Employee Engagement in Health and Retirement Challenges and Reforms

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Innovations in Employee Engagement in Health

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
IBM's Commitment to a Culture of Health and Watson Health

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Behavioral Economics and Employee Engagement – Carrots, Sticks or Something Else?

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
BEHAVIORAL ECONOMICS AND
EMPLOYEE ENGAGEMENT

Carrots, Sticks or Something Else?

May 12, 2016

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Discussion Overview

- Understanding the Challenge
- Leveraging Behavioral Economics to Drive Employee Engagement
- Establishing a Framework for Effective Incentive Design
- Some Practical Tips
- For Additional Information
Understanding the Challenge
Sample Efforts to Promote Healthier Behaviors

51% of US employers with 50+ employees have a wellness program

Among employers offering wellness programs:

- 80% screen employees for health risks
- 77% offer lifestyle management interventions; among these:
  - 79% provide nutrition/weight management programs
  - 77% offer smoking cessation
  - 72% provide fitness resources
  - 52% offer stress management programs
- 56% provide Disease Management programs; among these:
  - 85% target diabetes
  - 60% focus on asthma
  - 59% target coronary artery disease
  - 54% focus on heart failure
- 44% regularly evaluate wellness program; only 2% measure financial impact

Source: Rand Corporation – 2013 Workplace Wellness Programs Study
Despite Employer Efforts
Limited Engagement

Participation Rates for Employees Identified through Screenings or Claims Data

Disease Management 16%
Weight/Obesity 10%
Smoking Cessation 7%
Fitness 21%

Source: Rand Corporation – 2013 Workplace Wellness Programs Study
Leveraging Behavioral Economics to Drive Employee Engagement in Health Improvement
What is Behavioral Economics?

Traditional Economics

What rationale people *should* do

Behavioral Economics

What sometimes irrational people *actually* do
CRUMPs vs SIRPs

*Behavioral Economics in the Workplace*

**Completely Rational Utility Maximizing Person**

- Incentives
- Information
- Capabilities/Resources

**Sometimes Irrational Real Person**

- Nudges
- Guardrails
- Habit Cues
Five Key Insights for Health Engagement

1. Employees often make poor decisions—in a predictable manner

2. Heuristics (mental shortcuts), can influence choices more than a person’s conscious intentions

3. Incentives can be quite effective, if used appropriately

4. Incentives are just one of the myriad tools employers can use to drive healthier behaviors

5. Intrinsic motivation can be the most effective motivator
Factors Impacting Employee Health

**Individual Drivers**
1. Nutrition
2. Physical activity/sleep
3. Avoiding risky behaviors
4. Emotional health
5. Preventive care

**Employer Drivers**
1. Culture
2. Environment
3. Programs/resources
4. Incentives
5. Communications
Converting Good Intentions into Healthy Habits

**Focus of Most Wellness Programs**

**Key Question:** How much impact do these really have—
if they don’t ultimately lead to sustained behavior change?

**Where the Real Impact Is**

Once implemented, habits require less ongoing motivation, allowing individuals to focus on creating additional healthy habits.
Factors Impacting Sustained Behavior Change

Intentions → Conscious Behaviors → Habits

Readiness to Change
Attitudes
Perceived Norms
Self-Efficacy
Motivation
Repetition in a Stable Context
Ability
Convenience
Coaching

Sources
1 Transtheoretical Model developed by James Prochaska, PhD, Carlo DiClemente, PhD, and John Norcross, PhD
2 Theory of Planned Behavior developed by Icek Ajzen, PhD
3 Fogg Behavioral Model developed by B.J. Fogg, PhD
4 Research in habit formation developed by Wendy Wood, PhD
What Can Happen When All Areas Are Not Addressed

- Readiness to Change
- Attitudes
- Perceived Norms
- Self-Efficacy
- Intentions
- Motivation
- Conscious Behaviors
- Repetition in a Stable Context
- Habits
- Ability
- Convenience
- Coaching
Establishing a Framework for Effective Incentive Design
When Do Incentives Work Best?

“One & Done”

**Periodic completion of:**
- Health assessment
- Biometric testing
- Preventive screenings
- Flu shot

“Let’s Give It a Try”

**Participation in:**
- Telephonic coaching
- Online learning modules
- Weight management/exercise programs
- Smoking cessation

Ongoing Habits

**Daily routines relating to:**
- Nutrition
- Physical activity
- Sleep
- Avoiding risky behaviors
- Handling stress

More Effective

Less Effective
Establishing the Optimal Incentive Amount

- **Employee A** lacks intrinsic motivation, but finds task is relatively easy to do, so $150 incentive is enough to drive compliance.

- **Employee B** finds task difficult to complete, but has high intrinsic motivation to do it, so the $150 incentive drives compliance.

- **Employee C** would have completed task for <$150.

- **Employee D** lacks motivation and ability, but would be willing to complete task for $200.
Maximizing the Motivational Power of Incentives

- Losses Motivate More than Gains
- “Opportunity Regret” Motivates
- Delaying Incentive Minimizes Impact
- Lotteries Motivate
- Team-Based Incentives Work
- Simplicity Beats Complexity
Some Practical Tips from Experiments in Behavioral Economics
Avoid Reward Undermining

**PICK-UP TIME AT DAYCARE CENTER**¹

**PAYING FOR CREATIVITY**²

1 Source: Uri Gneezy and Aldo Rustichini
2 Source: Lepper, M. P., Greene, D., & Nisbett, R. E
Be Mindful of Timing and Delivery Method

Which is more compelling?

Option A
Sometime this year, go to our health plan website to complete your HRA and we’ll reduce your 2017 medical contributions by $50

Option B
Click here to complete your HRA by May 31st and immediately win a $50 gift card from Amazon.com
Leverage the Motivating Power of “Luxury” Goods

Complete your Biometric Screening and Get...

$200 Meal at a 4 Star Restaurant

$200 Direct Deposit into Your Account

Source: Choices derived from research by Kivetz and Simonson (2002)
## Avoid Choice Overload

<table>
<thead>
<tr>
<th>Shoppers who stopped</th>
<th>6 kinds of jams</th>
<th>24 kinds of jams</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoppers who bought jam</td>
<td>30%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Consider Pre-commitment Strategies

- If given the choice, which snack would you prefer?

- If you are selecting a snack for **NEXT WEEK**, which would you choose?
  - 74% choose…

- If you are selecting a choice for **TODAY**, which would you choose?
  - 70% choose…

Source: Phelps and Pollk (1968); Akerlof (1991), Laibson (1997)
Think about how Americans die from Heart Disease each year. Is it more or less than 5 million?

How many Americans die of heart disease annually?
How many of you set the clock on your DVD player?
A father and daughter have simultaneously decided to replace their existing vehicles with more efficient models:

- Father increases his MPG from 16.5 to 20 with his purchase
- Daughter increases her MPG from 33 to 50 with her purchase

Who will save the most gas over 10,000 miles?

Both will save about 100 gallons over 10,000 miles

Source: Based upon The MPG Illusion, Rick Larrick and Jack Soll (http://www.mpgillusion.com/)
Doing the Arithmetic

**Father**
- $10,000 \text{ miles} \div 16.6 \text{ miles per gallon} = 606 \text{ gallons}$
- $10,000 \text{ miles} \div 20.0 \text{ miles per gallon} = 500 \text{ gallons}$

**Difference** = 106 gallons

**Daughter**
- $10,000 \text{ miles} \div 33 \text{ miles per gallon} = 303 \text{ gallons}$
- $10,000 \text{ miles} \div 50 \text{ miles per gallon} = 200 \text{ gallons}$

**Difference** = 103 gallons
For Additional Information…
Some Good Reading on Behavioral Economics

- Nudge: Improving Decisions about Health, Wealth, and Happiness
  Richard H. Thaler and Cass R. Sunstein

- Misbehaving: The Making of Behavioral Economics
  Richard H. Thaler

- Thinking, Fast and Slow
  Daniel Kahneman

- Predictably Irrational: The Hidden Forces That Shape Our Decisions
  Dan Ariely
Behavioral Economics

Behavioral economics is a field of study that blends psychology and consumer economics in order to understand why people make sub-optimal decisions about important financial and health care matters. Most decisions that people make involve “mental short cuts” and some degree of emotion. Often, behavioral biases come into play and the result can be sub-optimal decisions.

Is your organization struggling with increasing health costs or low employee participation in wellness initiatives? Behavioral economics is critical to solving these challenges. Here are just a few recent examples:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Impact of Behavioral Economics</th>
</tr>
</thead>
<tbody>
<tr>
<td>A client struggled to gain employee participation in a health risk questionnaire even with a cash incentive.</td>
<td>Achieved 91% employee participation and 85% spouse participation (up from 0%).</td>
</tr>
<tr>
<td>A higher education client faced employee relations issues related to absence and retention.</td>
<td>Reduced unscheduled absence by more than 50%, reduced turnover by 29%, reduced extended absence by 72% and reduced employee relations issues by over 90%.</td>
</tr>
<tr>
<td>A client had 13.5% of their participants using antidepressant drugs (at a cost of 6.5 times more than those not using such drugs) -- but only 21% were also seeing a behavioral health clinician.</td>
<td>Increased the use of clinicians by 130% by reframing the plan and reducing both financial and perception barriers.</td>
</tr>
</tbody>
</table>

Is your company using behavioral economics to control costs?

Take our short (3 question) quiz to find out!

Contact Us

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Vice President
216.687.4432
cgoldsmith@sibson.com
Thank you
Using the Affordable Care Act to Convert Healthcare to Wellness
<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Health Risk Assessment with Biometrics</td>
<td>75%</td>
</tr>
<tr>
<td>2008</td>
<td>HRA with telephone coaching</td>
<td>22%</td>
</tr>
<tr>
<td>2009</td>
<td>Gym Memberships</td>
<td>25%</td>
</tr>
<tr>
<td>2010</td>
<td>Loews Paid, Weight Watchers</td>
<td>8%</td>
</tr>
<tr>
<td>2011</td>
<td>Disease Management</td>
<td>0%</td>
</tr>
<tr>
<td>2012</td>
<td>Telephonic Coaching</td>
<td>2%</td>
</tr>
<tr>
<td>2013</td>
<td>Annual checkups</td>
<td>60%</td>
</tr>
</tbody>
</table>
Loews results

Financial impact to Loews (unadjusted for P&L impact)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Total Employer Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status Quo – No HCR</td>
<td>$120.5</td>
</tr>
<tr>
<td>Optimal Play</td>
<td>$121.6</td>
</tr>
<tr>
<td>Play and Redirect</td>
<td>$112.1</td>
</tr>
<tr>
<td>Selective Play</td>
<td>$107.0</td>
</tr>
<tr>
<td>Pay and Exit</td>
<td>$70.9</td>
</tr>
</tbody>
</table>

- Additional cost of $1.1M under the optimal play scenario due to increased enrollment in Loews sponsored plans
- Summary reflects all Loews subsidiaries, including Diamond Offshore and Boardwalk

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Three Strategies to Avoid Excise Tax

1. Employees pay more.
2. Employees cost less because they are healthier (impact of wellness incentives).
3. Cut medical plan design to be under threshold limits for 1/1/18.
Our Strategy

• Combine strategies by offering a menu of wellness options and creating a higher tier for employees who don’t participate.

• Communicate and continue to engage employees to change long-term behavior towards healthier lifestyle.
What Works?

Carrot
What Works?

Carrot AND Stick
## Menu of Options

### Required
- Annual Physical with Biometrics Screening

### Engage in any three (Pick 3)
1. Preventive Examination  
2. Disease Management Program  
3. Telephonic Wellness Coaching Program  
4. Healthy Pregnancy Program  
5. Health Risk Assessment  
6. Routine Dental Examination  
7. Gym Membership  
8. WeightWatchers  
9. Loews organized fitness activity  
10. Lunch & Learn Seminars  
11. Virgin HealthMiles
Consequence of Not Playing

• Those who participate: Current Contribution Cost
• Those who don’t: 2X Current Contribution Cost
Results

500 Employees
485 Participants!
Innovation to Improve Health, Well-Being and Value

EBRI-ERF Policy Forum #78
Thursday, May 12, 2016
Employee Benefits Research Institute

Innovations around
Health, Well-being & Value

May, 2016
Consumerism going mainstream

Medical Plan with the Highest Enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>PPO</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>57%</td>
<td>17%</td>
</tr>
<tr>
<td>2012</td>
<td>57%</td>
<td>17%</td>
</tr>
<tr>
<td>2013</td>
<td>54%</td>
<td>21%</td>
</tr>
<tr>
<td>2014</td>
<td>51%</td>
<td>26%</td>
</tr>
<tr>
<td>2015</td>
<td>49%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: 2015 PwC Health and Well-Being Touchstone Survey
Future Directions – Total Replacement HDHP?

Source: 2015 PwC Health and Well-Being Touchstone Survey
Where do we go from here?

Potential Concerns

- Deferral of care
- Design inflexibility
- Benefits convergence
- Lack of consumer readiness

Consumers feel less ready to be a consumer of healthcare than buying a house

Future Directions

- Evolution of Value Based Design
- Increased focus of care delivery
- Shift of focus to employee experience/well-being
Where do we go from here?

Potential Concerns

• Deferral of care
• Design inflexibility
• Benefits convergence
• Lack of consumer readiness

Future Directions

• Evolution of Value Based Design
• Increased focus of care delivery
• Shift of focus to employee experience/well-being

New Health Economy

Consumer Centric
Value Driven
Technology Enabled
Innovators Proliferate

Advocacy
Telehealth
Second Opinion
Health Literacy
Social Networks
Well-being
Population Health
Health Savings Accounts
Transparency
Onsite/Near Site
Concierge

>100,000
Health Apps
Innovators Proliferate → Battle for Consumer Hub

Advocacy
Telehealth
Second Opinion
Health Literacy
Social Networks
Well-being
Population Health
Health Savings Accounts
Transparency
Onsite/Near Site
Concierge
Innovation in the Enrollment Experience

- Increased choice
- Development of “marketplace experience”
- Personalizing value-based choice
- Arbitrage of relative value of plan and network choices

### Emerging trends

- Delivery Based Options (tradeoff of access for benefits)
- 365 day experience
- Intelligent virtual assistance
Innovation in Consumer Engagement

- Integration of SMAC technology
- Leveraging “mind-share”
- Improved transparency tools (redefining quality)
- Advocacy support

Emerging trends

- Extended transparency across consumer experience
- Social networks to crowdsourcing
- mHealth curators
Innovation in Population Health

- More focused interventions
- Incentives vs intrinsic motivation
- Shift care management back to providers
- Actionable “big data’

Emerging trends

- Targeted populations ("tipping point", “morbidly obese”)
- Social determinants of health
- Integration with community initiatives
- Enhanced remote monitoring
Innovation in the Payment and Delivery

- Accountable Care Organization
- Bundled payments
- Near-site and on-site clinics
- Employer direct, integrated health experience

Emerging trends

- Advanced primary care
- Regional Centers of Excellence
- Blurring of lines between payers and providers
- Virtual referrals
Innovation in Well-being

- Shift mindset from “wellness” to “well-being”
- Expansion of financial well-being
- Integration of mental health, resilience, mindfulness strategies
- Leverage technology and behavioral science

**Benefits of Well-being**

Happier employees have
- 33% higher profitability (Gallup)
- 43% more productivity (Hay Group)
- 37% higher sales (Shawn Achor)
- 300% more innovation (HBR)
- 51% lower turnover (Gallup)
- 66% decrease in sick leave (Forbes)
- 125% less burnout (HBR)

**Emerging trends**

- Leadership, environment & cultural alignment
- Employee experience across silos (eg. talent, diversity, management)
- Go local, go global
For more innovation...

The 3rd Thursday

PwC Health Innovation Webcast Series

www.pwc.com/us/the3rdthursday

- Innovator Hall
- Well-being Institute

Contact Michael Thompson

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Michael.thompson@us.pwc.com

Starting June
973-464-1530
mthompson@nbch.org
Care Pathways: 
*Insights from a Clinical Analytic*
Financial Risk Snap-Shot

Percent of Members
- Very Low: 20%
- Low: 40%
- Moderate: 30%
- High: 7%
- Very High: 3%

Percent of Average Cost
- Very Low: 4%
- Low: 26%
- Moderate: 25%
- High: 45%
- Very High: <1%
A Randomized Trial of a Telephone Care-Management Strategy

*New England Journal of Medicine*

Reduced medical and pharmacy costs by $7.96 PMPM

Reduced hospital admissions by over 10%
Financial Risk: Migration Out of High Risk (one-year)

78% of Very High Risk members migrate to a lower level of financial risk.

64% of High Risk members migrate to a lower level of financial risk.
Financial Risk: Migration Into High Risk (one-year)

Percent of Members

53% of Very Low Risk migrate to a higher level of financial risk.

38% of Low Risk members migrate to a higher level of financial risk.

15% of Moderate Risk members migrate to a higher level of financial risk.

10% of High Financial Risk members migrate to Very High Risk after one year.
Engagement Analysis of the Population: Clinical Risk

• Mostly Digital Engagement predicts how individuals in each stage will progress into riskier cohorts.

• Mostly Telephonic or in Person Coaching focuses on addressing the unique needs of each individual at every stage of health and wellness.
Outcomes of a Clinical Risk Stratification Approach: Delaying Disease Progression

Members with program contact demonstrate delayed risk progression through each stage of the pathway

- Progression is delayed by 370 days for contacted individuals who progress to a sentinel clinical event (e.g. stroke)
- 104 sentinel events (2.6%) avoided
Financial Risk Models, the Industry Standard, are Insufficient to Identify Truly Emerging Clinical Risk

A cohort of 43,000 members with continuous eligibility was followed for five years between January 1\textsuperscript{st} 2010 and January 1\textsuperscript{st} 2015

![Graph showing disease stage and average prior 12-month cost.](image.png)
Who Makes Up the Silent Population?

Some have conditions that *cannot* be predicted
- E.g. cancer, accidents, major mental illness

Many have conditions that *can* be predicted and that rapidly lead to disease
- 37% of Americans are pre-diabetics
- 97% of pre-diabetics are not diagnosed
- 23% of diabetics are not diagnosed
- 31% if adult Americans have pre-hypertension
- Half of people with hypertension fail to control their BP
Type 2 diabetes can be prevented.

Loosing just 7% of your body weight and exercising moderately can reduce your risk by 58%
Feds mull Medicare changes after big success in YMCA's diabetes program

“People at high risk of developing diabetes lost about 5% of their body weight in a YMCA program ... 

...CMS' actuaries certified the YMCA's Diabetes Prevention Program would more than pay for itself for Medicare if the YMCA program was expanded, saving $2,650 per participant over 15 months...

...The Diabetes Prevention Program can reduce the number of new cases of Type 2 diabetes by 58% and 71% for those over age 60, according to the YMCA”

Claims Based Analysis of 13,000 Diabetic Members Pre and Post Initial Diagnosis
Motivate individuals to achieve a series of small and attainable health goals that lead to meaningful and long-lasting behavior change.

Identification & Engagement are the Key

- Identify & Engage people with pre-conditions
- Deliver personalized, multi-channel health engagement

Motivate individuals to achieve a series of small and attainable health goals that lead to meaningful and long-lasting behavior change.
Final Thoughts

• Disease management efforts focus on the very sick

• Clinical analytics can target the “soon to be sick” segments of your population

• Digital technology can help to identify and serve the entire population with personalized programs
Retirement Challenges and Reforms

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Bipartisan Policy Center Commission on Retirement Security and Personal Savings

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Who’s In, Who’s Out – A Look at Access to Employer-Based Retirement Plans and Participation in the States

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Who’s In, Who’s Out
A discussion about state and federal proposals to boost access to private sector retirement plans

May 12, 2016
EBRI Policy Forum #78

pewtrusts.org
Overview

• Background
• Retirement savings across the states
• State policy approaches
• Small employer views
Why retirement savings is important

- **Longevity: additional years of life at age 65**
  - 1950: 14 years
  - 2013: 19 years

- **Annual cost of long term care**
  - Adult day health care: $17,904
  - Assisted living: $43,200
  - Nursing home: $80,300

Current Savings Situation

• “Rule of thumb” for retiree income: live on 4 percent of accounts per year or save 10 times their annual income.

• Median income for households between 55 and 64 is $56,575

• Median DC savings accounts for persons between the ages of 55 and 64 is approximately $76,000.
Current Savings Situation

• 56 percent of retired Americans born between 1928 and 1945 have debt
• Half of single elderly and one-third of elderly in relationships die with less than $10,000 in assets
• Retirement savings shortfall of $4.13 trillion
• More than half of American households face a standard of living decline in retirement

Retirement Savings Across the States

3 Key Terms

– Access
– Take-up
– Participation

Example:

– 60 percent **access**
– 85 percent take-up rate
– 51 percent **participation** rate
Access across the 50 states
Take-up range

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What factors can influence access and participation?

Various factors associated with access and participation, including:

- Employer size
- Industry
- Wage and salary income
- Age
- Education
- Race and ethnicity

Many of these elements vary across the states.
### Access by Employer size

<table>
<thead>
<tr>
<th>Employer size</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10 employees</td>
<td>22%</td>
</tr>
<tr>
<td>10-49 employees</td>
<td>37%</td>
</tr>
<tr>
<td>50-99 employees</td>
<td>52%</td>
</tr>
<tr>
<td>100-499 employees</td>
<td>63%</td>
</tr>
<tr>
<td>500+ employees</td>
<td>74%</td>
</tr>
</tbody>
</table>

Proportion working at small employers (less than 50 workers):
Low: Minnesota (23 percent)
High: Montana (39 percent)
## Access by Industry

<table>
<thead>
<tr>
<th>Industry</th>
<th>Access Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td>69%</td>
</tr>
<tr>
<td>Financial activities</td>
<td>68%</td>
</tr>
<tr>
<td>Educational and health services</td>
<td>64%</td>
</tr>
<tr>
<td>Transportation and utilities</td>
<td>61%</td>
</tr>
<tr>
<td>Professional and business</td>
<td>56%</td>
</tr>
<tr>
<td>Wholesale and retail trade</td>
<td>56%</td>
</tr>
<tr>
<td>Other industries</td>
<td>50%</td>
</tr>
<tr>
<td>Construction</td>
<td>40%</td>
</tr>
<tr>
<td>Leisure and hospitality</td>
<td>34%</td>
</tr>
</tbody>
</table>

Proportion of workers in construction industry:
- Low: Michigan (4 percent)
- High: New Mexico and Texas (8 percent)
<table>
<thead>
<tr>
<th>Income Range</th>
<th>Access Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $25,000</td>
<td>32%</td>
</tr>
<tr>
<td>$25,000 - $49,999</td>
<td>56%</td>
</tr>
<tr>
<td>$50,000 - $99,999</td>
<td>71%</td>
</tr>
<tr>
<td>$100,000+</td>
<td>75%</td>
</tr>
</tbody>
</table>

Proportion of workers in low income households:
Low: New Hampshire (12 percent)
High: Arkansas (29 percent)
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Access (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>63%</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>56%</td>
</tr>
<tr>
<td>Asian non-Hispanic</td>
<td>55%</td>
</tr>
<tr>
<td>Other non-Hispanic</td>
<td>59%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>38%</td>
</tr>
</tbody>
</table>

Proportion of Hispanic workers:
- Low: Vermont (1 percent)
- High: New Mexico (52 percent)
The State Policy Response
Our Report: “How States Are Working to Address the Retirement Savings Challenge”

• Analysis of state proposals on retirement savings
• State legislation from 2012 to 2015
  – Focus on California, Illinois, Washington State, Massachusetts
• Why does this matter?
  – States operating in semi-isolation
  – U.S. Department of Labor guidance
  – More activity into 2017
  – Thoughtful consideration of goals and means
3 public policy goals:

– Increasing retirement savings
– Minimizing burdens for employers
– Managing legal and financial risk for states

Tradeoffs among these goals?
Threshold Question

- ERISA or not ERISA?
- State Plan or no State Plan?

<table>
<thead>
<tr>
<th></th>
<th>ERISA</th>
<th>Not ERISA</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Plan</td>
<td>Prototype/MEP</td>
<td>Auto-IRA</td>
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<tr>
<td>No State Plan</td>
<td>Marketplace</td>
<td>X</td>
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State Policy Options

• ERISA and State-sponsored Plan
  – Prototype/MEP: State as administrator/oversight
  – *Example: Massachusetts non-profits*

• Non-ERISA State-sponsored Plan: Payroll Deduction Auto-IRA
  – Employer mandate, auto-enroll
  – *Example: Illinois, Maryland and Oregon Secure Choice*

• ERISA and No State-sponsored Plan
  – *Example: Marketplace: Washington and New Jersey*
Specific choices facing policymakers, including the range of approaches to:

- Employers’ participation, responsibilities, and liabilities.
- Employees’ enrollment, contributions, and withdrawals.
- How contributions will be invested and savings will be protected
- How the programs will be governed and administered, including the likely costs and the potential state liabilities.
Example of policy tradeoff – threshold for employer mandate: Number of workers excluded from Illinois Secure Choice
Small employer views on state policy initiatives

- Pew conducted focus groups of small to mid-sized businesses, 8 total across the country
- Plan sponsors and non-sponsors
- Questions on offering retirement plan, Secure Choice and marketplace exchange approaches

<table>
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<th>No retirement plan offered</th>
<th>Small Company (5-49 employees)</th>
<th>Mid-Sized Company (50-249 employees)</th>
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<td>1 Philadelphia group</td>
<td>1 Chicago group</td>
<td>4 groups</td>
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<tr>
<td></td>
<td>1 Dallas group</td>
<td>1 Los Angeles group</td>
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<tr>
<td>Retirement plan offered</td>
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<td></td>
<td>1 Los Angeles group</td>
<td>1 Dallas group</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>4 groups</td>
<td>4 groups</td>
<td>8 groups</td>
</tr>
</tbody>
</table>
Small employers on ‘Secure Choice’ approach

• “And it doesn’t matter what state because if I need to talk to somebody, what red tape am I going to have to go through because you’re talking about millions of people, probably, that are going to be enrolled in this. And so if I have an immediate personal issue, am I going to be able to talk to somebody? Or am I go through what I go through if I have to call the city for anything? Or the state for anything? Which is a nightmare.”

• “We don't have a state that is organized enough to handle its own future. We're in really big trouble, and you're talking about they're going to organize a retirement plan?”

Deep skepticism about government capability beyond ideology
Employers without retirement plans more open to Secure Choice approach
Small employers on automatic enrollment

• “I think it's very un-American. I don't like it. I don't want someone telling me or my employees they're automatically enrolled, and then now you have to figure out a way, you have to call somebody, you have to get on the computer, you have to do something to get out of it.”

• “[I]t’s like you’ve been forced. You’ve been tricked. You know, you haven’t been treated as an adult that’s able to make their own decision.”

• But...

• “I think it would be a good thing for certain people. Some employees might like that because they won't take the time to actually sign up for it, and if they want, they can actually just go in there and deny it, so they would probably benefit either which way it goes.”

Automatic enrollment and Secure Choice approaches pose a communications challenge for employers and for low income employees
Small employers on marketplace exchanges

• “That’s redundant. My investment company already does that, and I don’t want my tax dollars going into this particular program. That money could be better spent someplace else.”

• “I think you can do that now on Google.”

• “You could do this on your own! [laughs] You get on the website, go online. Why do you need the government to give you a list?”

Without a corresponding financial education effort, a marketplace will not reduce the retirement plan coverage gap. If cost is a major issue, a marketplace would need to increase competition among providers.
Thank you!
John Scott, Director, Retirement Savings Project
The Pew Charitable Trusts
Email: jscott@pewtrusts.org

Retirement Savings
Research and Perspectives on Turning Savings Plans into Retirement Plans

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Reducing Leakage & Incubating Savings

EBRI–ERF Policy Forum #78
Thursday, May 12, 2016
Employee Engagement in Health and Retirement Challenges and Reforms

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