010 for companies in this analysis.
- The percentage of current *Fortune* 100 companies with automatic enrollment in 2010 was 43%. Of these, 43% automatically increased employee contributions over time.

Aggregate cash flow statement for 2010 *Fortune* 100

Among *Fortune* 100⁴ companies, individual corporate net revenue was at least \$25.6 billion, and DC plan assets averaged roughly \$6 billion in 2010. These DC plans held approximately \$598 billion in total assets, as shown in *Figure 1*.

Figure 1. Aggregate cash flow statement of DC plans in the 2010 *Fortune* 100

	2010 (\$ billions)
Beginning-of-year assets	\$520
Company contributions	\$14
Employee contributions	\$26
Rollovers, incoming transfers, other contributions	\$15
Appreciation/depreciation, dividends and interest (investment income)	\$65
Benefit payments	-\$41
Expenses, outgoing transfers and other reductions	-\$1
End-of-year assets	\$598

Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

¹ For last year's analysis, see Towers Watson, "The Defined Contribution Plans of *Fortune* 100 Companies in 2009," *Insider*, February 2011.

² *Fortune* magazine's annual *Fortune* 100 (2011) list consists of the largest U.S. companies based on net revenue.

³ Ninety-five percent of the *Fortune* 100 employers in this study use the calendar plan year as reported in their Form 5500 filings. Results on investment returns are reported only for companies using a calendar plan year, but other results reflect all companies regardless of fiscal year-end date.

⁴ Our analysis does not reflect two *Fortune* 100 companies whose accounting reports were not available on the Department of Labor website.

"The analysis looks at eligibility and vesting rules, employee and employer contributions, and plan investments, as well as five-year trends in plan design and practices."

Aggregate plan assets grew by 15% in 2010 — compared with 21% in 2009 — with much of the growth attributable to investment gains. Employers in this analysis contributed roughly \$14 billion to their DC plans in 2010. *Fortune* 100 companies contributed \$13 billion to their DC plans for the 2009 plan year, according to last year's analysis.

Eligibility and vesting requirements for DC plan participation

Most of the *Fortune* 100 companies had no age or service requirements for participating in the DC plan. Only 25% imposed an age requirement — either age 18 or 21 — and 31% had a service requirement (Figures 2 and 3). The most common service requirements were three months (11%) and one month (8%).

Figure 4 shows combined age and service requirements for DC plan participation.

Service requirements for receiving employer contributions

While 51% of companies had no service condition for receiving employer contributions, 27% required employees to complete one year of service before becoming eligible for employer contributions (Figure 5).

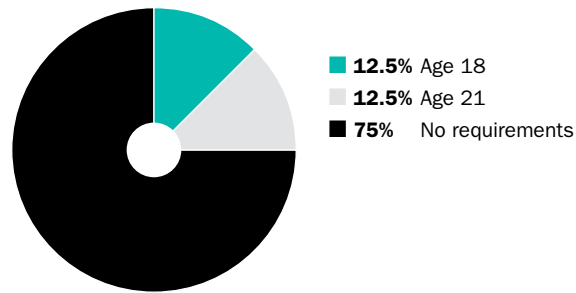
In 65% of companies, employees became eligible for plan participation and employer contributions at the same time. In the remaining 35%, employees had to wait for some period —the most common being one year — after becoming eligible to join the DC plan to begin receiving employer contributions.

Employer matching contributions often vest immediately

In 58% of the DC plans in this analysis, the employer's matching contributions vested immediately. Slightly more than one-quarter (28%) of plans had cliff vesting for matching contributions, and 14% used a graded vesting schedule that began during the second year of service and continued for another one to four years, typically ending with the fifth year.

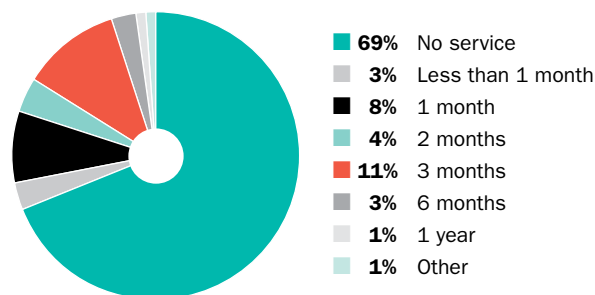
With cliff vesting, employees must meet a service requirement (usually three years) before they can take company contributions with them if they leave their employer. With graded vesting, the amount employees can take with them depends on how long they worked for the company. Figure 6 (next page) shows 2010 vesting requirements.

Figure 2. Age requirements for DC plan participation among *Fortune* 100 companies



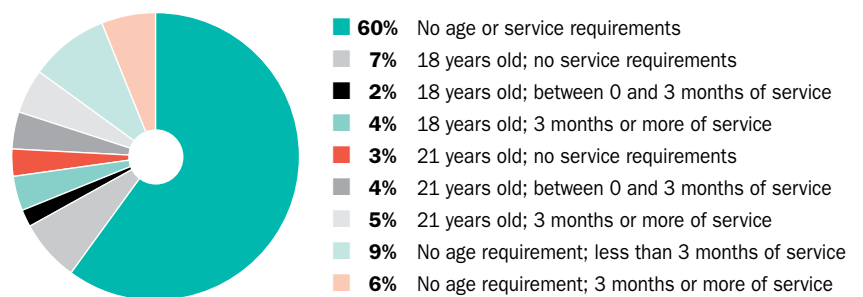
N=95
Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

Figure 3. Service requirements for DC plan participation among *Fortune* 100 companies (employee contributions only)



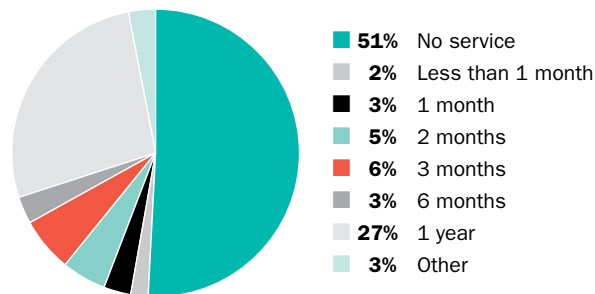
N=94
Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

Figure 4. Combination of age and service requirements for DC plan participation among *Fortune* 100 companies (employee contributions only)



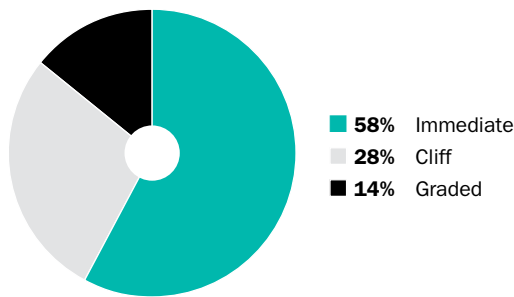
N=94
Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

Figure 5. Service requirements for employer contributions among *Fortune* 100 companies



N=90
Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

Figure 6. Vesting requirements for receiving company matching contributions among Fortune 100 companies



N=93
Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

Of those who have cliff vesting (N=26)

1 year	4%
2 years	38%
3 years	58%

Of those who have graded vesting (N=12)

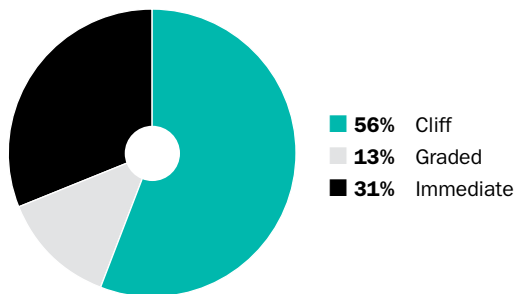
Over 2 years	8%
Over 3 years	8%
Over 4 years	15%
Over 5 years	54%
Over 6 years	15%

Employer non-matching contributions usually take longer to vest

Most employees undergo some waiting period before becoming fully vested in non-matching contributions (Figure 7). Of Fortune 100 employers offering non-matching contributions, 56% used cliff vesting (typically a three-year schedule), 31% vested them immediately and 13% used a graded schedule.

Among employers that offer both a matching and non-matching contribution, 70% had the same vesting requirements for both types of contributions, while 30% had different vesting requirements. For those with different requirements, the vesting period for non-matching contributions was longer than the vesting period for the match.

Figure 7. Vesting requirements for non-matching contributions among Fortune 100 companies



N=39
Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

Of those who have cliff vesting (N=22)

2 years	27%
3 years	63%
Other	10%

Of those who have graded vesting (N=5)

Over 4 years	20%
Over 5 years	80%

Contributions and match rates

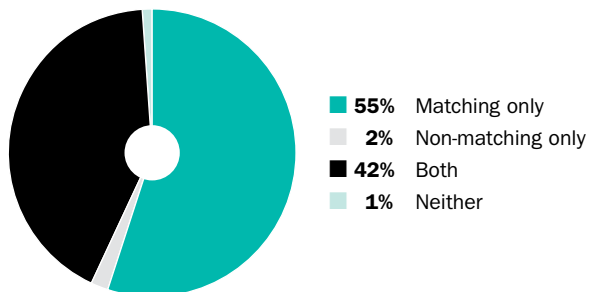
Employers with active DB plans are less likely to offer non-matching contributions

In 2010, 55% of Fortune 100 companies made only matching contributions to DC accounts, and 42% made both matching and non-matching contributions (Figure 8). Only one of these employers contributed nothing to its employees' 401(k) accounts, and two made only non-matching contributions.

Of companies offering only a DC plan to newly hired employees in 2010, 51% offered both matching and non-matching contributions, 46% offered only matching contributions, and 3% made only non-matching contributions. Of companies with active DB plans — those open to newly hired employees — 76% offered only matching contributions to their 401(k) plans, 21% offered both matching and non-matching contributions, and 3% provided neither.⁵

Several companies introduced the non-matching contribution to the DC plan shortly after freezing or closing the DB plan, presumably to mitigate the DB pension loss.

Figure 8. Types of employer contributions provided to newly hired employees among Fortune 100 companies



N=98
Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

⁵ Roughly 31% of companies in this analysis have an active DB plan for salaried employees, according to various other sources.

“Several companies introduced the non-matching contribution to the DC plan shortly after freezing or closing the DB plan.”

Employers with only DC plans make higher contributions as a percentage of pay

This analysis defines matching contributions as the maximum match offered by the employer. In 2010, the average matching contribution to DC plans sponsored by *Fortune* 100 companies was approximately 4.5% of pay, while the median was roughly 4.3% of pay. *Figure 9* shows the distribution of employer matching contributions.

Among *Fortune* 100 companies providing non-matching contributions in 2010, the amounts were fixed in 58% of them, with the average being 3.2% of pay and the median 3.0%. In the other 42% of companies offering a non-matching contribution, contributions are made at the employer's discretion and range from 0 to 15% of compensation. Almost a quarter (22%) of plans with discretionary non-matching contributions did not make them in 2010.

In 2010, total contributions (matching plus non-matching) for all *Fortune* 100 companies averaged 5.9% of pay, while the median was 5.0% of pay.⁶

In companies offering only a DC plan to new hires in 2010, the average matching contribution was 4.6% of pay, and the median matching contribution was 4.5% of pay. Of those offering a non-matching contribution, 62% of the contributions were fixed and 38% were discretionary. For 2010, average and median fixed non-matching contributions were 3.4% and 3.0%, respectively. Total contributions (matching plus non-matching) made by companies offering only DC plans to new workers averaged 6.4% of pay, while the median was 6.0%.

Companies that sponsor both an active DB plan and a DC plan contributed less — for 2010, the average matching contribution was 4.1% of pay, and the median was 4.0%. DB plan sponsors contributed an average (matching plus non-matching) 4.6% of pay to the DC plan, and a median 4.3% of pay.

⁶ Of filers that provided a discretionary non-match over the last year and reported the contribution amount as a range, the study used the maximum value.

“Almost a quarter (22%) of plans with discretionary non-matching contributions did not make them in 2010.”

Investment of matching contributions is mostly participant-directed

Investment of employer contributions to employees' DC accounts takes different forms. The investment might be at the participant's direction, in company stock or a combination of the two. As shown in *Figure 10*, 82% of plans allow participants to choose their investment. Of the remaining employers, 13% make contributions in the form of employer stock, and 5% split their contributions between employer stock and participant direction.

All but two of the companies whose matches are in company stock allow employees to diversify out of the company stock immediately. The other two companies allow diversification according to the plan's vesting rules.

Figure 9. Distribution of employer matching contributions among *Fortune* 100 companies

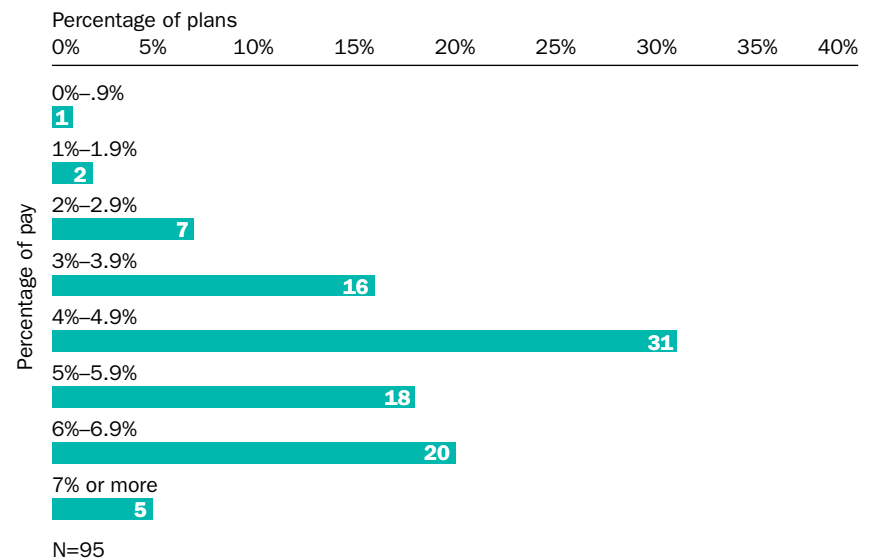


Figure 10. How matching contributions are invested

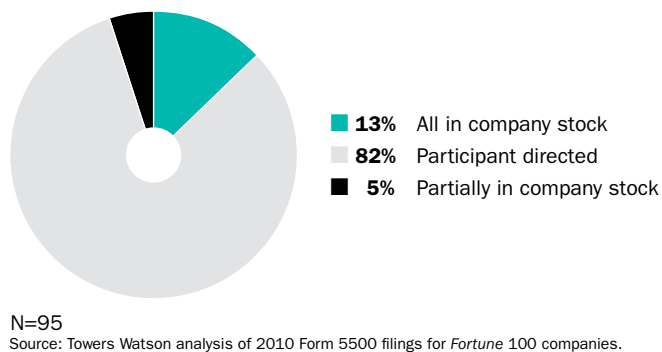
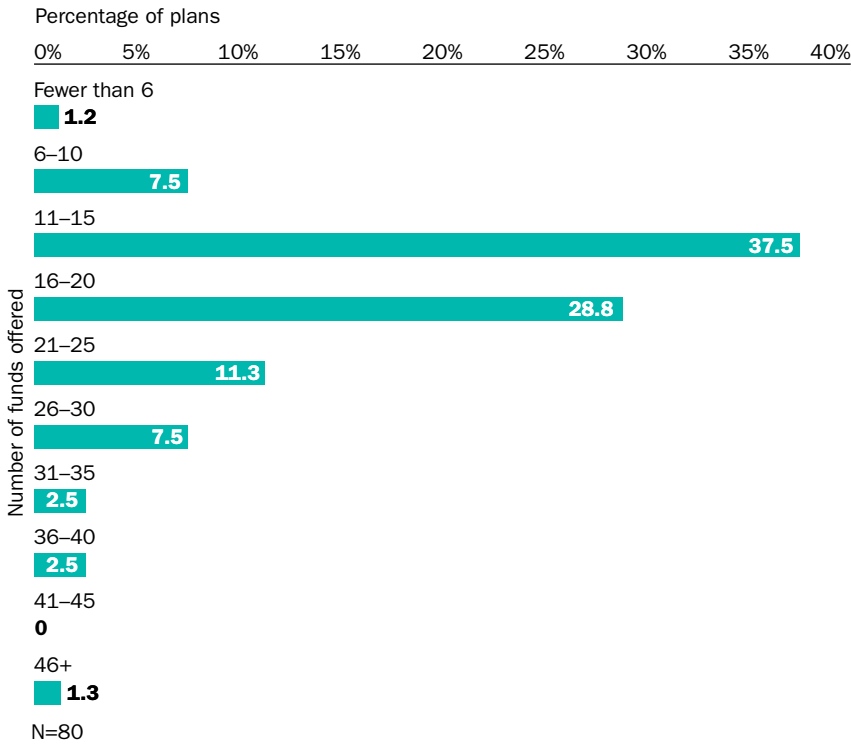
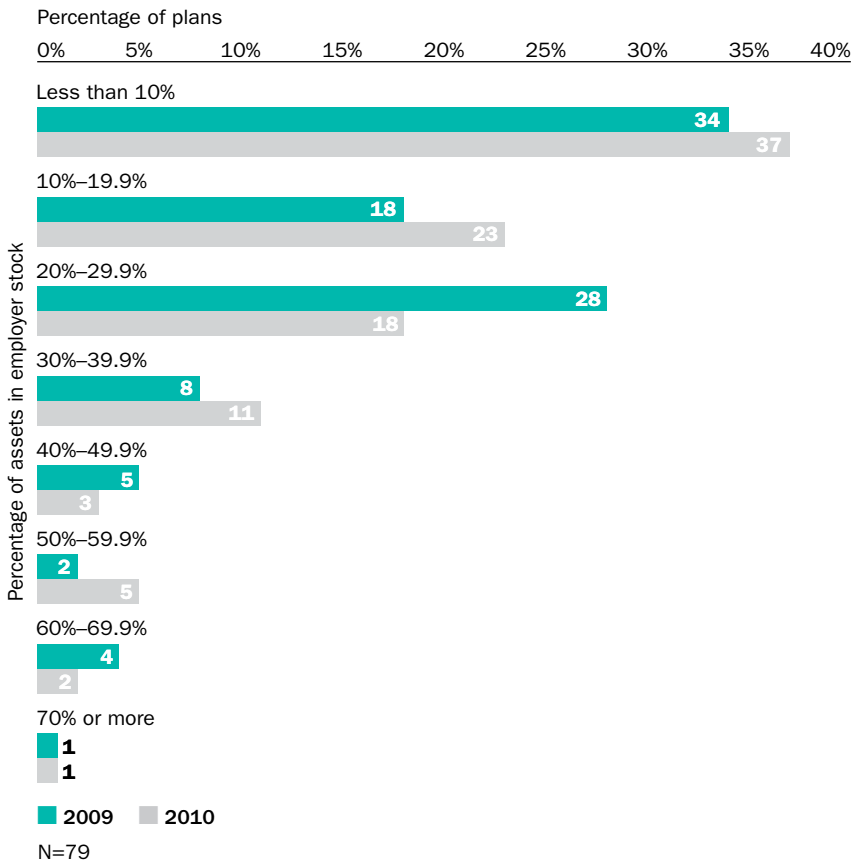


Figure 11. Investment funds offered in DC plans among Fortune 100 companies*



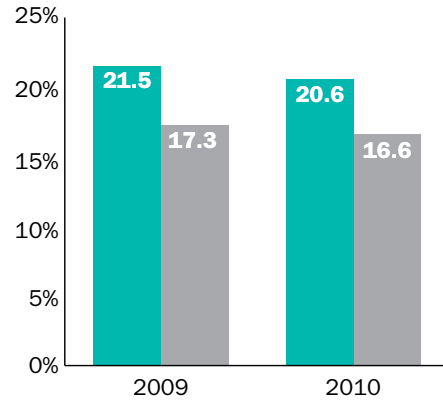
*This analysis considers target date funds and brokerage windows as one investment option. Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

Figure 13. Distribution of net plan assets in employer stock in companies that maintain this investment class (2009 versus 2010)



Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

Figure 12. Average allocation of plan assets to employer stock in Fortune 100 DC plans



All DC plans with employer stock

All DC Plans

N=98 for all plans; 79 for DC plans

Source: Towers Watson analysis of 2010 Form 5500 filings for Fortune 100 companies.

Plan investments

Most companies offer 11 to 20 investment options

In 2010, these Fortune 100 companies' DC plans offered four to 62 investment options, with a median of 16 funds. Figure 11 shows the distribution of the number of options offered.

Prevalence of employer stock in DC plans declines

Between 2009 and 2010, the overall percentage of plan assets invested in employer stock declined slightly (Figure 12). Asset allocations in 79 of 98 companies (81%) included employer stock.⁷ Among all Fortune 100 companies in this analysis, 16.6% of plan assets were allocated in company stock. Among those whose plan assets include company stock, the holdings made up 20.6% of plan assets.

At the plan level, the percentage of assets invested in employer stock varied, as shown in Figure 13. Of DC plans holding company stock, 37% had less than 10% of their assets in employer stock at year-end 2010, and 23% held between 10% and 19.9%. The majority of DC plans with company stock — roughly 78% — invested less than 30% of their assets in company stock during 2010. Only one of the Fortune 100 plans with company stock invested more than 70% of plan assets in this asset class in 2010.

⁷ Seven of the 19 Fortune 100 companies that maintain employer stock in their plan assets do not offer publicly traded stock.

Between 2009 and 2010, the number of DC plans with relatively low allocations to company stock increased — the percentage investing less than 10% of plan assets in company stock rose from 34% to 37%. Similarly, the number of plans investing between 10% and 19.9% in company stock rose from 18% in 2009 to 23% in 2010.

Investment returns strong in 2010

For the DC calendar-year plans of *Fortune* 100 companies for which data were available, investment returns on plan assets averaged 12.5% during 2010, and the median return was 12.2%. Returns ranged between 10% and 14.9% for 61% of these plans. *Figure 14* shows the distribution of 2010 investment returns across plans.

Among the companies in this study that also manage DB plan assets, the average return on DC plan assets was 12.5%, while the average return on DB plan assets was 13.0%.

Automatic enrollment

Forty-three percent of companies on today's *Fortune* 100 list automatically enroll employees in their DC plans. Of these, 43% also automatically increase employees' contribution percentages over time, with all but two increasing them by 1% annually. In 2010, the initial default contribution percentage was most commonly 3%, although it ranged from 1% to 6%. Contributions can eventually reach 15% of an employee's salary through such auto-escalation provisions. *Figure 15* shows the distribution of initial default contribution percentages for companies with automatic enrollment.

Five-Year trends

Towers Watson has been conducting this analysis for five years, and we analyzed data on the 54 companies in our study for all five years to see trends over time.

Automatic enrollment becoming increasingly popular

Among the 54 *Fortune* 100 companies in the five-year group, automatic enrollment jumped from 13% in 2006 to 38% in 2010 (*Figure 16*).

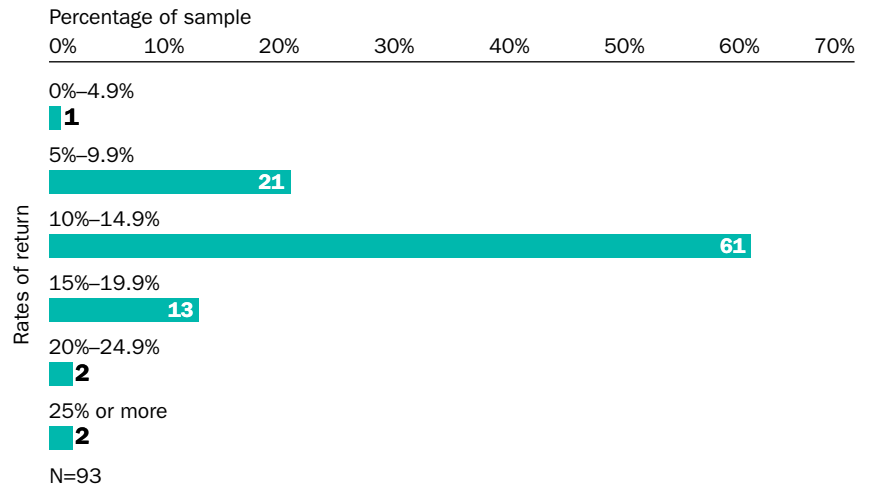
Employer stock becoming less prevalent

Employer stock as a percentage of total assets fell in each of the last five years. *Figure 17* (next page) shows the steady shift away from employer stock.

Investment returns over last five years have fluctuated widely

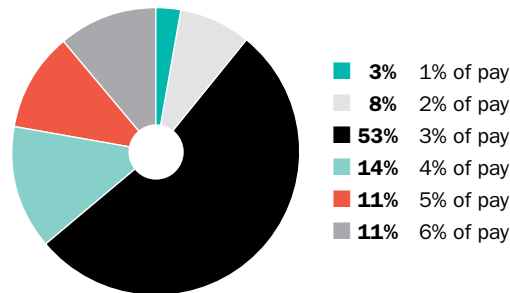
Figure 18 (next page) shows returns on DC plan assets over the last five years. The five-year average was 5.72%.

Figure 14. Distribution of *Fortune* 100 investment returns in DC plans for 2010



Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

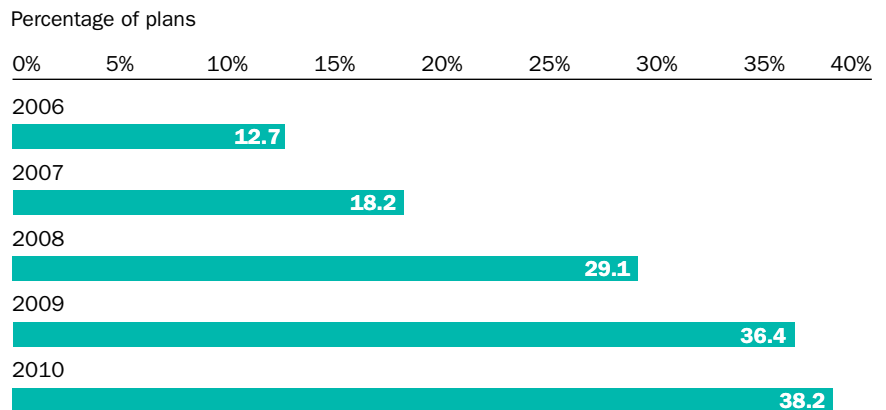
Figure 15. Default employee contribution rates among *Fortune* 100 companies with automatic enrollment



N=37

Source: Towers Watson analysis of 2010 Form 5500 filings for *Fortune* 100 companies.

Figure 16. Automatic enrollment among *Fortune* 100 companies, 2006–2010



N=54

Source: Towers Watson analysis of 2006–2010 Form 5500 filings for *Fortune* 100 companies.

“Employers will likely keep enhancing their DC plan designs and introducing new features to help employees meet their income needs.”

After freezing/closing DB plan, companies contribute more to DC plans

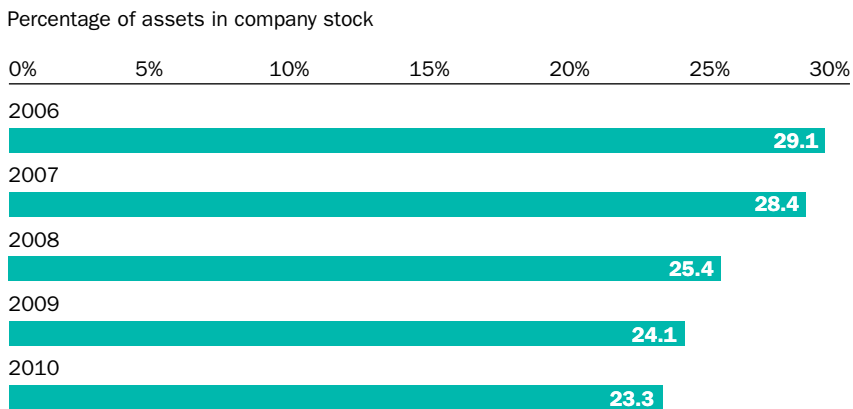
Of the 54 companies in the study group for the last five years, 20 froze or closed their DB plans between year-end 2006 and the beginning of 2011. To mitigate the loss of retirement income, many of these companies made changes to their DC plans — most often in contribution types and amounts.

After freezing or closing their DB plan, many employers added a non-matching contribution to the DC plan design. In 2006, 75% of these plans provided

only matching contributions, 20% provided both matching and non-matching contributions, and 5% made no contributions. In 2010, 75% of these plans made both matching and non-matching contributions, and 25% provided matching contributions only.

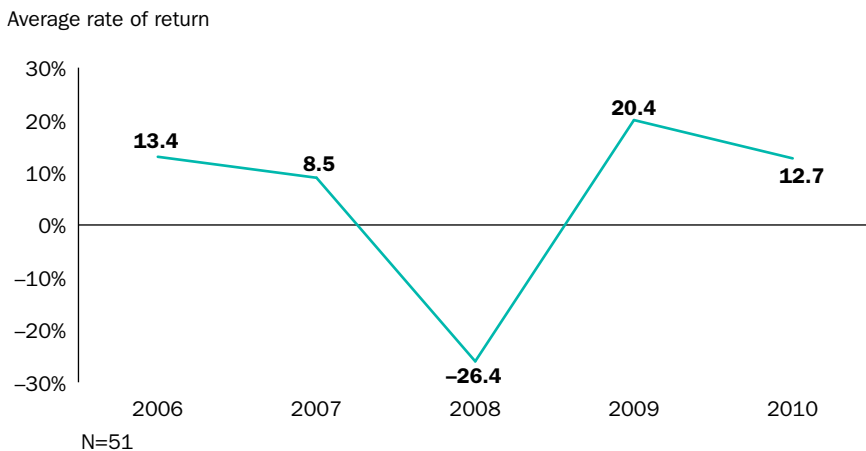
Many of these employers also increased total contributions to their DC plans as a percentage of pay. Among this group in 2006, the average and median total employer contributions to DC plans were 4.4% and 4.5% of pay, respectively. By 2010 — after closing or freezing their DB plan — the group’s average and median total employer contributions were 7.1% and 7.7%, respectively. For most participants, however, these higher contributions are not likely to fully replace the future retirement income associated with an active DB plan.

Figure 17. Plan assets held in employer stock among Fortune 100 companies, 2006–2010



N=52
Source: Towers Watson analysis of 2006–2010 Form 5500 filings for Fortune 100 companies.

Figure 18. Investment returns in Fortune 100 DC plans, 2006–2010



N=51
Source: Towers Watson analysis of 2006–2010 Form 5500 filings for Fortune 100 companies.

Conclusion

DC plans have become increasingly important to American workers. All the Fortune 100 employers offer 401(k) plans, and the vast majority offer them to all employees with one month or less of service. Moreover, almost all these employers offer matching contributions, and many also make non-matching contributions.

For DC plans to be effective retirement savings vehicles, employees must take advantage of them. Employers are moving beyond making these benefits available — they are designing plans to encourage employees to participate, to save more and to make educated investment decisions. Of companies in this study, for example, roughly two in five automatically enroll employees in their 401(k) plan. Assuming DC plans continue to provide an increasingly large share of retirees’ income, employers will likely keep enhancing their DC plan designs and introducing new features to help employees meet their income needs.

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