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Single-Employer DB Plan Funding Obligations Under 2010 Funding Relief

By Gaobo Pang and Mark Warshawsky

On June 25, President Obama signed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (the Act) into law, thereby making further funding relief available to defined benefit (DB) plans. To advance discussions in the pension community, this analysis projects aggregate regulatory funded status and minimum required contributions for single-employer DB plans both with and without this latest relief.[1]

The projections reflect financial and economic conditions and outlooks as of May 31, 2010. Without this relief, DB plan funding obligations would be expected to increase sharply. The funding relief significantly eases financial pressures for at least two years, but after that, sponsors should be prepared for funding obligations to trend upward (absent significant changes in asset markets or interest rates).

Our model incorporates the main provisions of the Pension Protection Act of 2006 (PPA), the Worker, Retiree and Employer Recovery Act of 2008 (WRERA), and March and October 2009 IRS guidance and regulations. The PPA establishes the general seven-year schedule for funding shortfall amortization, and the WRERA clarifies and improves the use of smoothed asset values. For minimum funding purposes, plan sponsors can measure pension liabilities using either the full yield curve (a one-month average of interest rates) or the 24-month-average segment rates. The March 2009 IRS guidance allows sponsors to choose the most favorable interest rate for valuing 2009 liability. Under the October IRS regulations, sponsors can switch to a different interest rate and asset valuation method for plan year 2010 without seeking IRS approval first. Plans may also switch from segment rates for 2010 to the yield curve for 2011 or a later plan year. Subsequent changes will require IRS approval.

The Act allows underfunded DB plans to elect either the 2+7 rule or the 15-year amortization rule for any two years between 2008 and 2011. Under the 2+7 rule, the sponsor makes interest-only payments for two years followed by regular seven-year amortization. Under the 15-year rule, the sponsor amortizes the funding shortfall over 15 years. The two relief years need not be consecutive, but the same relief method must apply to both years (a mix of the 2+7 and 15-year rules is not allowed). Also, plans that were at least 60% funded in the 2008 plan year need not freeze benefit accruals for 2009 and 2010.[2] This lookback provision only applies to 2009 under prior relief.

Under the Act's so-called cash flow rule, relief recipients must make higher contributions if they pay "excess" employee compensation, declare extraordinary dividends or redeem company stock in excess of certain thresholds. The restriction period is three years under the 2+7 rule and five years under the 15-year rule. The extra contributions must equal the excess payments over the restriction period but are capped at the relief amount. Our analysis does not model this cash flow rule because we cannot project how it will affect a sponsor's funding choice (see "Pension Funding Relief Will Affect Executive Pay Design" on page 4). Also, the analysis excludes 2008 as a relief year — it is long past and no longer relevant for most plans.

This analysis updates the funding projections for capital market conditions as of May 31, 2010, segment rates and composite corporate bond rate

[1] The series of prior studies on the DB plan funding problem and relief efforts appear in the January, April, June, October and November 2009 and March 2010 issues of *Insider*, available at www.towerswatson.com/research/insider.

[2] Fiscal year is identical to calendar year in our model. The lookback rule in the Act generally applies for plan years beginning on or after October 1, 2008, and before October 1, 2010.

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(CCBR, as a proxy in the model for the yield curve) recently published by the IRS, and newer forward-looking assumptions for 2011–2013.[3] The Appendix outlines the projection methodology, and Figure A-1 lists the financial and economic assumptions.

The results appear in **Figures 1** and **2.** Under pre-Act provisions, average funded status on a regulatory basis would be 87% for plan year 2010, 79.8% for 2011, 78.8% for 2012 and 81.9% for 2013. The minimum required contributions for these years in aggregate for single-employer DB plans would be $78.4 billion, $130.9 billion, $159 billion and $158.5 billion, respectively. These required contributions, which are substantial and rapidly rising — particularly compared with 2007-2009 levels — thus subject sponsors to continued financial pressures. Some plan sponsors would also have to make extra contributions, as shown in Figure A-2 in the Appendix, to avoid the benefit restrictions imposed on plans whose funded status falls below 80%. (The new pension relief does not address lump-sum restrictions.)

The Act's funding relief reduces required contributions by $19 billion to $63 billion, summing all reductions and later reversals over 2009-2013. Using the 2+7 rule for 2009 and 2010 delivers the least relief over this period for two reasons: The relief vanishes — and reverses — as early as plan year 2012, and earlier relief made the 2009 shortfall base relatively small. Using 15-year amortization for 2010 and 2011 shortfalls maximizes the relief, increasing contributions gradually over the five-year horizon.

To maximize relief for the 2010 and 2011 plan years, sponsors can take advantage of the interest-only provision in the 2+7 option, thereby reducing minimum required contributions by about $47 billion for these two years. Once the relief expires in 2013, however, these sponsors will have to contribute roughly $11 billion more than they would without the relief. By contrast, opting for 15-year amortization reduces contributions by about $29 billion in 2010 and 2011. So the 2+7 rule may be the better choice for those sponsors more concerned with immediate cash flow. Otherwise, the 15-year amortization rule gives more and smoother relief.

Although the Act is generally good news for plan sponsors, it presents new complexities along with potential relief. In considering whether to opt for relief, sponsors must consider the effects of the cash flow rule, including the linkage with executive compensation/corporate governance.

Appendix: The funding model and assumptions

The model simulates plans of various initial funded statuses, asset allocations, valuation methods and active statuses. Weights are applied to these plans to reflect their empirical distributions, as calculated from Form 5500 data files and Towers Watson surveys. These plans elect valuation methods and amortize funding shortfalls as required by the PPA, the WRERA, and IRS guidance and regulations.

Depending on the plan sponsor's election, pension assets are measured at fair market value or smoothed value. The latter is computed as the average value of three year-end market values in the model. It includes expected future investment earnings (at no more than a specified interest rate, the third segment rate) and is constrained by the legal requirement that such smoothed value fall between 90% and 110% of market value.

[3] We have updated and modified our model since the March 2010 projections. Equity return for 2010 is lower than the previous expectation of 9.2%. Bond returns are now proxied by the Barclays Capital Long Government/Credit Bond Index because it better represents pension investment practice, replacing the Dow Jones Corporate Bond Index. This new index makes the historical 2009 bond return lower but expected returns in 2010–2013 higher. For a better alignment with the reality of slow economic recovery, CCBRs for 2011-2013 are set lower than in prior analyses based on projected yields on high-quality corporate bonds. With these changes, funded status is about two percentage points higher and minimum contribution is roughly $12 billion lower for plan year 2011 under pre-Act law. The funded status for 2012-2013, however, is about seven percentage points lower and the required contribution is about $40 billion higher than our prior estimates.

Figure 1. Measured funded status under pre-Act provisions and the Act (%)

	Pre-Act provisions	2+7 amortization			15-year amortization		
Plan year		2009 & 2010	2010 & 2011	2009 & 2011	2009 & 2010	2010 & 2011	2009 & 2011
2007	**95.9**	**95.9**	**95.9**	**95.9**	**95.9**	**95.9**	**95.9**
2008	**96.7**	**96.7**	**96.7**	**96.7**	**96.7**	**96.7**	**96.7**
2009	**96.6**	**96.6**	**96.6**	**96.6**	**96.6**	**96.6**	**96.6**
2010	**87.0**	**86.9**	**87.0**	**86.9**	**86.9**	**87.0**	**86.9**
2011	**79.8**	**78.9**	**79.1**	**79.6**	**79.4**	**79.4**	**79.7**
2012	**78.8**	**77.3**	**76.6**	**77.7**	**77.9**	**77.5**	**78.1**
2013	**81.9**	**80.7**	**79.2**	**80.1**	**80.5**	**79.8**	**80.6**

Source: Towers Watson.

Figure 2. Required minimum contributions under pre-Act provisions and the Act ($ billion)

	Pre-Act provisions	2+7 amortization			15-year amortization		
Plan year		2009 & 2010	2010 & 2011	2009 & 2011	2009 & 2010	2010 & 2011	2009 & 2011
2007	**53.1**	**53.1**	**53.1**	**53.1**	**53.1**	**53.1**	**53.1**
2008	**37.1**	**37.1**	**37.1**	**37.1**	**37.1**	**37.1**	**37.1**
2009	**24.7**	**23.4**	**24.7**	**23.4**	**24.2**	**24.7**	**24.2**
2010	**78.4**	**64.3**	**65.5**	**75.9**	**71.2**	**71.6**	**76.8**
2011	**130.9**	**116.7**	**96.4**	**111.3**	**119.6**	**109.1**	**116.5**
2012	**159.0**	**164.5**	**146.6**	**142.4**	**149.6**	**140.0**	**147.0**
2013	**158.5**	**163.3**	**169.7**	**165.8**	**150.9**	**143.1**	**148.7**
Difference from pre-Act results							
Sum 2010–2011		**–28.3**	**–47.3**	**–22.1**	**–18.5**	**–28.6**	**–16.1**
Sum 2009–2013		**–19.3**	**–48.6**	**–32.7**	**–35.9**	**–63.1**	**–38.3**

Source: Towers Watson.

The 2+7 rule may be the better choice for those sponsors more concerned with immediate cash flow. Otherwise, the 15-year amortization rule gives more and smoother relief.

Pension liabilities are valued using either the spot bond yield curve (in actuality, a one-month average, approximated by the CCBR in the model) or the smoothed segment rates (in the model, the second segment rate). These rates are published by the IRS. The model assumes an average duration of 14 years for active plans and nine years for frozen plans.

Certain economic and financial assumptions are made, as in **Figure A-1** (next page):

- The most favorable CCBR (as a proxy for spot yield curve) for the 2009 plan year was 7.9% in October 2008, while December 2008 had the highest segment rates.
- CCBR and second and third segment rates for 2010 are as of May 31, 2010. CCBRs for 2011–2013 are set to be high-quality corporate yields with 10-year maturity projected by Towers Watson Investment Services (TWIS), Inc. Second and third segment rates for 2011–2013 are set equal and calculated as 24-month moving averages of CCBRs.
- Equity and bond returns for 2010 are actual market outcomes, which were –1.5% and 6% as of May 31, 2010, based on the S&P 500 equity and Barclays Capital Long Government/Credit Bond indexes, respectively, plus expected returns for the rest of the year according to the TWIS projections. Annual equity and bond returns for 2011-2013 are based on the forward-looking (January 2010) TWIS projections. Monthly returns are log-linearly interpolated.

Under the PPA, lump-sum payments are constrained for plans whose funded status falls below 80%, and the Act provides no relief from this restriction. Some plan sponsors will have to make extra contributions to avoid such benefit restrictions. **Figure A-2** (next page) shows the aggregate amounts, assuming that plans within five percentage points of the 80% funding level make the extra contributions.

Figure A-1. Economic and financial assumptions at calendar year end (%)

	2007	2008	2009	2010	2011	2012	2013
Equity return	5.49	–37.00	26.45	3.69	8.92	8.56	8.63
Bond return	6.60	8.44	1.92	10.11	6.14	5.85	5.74
CCBR	6.28	7.90	5.88	5.84	5.57	5.64	5.64
2nd segment rate	5.90	6.38	6.67	6.56	5.79	5.66	5.62
3rd segment rate	6.41	6.68	6.77	6.70	5.79	5.66	5.62

Source: Towers Watson.

Figure A-2. Extra contributions under pre-Act provisions and the Act ($ billion)

	Pre-Act provisions	2+7 amortization			15-year amortization		
Plan year		2009 & 2010	2010 & 2011	2009 & 2011	2009 & 2010	2010 & 2011	2009 & 2011
2008	0.5	0.5	0.5	0.5	0.5	0.5	0.5
2009	0.6	0.6	0.6	0.6	0.6	0.6	0.6
2010	1.7	1.8	1.7	1.8	1.7	1.7	1.7
2011	10.0	10.6	11.5	9.5	10.1	10.9	9.6
2012	16.5	7.1	5.9	11.5	9.3	7.8	13.6
2013	5.8	12.7	18.4	13.0	13.1	16.7	10.7

Note: Extra contributions are those assumed to be made by certain plans to avoid benefit restrictions at the 80% funded status level.
Source: Towers Watson.

Pension Funding Relief Will Affect Executive Pay Design

By Steven Seelig

The pension funding relief in the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act comes with conditions. Relief recipients that pay "excess employee compensation" or make certain dividend payments in stock redemptions must also make higher pension contributions. The "excess" essentially includes any W-2 compensation of more than $1 million (indexed after 2010 for inflation), along with any amounts set aside from corporate assets for employees under a nonqualified deferred compensation (NQDC) plan. A grandfather rule excludes NQDC, restricted stock, stock options and stock appreciation rights payable or granted under a written binding contract in effect on March 1, 2010, and there are a few other exclusions as well.

On its face, the law encourages recipients of pension relief to craft pay programs without funding NQDC for higher-paid employees. By generally basing excess employee compensation on W-2 income, the Act also will tend to punish companies that grant equity compensation whose value is realized in a later year where stock values have increased. Given the vagaries of stock volatility, companies that elect funding relief might decide to go with cash-based programs, so they can at least cap the amount of relief they lose.

Given the vagaries of stock volatility, companies that elect funding relief might decide to go with cash-based programs, so they can at least cap the amount of relief they lose.

Regardless of the pay program, companies considering whether to elect funding relief need to weigh the relative cost of their current executive pay program versus the additional cash cost of contributing more to their pension plan. The relief structure creates an interesting dynamic, in which the very executives who choose whether to accept funding relief might be at risk of receiving scaled-back or nonequity-based compensation themselves. In companies that elect funding relief, the compensation committee must consider the potential cash cost of lost relief, as well as the other tax, accounting and cost implications of the pay program.

Boosting Wellness Participation Without Breaking the Bank

By Steven Nyce

During 2009, rising health care costs, rocky economic conditions and the specter of health care reform drove employers to seek new ways to manage costs and help their workers lead healthier lives. Many companies made considerable investments in wellness programs, hoping that motivating employees to take control of their health would reduce costs and enhance productivity. Their investments often include monetary rewards for participation, but that wellness strategy is expensive and does not always attain desired results. This analysis explores other, less expensive — but equally successful — alternatives that hold out great promise.

Today, employers devote nearly 2% of their health claim dollars to wellness programs, which have become a standard workplace benefit.[1] But while more employers sponsor such programs, many are increasingly frustrated by the results. According to the *15th Annual National Business Group on Health/ Towers Watson Employer Survey on Purchasing Value in Health Care,* nearly two-thirds of employers say employees' poor health habits are the biggest challenge to managing health care costs. Likewise, 58% of companies cite low employee engagement as the greatest obstacle to changing unhealthy behaviors. Many employers point to medical vendors' ineffectiveness in promoting healthy lifestyles and encouraging more efficient use of health care services.

The success of wellness programs hinges on whether employees participate. To that end, employers have been actively and even aggressively taking actions to boost program enrollment. Financial incentives — notably cash — have been the strategy of choice. But even though cash rewards have worked for many employers, they are not a panacea. Ongoing cash rewards are not financially sustainable and/or scalable, especially in the current economic climate, and research suggests participants' healthier behaviors often end when the financial incentives disappear.

Research suggests participants' healthier behaviors often end when the financial incentives disappear.

Successful employers share a common commitment in their wellness strategy. They provide broad-based and targeted communication to their workforce and develop a healthy workplace culture with strong support from senior leadership. These efforts emphasize the power of the organization to tap into employees' intrinsic motives and to cultivate an inherent drive to manage their own health, thus ultimately leading to sustainable behavior change.

Struggling to engage employees in wellness activities

Participation rates in health management programs vary widely across organizations. Over 30% of companies that offer health risk appraisals (HRAs) report more than 50% participation — yet one-quarter report participation levels of 10% or less (see **Figure 1**). Likewise, while 16% of responding

[1] http://ebn.benefitnews.com/news/wellness-programs-get-checkup-2682896-1.html

Figure 1. Employee participation/completion rates in wellness activities

	Participation rates						
Health program	0 to 5%	6% to 10%	11% to 20%	21% to 50%	51% to 75%	More than 75%	Don't know
Complete adult health exam	1%	4%	12%	27%	10%	4%	42%
Complete health risk appraisal	19%	6%	7%	20%	19%	13%	16%
Complete biometric screening	14%	7%	9%	19%	9%	7%	35%
Participate in weight management program	33%	16%	8%	3%	0%	0%	40%
Participate in smoking cessation program	50%	9%	5%	1%	0%	0%	34%
Participate in disease management program	34%	20%	11%	7%	1%	1%	26%
Participate in health coaching	34%	13%	9%	3%	2%	1%	38%
Maintain personal health record	27%	5%	2%	2%	1%	2%	61%

Notes: Based on companies that offer the program and report the participation rate. Participation rates reflect only employees who qualify and/or are recommended for the programs.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 2. Health management program participation and cost trends

	Median 2009 cost trend		
Health program	Low participation	High participation	Definition of high participation
Complete adult health exam	7.0%	6.0%	50%+
Complete health risk appraisal	7.2%	6.0%	50%+
Complete biometric screening	7.5%	6.0%	50%+
Participate in weight management program	7.0%	6.8%	11%+
Participate in smoking cessation program	7.0%	6.4%	11%+
Participate in disease management program	7.0%	7.0%	11%+
Participate in health coaching	8.0%	6.0%	11%+
Maintain personal health record	6.9%	5.5%	11%+

Note: Based on companies that offer the program and report participation rates.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Employers with the greatest success use many different tactics to bend the cost curve.

employers report that 50% of employees participated in biometric screenings, nearly an equal percentage report participation rates of 5% or less. Despite rising obesity in recent decades, participation rates in weight management programs remain quite low at most companies. Moreover, few employees use health coaching services or participate in a smoking cessation program when they are offered.

Many employers struggle to track participation in their wellness and health management programs, especially for personal health records and adult health exams. The lack of good data can be a barrier to informed decision making. But tracking wellness data more closely is not always possible, especially given federal laws that restrict access to some of this information.

Many benefits from boosting wellness participation

Companies whose employees participate in health management programs report lower overall health cost trends across nearly all health-related activities (see **Figure 2**). For example, if at least 50% of employees complete a biometric screening, cost trends average 6%, compared with 7.5% when participation is lower. However, the association between higher participation and lower cost trends is weaker for weight management programs and disappears for disease management programs.

This is not meant to imply that health management participation is the only factor in driving trends lower. In fact, employers with the greatest success use many different tactics to bend the cost curve.[2]

But as we discuss below, companies with high participation in health management programs stand apart from other organizations in a number of ways, and these strategies are central to defining their success.

Increasing participation with monetary incentives

Many employers use financial incentives to obtain the "returns" that accrue from higher participation rates in their health programs (see **Figure 3**). Financial incentives are most commonly offered to employees who complete HRAs and participate in smoking cessation and weight management programs. However, two-thirds to three-quarters of employers do not offer monetary incentives for many wellness interventions. Only 15% of companies provide financial incentives for completing an adult health exam (beyond offering 100% coverage in their plan), and only 7% offer rewards to employees who maintain a personal health record.

How much employers offer can strongly affect workers' responses. Incentive amounts vary widely across organizations, with the most generous incentives linked to HRAs and biometric screenings (see **Figure 4**).

A successful wellness strategy is built on appropriate and targeted action. Both lifestyle risks and biometric information offer employers considerable predictive power in identifying future high-cost cases. For example, many companies focus on strategies to discourage smoking by providing larger incentives for workers who enroll in smoking cessation programs. However, most employers offer smaller incentives for other health programs, such as weight management, disease management and health coaching.

In many health programs, bigger financial rewards are strongly linked to higher participation rates

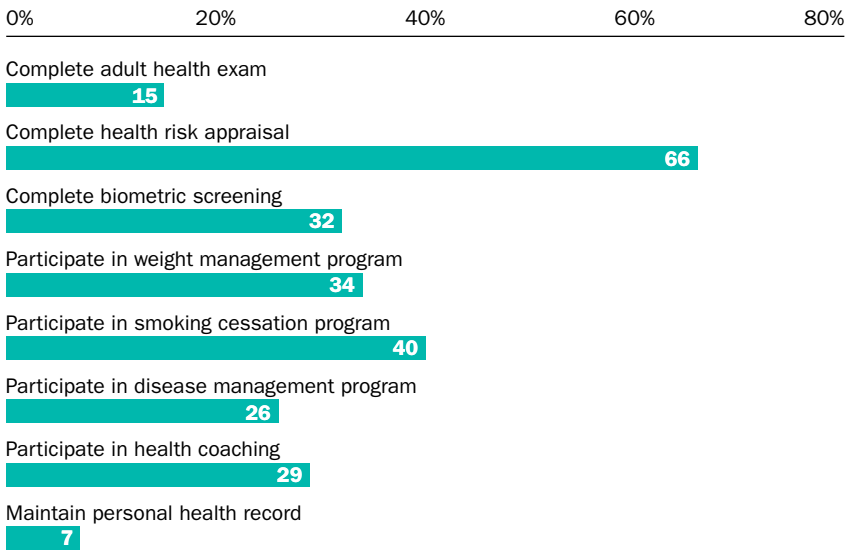
[2] See the *15th Annual National Busines Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care* report, "Raising the Bar on Health Care: Moving Beyond Incremental Change."

(see **Figure 5**). The link is especially robust with HRAs, biometric screenings and health coaching. The impact of financial incentives is less noticeable for "action based" programs like weight management and smoking cessation, which require ongoing commitment from individuals. For these programs, modest financial incentives can be effective at boosting initial participation. However, alternatives to monetary rewards might be necessary to encourage change; more specifically, to help individuals embrace the need for change. Higher participation in disease management programs is not strongly linked to larger monetary rewards.

Establishing requirements and standards

Although financial incentives help to engage workers in some health programs, boosting participation is an uphill battle in many others. Moreover, generous financial incentives are not always economically viable, driving many employers to seek other, less expensive alternatives.

Figure 3. Boosting participation through monetary incentives



Notes: Based on companies that offer the program.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 4. Incentive amounts for employers offering cash or premium differentials

	Incentive amounts					
Health program	**None**	**$50 or less**	**$51 to $100**	**$101 to $150**	**$151 to $250**	**More than $250**
Complete adult health exam	**87%**	**7%**	**3%**	**1%**	**1%**	**1%**
Complete health risk appraisal	**39%**	**19%**	**16%**	**7%**	**8%**	**11%**
Complete biometric screening	**72%**	**12%**	**5%**	**2%**	**3%**	**7%**
Participate in weight management program	**69%**	**12%**	**9%**	**2%**	**5%**	**3%**
Participate in smoking cessation program	**68%**	**9%**	**7%**	**3%**	**6%**	**8%**
Participate in disease management program	**79%**	**6%**	**6%**	**1%**	**4%**	**3%**
Participate in health coaching	**77%**	**11%**	**6%**	**0%**	**4%**	**2%**
Maintain personal health record	**94%**	**4%**	**1%**	**0%**	**0%**	**1%**

Note: Based on companies that offer the program and incentives with an identifiable dollar amount, such as cash and premium differentials.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 5. Percentage of employers with high program participation by incentive amount

	Incentive amounts				
Health program	**None**	**$50 or less**	**$51 to $100**	**$101 to $250**	**More than $250**
Complete health risk appraisal	**17%**	**24%**	**40%**	**57%**	**89%**
Complete biometric screening	**13%**	**15%**	**40%**	**54%**	**82%**
Participate in weight management program	**14%**	**23%**	**20%**	**39%**	**20%**
Participate in smoking cessation program	**10%**	**9%**	**9%**	**23%**	**10%**
Participate in disease management program	**27%**	**25%**	**25%**	**35%**	**18%**
Participate in health coaching	**18%**	**28%**	**38%**	**50%**	**50%**

Notes: Based on companies that offer the program and identify their participation rate. High program participation is defined as 50% or more for health risk appraisals and biometric screenings and 11% or more for all other health programs.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 6. Conditions for receiving financial incentives or enrolling in preferred plan option

	Requirements/standards					
	To receive financial incentive			To enroll in preferred plan option		
Health program	In place	Considering	Neither	In place	Considering	Neither
Smoker, tobacco-use status	25%	11%	64%	4%	6%	90%
Complete health risk appraisal	46%	12%	41%	12%	9%	79%
Complete biometric screening	23%	17%	60%	5%	8%	87%
Complete both health risk appraisal and biometric screening	22%	19%	59%	5%	10%	85%
Complete adult health exam	14%	13%	74%	4%	6%	90%
Maintain body mass index (BMI) within target levels	4%	14%	83%	1%	6%	92%
Maintain blood pressure within target levels	3%	13%	83%	1%	7%	92%
Maintain cholesterol within target levels	3%	14%	83%	1%	7%	92%
Complete health coaching or disease management (for those with chronic conditions)	22%	20%	58%	5%	9%	85%

Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 7. Effects of requirements/standards for receiving financial incentive or enrolling in preferred plan on program participation

		Percentage of employers achieving high participation rates that …		
Requirements/standards	Program	Impose no standard/ requirement	Impose standard/ requirement for financial incentive	Impose standard/ requirement for preferred plan option
Complete health risk appraisal	Health risk appraisal	9%	47%	60%
Complete biometric screening	Biometric screening	5%	36%	55%
Complete health risk appraisal and biometric screening	Health risk appraisal	23%	55%	68%
	Biometric screening	3%	41%	55%
Complete adult health exam	Adult health exam	12%	19%	26%
Maintain BMI within target levels	Weight management	11%	24%	*
Smoker, tobacco-use status	Smoking cessation	6%	11%	11%
Complete health coaching or disease management (for those with chronic conditions)	Disease management	19%	23%	30%
	Health coaching	11%	24%	55%

Notes: Based on companies that offer the program and identify the participation rate. High program participation is defined as 50% or more for health risk appraisals and biometric screenings and 11% or more for all other health programs. (*) Insufficient sample size to report estimates.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Some companies are introducing tougher requirements for monetary incentives and/or enrollment in the company's most attractive health plan (see **Figure 6**). While responding employers have yet to broadly establish standards for health status factors such as target body mass index (BMI), blood pressure or cholesterol levels, many are considering doing so for the upcoming year. Likewise, few employers have made enrolling in a preferred plan option conditional on specific health behaviors, although a small number of employers are considering it. The number of employers looking at these approaches for the future represents a significant shift toward achievement-based health strategies, and indicates that companies are embracing insights from behavioral economics and applying them to their health plans by using defaults and choice architecture to encourage employees to rethink their options.[3]

Employers' hesitation to adopt these tactics could be explained, at least in part, by antidiscrimination laws under the Health Insurance Portability and Accountability Act, which caps premium discounts at 20% of total coverage costs. But starting in 2014, the Patient Protection and Affordable Care Act (PPACA) increases these limits to 30% — possibly up to 50% — of premium cost.[4] These higher limits under the PPACA could make such wellness strategies more attractive to employers, but lingering uncertainty within the legal landscape could deter employers from this approach.

As shown in **Figure 7,** tougher standards and target requirements can be effective strategies for boosting participation in health programs. For example, in one-third of companies that offer a financial incentive in exchange for completing a biometric screening, at least half of workers got the screening. And completion rates are 50% or higher in more than half of companies that require workers to have a biometric screening before enrolling in a preferred plan option. Furthermore, participation rates are even higher for HRAs and biometric screenings in organizations that require both.

While tougher standards and targets can boost wellness participation, employees are likely to object to some of the more aggressive measures (see **Figure 8**). Most workers respond positively to employer programs encouraging them to adopt healthier lifestyles. More than half of employees are happy receiving reminders from their health plans to fill prescriptions or get an annual checkup, and most are comfortable with outreach programs that encourage them to join a wellness program.

Employees react most positively to rewards for healthy workers or programs that help them manage their illnesses or lower their health risks, and are least comfortable with penalties. In fact, nearly a third of workers balk at higher premiums for those unwilling to take steps to manage an illness or reduce their health risks. So, more aggressive approaches could have unintended consequences, ultimately undermining one of employers' primary goals — cultivating a healthier and more productive workforce.

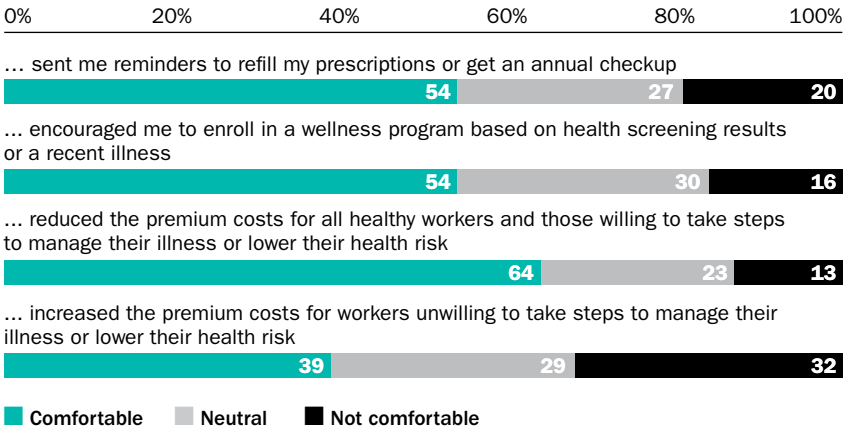
Moving beyond financial incentives

Although many consider financial rewards the best way to motivate workers to participate in wellness activities, there is little evidence that such incentives achieve sustainable behavior change. Sustained behavioral change requires a lifelong commitment to maintaining a target weight, not smoking or following a prescribed regimen for a chronic condition. Motivating employees to take the first step is crucial, but if the link between monetary rewards and behavior change and risk modification is too tight, removing the rewards can unravel the health effects as well.

Companies are embracing insights from behavioral economics and applying them to their health plans.

An effective catalyst to long-standing behavior change requires more than money. To tap into workers' intrinsic desire to manage their own health and lead healthier lives requires wellness education, regular

Figure 8. Employees' attitudes toward health initiatives
I would feel comfortable if my company …



Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

[3] For more discussion on how behavior economics is being incorporated into health care strategies, see the Towers Watson 2010 Health Care Cost Survey report, *Workforce Health 2010: New Deal, New Dividend.*

[4] This provision takes effect Jan. 1, 2014. The reward may be increased from 30% to 50% of the total cost of coverage for participating in a wellness program and attaining certain health-related standards following a joint study by the secretaries of Labor, Health and Human Services, and the Treasury.

and targeted communication, and, perhaps most important, a workplace environment that supports and cultivates a healthy lifestyle.

The employers best able to control their health care cost trend are those that take steps to improve communication and education across the workforce, according to the survey results (see **Figure 9**). The most successful companies make wellness and health care a family affair by extending their communication to employees' spouses and other dependents. Best-performing companies personalize their communication and provide tools to help employees make good decisions about their own health care. They also place greater emphasis on providing information that empowers employees to take more responsibility for managing their own health care.

The employers best able to control their health care cost trend are those that take steps to improve communication and education across the workforce.

While education and communication are essential, the most successful companies "walk the talk" by visibly involving senior leaders and other managers in promoting a healthy workplace (see **Figure 10**). Likewise, these employers actively collaborate with vendors to align the delivery of information with the corporate wellness strategy and to ensure their messages are consistent. They differentiate themselves by making health a key ingredient in their value proposition and creating a culture that enables employees to improve and sustain a healthy lifestyle.

Modeling program participation

As indicated by the results above, financial incentives are one means of boosting wellness participation, and employers that impose more stringent standards or requirements have higher take-up rates in wellness programs. However, the analysis does not control for the effects of other potential influences on wellness participation rates, such as industry/sector, demographic makeup, geographic location and environmental factors. Nor does it address the potential tradeoffs between larger monetary incentives and participation strategies such as lifestyle risk targets or wellness education.

To dig deeper, we use a multivariate regression analysis to regress the impact of various participation strategies — including monetary incentives — on participation rates. The value of the regression analysis is twofold. First, it isolates and quantifies the impact of various participation strategies on wellness program participation, while controlling for the confounding effects of other factors. Second, in a similar vein, it enables us to link the increased (or decreased) use of a specific participation strategy with changes in expected participation rates — identifying the tradeoffs in using strategies other than financial incentives.

The survey asked employers for detailed information about wellness participation rates and the amount of the financial incentive (if any) for eight separate wellness activities. This analysis imputes separate models for four programs — HRAs, biometric screenings, weight management and health coaching — and estimates the relationship between financial incentives and program participation.

Separately, employers were asked about any requirements/standards workers must meet to receive financial incentives and/or enroll in a preferred plan option. We included a variable in each model to capture the existence of standards or targets for the program. The survey also asked several questions about wellness education/communication and a healthy workplace culture.

We created summary scores for education/communication strategies and a healthy workplace culture by adding the items across the nine specific questions in each category.[5] Both summary scores take a value between 0 and 9, with higher values indicating more tactics in place. Employers average five education/communication programs in place today and four strategies to promote a healthy workplace culture. Lastly, we included additional variables as controls in each model, including whether the company offers a consumer-directed health plan, average age of the workforce, industry affiliation, gender and company size.

The multivariate modeling shows that participation rates rise steadily along with larger monetary incentives for all wellness activities except weight management (see **Figure 11** on page 12). Completion rates for HRAs rise by nearly 11 percentage points per each $100 increase in financial incentives, and participation in biometric screenings increases by about 10 percentage points for a similar reward. Health risk assessments reach universal participation given a $600 incentive, assuming all other factors hold steady. Health coaching participation is also responsive to financial incentives but average participation remains low even at modest incentive amounts.

The fact that financial incentives do not strongly affect weight management participation could signal that the effectiveness of monetary rewards wanes as the degree and duration of the required

[5] We used principal components analysis on the 18 items within Figures 9 and 10. The analysis produced two scales with nine items in each factor. Cronbach alpha coefficient measuring scale reliability was 0.82 for the Healthy Culture construct and 0.78 for the Education/Communication score. The summary scores are based on equally weighting the nine items in each construct.

Figure 9. Controlling health care costs through communication and education

Communication/education practice	Consistent performers	Best performers	Poor performers	Ratio of consistent to poor
Communicate to spouses about wellness initiatives	31%	18%	24%	1.28
Provide personalized reminders of need and timing for preventive procedures	46%	43%	37%	1.24
Provide education on health care costs and ways to help manage those costs	78%	66%	64%	1.20
Provide tools that help consumers manage their own health and health care	70%	67%	59%	1.19
Educate employees to be more informed/active consumers of health care	89%	76%	77%	1.15
Provide employees with decision-making tools	69%	61%	64%	1.09
Provide general education material to employees and dependents	61%	71%	56%	1.09
Offer web-based programs to increase enrollees' knowledge of lifestyle risk factors and health conditions	68%	70%	68%	1.01
Offer web-based programs to help enrollees reduce lifestyle risk factors or manage health conditions	63%	69%	67%	0.95

Notes: Best-performing companies are those with a median two-year average cost increase in the lowest quartile among all respondents, and poor-performing companies are those in the highest quartile. Consistent performers have maintained health care cost trends at or below the norm for each of the last four years.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

While education and communication are essential, the most successful companies "walk the talk" by visibly involving senior leaders and other managers in promoting a healthy workplace.

Figure 10. Creating a culture of health and boosting employee participation

Strategy	Consistent performers	Best performers	Poor performers	Ratio of consistent to poor
Ensure that managers and/or senior leaders receive regular reports with health and productivity program utilization metrics	39%	18%	20%	1.92
Integrate multiple vendors to improve the delivery of information to members (e.g., vendor summits)	47%	30%	26%	1.80
Offer significantly healthier food options in cafeteria/vending machines	69%	42%	39%	1.77
Support local wellness champions/advocates	56%	46%	43%	1.30
Actively manage vendor-prepared communication/ education on health care costs and living a healthier lifestyle	69%	56%	57%	1.22
Senior leadership visibly values and supports a healthy work environment	56%	53%	48%	1.17
Create company-specific communication/ education on health care costs and living a healthier lifestyle	72%	62%	68%	1.06
Senior leadership allocates adequate budget for health and productivity programs	50%	46%	50%	1.00
Brand the wellness program for use in all communication related to wellness	64%	68%	68%	0.94

Notes: Best-performing companies are those whose median two-year average cost increase is in the lowest quartile, and poor-performing companies are those in the highest quartile. Consistent performers have maintained health care cost trends at or below the norm for each of the last four years.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

Figure 11. Predicted participation rates in wellness activities by company incentives, standards, culture and communication tactics

	Wellness activity			
Employer strategy	**Health risk appraisals**	**Biometric screenings**	**Weight management participation**	**Health coaching participation**
Baseline – $200 incentive; no standards in place; 5 healthy culture & communication tactics	**57.5**	**41.9**	**8.5**	**22.1**
Incentive amount	**p<0.01**	**p<0.01**	**p=0.87**	**p<0.01**
None	**36.2**	**22.1**	**8.1**	**6.2**
$50	**41.5**	**27.1**	**8.2**	**10.2**
$100	**46.9**	**32.0**	**8.3**	**14.2**
$350	**73.4**	**56.7**	**8.8**	**34.1**
$600	**100.0**	**81.4**	**9.3**	**54.0**
Standards/requirements	**p<0.01**	**p<0.01**	**p=0.15**	**p=0.18**
In place now	**75.1**	**66.1**	**12.0**	**26.1**
Healthy culture	**p<0.01**	**p<0.01**	**P<0.01**	**p=0.87**
Low (1 tactic)	**43.0**	**33.0**	**5.4**	**21.9**
High (9 tactics)	**72.0**	**50.8**	**11.6**	**22.4**
Education/communication	**p=0.17**	**p=0.20**	**p=0.51**	**p=0.09**
Low (1 tactic)	**53.9**	**39.0**	**7.7**	**19.5**
High (9 tactics)	**61.1**	**44.8**	**9.4**	**24.8**
Number of observations	**293**	**197**	**212**	**187**
Adjusted R^2	**0.424**	**0.422**	**0.142**	**0.299**

Notes: Predicted values are based on multivariate regression results. Unless otherwise noted, baseline case uses $200 incentive, no standards/requirements in place, average number of tactics (n=5) for healthy culture and education, 7,500 employees with an average workforce age of 43 years, 55% male population and average industry distribution. A simple linear regression was determined to have the best fit.
Source: *15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care.*

commitment rises. Conversely, HRAs and biometric screenings require relatively little effort from employees, making financial incentives more effective at encouraging this one-time behavior.

Participation rates are also responsive to requirements/standards for earning a financial incentive. In fact, estimated participation rates are nearly 18 percentage points higher at companies that require employees to complete an HRA before enrolling in the most popular health plan than at those that do not. Companies with similar requirements for biometric screenings enjoy a 24-percentage-point advantage over other companies. However, making preferred plan participation contingent on achieving target BMI levels or completing a health coaching session has only a minimal impact on wellness participation.

These strategies can boost wellness participation, but financial incentives are expensive and stringent standards/requirements might be unpopular with workers. Instead, some employers realize a significant payoff by making health an important strategic advantage of their organization.

HRA participation is estimated to be 29 percentage points higher at companies that strongly emphasize a healthy culture versus other companies.

Employers that promote a healthy culture enjoy significantly higher participation in their wellness activities, according to our modeling analysis. In fact, HRA participation is estimated to be 29 percentage points higher at companies that strongly emphasize a healthy culture versus other companies. Similarly, focusing on promoting a healthy culture can boost otherwise low participation in biometric screenings by nearly 18 percentage points. While financial incentives have little impact on take-up rates in weight management programs according to our estimates, a healthy culture can be quite effective at boosting participation. A healthy culture, however, is not a significant driver of health coaching participation, which is far more responsive to targeted and personalized communication. Participation rates in the other wellness activities are only modestly affected by an emphasis on communication and education strategies (although none of the estimates is statistically significant).

Although a healthy workplace culture can effectively increase take-up rates in wellness activities, what is its dollar value? In other words, how do more

generous financial incentives compare with a greater emphasis on tactics and programs that cultivate a healthy workplace?

Our analysis indicates that an emphasis on a healthier workplace can be quite valuable, especially for HRA participation and biometric screenings. In fact, strengthening the focus on a healthy workplace culture (by adding four additional tactics) can boost HRA participation by as much as offering a $140 financial incentive, and the boost to biometric screenings is roughly equivalent to a $90 reward.

Summary

Many employers are currently challenged by low levels of participation in their wellness programs. As this analysis confirms, a well-developed health engagement strategy can be more effective than simply paying people to be healthy. Sustainable change requires strategies that make risk modification meaningful to employees. Employers that cultivate a healthy workplace culture and use targeted communication approaches often achieve high levels of employee participation in their wellness programs, even with modest financial incentives.

Finding the right carrot-and-stick balance between nudging employees to take the steps necessary to improve their health and creating a supportive environment depends on a number of factors, which vary among organizations and workforces. But for many employers, the road to a more engaged and healthy workforce does not necessarily demand an expensive incentive campaign. Rather, understanding the workplace culture and taking actions to connect employee health to other values can create an optimal solution without breaking the bank.

About the data

The *15th Annual National Business Group on Health/ Towers Watson Employer Survey on Purchasing Value in Health Care* was completed by 507 employers with at least 1,000 employees between November 2009 and January 2010, and reflects respondents' 2009 and 2010 health program decisions and strategies. The survey includes more than 350 data items that track employers' strategies and practices, and the results of their efforts to provide and manage health benefits for their workforce. Respondents collectively employ 11.5 million employees, 9.2 million of whom are eligible for the health care program, and operate in all major industry sectors. Respondents spend on average $7,700 per employee per year on health care, which equates to $70 billion in total health care expenditures.

News in Brief

Medicare Payment Rates Fixed Until December

By Ann Marie Breheny

On June 25, President Obama signed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (H.R. 3962). The act replaces a scheduled 21% reduction in Medicare's physician payment rates with a 2.2% increase for the period from June 1 to November 30, 2010.

Lawmakers considered further delaying the scheduled payment cut but had to settle for the short-term fix to avoid the higher cost of a longer delay. So, Congress will have to act again this year to avert the decrease now scheduled to take effect on December 1.

IRS Revenue Ruling 2008-40: Deadline Approaching for U.S.-Qualified Plans With Puerto Rico Participants

By Lynn Cook and Russell Hall

Another benefit of the transfer — especially for 401(k) plans — is that the U.S.-qualified plan would no longer have to perform non-discrimination testing on contributions for Puerto Rico residents.

Sponsors of U.S. retirement plans with Puerto Rican participants (including "dual-qualified" plans) have until the end of 2010 to eliminate some potential tax troubles. In Revenue Ruling 2008-40, the IRS offered tax relief for transfers of assets and liabilities for Puerto Rican participants from the U.S. plan to a plan qualified under Puerto Rico law with a related Puerto Rico trust.

Such transfers will not subject Puerto Rican participants to current U.S. taxation or expose the U.S. plan to the risk of disqualification. In addition, all future distributions from the Puerto Rico plan and trust will be treated as Puerto Rico source income, thus allowing the participants who are residents of Puerto Rico to escape the U.S. income taxes and withholding that would otherwise apply to a portion of each distribution if the plan trust remained in the United States.

In addition to the tax advantage to Puerto Rican participants, another benefit of the transfer — especially for 401(k) plans — is that the U.S.-qualified plan would no longer have to perform nondiscrimination testing on contributions for Puerto Rico residents under the sometimes difficult to reconcile rules in the U.S. and Puerto Rico tax codes.

Some 401(k) and other plan sponsors have considered spinning off the portion of the 401(k) plan covering Puerto Rican participants into a separate plan with a Puerto Rico trust. However, if the spin-off does not occur within the window of relief provided in Rev. Rul. 2008-40, the IRS will consider the transfers in-service distributions to a nonqualified plan, and the affected participants will be subject to U.S. tax on a portion of the deemed distribution. Such a transfer could also disqualify a U.S. plan that is not permitted to make in-service distributions. In deciding whether to make a transfer by the 2010 deadline, a sponsor will want to weigh the advantages described above against the additional burden of maintaining a separate plan and trust in Puerto Rico.

A U.S.-qualified plan that has not been approved by the Hacienda (Puerto Rico's equivalent of the IRS) is not considered tax-qualified in Puerto Rico, exposing Puerto Rican participants to adverse Puerto Rico tax consequences. So far, however, the Hacienda has been willing to accept retroactive requests for approval.

Sponsors that wish to take advantage of the relief must act before January 1, 2011.