

Notes

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A T A G L A N C E

Satisfaction With Health Coverage and Care: Findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey, *by Paul Fronstin, Ph.D., EBRI*

- Satisfaction levels have been trending up among CDHP enrollees, and trending down among traditional-plan enrollees. Satisfaction levels with getting doctor appointments were high relative to other aspects of health care, regardless of plan type.
- Individuals in consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs) were less likely than those in traditional plans both to recommend their health plan or to stay with their current plan, if they had the opportunity to switch.
- Dissatisfaction with out-of-pocket costs may be driving overall satisfaction trends.

Is Working to Age 70 Really the Answer for Retirement Income Adequacy? *by Jack VanDerhei, Ph.D., EBRI*

- It would be comforting from a public policy standpoint to assume that merely working to age 70 would be a panacea to the significant challenges of assuring retirement income adequacy, but this may be a particularly risky strategy, especially for the vulnerable group of low-income workers.
- Prior research demonstrates the significant error introduced into retirement readiness calculations if nursing-home costs are excluded, and highlighted the need for a re-examination of the methodologies behind studies that only extrapolate a relatively static picture of retirement savings
- A worker's participation status in a defined contribution (DC) plan at age 65 will be extremely important due to the multi-year consequences for additional employee and employer contributions to the plan.
- While workers need to make their own decisions on the correct trade-offs of saving today vs. deferring retirement, they should be able to expect that those presenting alternatives be as accurate and complete as possible, avoiding simplistic "rules of thumb" that may result in future retirees, through no fault of their own, coming up short.

Satisfaction With Health Coverage and Care: Findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

Introduction

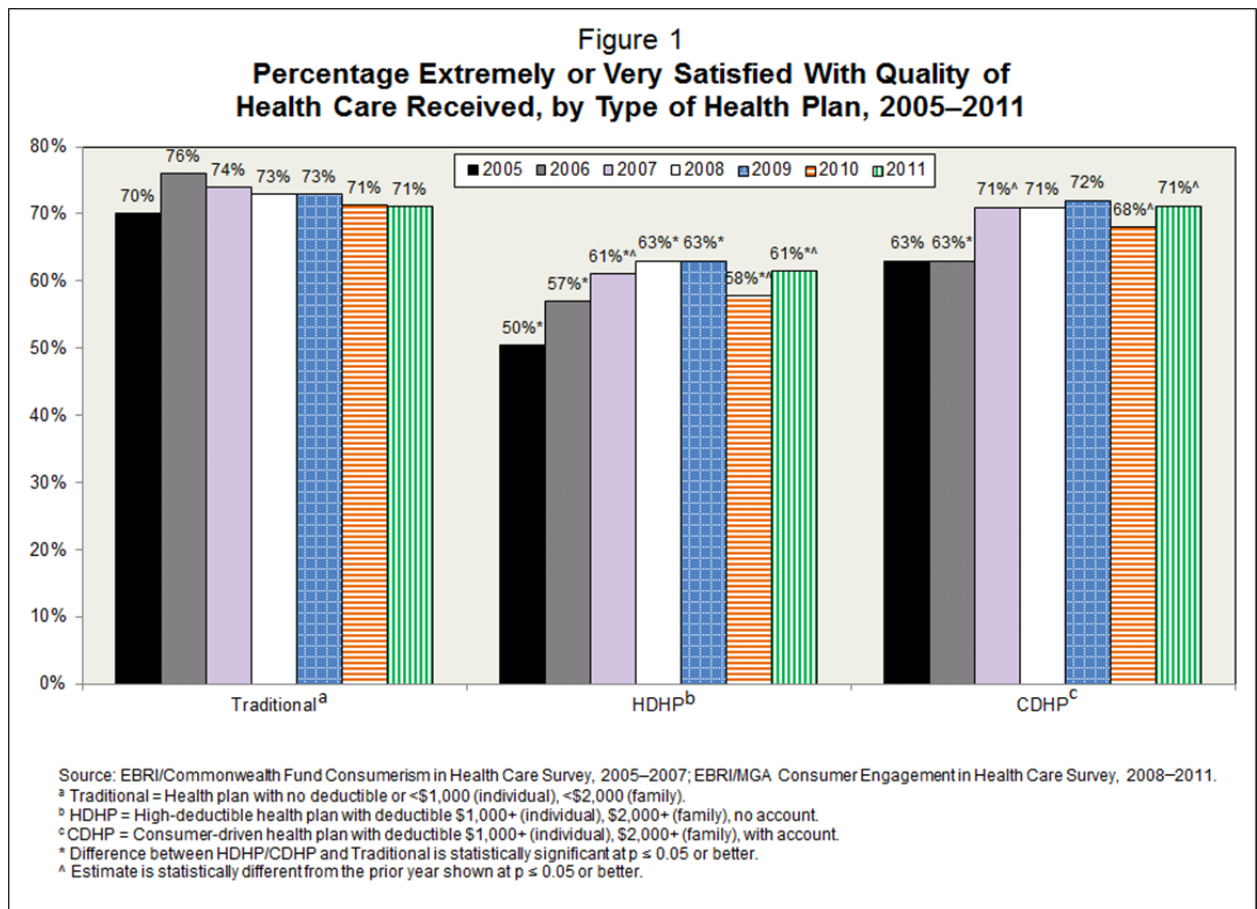
This paper examines satisfaction with various aspects of health care by type of health plan among three groups of health-plan enrollees: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional coverage. The findings presented in this paper are derived from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey, an online survey that examines issues surrounding consumer-directed health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with health care plans, reasons for choosing a plan, and sources of health information. This paper also incorporates findings from the 2011 survey as well as findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008, 2009 and 2010 EBRI/MGA Consumer Engagement in Health Care Survey. More information about the surveys can be found in Fronstin (2011).

As noted above, the survey sample was divided into one of three groups: those with a CDHP, those with a HDHP and those with traditional health coverage. Individuals were assigned to the CDHP and HDHP groups if they had deductibles of at least \$1,000 for individual coverage or \$2,000 for family coverage. To be assigned to the CDHP group, they must also have had an account, such as a health savings account (HSA) or health reimbursement arrangement (HRA) with a rollover provision that they could use to pay for medical expenses, or an account with portability so that they could take that account with them if they changed jobs. Individuals were assigned to the HDHP group if they did not have an account that met those conditions. This latter group includes individuals with HSA-eligible health plans, but may also include individuals with high deductibles who were not eligible to contribute to an HSA. Individuals with traditional health coverage had a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans, and plans with a variety of cost-sharing arrangements. The shared characteristics of this group were that they either had no deductibles or deductibles that were below current thresholds that would qualify for HSA tax preference, and that they did not have an HRA-based plan.

Satisfaction

Respondents were asked a series of questions about overall satisfaction with the health plan, as well as satisfaction with the quality of care received, out-of-pocket expenses, choice of doctors, and ability to get doctor appointments.

Quality of Care—The 2006 survey found that individuals in CDHPs and HDHPs were less likely to be satisfied with the quality of care received than those in traditional plans. However, in 2007 the gap in satisfaction between those in traditional plans and those with CDHPs disappeared, because satisfaction increased significantly among those with CDHPs, and since that time there has been no difference in satisfaction with quality of care between those in traditional plans and those with CDHPs (Figure 1). While the percentage of HDHP enrollees reporting that they were extremely or very satisfied with the quality of care received increased between 2005 and 2009, satisfaction levels have held steady since 2007, other than a drop in 2010. The gap in satisfaction between traditional enrollees and HDHP enrollees was present in all years of the survey.



Overall Satisfaction With Health Plan—Unlike satisfaction with *quality of care* received, which was steady, differences were found in overall satisfaction levels by *plan type* (Figure 2). Traditional-plan enrollees were more likely than CDHP and HDHP enrollees to be extremely or very satisfied with their overall plan in all years of the survey. In 2011, 57 percent of traditional-plan enrollees were extremely or very satisfied with their overall health plan, compared with 46 percent of CDHP enrollees and 37 percent of HDHP enrollees.

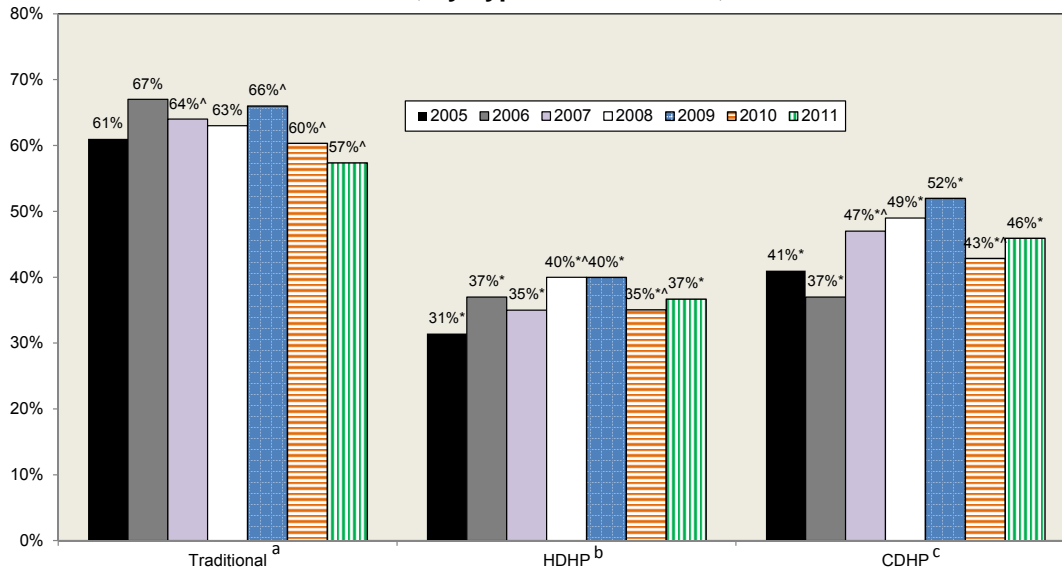
Overall satisfaction levels among CDHP enrollees increased from 37 percent to 52 percent between 2006 and 2009, although there was a drop in satisfaction rates between 2009 and 2010. Satisfaction rates increased from 43 percent to 46 percent between 2010 and 2011, but the increase was not statistically significant.

While the overall satisfaction rates for CDHP enrollees increased in most years of the survey, satisfaction rates among traditional enrollees decreased in most years. Between 2006 and 2008 they slipped from 67 percent to 63 percent, and, after increasing between 2008 and 2009, they fell from 66 percent to 57 percent between 2009 and 2011.

Very few traditional-plan enrollees were not too or not at all satisfied with their health plans in any year of the survey (Figure 3). While HDHP and CDHP enrollees were much more likely to report that they were not too or not at all satisfied with their health plan, dissatisfaction levels appeared to be trending downward in most years of the survey.

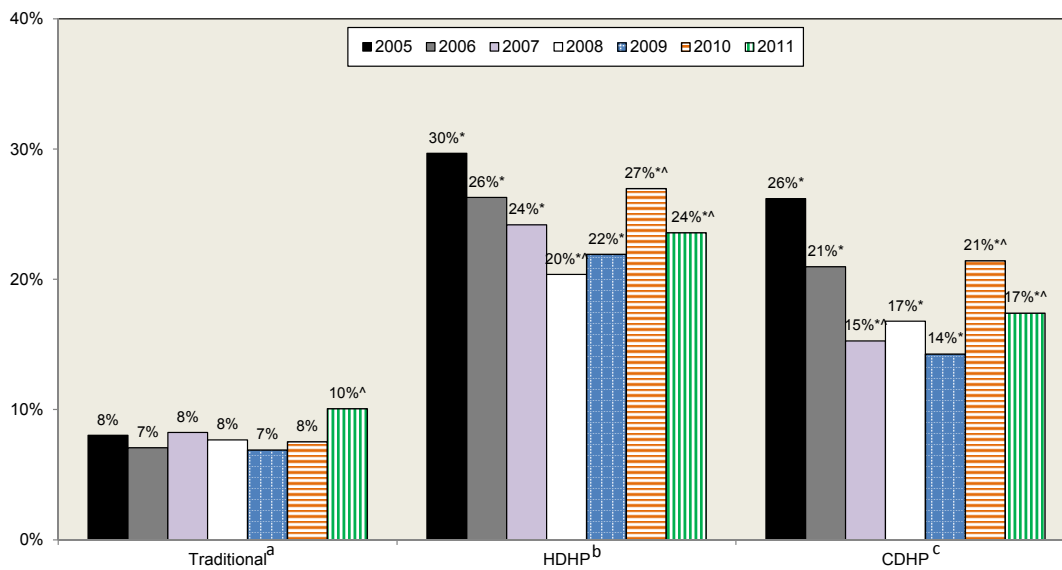
Out-of-Pocket Costs—Differences in out-of-pocket costs may explain some of the difference in overall satisfaction rates among enrollees in traditional plans, HDHPs, and CDHPs. In 2011, 41 percent of traditional-plan participants were either extremely or very satisfied with out-of-pocket costs (for health care services other than for

Figure 2
Percentage Extremely or Very Satisfied With Overall Health Plan, by Type of Health Plan, 2005–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).
^b HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.
^c CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2,000+ (family), with account.
 * Difference between HDHP/CDHP and Traditional is statistically significant at $p \leq 0.05$ or better.
[^] Estimate is statistically different from the prior year shown at $p \leq 0.05$ or better.

Figure 3
Percentage Not Too or Not at All Satisfied With Overall Health Plan, by Type of Health Plan, 2005–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).
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prescription drugs), while 16 percent of HDHP enrollees and 24 percent of CDHP participants were extremely or very satisfied (Figure 4). Satisfaction rates appeared to be trending downward among those with traditional coverage and upward for those with a CDHP, when the higher 2009 satisfaction rate was ignored.

A separate question on out-of-pocket spending related specifically to prescription drugs was added to the survey in 2009. Given that only three years of data were available for this question and that 2009 appeared to be an outlier for satisfaction rates on overall out-of-pocket costs, there was no clear trend for any plan type. However, those with traditional coverage were more likely to report being extremely or very satisfied with out-of-pocket costs for prescription drugs than those with a HDHP or CDHP (Figure 5). Overall, however, satisfaction rates with out-of-pocket costs are low among all plan types.

Access to Doctors—Satisfaction levels with getting doctor appointments were high relative to other aspects of health care, regardless of plan type, yet some differences were found: In 2006, traditional-plan enrollees were more likely than CDHP enrollees to be extremely or very satisfied with their ability to get doctor appointments. However, between 2007 and 2010, differences were not statistically significant, and in 2011, CDHP enrollees were more likely than traditional-plan enrollees to be extremely or very satisfied with their ability to get doctor appointments. In 2011, 73 percent of CDHP enrollees were extremely or very satisfied with their ability to get doctor appointments, compared with 68 percent among traditional-plan enrollees (Figure 6). Furthermore, while the year-to-year increases were not statistically significant, satisfaction levels among CDHP enrollees appeared to be trending up, which was not the case for traditional-plan enrollees or HDHP enrollees.

Satisfaction with choice of doctors was relatively high regardless of plan type. In 2005 and 2006, traditional-plan enrollees were more likely than CDHP enrollees to be extremely or very satisfied with their choice of doctors, but in 2008 and 2009, CDHP enrollees were more likely than traditional-plan enrollees to be extremely or very satisfied with their choice of doctors (Figure 7). With the exception of 2010, satisfaction with choice of doctors has been trending higher among CDHP enrollees.

Attitudes Toward Health Plan

As in previous years of the survey, in 2011, individuals in CDHPs and HDHPs were found to be less likely than those in traditional plans both to recommend their health plan to friends or co-workers (Figure 8) and to stay with their current health plans if they had the opportunity to switch plans (Figure 9). The percentage of CDHP enrollees reporting that they would be extremely or very likely to recommend their plan to friends or co-workers increased from 30 percent to 39 percent between 2006 and 2007, and reached 45 percent in 2009. It then dropped to 37 percent in 2010 and increased to 41 percent in 2011. One-half (49 percent) of traditional-plan enrollees were extremely or very likely to recommend their plan in 2011, compared with 29 percent of HDHP enrollees.

In 2011, almost 60 percent of traditional-plan enrollees reported that they were extremely or very likely to stay with their health plan if they were allowed to switch, whereas 34 percent of HDHP enrollees would switch, and 49 percent of CDHP enrollees would switch. The percentage of traditional-plan enrollees who reported being extremely or very likely to switch health plans if they could appeared to be trending downward, with a statistically significant decline between 2010 and 2011. In contrast, there was not a clear upward trend among CDHP enrollees.

Conclusion

The EBRI/MGA Consumer Engagement in Health Care Survey finds a number of divergent trends related to satisfaction with various aspects of health coverage and care. Concerning overall satisfaction with health coverage, traditional-plan enrollees were more likely than CDHP or HDHP enrollees to be extremely or very satisfied with the overall plan in all years of the survey. However, satisfaction levels were trending up in most years of the survey among CDHP enrollees, and trending down among traditional-plan enrollees.

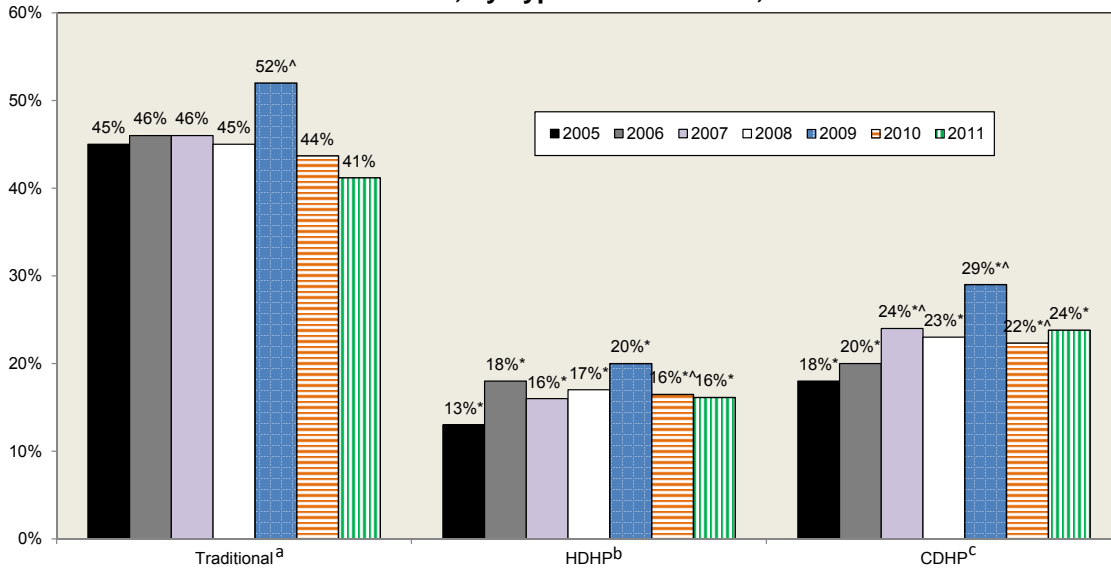
Dissatisfaction with out-of-pocket costs may be driving the overall satisfaction trends. Similar to overall satisfaction rates, satisfaction rates for out-of-pocket costs appear to be trending downward among those with traditional coverage and upward for those with a CDHP.

Initial differences in satisfaction rates with respect to quality of care disappeared between traditional plan and CDHP enrollees, and there were high satisfaction rates with respect to access to doctors regardless of plan type. Yet, in 2011, the survey continued to find that individuals in CDHPs and HDHPs were less likely than those in traditional plans both to recommend their health plan to friends or co-workers, and to stay with their current health plan if they had the opportunity to switch plans. These findings may have been driven more by out-of-pocket spending than by quality of care or access to care.

References

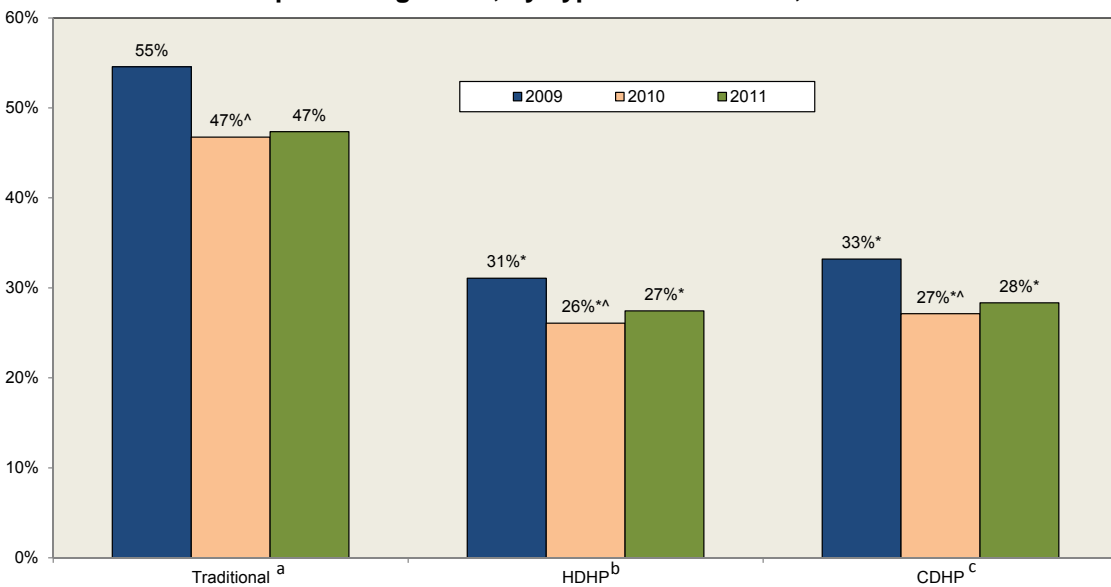
Fronstin, Paul. "Findings From the 2011 EBRI/MGA Consumer Engagement in Health Care Survey." *EBRI Issue Brief*, no. 365 (Employee Benefit Research Institute, December 2011).

Figure 4
Percentage Extremely or Very Satisfied With Out-of-Pocket Health Care Costs, by Type of Health Plan, 2005–2011



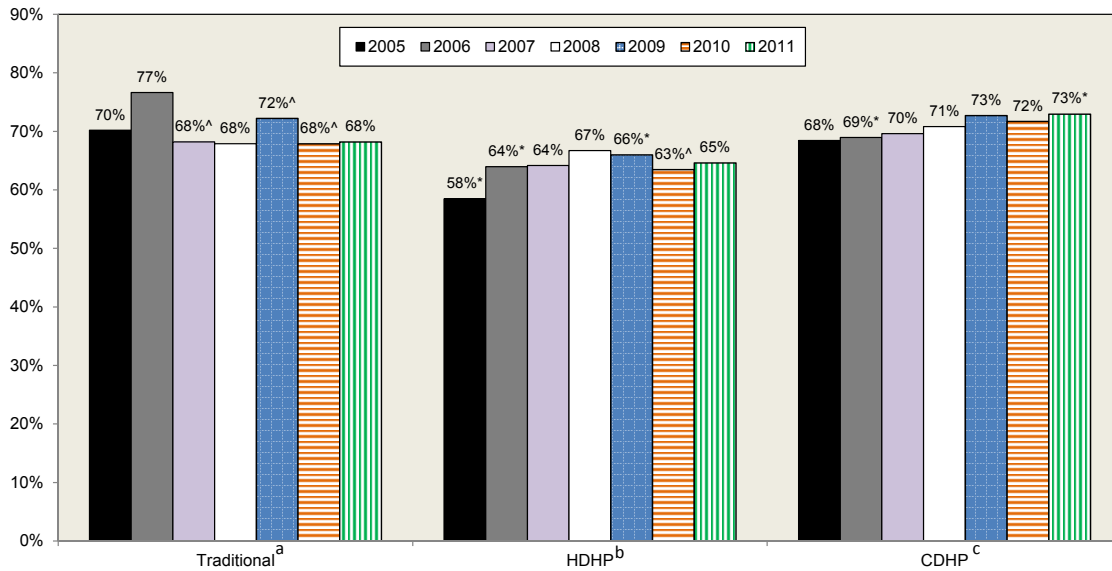
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
 Note: Survey question changed in 2009 from asking about "out-of-pocket health care costs for my health care" to "out-of-pocket health care costs for my other health care" because of the introduction of a question specifically asking about out-of-pocket costs for drugs.
^a Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).
^b HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.
^c CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2,000+ (family), with account.
 * Difference between HDHP/CDHP and Traditional is statistically significant at $p \leq 0.05$ or better.
[^] Estimate is statistically different from the prior year shown at $p \leq 0.05$ or better.

Figure 5
Percentage Extremely or Very Satisfied With Out-of-Pocket Prescription Drug Costs, by Type of Health Plan, 2009–2011



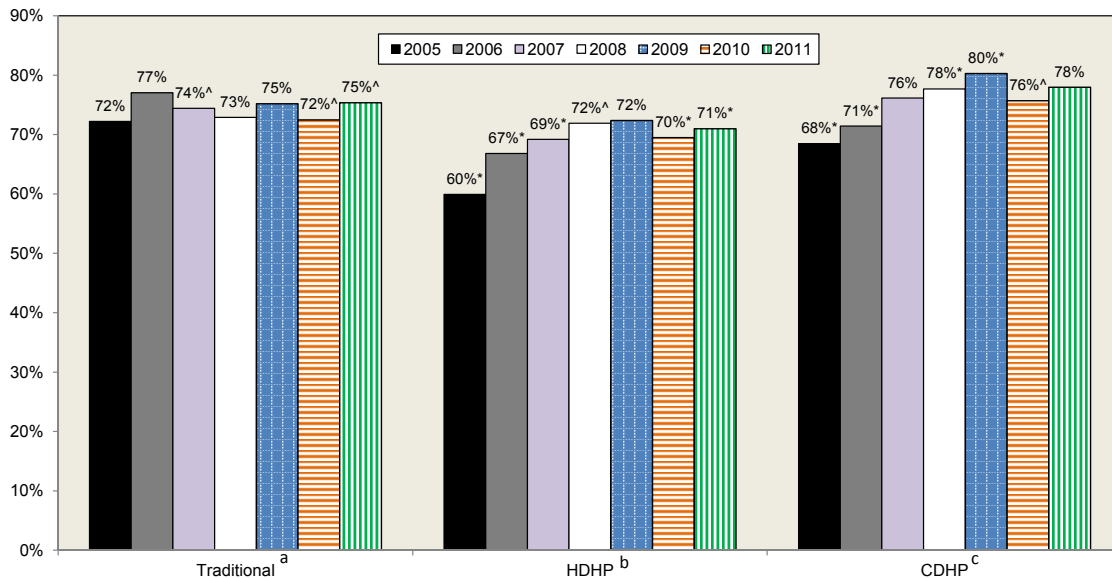
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009–2011.
^a Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).
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Figure 6
Percentage Extremely or Very Satisfied With Ease of Getting Doctor Appointments When Needed, 2005–2011



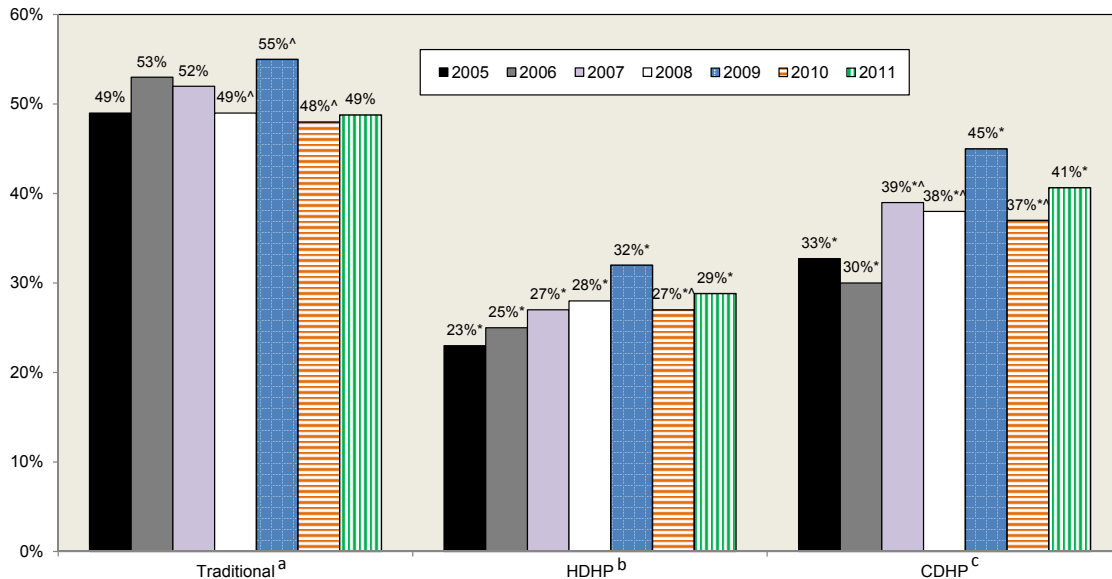
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
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Figure 7
Percentage Extremely or Very Satisfied With Choice of Doctors, 2005–2011



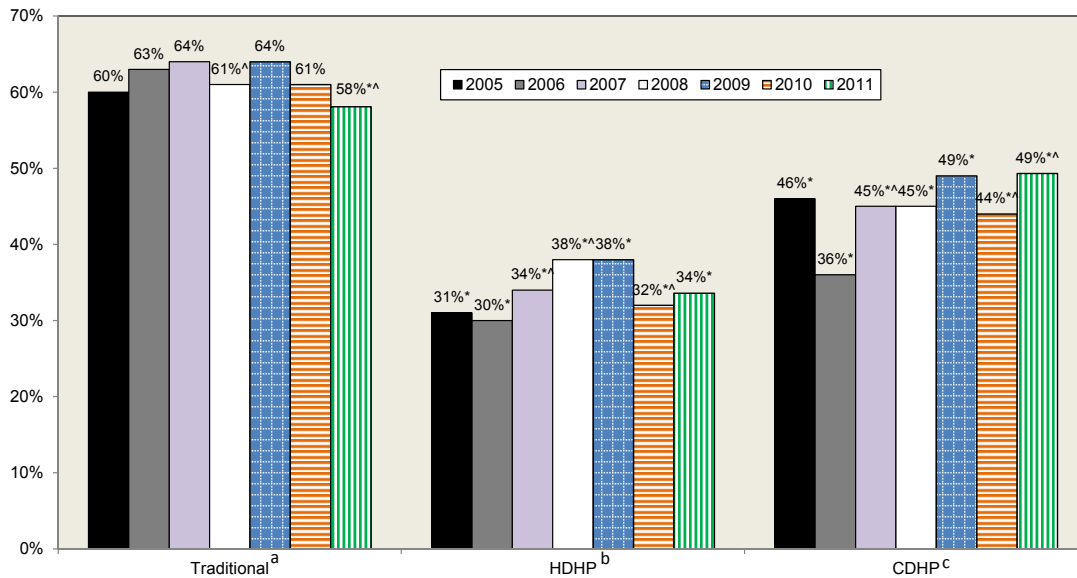
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
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Figure 8
Percentage Extremely or Very Likely to Recommend Health Plan to Friends or Co-Workers, by Type of Health Plan, 2005–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
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^{*} Difference between HDHP/CDHP and Traditional is statistically significant at $p \leq 0.05$ or better.
[^] Estimate is statistically different from the prior year shown at $p \leq 0.05$ or better.

Figure 9
Percentage Extremely or Very Likely to Stay With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan, 2005–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).
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Is Working to Age 70 Really the Answer for Retirement Income Adequacy?

By Jack VanDerhei, Ph.D., Employee Benefit Research Institute

Introduction

Individuals, institutions, and policy makers alike have long been challenged to determine not only the best means of accumulating resources necessary to provide adequate income in retirement, but to consider alternative accumulation approaches to address potential shortfalls. One of the more recent alternatives proposed is that of extending one's working career, which, if possible, would have the dual beneficial effects of both deferring the depletion of accumulated resources and providing additional time to accumulate wealth. There are concerns as to whether this approach represents a realistic alternative for most people in view of the current trends in retirement age. However, this analysis explores only the viability of this approach to produce an adequate level of retirement income.

In recent years there have been several models constructed in an attempt to analyze the percentage of Baby Boomer¹ and Generation Xer households² that are likely to have adequate retirement income. While the results depend to a large extent on the model's definition of "adequacy," there remains a consensus that a significant percentage of these households will fall short of the adequacy threshold, certainly if they retire at age 65.

Earlier this year, the National Retirement Risk Index (NRRRI)³ was used to provide an assessment of the value of deferring retirement beyond age 65 (Munnell, Webb, Delorme and Golub-Sass 2012). The authors concluded that by age 66 "about 55 percent of households are projected to be prepared for retirement" and that by a retirement age of 70 that number increases to 86 percent. Perhaps most surprising was the conclusion that at age 70, "low-income households ... are nearly as prepared for retirement as their high-income counterparts (82 percent vs. 88 percent)."⁴

The EBRI Retirement Security Projection Model[®] (RSPM)

In 2003, the Employee Benefit Research Institute (EBRI) constructed the EBRI-ERF Retirement Security Projection Model[®] (RSPM)⁵—the first nationally representative, micro-simulation model based on actual 401(k) participant behavior and a stochastic decumulation model.⁶ Although it was explicitly recognized at that time that many individuals were retiring at earlier ages, a retirement age of 65 was chosen for baseline results, based upon the assumption that most workers would have the flexibility to work until that age, if they so chose.

The retirement-age assumption of 65 was also used for congressional testimonies and research reports through 2010 (see Appendix B); however, the 2011 version of the model was modified to determine whether just "working a few more years after age 65" would indeed be a feasible financial⁷ solution to the retirement income adequacy problems for those families determined to be "at risk." The answer from that modeling, unfortunately, is not always "yes"—even if retirement age is deferred into the 80s.

Results from VanDerhei and Copeland (2011) indicated that the lowest pre-retirement income quartile would need to defer retirement to age 84 before 90 percent of the households would have even a 50 percent probability of success.⁸ Although a significant portion of the improvement would take place in the first four years after age 65, the improvement would tend to level off in the early 70s before picking up in the late 70s and early 80s. Higher-income households would be in a much better situation: 90 percent of the highest-income quartile would already have a 50 percent probability of success by age 65, while those in the next-highest income quartile would need to wait until age 72 for 90 percent of their group to have a 50 percent probability. Those in the second-lowest income quartile would need to wait until age 81 before 90 percent of their group had a 50 percent probability of success.

Differences Between NRRI and RSPM

There are several possible reasons for the different results for an age-65 retirement between the assessment offered from the NRRI and RSPM.⁹ However, the most likely difference is the treatment of defined contribution (DC) account balances with respect to future time periods. While NRRI projects financial assets in 401(k) plans and other accounts “based on wealth-to-income patterns by age group from the 1983–2007 Federal Reserve Surveys of Consumer Finances (SCF),” the RSPM has been completely revamped since the original 2003 model to account for the dramatic trends in automatic enrollment (AE) in 401(k) plans, automatic escalation of contributions, and the increased utilization of target-date funds (TDFs), whether through qualified default investment accounts (QDIAs) or through participant-directed investments, since the passage of the Pension Protection Act of 2006 (PPA). In essence, the NRRI projections appear to rely on an outdated perspective of 401(k)-plan designs and savings trends.

How much difference might this make? Holden and VanDerhei (2005) demonstrated the large impact AE would likely have on employees eligible to participate in 401(k) plans, especially at the lower-income quartiles. VanDerhei (September 2007) used the PPA auto-enrollment safe harbors to show how much larger balances in AE 401(k) plans would likely be for eligible employees as a result of automatic escalation of employee contributions. VanDerhei and Copeland (2008) used a version of the RSPM to model the impact of automatic enrollment and automatic escalation of employee contributions for all workers (whether or not they are currently 401(k) participants or eligible nonparticipants).

However, for purposes of determining why one might expect significant differences between the two models in terms of relative improvement of retirement-income adequacy by deferring retirement age to 70, a comparative analysis of the treatment of households in retirement needs to be undertaken. For a household to be classified as “ready for retirement” under NRRI, its projected replacement rate is simply compared with a benchmark rate.¹⁰ However, the RSPM uses a fully developed stochastic decumulation process to determine whether a family will run short of money in retirement (and, if so, at what age) under each of a thousand alternative, simulated retirement paths. This allows for the simultaneous treatment of:

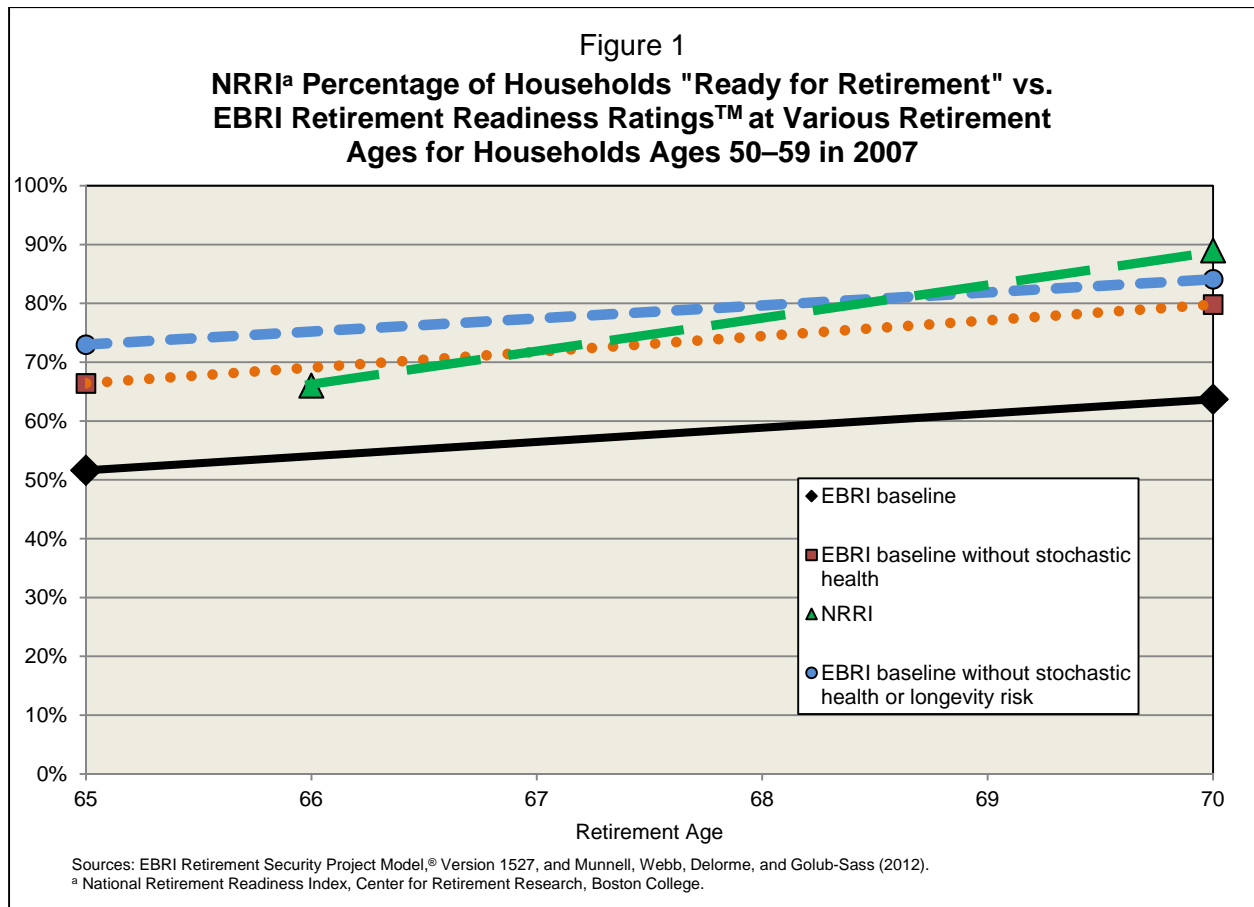
- Longevity risk.
- Investment risk.
- The risk of potentially catastrophic health care costs (such as prolonged stays in a nursing home).

While a simplistic, single deterministic extrapolation of age 65 resources to alternative-retirement ages to determine retirement readiness is certainly a convenient way to measure the impact of deferring retirement age, the ability of the NRRI methodology to adequately deal with these types of processes appears questionable.

Comparison of Percentage of Households “Ready for Retirement”

Munnell, Webb, Delorme, and Golub-Sass (2012) provide estimates of the percentage of households “ready for retirement” at selected ages. Figure 1 provides a comparison for households ages 50–59 in 2007 between the NRRI findings at retirement ages 66 and 70 and the EBRI Retirement Readiness Ratings™ (RRR)¹¹ derived from the RSPM at retirement ages 65 and 70. The NRRI model shows that 66 percent of households in this age range would be ready for retirement (under their definition) at age 66, and that by age 70 this would increase to 89 percent. Similar numbers for the EBRI baseline show that only 52 percent would be considered to be “ready”¹² at age 65 and that the number increases much less dramatically by age 70: only 64 percent would be considered ready for retirement.

However, when the EBRI baseline is modified to ignore the stochastic health costs outlined above, the figures improve substantially: 66 percent of these households would be considered to be ready by age 65, increasing to 80 percent by age 70. When the EBRI baseline is further modified to disregard longevity risk in addition to the stochastic health



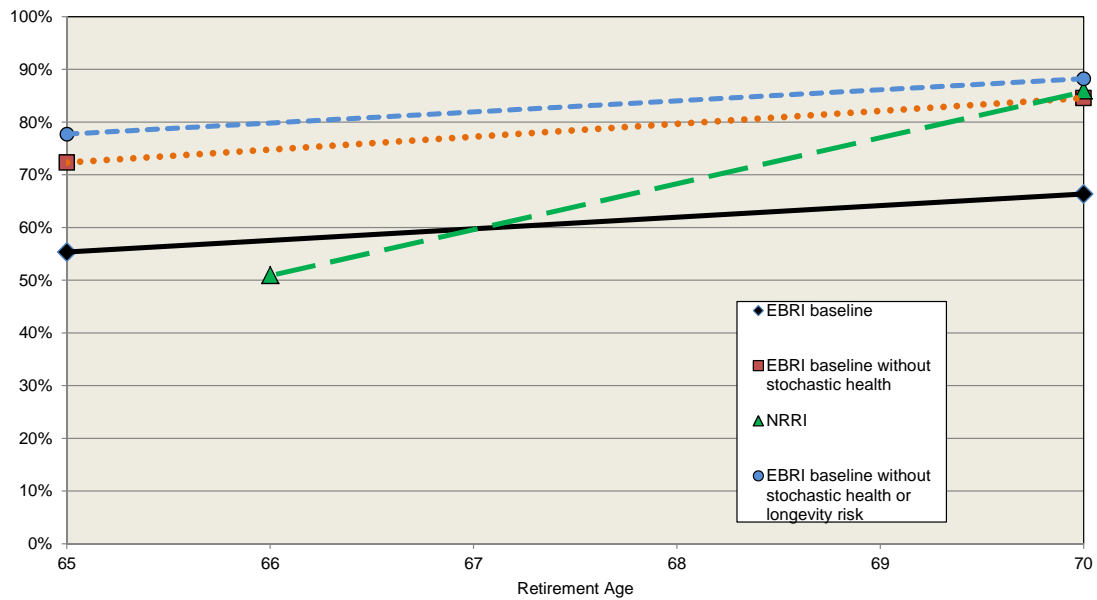
costs, the figures improve even more: 73 percent of these households would then be considered to be ready by age 65, increasing to 84 percent by age 70. Figure 2 provides a similar comparison between the two models for those ages 40–49 in 2007 and Figure 3 shows the comparisons for those ages 30–39 in 2007.

Comparing the slopes of the baseline RSPM with the NRRI model in these figures quantifies just how different the results are:

- In Figure 1 (ages 50–59 in 2007), the NRRI model shows an improvement of 23 percentage points over four years (or an average increase of 5.8 percentage points per year), whereas the baseline RSPM shows an improvement of 12 percentage points over five years (or an average increase of only 2.4 percentage points per year).
- In Figure 2 (ages 40–49 in 2007), the NRRI model shows an average improvement of 8.8 percentage points per year, whereas the baseline RSPM shows an average improvement of only 2.2 percentage points per year.
- In Figure 3 (ages 30–39 in 2007), the NRRI model shows an average improvement of 9.0 percentage points per year, whereas the baseline RSPM shows an average improvement of only 2.1 percentage points per year.

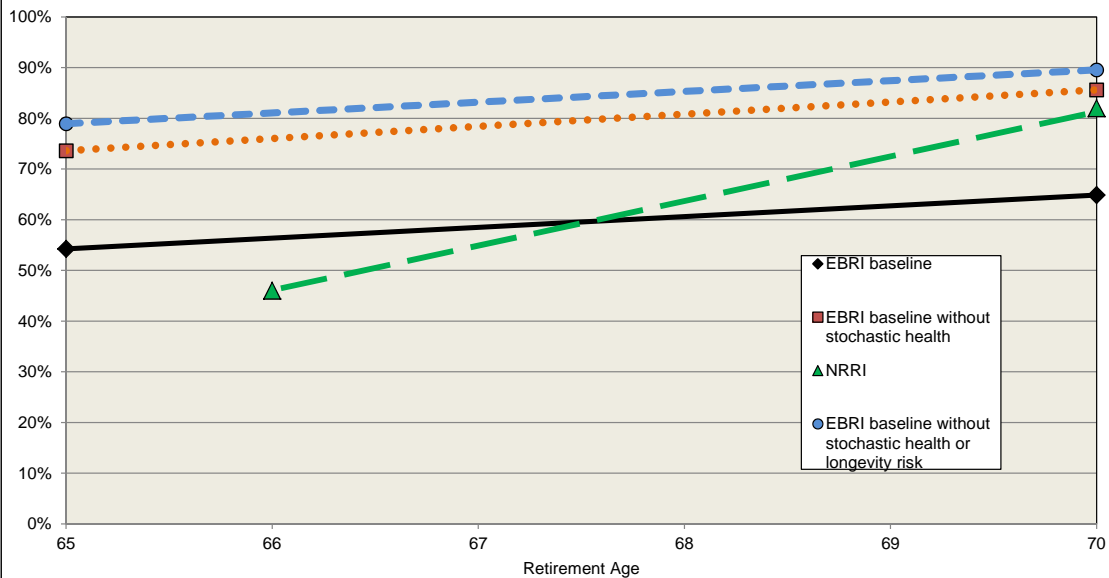
In essence, by ignoring the potential dramatic impact of long-term care costs and by choosing to disregard longevity risk, the NRRI model produces a much more optimistic (if arguably less realistic) result.

Figure 2
NRRI^a Percentage of Households "Ready for Retirement" vs. EBRI Retirement Readiness RatingsTM at Various Retirement Ages for Households Ages 40–49 in 2007



Sources: EBRI Retirement Security Project Model,[®] Version 1527, and Munnell, Webb, Delorme, and Golub-Sass (2012).
^a National Retirement Readiness Index, Center for Retirement Research, Boston College.

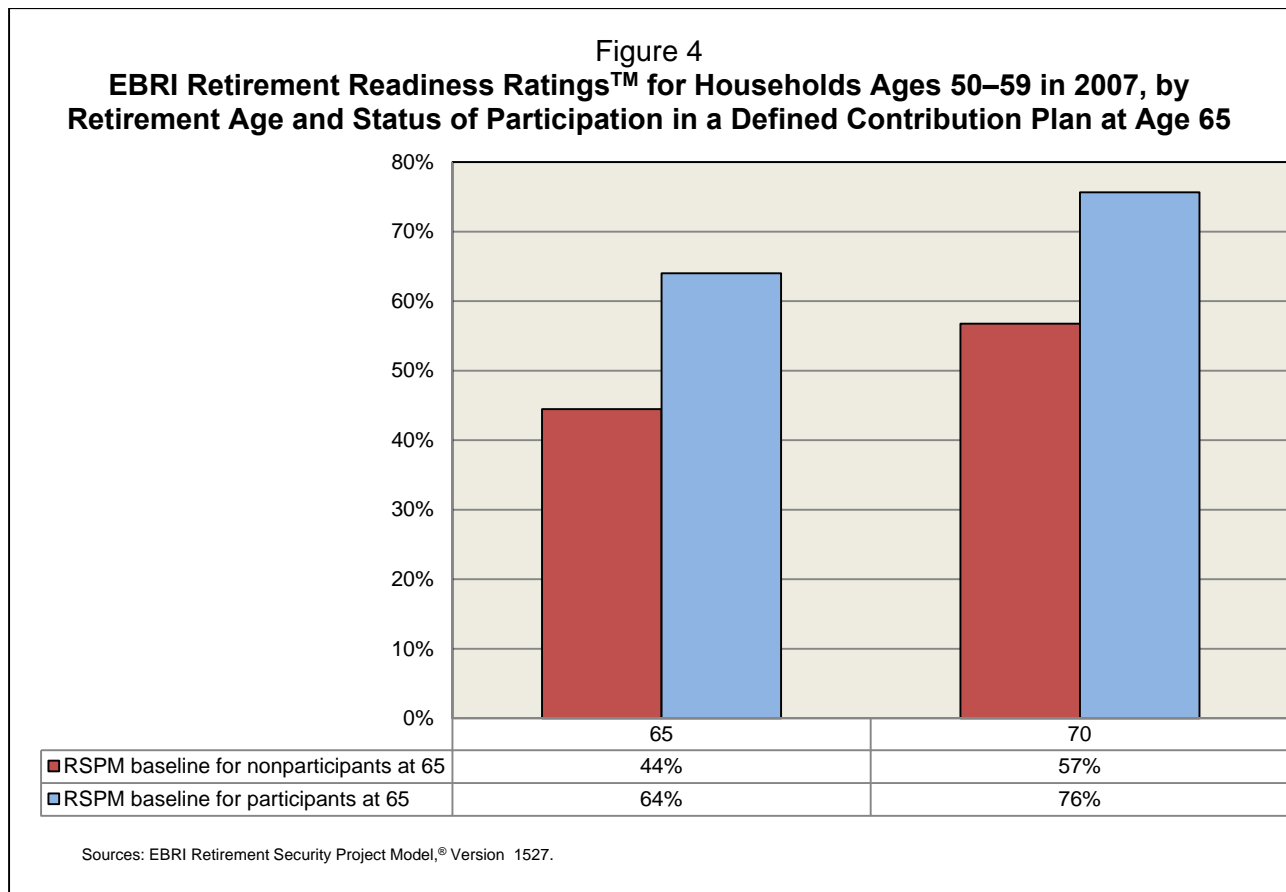
Figure 3
NRRI^a Percentage of Households "Ready for Retirement" vs. EBRI Retirement Readiness RatingsTM at Various Retirement Ages for Households Ages 30–39 in 2007



Sources: EBRI Retirement Security Project Model,[®] Version 1527, and Munnell, Webb, Delorme, and Golub-Sass (2012).
^a National Retirement Readiness Index, Center for Retirement Research, Boston College.

The Value of Participating in a Defined Contribution Plan After Age 64

As explained in more detail in VanDerhei and Copeland (2011), when the RSPM was modified to allow retirement to be deferred beyond age 65, the baseline assumption of no job change after age 64 was introduced. As a result, the participation status in a DC plan at age 65 for a worker will be extremely important due to its multi-year consequences for additional employee and employer contributions to the plan. Figure 4 shows the results of bifurcating the households into those with workers who remain DC participants at age 65 versus those not in that situation. Note that this results in a substantially improved RRR even at age 65 (64 percent vs. 44 percent) because those households with members in participant status at age 65 would likely have already been in defined contribution plans for a number of years with their current employers.¹³



When the households without DC-participating members are assumed to retire five years later (without the benefit of any additional years of employee or employer retirement-plan contributions), the RRR increases to 57 percent. In other words, 23 percent of those who would have been at risk if they retired at age 65 would now be “ready to retire.” However, when the same calculation is performed for plan-participant households, 33 percent of those who would have been at risk if they retired at age 65 would be “ready” to retire at age 70. Similar results (not shown) were obtained for the two younger cohorts. Clearly, continuing to work until age 70 would help in enhancing retirement readiness—but continuing to work and participate in a DC plan until age 70 would produce an even more dramatic improvement.

Conclusion

Previously, VanDerhei and Copeland (2011) attempted to quantify the impact that deferring retirement age past 65 would have on various groups of retirees. That research has documented in considerable detail that the impact will depend upon the relative pre-retirement income of the household, whether a member of the household continues to participate in a defined contribution plan after age 65, and how confident the household wants to be that it will not run short of money in retirement.¹⁴

They also demonstrated the significant error introduced into these calculations if nursing-home costs are excluded from the simulations, and highlighted the need for a re-examination of the methodologies behind studies that only extrapolate a relatively static picture of retirement savings from historical ratios of wealth to income and assume away longevity and investment risk in retirement, as well as the risks of potentially catastrophic uninsured health care costs in retirement (for example nursing-home costs for retirees without long-term care insurance and those not eligible for Medicaid).

It would be comforting from a public-policy standpoint to assume that merely working to age 70 would be a panacea to the significant challenges of assuring retirement-income adequacy (especially among lower-income families), but this may be a particularly risky strategy for this vulnerable group in view of the uncertainties of their future health status and the marketability of their job skills.

While workers need to make their own decisions on the correct trade-offs of saving today vs. deferring retirement, they should be able to expect that those presenting alternatives be as accurate and complete as possible, avoiding simplistic “rules of thumb” that may result in future retirees, through no fault of their own, coming up short.

Appendix A: Brief Description of RSPM

One of the basic objectives of EBRI’s Retirement Security Projection Model® (RSPM) is to simulate the percentage of the population that will be “at risk” of having retirement income inadequate to cover average expenses of those age 65 or older throughout retirement in specific income and age groupings and uninsured health care costs for the remainder of their lives once they retire. The EBRI Retirement Readiness Rating™ also provides information on the distribution of the likely number of years before those at risk “run short of money,” as well as the percentage of compensation they would need in terms of additional savings in order to have a 50, 70, or 90 percent probability of retirement income adequacy.

VanDerhei (February 2011) describes how households (whose heads are currently ages 36–62) are tracked through retirement age and how their retirement income/wealth is simulated for the following components:

- Social Security.
- Defined contribution balances.
- IRA balances.
- Defined benefit annuities and/or lump-sum distributions.
- Net housing equity.

A household is considered to run short of money in this model if aggregate resources in retirement are not sufficient to meet minimum retirement expenditures, defined as a combination of deterministic expenses from the Consumer Expenditure Survey (as a function of income), and some health insurance and out-of-pocket health-related expenses,

plus stochastic expenses from nursing homes and home-health care (at least until the point such expenses are picked up by Medicaid). This version of the model is constructed to simulate retirement income adequacy based upon meeting the average expenses of those age 65 or older throughout retirement in specific income and age groupings determined by a proxy for the household's retirement income plus uninsured medical costs for the duration of their retirement; however, alternative versions of the model allow similar analysis for replacement rates, standard-of-living calculations, and other ad-hoc thresholds.

The baseline version of the model used for this analysis assumes all workers retire at age 65 and immediately begin to withdraw money from their individual accounts (defined contribution and cash balance plans, as well as IRAs) whenever the sum of their expenses and uninsured medical expenses exceed the after-tax annual income from Social Security and defined benefit plans (if any). If there is sufficient money to pay expenses without tapping into the tax-qualified individual accounts, the excess is assumed to be invested in non-tax-advantaged accounts where the investment income is taxed as ordinary income. The individual accounts are tracked until the point at which they are depleted. At that point, any net housing equity is assumed to be added to retirement savings in the form of lump-sum distributions (not reverse annuity mortgages). If all the retirement savings are exhausted and if the Social Security and defined benefit payments are not sufficient to pay expenses, the entity is designated as having "run short of money" at that time.

Appendix B: Brief Chronology of RSPM

The original version of RSPM was used to analyze the future economic well-being of the retired population at the state level. EBRI and the Milbank Memorial Fund, working with the governor of Oregon, set out in the late 1990s to see if this situation could be addressed for the state. That analysis (VanDerhei and Copeland 2001a) focused primarily on simulated retirement wealth with a comparison to ad-hoc thresholds for retirement expenditures.

Subsequent to the release of the Oregon study, it was decided that the approach could be applied to other states as well. Kansas and Massachusetts were chosen as the next states for analysis. Results of the Kansas study were presented to the state's Long-Term Care Services Task Force on July 11, 2002 (VanDerhei and Copeland July 2002), and the results of the Massachusetts study were presented on Dec. 1, 2002 (VanDerhei and Copeland December 2002). With the assistance of the Kansas Insurance Department, EBRI was able to create the EBRI Retirement Readiness Ratings™ based on a full stochastic decumulation model that took into account the households' longevity risks, post-retirement investment risks, and exposure to potentially catastrophic nursing-home and home-health-care risks. This was followed by the expansion of RSPM and the EBRI Retirement Readiness Ratings™ to a national model and the presentation of the first micro-simulation, retirement-income-adequacy model, built in part from administrative 401(k) data presented at the EBRI December 2003 policy forum (VanDerhei and Copeland 2003). The basic model was subsequently modified for testimony for the Senate Special Committee on Aging in 2004 to quantify the beneficial impact of a mandatory contribution of 5 percent of compensation (VanDerhei January 2004).

In an analysis to determine the impact of annuitizing defined contribution and IRA balances at retirement age, VanDerhei and Copeland (2004) were able to demonstrate that for a household seeking a 75 percent probability of retirement income adequacy, the additional savings that would otherwise need to be set aside each year until retirement would decrease by a median amount of 30 percent. Additional refinements were introduced in 2005 to evaluate the impact of purchasing long-term care insurance on retirement income adequacy (VanDerhei 2005).

The model was next used to evaluate the impact of defined benefit freezes on participants by simulating the minimum employer-contribution rate that would be needed to financially indemnify the employees for the reduction in their expected retirement income under various rate-of-return assumptions (VanDerhei March 2006). Later that year, an updated version of the model was developed to enhance the EBRI interactive Ballpark E\$timat[®] worksheet by

providing Monte Carlo simulations of the necessary replacement rates needed for specific probabilities of retirement-income adequacy under alternative-risk-management treatments (VanDerhei September 2006).

RSPM was significantly enhanced for the May 2008 EBRI policy forum by allowing automatic enrollment of 401(k) participants with the potential for automatic escalation of contributions to be included (VanDerhei and Copeland 2008). Additional modifications were added in 2009 for a Pension Research Council presentation that involved a “winners/losers” analysis of defined benefit freezes and the enhanced employer contributions provided to defined contribution plans at the time the defined benefit plans were frozen (Copeland and VanDerhei 2010).

Also in 2009 a new subroutine was added to the model to allow simulations of various styles of target-date funds for a comparison with participant-directed investments (VanDerhei, 2009). In April 2010, the model was completely re-parameterized with 401(k) plan-design parameters for sponsors that had adopted automatic-enrollment provisions (VanDerhei April 2010). A completely updated version of the national model was produced for the May 2010 EBRI policy forum and used in the July 2010 *Issue Brief* (VanDerhei and Copeland 2010).

The new model was used to analyze how eligibility for participation in defined contribution plans impacts retirement income adequacy in September 2010 (VanDerhei September 2010). It was also used to compute Retirement Savings Shortfalls for Baby Boomers and Generation Xers in October 2010 (VanDerhei October 2010a).

In October 2010 testimony before the Senate Health, Education, Labor and Pensions Committee on “The Wobbly Stool: Retirement (In)security in America,” the model was used to analyze the relative importance of employer-provided retirement benefits and Social Security (VanDerhei October 2010b).

In February 2011, the model was used to analyze the impact of the 2008–2009 crisis in the financial and real estate markets on retirement income adequacy (VanDerhei February 2011).

An April 2011 article introduced a new method of analyzing the results from the RSPM (VanDerhei April 2011). Instead of simply computing an overall percentage of the simulated life paths in a particular cohort that would not have sufficient retirement income to pay for the simulated expenses, the new method computed the percentage of households that would meet that requirement more than a specified percentage of times in the simulation.

As explored in the June 2011 *EBRI Issue Brief*, the RSPM allowed retirement-income adequacy to be assessed at retirement ages older than 65 (VanDerhei and Copeland June 2011).

In a July 2011 *EBRI Notes* article (VanDerhei July 2011), it provided preliminary evidence of the impact of the “20/20 caps” on projected retirement accumulations proposed by the National Commission on Fiscal Responsibility and Reform.

The August 2011 *EBRI Notes* article (VanDerhei August 2011) evaluated the importance of defined benefit plans for households, assuming individuals retire at age 65, while demonstrating the impact of defined benefit plans in achieving retirement income adequacy for Baby Boomers and Gen Xers.

Finally, EBRI's September 2011 Senate Finance testimony (VanDerhei September 2011) analyzed the potential impact of various types of tax-reform options on retirement income adequacy. This was expanded in the November 2011 *EBRI Issue Brief* (VanDerhei November 2011), and a new set of survey results were added to the model in the March 2012 *EBRI Notes* article (VanDerhei March 2012).

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Endnotes

¹ The cohort of people born between 1946–1964

² The cohort of people born between 1965–1973.

³ Center for Retirement Research, Boston College, <http://crr.bc.edu/special-projects/national-retirement-risk-index/>

⁴ The authors categorize the households as low, middle or high income.

⁵ Employee Benefit Research Institute, www.ebri.org/research/?fa=model

⁶ See Appendix A for more detail.

⁷ Note this does not account for the fact that many individuals may not have the ability to continue to work past this age. For example, the 2012 Retirement Confidence Survey found that 50 percent of current retirees surveyed indicated that they left the work force earlier than planned, consistent with the findings of the RCS in previous years. In most cases, this was due to health problems for themselves or their spouses, changes at their companies, skills required for jobs, or other work-related reasons (Helman, Copeland and VanDerhei, 2012).

⁸ If the success rate is moved to a threshold of 70 percent, only 2 in 5 households in the lowest-income quartile will attain retirement income adequacy even if they defer retirement age to 84. Increasing the threshold to 80 percent reduces the number of lowest pre-retirement income quartile households that can satisfy this standard at a retirement age of 84 to approximately 1 in 7.

⁹ One likely difference deals with the asset allocation of investments in defined contribution plans. VanDerhei (June 2009) conducts simulations using RSPM showing the improvement in terms of risk and return for large cohorts of 401(k) participants when TDF asset allocations (simulations are run for average, conservative, and aggressive TDF asset allocations) are substituted for participant-directed investments. In contrast, the NRRRI methodology is based on historical data over a time period that largely excludes any potential beneficial impact from this trend. Another difference that remains to be quantified is the assessment of defined benefit accruals. Whereas NRRRI is based on SCF data that have the survey respondents assess what their eventual defined benefit payouts will be, RSPM bases the defined benefit accruals on a time series of defined-benefit-plan-type and generosity parameters coded from, inter alia, summary plan description-type information on more than 1,000 large-salaried, defined benefit plans per year. Park (2011) analyzed the SCF respondents' self-reported, expected benefits from defined benefit pension plans and found that, as a percentage of final pay, the mean annual benefit accrual rates in 2004 and 2007 are estimated at 2.06 percent and 2.48 percent, respectively. These rates are higher than the average annual accrual rate of 1.59 percent reported by the U.S. Department of Labor's 2005 National Compensation Survey (NCS), which is based on official plan documents. This suggests that the 2004 and 2007 SCF respondents overestimated their expected pension benefits at retirement, unless they had more generous accrual formulas than plan participants in the 2005 NCS.

¹⁰ Although the benchmark rates were not provided in Munnell, Webb, Delorme and Golub-Sass (2012), previous publications utilizing NRRRI (Munnell, Webb, Golub-Sass, and Muldoon, 2009) do provide these values. What is not clear, however, is whether these benchmark rates have been modified for later retirement ages and, if so, how various age-related expenditure patterns were factored into the modification.

¹¹ The EBRI Retirement Readiness Ratings™ measure the percentage of households that are likely to have sufficient money in retirement to pay for average expenses of those age 65 or older throughout retirement in specific income and age groupings plus uninsured health care costs.

¹² In essence, this number is simply 100 percent minus the “at-risk” ratings described in VanDerhei and Copeland (2011).

¹³ Note that this is a simple bifurcation of the participation status. For a more detailed analysis of the number of years of plan eligibility and its impact of retirement income adequacy see VanDerhei (May, 2012).

¹⁴ For example, VanDerhei and Copeland (2011) present alternative results for 50, 70 and 80 percent probabilities of retirement income adequacy.

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