

GAO

Report to the Chairman, Committee
on Education and Labor, House of
Representatives

March 2007

**EMPLOYER-
SPONSORED
HEALTH AND
RETIREMENT
BENEFITS**

**Efforts to Control
Employer Costs and
the Implications for
Workers**





Highlights of [GAO-07-355](#), a report to the Chairman, Committee on Education and Labor, House of Representatives

Why GAO Did This Study

Many U.S. workers receive health and pension benefits from employers, and the cost of these benefits represents a growing share of workers' total compensation. Employers have made changes to control these rising costs, contending that these changes will allow them to remain competitive, particularly in an increasingly global market. Some advocacy groups are concerned that workers may receive reduced benefits or incur additional costs as a result of employers' cost-control strategies. Moreover, they contend that these changes may disadvantage certain groups of workers, such as sicker, older, or low-wage workers.

GAO was asked to examine the practices employers are using to control the costs of benefits. To evaluate changing employer benefit practices and their potential implications, GAO examined: (1) current and emerging practices employers are using to control the costs of health care benefits; (2) current and emerging practices employers are using to control the costs of retirement benefits; and (3) employers' workforce restructuring changes. GAO reviewed studies of employer benefit trends; interviewed representatives of business, government, labor, and consumer advocacy and research organizations; and reviewed and analyzed data from surveys of employee benefits. The Department of Labor provided technical comments, which were incorporated as appropriate.

www.gao.gov/cgi-bin/getrpt?GAO-07-355.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Barbara D. Bovbjerg at bovbjergb@gao.gov, or John E. Dicken at dickenj@gao.gov.

EMPLOYER-SPONSORED HEALTH AND RETIREMENT BENEFITS

Efforts to Control Employer Costs and the Implications for Workers

What GAO Found

Many employers have recently changed health benefits, often to control costs. The share of employers offering health benefits has declined from 2001 to 2006, due mostly to an 8-percentage point drop in the share of small employers offering benefits. Many employers that offer health benefits have required workers to pay a higher share of out-of-pocket costs and some have recently introduced consumer-directed health plans, which trade lower premiums for significantly higher deductibles. Also, some employers now offer mini-medical plans that provide more limited coverage at lower premiums. Similar to coverage for active workers, an increasing share of retiree health benefits costs is being shifted to retirees and many employers have terminated benefits for future retirees—a trend that experts believe will continue. Some of these recent changes may affect some workers more than others, such as low-wage workers who are less able to afford higher out-of-pocket costs and less healthy workers who use more health care.

The trends in retirement benefits that have emerged over the last several decades are continuing. Active participation in defined benefit plans fell from 29 million in 1985 to 21 million in 2003 as employers terminated existing plans or froze benefits for active employees. At the same time, active participation in defined contribution plans rose from 33 million in 1985 to 52 million in 2003 as employers increased their offerings of these plans. Benefits experts stated that employers' decisions on what type of retirement plans to offer reflects their preference for benefit cost control and predictability in funding and accounting. Employers' decisions to offer defined contribution plans requires workers to assume more responsibility for their retirement planning; however, a growing number of employers are attempting to increase retirement savings by automatically enrolling workers and offering investment advice, for which recent legislation provides additional flexibilities.

Workforce restructuring through the use of contingent workers—workers who are not employed full-time and year round with an employer—may affect workers' access to and participation in benefit programs. Benefits experts presented mixed views on whether employers have been changing the composition of their workforces to reduce benefit costs.

Employers, individuals, and government share the responsibility for providing a U.S. benefits system that addresses the health and retirement needs of individuals of varying economic and health backgrounds, while allowing employers to remain competitive in a global market environment. The challenges workers face in assuming greater cost, risk, and control of their health and retirement benefits make it more difficult for low-wage earners to afford health care coverage and save for retirement. Although these challenges may weigh most heavily on the less wealthy and less healthy segments of the workforce, they affect a broad spectrum of the American workforce and could prove challenging to many over time.

Contents

Letter		1
	Results in Brief	3
	Background	5
	Recent Changes in Employer-Sponsored Health Benefits Prompted by Cost Concerns May Particularly Affect Lower-Wage and Less Healthy Workers	17
	The Ongoing Shift to Different Types of Employer-Sponsored Retirement Plans Continues to Affect Both Employers' and Workers' Roles in Retirement Planning	28
	Workforce Restructuring Can Result in Different Benefit Arrangements for Workers and May Affect Employer Benefit Costs	37
	Concluding Observations	41
	Agency Comments	43
Appendix I	Description of Survey Data Used in Our Analysis	44
Appendix II	GAO Contacts and Staff Acknowledgments	48
Related GAO Products		49
Tables		
	Table 1: Percentage of Firms Offering Health Benefits by Firm Size, 2001 and 2006	18
	Table 2: Change in the Share of PPO-Enrolled Workers with Selected Cost-sharing Arrangements, 2004 and 2006	19
	Table 3: Share of Employers with over 500 Workers That Offer Health and Wellness Programs, 2001-2005	22
	Table 4: Percent of Surveyed Private-Sector Employers with 1,000 or More Workers That Made Cost-Shifting Changes to Their Retiree Health Benefits in the Previous Year	23
	Table 5: Percentage Point Change in Rates of Employer Sponsorship of Health Benefits, and Worker Eligibility, Enrollment, Coverage, and Uninsurance, 2001-2005, by Income Level, Based on the Federal Poverty Level (FPL)	25

Table 6: Employer-Sponsored Defined Benefit Plans and Active Participants, 1985, 1999, and 2003	29
Table 7: Employer-Sponsored Defined Contribution Plans and Active Participants, 1985, 1999, and 2003	31
Table 8: Percentage of Part-time Workers Participating in Employer-Provided Pension and Health Care Benefits, 1999 and 2005	40
Table 9: Hourly Cost of Retirement and Health Care Benefits for Full-time and Part-time Workers, 2005	41

Figures

Figure 1: Real Growth in Hourly Expenses Attributable to Wages, Health and Retirement Benefits, and Other Benefits between 1991 and 2005	7
Figure 2: Composition of the Contingent Workforce (February 2005)	13
Figure 3: Share of Workforce Participating in Employer-Sponsored Retirement Plans, by Type of Plan 1985-1999	32
Figure 4: Percentage of Full-time and Contingent Workers Offered Employer-Provided Pension and Health Care Benefits, 2005	38
Figure 5: Percentage of Full-time and Contingent Workers Participating in Employer-Provided Pension and Health Care Benefits, 2005	39

Abbreviations

ADA	Americans with Disabilities Act of 1990
ADEA	Age Discrimination in Employment Act of 1967
BLS	Bureau of Labor Statistics
CDHP	consumer-directed health plan
CPS	Current Population Survey
DB	defined benefit
DC	defined contribution
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act of 1974
FASB	Financial Accounting Standards Board
FPL	Federal Poverty Level
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRA	health reimbursement arrangement
HRET	Health Research and Education Trust
HSA	health savings account
IRA	individual retirement account
PBGC	Pension Benefit Guaranty Corporation
PEO	Professional Employer Organization
PPA	Pension Protection Act of 2006
PPO	preferred provider organization
PSCA	Profit Sharing/401k Council of America

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

March 30, 2007

The Honorable George Miller
Chairman
Committee on Education and Labor
House of Representatives

Dear Mr. Chairman:

Many workers receive health and retirement benefits from their employers, and the cost of these benefits in recent years has risen faster than wages.¹ Between 1991 and 2005 the costs of health and retirement benefits increased by 34 percent compared to a 10 percent increase in wages. Employers have made changes to control the rising costs of these benefits, contending that these changes will allow them to remain competitive, particularly in an increasingly global market, by balancing cost containment with the need to offer attractive benefits. Some consumer advocacy groups and union representatives are concerned that workers may receive reduced benefits or be required to absorb these rising costs as a result of employers' cost control strategies. Moreover, they are concerned that cost control strategies may disadvantage certain groups of workers, such as those who are sicker, older, or low-wage earners.

Although changes to control rising benefit costs are not limited to a particular industry, changes considered by industries that employ large numbers of workers, such as manufacturing and retail, have received widespread publicity and prompted public debate on the role of employer-sponsored benefits in the United States. For example, an internal Wal-Mart memo that was released to the media in late-2005 described several proposed benefit changes that some labor and advocacy representatives thought would disadvantage certain low-wage workers. The strategies adopted by employers to control rising health and retirement benefits costs and the sustainability of employers' continued ability to provide the benefits has significant implications for workers. Such strategies also have implications for the federal government, which plays a key role in

¹ See GAO, *Employee Compensation: Employer Spending on Benefits Has Grown Faster Than Wages, Due Largely to Rising Costs for Health Insurance and Retirement Benefits*, [GAO-06-285](#) (Washington, D.C.: Feb. 24, 2006).

financing these benefits through favorable tax treatment to employers that provide these benefits and to individuals directly through certain federal programs.

You requested that we examine certain practices employers are using to control the costs of benefits. To evaluate changes in employer benefits and their potential implications, we examined:

1. current and emerging practices employers are using to control the costs of health care benefits and the potential implications of these changes;
2. current and emerging practices employers are using to control the costs of retirement benefits and the potential implications of these changes; and
3. employers' workforce restructuring changes that may affect health and retirement benefit costs and the potential implications of these changes.

To examine the extent to which employers have changed health or retirement benefits and restructured their workforces, we obtained and reviewed published studies examining trends in employer benefits, particularly employer strategies to contain rising benefits costs. We interviewed individuals representing many perspectives on this issue, including benefits consultants, labor union and industry representatives, consumer advocates, academic and policy researchers with expertise on employer-sponsored benefits, and officials from the U.S. Department of Labor (DOL). We also reviewed and analyzed data from several surveys that are conducted annually, including two nationally representative surveys of employers' health benefit plans, one national survey on the retiree health benefits offered by large private-sector employers, and two large federal surveys that address employer-sponsored health and retirement benefits. In addition, we reviewed relevant federal laws and regulations. We also reviewed and analyzed data from employers' required annual filings on their retirement plans with federal agencies such as DOL and with the Pension Benefit Guaranty Corporation (PBGC). We assessed the reliability of the data from these surveys and determined that the data were sufficiently reliable for the purposes of our study. Our analyses of changes in employer benefit practices focused on the most recent years of data available. The analysis of health benefits focused primarily on years 2001 through 2006. Our analysis of changes in private employers' retirement benefit plans and participation focused primarily on years 1999

through 2003. Our analysis of changes in the composition of employers' workforces focused primarily on years 1999 through 2005. Because we relied on existing survey data to measure the extent of changes in employee benefits, this report may not address certain changes that may have occurred very recently or are not widespread. (See app. I for a detailed description of survey data we reviewed and analyzed.) For a list of related GAO products see the end of this report. We performed our work from April 2006 through February 2007 in accordance with generally accepted government auditing standards.

Results in Brief

Many employers have recently changed employee health benefits, often to control costs, and some of these changes may particularly affect lower-income and less healthy workers. Overall, the share of employers offering health benefits has declined from 2001 to 2006, due mostly to an 8-percentage point drop in the share of small employers offering benefits. Among employers that offer health benefits, many have changed plan design features or begun offering different types of health plans to control costs. For example, employers have shifted additional responsibility for health care costs to workers in the form of increased deductibles, co-payments, and coinsurance that employees must pay out-of-pocket, and some have recently introduced consumer-directed health plans (CDHP), which trade lower premiums for significantly higher deductibles. Also, some employers are beginning to offer mini-medical plans that provide more limited coverage at lower premiums. These plans may benefit low-wage workers who were previously uninsured, but may also represent erosion in coverage where they replace more comprehensive plans. In addition, regarding retiree health benefits, the share of employers that offer benefits to current retirees has remained relatively stable in recent years, although similar to active workers, employers have shifted additional costs for these benefits to retirees. In addition, many employers have terminated benefits for future retirees, and experts believe this trend will continue. Some of these recent changes to health benefits may particularly affect low-wage workers who are less able to afford higher out-of-pocket costs, and less healthy workers who use more health services. Survey data indicate that from 2001 through 2005, eligibility for health coverage and the extent to which workers are covered have both declined most among low-wage workers.

With regard to retirement benefits, the changes that employers are making to their pension plans represent a continuation of trends that have emerged over the last several decades. The number of defined benefit (DB) plans and the percentage of active workers participating in these

plans have decreased over the past several decades, while defined contribution (DC) figures have risen.² In 1985, there were approximately 29 million active participants in about 170,000 DB plans. In 2003, these numbers had declined to 21 million active participants in about 47,000 plans. Of the remaining DB plans, some are hybrid plans—sharing characteristics of both DB and DC plans—a trend that may increase in response to recent legislation. In contrast to DB plans, the number of DC plans and active participants in these plans has generally continued to increase. In 1985, there were approximately 33 million active participants in over 460,000 DC plans, which increased to 52 million active participants in over 650,000 plans in 2003. Some workers participate in both types of plans. Benefit experts stated that employers' decisions on what type of retirement plans to offer reflects their preference for retirement benefit cost control and funding and accounting predictability. However, employers' decisions affect worker roles in retirement planning. With DC plans, workers assume the responsibilities and risks for managing their retirement accounts. A growing number of employers are attempting to increase participation rates and retirement savings in DC plans by automatically enrolling workers and offering new types of investment funds, and may take advantage of flexibilities available under recent legislation by offering workers investment advice.

Workforce restructuring through the use of contingent workers—workers that are not employed full-time and year round with a single employer—may affect workers' access to and participation in employer-sponsored benefit programs. For example, contingent workers are not offered and do not participate in employer-provided pension and health care benefits to the same extent as full-time workers. In 2005, 64 percent of full-time private- and public-sector workers participated in employer-provided pension plans and 72 percent participated in employer-sponsored health plans, compared to only 17 percent and 13 percent of contingent workers, respectively. The use of contingent workers can reduce employers' costs associated with providing these benefits; however, benefits experts presented mixed views on whether employers have been changing the composition of their workforces for this reason.

² DB pension plans are funded by employers and typically provide periodic payments to retirees beginning at retirement age that are based on a formula that considers participant pay, age, and years of service. DC plans are individual worker accounts to which employers and workers can make contributions, with the amount available for retirement dependent upon accumulated contributions and investment returns over the course of the period leading up to retirement.

The responsibilities of employers and workers in financing health care and retirement benefits continue to evolve in an increasingly competitive global market. Changes in benefit design that shift more of the cost, risk, and control to workers may help employers control their benefit costs and provide greater benefit choices for some workers; however, such changes have other consequences. The challenges workers face can make it more difficult for low-wage earners to afford health care coverage and save for retirement. Although these challenges may weigh most heavily on the less wealthy and less healthy segments of the workforce, they affect a broad spectrum of the American workforce and could prove challenging to many. Employers, individuals, and the government share the responsibility for providing a U.S. benefits system that addresses the health and retirement needs of individuals of varying economic and health backgrounds, while allowing employers to remain competitive in a global market environment.

We provided a draft of this report to DOL. DOL did not provide written comments, but did provide technical comments, which we incorporated as appropriate.

Background

Many U.S. workers participate in employer-sponsored health benefit and retirement pension programs and the costs of these benefits in recent years have risen faster than wages. The designs of these benefit programs have changed over the course of the past several decades, and these changes have often been made in response to growing costs associated with providing the benefits. Millions of workers are not in traditional full-time, year-round work arrangements and some may legally be excluded from benefit plans that are offered to full-time workers. Employers are not required to offer health and retirement benefits to any workers, although when they are offered, federal laws provide some protections to workers related to their provision.

The U.S. System of Employer-Sponsored Health and Retirement Benefits

The U.S. system of employer-sponsored health and retirement benefits is financed by employers, individual worker contributions, and state and federal governments through foregone tax revenue. The degree to which individuals rely on employer-sponsored health care and retirement benefits depends on several factors, including age, income, employment status, and access. In addition to wages and other benefits, employers often provide workers with health and retirement benefits as a part of their total compensation. Employer-sponsored health benefits provide coverage to over 155 million individuals through coverage of active

workers and their dependents.³ Employers may also provide health benefits to Medicare-eligible retirees and individuals who retire prior to their eligibility for Medicare (typically referred to as early retirees) and their dependents. Approximately 12 million retirees on Medicare and 3 million early retirees are covered under employer-sponsored health benefits.^{4,5} About half of all private-sector workers participate in an employer-sponsored retirement plan according to the Bureau of Labor Statistics (BLS) National Compensation Surveys.⁶ The overall rate of worker participation in employer-sponsored retirement pension plans has not changed significantly in the last few decades.

Health and retirement benefits help employers attract and retain skilled workers; however, the costs of these benefits have accounted for an increasingly larger share of workers' total compensation. During most of the period from 1991 until 2002, wages and benefits increased by about the same percentage, after which time real wages began to stagnate and real benefit costs continued to grow through 2005.⁷ Figure 1 shows the real growth in hourly expenses attributable to wages and benefits between 1991 and 2005.

³ The Kaiser Family Foundation (Kaiser) and Health Research and Educational Trust (HRET) Employer Health Benefits 2006 Annual Survey.

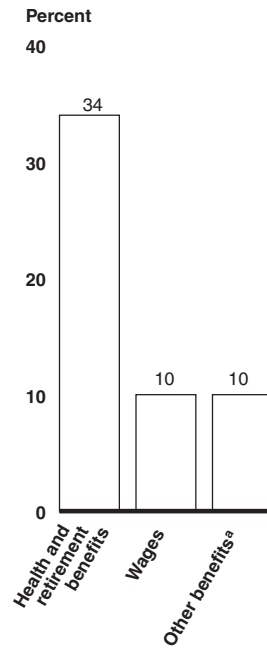
⁴ Kaiser/Hewitt Surveys on Retiree Health Benefits, 2003-2005.

⁵ Employer-sponsored coverage for early retirees often mirrors coverage for current workers. Retiree coverage for Medicare-eligible retirees supplements benefits covered under Medicare and provides additional cost-sharing protections, such as limiting retiree out-of-pocket expenses, which traditional Medicare fee-for-service does not provide.

⁶ According to the National Compensation Survey, the rates of private-sector workers participating in employer retirement plans were 49 percent in 2003 and 51 percent in 2006.

⁷ GAO, *Employee Compensation: Employer Spending on Benefits Has Grown Faster Than Wages, Due Largely to Rising Costs for Health and Retirement Benefits*, [GAO-06-285](#) (Washington, D.C.: February 2006).

Figure 1: Real Growth in Hourly Expenses Attributable to Wages, Health and Retirement Benefits, and Other Benefits between 1991 and 2005



Source: GAO analysis of the Bureau of Labor Statistics data from the National Compensation Survey.

Note: Data includes private employers and the analysis used constant 2004 dollars from the BLS Consumer Price Index Research Series to control for the effect of inflation.

^aThese benefits include Social Security, Medicare, federal and state unemployment and workers compensation, and voluntary benefits such as paid leave, supplemental pay, and life insurance.

Health and retirement benefits are given various forms of favorable federal tax treatment to encourage employer sponsorship and worker participation. For example, the cost of employer-sponsored health insurance premiums may be excluded from employers' taxable earnings and are not included in workers' income for income taxes and from the calculation of Social Security and Medicare payroll taxes. Similarly, the federal government provides preferential tax treatment to employers and workers under the Internal Revenue Code for retirement contributions that meet certain requirements.

Workers may generally choose whether or not to participate in employer-sponsored health programs and in some retirement programs. For example, some individuals may have access to health insurance through a

family member's employer or through a publicly funded program, such as Medicaid or Medicare,⁸ while others may choose to purchase health insurance on their own or decide to forego coverage. Almost all workers are covered by Social Security and workers may include other financial resources as part of their retirement planning, such as participation in an employer-sponsored retirement plan, when offered, and other savings and financial resources.⁹ Some employer-sponsored retirement plans make contributions toward workers' plans without requiring any additional contributions from workers.¹⁰ If workers are required to contribute in order to participate in an employer retirement plan, some workers may choose not to participate.

Evolution of Employer-Sponsored Health Benefits

The costs of health care and health-related benefits have been increasing for decades. Several factors help explain the rise in costs, including increasing demand for services, advances in expensive medical technology, and an aging population. The Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) Annual Employer Health Benefits Surveys found that from 2001 to 2006 annual premium costs for single and family coverage rose by about 60 and 63 percent, respectively, and in each of those years premiums grew more than twice the rate of wages.¹¹

To contain rising health care costs, employers have made several changes to health benefits. For several decades, traditional fee-for-service plans were the predominant form of private health benefits sponsored by employers. These plans essentially reimbursed any providers for services covered by a plan based on providers' actual costs with little or no incentives to control utilization. In the late 1980s employers increasingly

⁸ Medicaid is a joint federal and state program that finances health care for certain low-income individuals and Medicare is the federal health care program for the elderly and disabled.

⁹ Some ways of savings also provide tax incentives. For example, Individual Retirement Accounts (IRA) authorized by ERISA allow workers to make tax-deductible and nondeductible contributions to individual accounts for retirement savings.

¹⁰ Some employer-sponsored retirement plans may also allow additional voluntary worker contributions.

¹¹ Survey data show that 2006 had the slowest rate of premium growth at 7.7 percent. Premiums for family coverage have risen more quickly than for individual coverage, with the average annual costs for single and family coverage in 2006 across all employers of \$4,242 and \$11,480, respectively.

looked to managed care plans, such as health maintenance organizations (HMO) and preferred provider organizations (PPO), as a way to contain these rising costs. HMOs and PPOs generally rely on providers to control service utilization and they provide financial incentives to encourage patients to use network providers who have agreed to accept fee discounts. Under an HMO, patients may be restricted to using only network providers, and they typically require that all specialty care be coordinated through a primary care physician. While enrollment in HMOs increased, some enrollees became resistant to the restrictions imposed by the plans and employers increasingly offered PPOs that offered more provider choice and flexibility. PPO enrollees face lower cost-sharing requirements when they receive care from network providers, but may choose non-network providers at a higher cost and do not typically need referrals to see a specialist.¹² Despite these cost-control mechanisms, health care costs continued to rise.

While managed care relies primarily on health care providers to control rising costs, more recently employers have also looked to workers to assume greater responsibility for controlling these costs, such as by offering consumer-directed health plans (CDHP). CDHPs combine a high-deductible health plan with a tax-advantaged account that enrollees can use to pay for a portion of their health care expenses.¹³ Unused balances may accrue for future use, potentially giving employees an incentive to purchase health care more prudently. The higher deductibles generally result in lower health insurance premiums because the enrollee bears a greater share of the initial cost of care. Although not required to do so, CDHP insurance carriers typically provide enrollees with decision-support tools, such as Web-based information on costs of services and quality of

¹² Cost-sharing refers to the enrollee's share of payments for covered services, such as co-payments—a fixed charge—and coinsurance—a percentage of the payment.

¹³ The most common tax-advantaged savings arrangements that enrollees can use to pay for a portion of their health expenses are health reimbursement arrangements (HRA) or health savings accounts (HSA). These accounts allow funds to accrue over time. HRA accounts are owned by the employer, and only the employer may contribute to them. HSAs are owned by the enrollee and, therefore, are portable when workers change jobs. Both employers and enrollees can make contributions to the HSA.

providers, to help them become more actively involved in making health care purchasing decisions.¹⁴

While not a new concept, employers often offer voluntary health and wellness programs in combination with CDHPs. These programs are intended to encourage enrollees to engage in healthy behaviors to help prevent certain chronic diseases and improve overall health. These benefits often include disease management programs in which individuals with certain high-risk conditions have access to a case manager to help them manage their disease; access to health advice lines; behavior modification programs such as smoking cessation; and health risk assessment programs to assess enrollees' potential for health problems and suggest ways for participants to reduce their risk of disease. Health risk assessment programs can also provide employers with information about the overall health profile of their worker population that can be used to design targeted disease management and behavior modification programs.

While most employer-sponsored health benefit plans provide comprehensive coverage, employers may also offer health benefits through mini-medical plans. A mini-medical plan provides basic medical coverage combined with lower premium costs and a lower coverage cap than a comprehensive or major medical plan. Annual coverage limits typically include restrictions on the number of services covered, a low maximum dollar cap on spending, or both. For example, a mini-medical plan might cover no more than five doctor visits or no more than \$200 per year for physician services. While these plans may include coverage for a wide range of hospital or specialty services, annual and lifetime coverage caps for mini-medical plans are far below those of comprehensive health insurance plans. For example, a mini-medical plan's coverage cap might be set at \$25,000 annually with a lifetime cap of \$50,000, while many

¹⁴ Proponents of CDHPs contend that CDHPs can help restrain the growth in health care costs. They maintain that because account funds accrue over time, enrollees have an incentive to seek lower-cost health care services and to limit their discretionary spending on health care by obtaining care only when necessary. Critics of CDHPs are concerned that they will attract healthier workers than other plans, driving up costs in other plan options. There are concerns that these plans will lead some enrollees to stint on needed care and that enrollees may not have adequate information in order to seek lower-cost health care services.

comprehensive health plans have no coverage caps or have lifetime caps in excess of \$1,000,000.¹⁵

Types of Employer-Provided Retirement Benefits

Employer-provided retirement plans can generally be characterized as either DB or DC plans. Under a traditional DB plan, an employer provides periodic payments to workers beginning at retirement, using a formula that considers a worker's salary, age, and years of service. An employer is responsible for funding benefits in compliance with federal laws. To participate in employer-sponsored DB plans, workers must meet eligibility requirements; to receive any future benefits from the plans, workers must be vested. Vesting provisions specify when workers acquire the irrevocable right to pension benefits. Some employers offer hybrid DB plans that specify the current account balance as a dollar amount like a DC plan, but assume the financial risk to provide that amount, like a DB plan. For example, a common type of hybrid plan is a cash balance plan, which expresses benefits as an "account balance" based on hypothetical pay credits (percentage of salary or compensation) and hypothetical interest credits to employee accounts rather than predetermined payment amounts at retirement.¹⁶ Qualifying DB plans are federally insured by the PBGC. The agency provides retirement benefits to eligible workers in the event that their plans are terminated without sufficient assets to pay promised benefits. PBGC had an accumulated \$19 billion deficit at the end of federal fiscal year 2006. The recently passed Pension Protection Act of 2006 (PPA) seeks to increase PBGC funding by requiring some plans to pay higher PBGC insurance premiums and to bolster the financial viability of private pension plans by requiring some employers to increase the funding of their plans.

Under DC plans, a worker's benefits at retirement depend upon the accumulation of funds in a worker's account, which may include employer and worker contributions, as well as the net investment returns on these

¹⁵ According to the 2005 Mercer National Survey of Employer-Sponsored Health Plans, the median lifetime coverage caps for PPO plans was \$2,000,000.

¹⁶ Another type of hybrid DB plan is the pension equity plan, under which employees earn a percentage of final average pay expressed as a lump sum amount. These plans are similar to cash balance plans in that higher benefits accrue earlier in a career and lower benefits accrue later in a career than under traditional DB plans. See GAO, *Private Pensions: Implications of Conversions to Cash Balance Plans*, [GAO/HEHS-00-185](#) (Washington, D.C.: Sept. 29, 2000) and *Private Pensions: Information on Cash Balance Pension Plans*, [GAO-06-42](#) (Washington, D.C.: Nov. 3, 2005).

contributions. Workers are generally responsible for managing their retirement assets. The common type of DC plan is the 401(k), which allows workers to choose to contribute a portion of their pre-tax compensation to the plan under section 401(k) of the Internal Revenue Code.¹⁷ To encourage participation in and contributions to such plans, employers may wholly or partially match worker contributions.

Individuals covered by employer retirement plans include:

- active workers who currently work for the employer and participate in the plan;
- separated vested workers—workers who previously worked for an employer and qualify for future DB pension benefits or retain a DC account with their former employer;
- designated individuals of qualified deceased workers or retirees; and
- retirees.

For the purpose of studying changes in employer-sponsored retirement plan participation, active workers are considered a better measure because they are part of the plans that employers are currently offering to workers. In contrast, a retired worker may receive benefits from an employer plan, even when the employer does not offer such a plan to current workers.

Workforce Restructuring

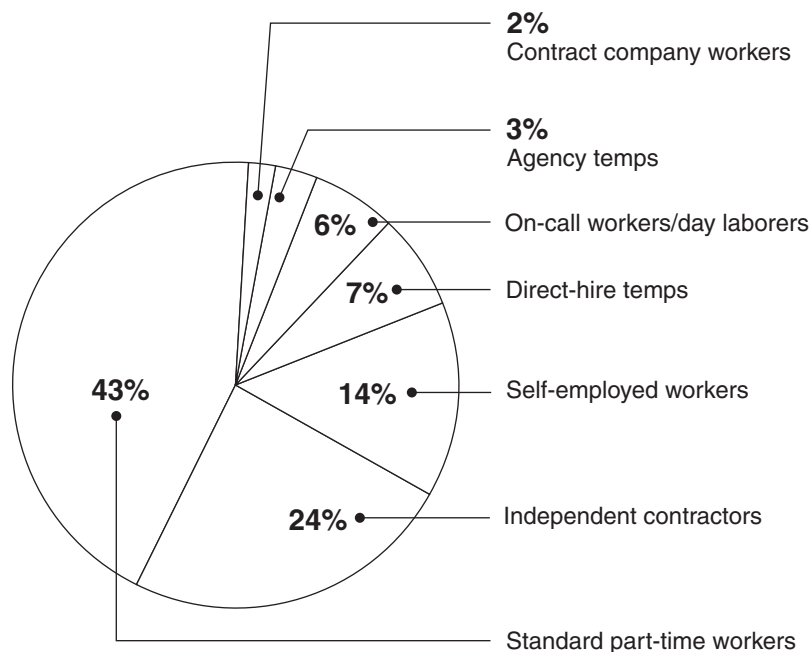
Millions of Americans are no longer in traditional work arrangements as full-time, year-round workers. Many workers are often characterized as contingent workers, which include a variety of categories such as agency temporary workers, contract company workers, day laborers, direct hire temps, independent contractors, on-call workers, self-employed, and part-time workers.¹⁸ Employers' use of contingent workers, workers that are not full-time, year-round employees, has remained constant over the last decade at about 30 percent of the total workforce. Employers hire

¹⁷ 26 U.S.C. § 401(k) sets out requirements for plans to qualify for tax-deferred treatment. Other types of DC plans include profit sharing plans, money purchase plans, target benefit plans, and employee stock-ownership plans.

¹⁸ “Contingent work” can be defined in many ways to refer to a variety of nonstandard work arrangements. See GAO, *Contingent Workers: Incomes and Benefits Lag behind Those of Rest of Workforce*, [GAO/HEHS-00-76](#) (Washington, D.C.: June 30, 2000) and *Employment Arrangements: Improved Outreach Could Help Ensure Proper Worker Classification*, [GAO-06-656](#) (Washington, D.C.: July 11, 2006).

contingent workers to accommodate workload fluctuations, fill temporary absences, and screen workers for permanent positions, among other reasons. Workers take contingent jobs for a variety of reasons, both personal and financial. These reasons include workers' preference for a flexible schedule due to school, family, or other obligations; need for additional income; inability to find a more permanent job; and hope that the position will lead to permanent employment. Figure 2 shows the composition of the contingent workforce as of February 2005.

Figure 2: Composition of the Contingent Workforce (February 2005)



Source: GAO analysis of data from the CPS February 2005 Contingent Work Supplement.

Notes: The CPS is based on a sample of the civilian non-institutionalized population, which includes both private- and public-sector workers. Actual estimated percentages do not add to 100 percent because of rounding.

Also, some workers are employed through alternative arrangements, such as with Professional Employer Organizations (PEO). PEOs usually operate as co-employers with traditional employers.¹⁹ According to the National

¹⁹ PEOs provide management of human resources, employee benefits, payroll, and workers compensation and unemployment insurance claims.

Association of Professional Employer Organizations there are currently 2 to 3 million workers in such arrangements.

Key Legal Protections for Workers and Retirees

There are many federal laws that employers must adhere to if they provide health or retirement benefits to workers and retirees and if they consider options for reducing costs associated with providing employee benefits. For example, the Employee Retirement and Income Security Act, the Age Discrimination in Employment Act, the Health Insurance Portability and Accountability Act, and the Americans with Disabilities Act each contain important protections for some workers and worker benefits.²⁰

The Employee Retirement Income Security Act of 1974 (ERISA) governs employee pension and welfare plans, which includes health care benefits.²¹ Although ERISA does not require any employer to establish benefit plans, it does set certain minimum standards that most employers must satisfy to obtain tax advantages if they voluntarily elect to offer pension or health care benefits to their employees. ERISA requires that plan fiduciaries run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits. Fiduciaries must act prudently and diligently and generally must diversify the plan's investments in order to minimize the risk of large losses. ERISA requires employers to provide their employees with a summary plan document that contains important information about the benefit plan. They must also submit an annual report to the Secretary of Labor and plan participants that includes, among other things, a detailed financial statement, the number of employees enrolled in the plan, and the names and addresses of plan fiduciaries.²² Under ERISA, pension plans are generally subject to more extensive regulation than health benefit plans. For example, while ERISA has detailed participation and vesting requirements for pension plans, these

²⁰ In addition, the National Labor Relations Act of 1935 is the primary law governing relations between unions and employers in the private sector. The statute guarantees the right of certain employees to organize and to bargain collectively with their employers over wages, hours, and other terms and conditions of employment, which courts have generally interpreted to include retirement and health care benefits for current workers. 29 U.S.C. § 151 et seq.

²¹ 29 U.S.C. § 1001 et seq.

²² Each company sponsoring a tax-qualified DB and DC pension plan must file Form 5500, "Annual Return/Report of Employee Benefit Plan," in a consolidated report for the Internal Revenue Service, the Department of Labor, and the PBGC. The latest DOL analysis of Forms 5500 is for the 2003 year filings.

rules do not apply to health plans. Furthermore, employers' pension plans must meet non-discrimination testing requirements that seek to ensure that the plan design does not exceed certain limits in favoring highly compensated employees in participation and benefits over non-highly compensated employees. Although ERISA provides protections for much of the workforce, other laws permit employers to exclude some contingent workers, such as temporary, on-call, and part-time workers, from certain benefits plans.²³

The Age Discrimination in Employment Act of 1967 (ADEA) was enacted to promote the employment of older persons based on their ability rather than age, to prohibit arbitrary age discrimination in employment, and to help employers and workers find ways of meeting problems arising from the impact of age on employment.²⁴ The ADEA, with some exceptions, prohibits employers, employment agencies, and labor organizations from discriminating against individuals over 40 on the basis of age. Specifically, employers may not refuse to hire an applicant or discharge an employee because of the individual's age, and they may not otherwise discriminate against individuals with respect to compensation, terms, conditions, or privileges of employment because of their age. Furthermore, employers may not classify employees in a way that would deprive them of employment opportunities or otherwise affect their status as employees on the basis of age. However, the ADEA does identify some practices that employers may engage in without violating the general prohibition against discrimination. For example, under certain circumstances, an employer may reduce benefit levels for older workers to the extent necessary to achieve approximate equivalency in cost for older and younger workers. A benefit plan is considered to be in compliance with the ADEA if the actual amount of payment made, or cost incurred, on behalf of an older worker is equal to that made or incurred on behalf of a younger worker, even though the older worker may thereby receive a lesser amount of benefits or insurance coverage.²⁵

²³ For example, ERISA allows employers to exclude workers who have worked less than 1,000 hours in a 12-month period from entering their pension plans. In addition, some temporary, on-call, or other contingent workers may not be considered employees and therefore would not be entitled to benefits under a plan.

²⁴ 29 U.S.C. § 621 et seq.

²⁵ 29 C.F.R. § 1625.10(a)(1).

Among other things, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits employers and health insurance companies from discriminating against employees on the basis of their health status.²⁶ Under HIPAA, an employer may not establish any employee eligibility or continued eligibility rules that are based on certain health-status-related factors, as applied either to the employee or his or her dependents. Health-status-related factors are defined broadly to include both physical and mental medical conditions, an individual's past claims experience, receipt of health care, medical history, genetic information, disability, and evidence of insurability. This prohibition on discrimination does not require that an employer offer particular benefits, nor does it prevent an employer from using limits or restrictions on the amount, level, extent, or nature of the benefits for similarly situated employees.

Title I of the Americans with Disabilities Act of 1990 (ADA) prohibits discrimination in employment on the basis of disability.²⁷ Specifically, employers with 15 more or employees are prohibited from discriminating against individuals with disabilities in regard to job application procedures, hiring, advancement, or discharge, compensation, job training, and other terms, conditions, and privileges of employment. To be protected by the ADA, a person must have a disability, as defined in the law, and be capable, with or without reasonable accommodation, of performing the essential functions of the position that he or she holds or desires. Reasonable accommodation may include, among other things, making existing facilities used by employees readily accessible to and usable by individuals with disabilities, as well as job restructuring, modified schedules, or the acquisition or modification of equipment or devices.

²⁶ 26 U.S.C. § 9802; 29 U.S.C. § 1182; 42 U.S.C. § 300gg-1.

²⁷ 42 U.S.C. § 12101 et seq.

Recent Changes in Employer-Sponsored Health Benefits Prompted by Cost Concerns May Particularly Affect Lower-Wage and Less Healthy Workers

Many employers have changed employee health benefits in several ways to respond to rising costs while trying to continue to meet the demands of their workforce. As health care costs rise, the share of employers offering health benefits has fallen and employers have shifted responsibility for paying more health care costs to current workers and retirees. Employers have also begun offering new types of health plans to their workers, including CDHPs and mini-medical plans. Some of these changes may particularly affect low-wage or less healthy workers.

Fewer Small Employers Offered Health Benefits

In recent years, the share of employers offering health benefits has declined, due largely to a decrease in the share of small employers offering coverage, and the share of individuals covered by these benefits has also declined.²⁸ While the share of large employers offering health benefits remained fairly constant between 2001 and 2006 at about 98 percent, the share of small employers (with 3-199 employees) offering them dropped from 68 percent to 60 percent (see table 1). Health policy experts from one organization we interviewed told us this decline is likely due to new employers choosing not to offer coverage rather than existing employers dropping coverage.²⁹ Employer survey data show that in 2006, 74 percent of employers not offering health benefits cited high premiums as very important in their decision not to offer them.³⁰ The percent of all workers covered by employer-sponsored health plans has also decreased in recent years, falling from about 73 percent in 2001 to about 70 percent in 2005.³¹

²⁸ Because workers may choose whether or not to participate in employer-sponsored health benefits, we separately report on the share of employers who offer coverage and the share of workers who are covered by these benefits.

²⁹ These experts told us that it is difficult to drop health benefits once offered because the offer of health benefits is an important factor for worker retention and morale.

³⁰ The Kaiser/HRET Employer Health Benefits 2006 Annual Survey.

³¹ Current Population Survey Data, 2001 to 2005. Data for 2006 were not available.

Table 1: Percentage of Firms Offering Health Benefits by Firm Size, 2001 and 2006

	2001	2002	2003	2004	2005	2006
All employers	68	66	66	63	60	61
Large employers (200 or more workers)	99	98	98	99	98	98
Small employers (3 to 199 workers)	68	66	65	63	59	60
50-199 workers	96	95	95	92	93	92
25-49 workers	90	86	84	87	87	87
10-24 workers	77	70	76	74	72	73
3-9 workers	58	58	55	52	47	48

Source: The Kaiser Family Foundation and Health Research and Educational Trust Employer Health Benefits, 2001 to 2006 Annual Surveys.

Note: Data include private- and public-sector employers, and exclude employers with fewer than three employees.

Many Employers Changed the Design of Health Benefit Packages

Industry experts and survey data indicate that employers are changing health benefits packages in several ways.

Shifted More Responsibility for the Costs of Health Benefits to Workers

While the share of premiums borne by workers showed little variation for several years, employers recently shifted more responsibility for the costs of health benefits to workers by increasing deductibles, co-payments, and coinsurance. Many employers recently introduced deductibles for services where none previously existed. According to one survey, there were steady increases in the share of employers that required deductibles for PPO in-network care and HMO inpatient hospital services between 2001 and 2005—with total increases of 20 and 24 percentage points, respectively.³² Employers also recently increased annual deductible amounts. According to another survey, annual deductibles increased by 58 percent between 2001 and 2005 for workers enrolled in single PPO coverage from \$204 to \$323.³³ Costs were also shifted to workers through increased co-payments and coinsurance at the point of care. Recent data

³² Mercer National Survey of Employer-Sponsored Health Plans, 2001 to 2005. Data for 2006 were not available.

³³ The Kaiser/HRET Employer Health Benefits Annual Survey, 2001 and 2005. Comparable data for 2006 were not available.

shows that among workers enrolled in PPOs that required either co-payments or coinsurance, the co-payment amounts and coinsurance rates increased for many workers (see table 2).

Table 2: Change in the Share of PPO-Enrolled Workers with Selected Cost-sharing Arrangements, 2004 and 2006

	Share of covered workers		Percentage point change 2004-2006
	2004	2006	
Co-payment worker pays			
\$5 to \$15	53	38	-15
\$20 to \$30	43	59	16
Coinsurance worker pays			
10 to 15%	40	28	-12
20 to 25%	56	68	12

Source: GAO analysis of the Kaiser Family Foundation and Health Research and Educational Trust Employer Health Benefits, 2004 and 2006 Annual Surveys.

Notes: Data include workers employed by private- and public-sector employers. Co-payments and coinsurance apply to an in-network physician office visit. Comparable data were not available prior to 2004.

Although employers continue to report cost-sharing increases, some benefits representatives have indicated that this trend may change due to employers' concerns about workers' willingness to absorb more costs. Employer survey data show that the share of employers that reported future plans to increase cost-sharing was 23 percent in 2003, but fell to 10 percent by 2005.³⁴

Introduced New Health Plan Options

Some employers are beginning to offer new health plan options to their workers, including CDHPs and mini-medical plans, either to control costs or to meet the needs of certain workers. For example, one employer survey found in 2006 that 7 percent of all firms offering health benefits offered CDHPs, up from 4 percent in 2005.³⁵ This growth was largely due to an increase in the percent of employers offering HSA-qualified plans, which increased from 2 percent in 2005 to 6 percent in 2006. According to this same survey, among employers who offered HSA-qualified CHDPs in 2006, 37 percent did not make a contribution to workers' HSA accounts.

³⁴ Mercer National Survey of Employer-Sponsored Health Plans, 2003 and 2005.

³⁵ The Kaiser/HRET Employer Health Benefits 2005 and 2006 Annual Surveys. Surveys prior to 2005 did not collect information related to CDHPs.

While employer interest in offering CDHPs is increasing, some survey results suggest that enrollment is either holding steady or growing slightly, and overall enrollment remains low.^{36, 37}

Surveys have found and benefits consultants told us that employers are offering CDHPs as a way to shift more of the cost and responsibility of health care to workers, while also encouraging them to become more actively engaged in their own health care decisions. According to consultants, employers hope that CDHP enrollees will decrease their use of unnecessary medical services, leading to immediate cost-savings, and also be encouraged to lead healthier lifestyles, potentially leading to long-term cost savings. Early evidence suggests that premiums are growing more slowly among CDHPs than among PPOs and HMOs.³⁸

Employer interest in mini-medical plans may also be growing, although data to measure this trend is limited.³⁹ For example, industry representatives told us that mini-medical plans are gaining acceptance among companies including some large employers in the retail and service sectors. In addition, in 2006 36 percent of employers with over 10,000 workers reported being interested or very interested in adopting these plans, with the highest reported interest among the retail, service, and transportation industries.⁴⁰ Experts and industry officials we interviewed

³⁶ The Kaiser Family Foundation has indicated that, among workers whose employers offer health benefits, enrollment in CHDPs held steady at 4 percent between 2005 and 2006. Mercer's survey found that of workers who were eligible for their employers' health plans, enrollment in CDHPs increased from 1 to 3 percent between 2005 and 2006.

³⁷ Benefits consultants told us that enrollment in CHDPs is low when offered along side other more traditional health benefit options. However, most employers continue to offer multiple options, citing concern about workers' reaction to the full-replacement of more traditional options. In 2006 we reported that, according to benefits consultants and insurance carrier representatives, there is growing interest among employers in fully replacing their traditional plans with CDHPs, and that one large employer we spoke with had done so. See GAO, *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, [GAO-06-514](#) (Washington, D.C.: Apr. 28, 2006).

³⁸ According to the Kaiser/HRET Employer Health Benefits 2006 Survey, high-deductible health plans with a savings option saw annual premium growth of about 5 percent, versus about 9-percent growth among HMOs and about 8-percent growth among PPOs.

³⁹ The National Association of Insurance Commissioners and America's Health Insurance Plans told us that the filing requirements mini-medical plans must follow vary by state, making it difficult to track their prevalence.

⁴⁰ Mercer National Survey of Employer-Sponsored Health Plans, 2006.

Offered Health and Wellness Programs

indicated that employers are offering mini-medical plans to meet the needs of low-wage workers who were previously ineligible for or could not afford more comprehensive health benefit options when offered. However, one insurance industry representative told us that a small number of employers have offered mini-medical plans as a replacement for previously offered comprehensive coverage.

Employers are increasingly offering health and wellness programs as well as financial incentives for workers to participate in them because they view them as a long-term strategy to control health costs. Table 3 summarizes the increasing prevalence of some of the most common health and wellness programs offered by large employers from 2001 through 2005. Some employers have also begun offering financial incentives for participation in these programs, often as cash bonuses or token rewards, and sometimes as discounts on premiums, co-payments, or deductibles. The share of large employers offering financial incentives increased from 7 percent in 2004 to 13 percent in 2005.⁴¹ Benefits consultants told us that offering these programs and incentives for participating in them has grown in recent years as employers believe they are a cost-effective way to help their workers avoid costly and preventable diseases.⁴²

⁴¹ According to the 2004 and 2005 Mercer National Surveys of Employer-Sponsored Health Plans. In 2005 some of the most commonly offered incentives were for completion of a health risk assessment, participation in a behavior modification program, and participation in a disease management program, with 17 percent, 12 percent, and 7 percent of large employers offering these, respectively. Data for 2006 or for years prior to 2004 were not available.

⁴² Large employers are more likely to offer such programs. However, benefits consultants told us that they are becoming more popular among small employers as insurance carriers are beginning to bundle these programs within their plans. According to the 2005 Mercer survey, 62 percent of large employers rated care management as a top cost management strategy for the next 5 years.

Table 3: Share of Employers with over 500 Workers That Offer Health and Wellness Programs, 2001-2005

Wellness program	2001	2002	2003	2004	2005
Disease management ^{a,b}	34	42	53	58	67
Behavior modification programs ^c	-	-	-	21	30
Health risk assessment ^d	20	24	27	35	46
Health advice line ^e	36	40	48	59	64

Source: Mercer National Survey of Employer Sponsored Health Plans, 2001-2005.

Note: Data include private- and public-sector employers. Data for 2006 were not available.

^aA disease management program is a voluntary program offered by health plans for those with certain high-risk conditions, such as diabetes, asthma, and congestive heart failure. Patients generally have access to a case manager who coordinates physician care and educational materials to help them learn how to effectively manage their disease and improve their quality of life.

^bThe numbers for 2001-2003 represent employers who offered diabetes disease management programs, which is the most commonly offered type of disease management program.

^cBehavior modification programs can include smoking cessation programs, onsite fitness facilities, or enrollment in health clubs and weight loss programs. Comparable data were not available for 2001-2003.

^dA health risk assessment generally includes a questionnaire about health-related behaviors and risk factors that generates a report that provides guidelines on ways to reduce the risk of disease.

^eThe plan offers on-call clinicians to answer health-related questions and provide medical advice.

Employers Continued to Offer Retiree Health Benefits, but Shifted More of the Costs to Retirees, and Some Employers Eliminated Health Benefits for Future Retirees

The extent to which employers offered health benefits to retired workers and the extent to which retired workers enrolled in these benefits has remained relatively steady for the last several years.⁴³ One annual survey found that between 2001 and 2006 the share of employers with 200 or more workers offering retiree health benefits remained relatively steady, with about 35 percent offering retiree health benefits in 2006.⁴⁴ Between 2001 and 2005, the share of the retired U.S. population covered by employer-sponsored health insurance also remained relatively steady, with about 37 percent covered by such plans in 2005.⁴⁵

⁴³ We previously reported that, according to employer surveys, a long-term decline in the share of employers offering retiree health coverage had leveled off in recent years. See GAO, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act*, [GAO-05-205](#) (Washington, D.C.: Feb. 14, 2005).

⁴⁴ The Kaiser/HRET Employer Health Benefits 2001 to 2006 Annual Surveys. Survey data also show that retiree health benefits are most likely offered by large or unionized firms.

⁴⁵ Current Population Survey Data, 2001 to 2005. Data for 2006 were not available.

Employers have shifted costs to retirees through higher cost-sharing and premium contributions. A Kaiser Family Foundation and Hewitt Associates (Kaiser/Hewitt) survey of private-sector employers with 1,000 or more workers that offer retiree health benefits found that in 2003, 2004, and 2005, many of these employers increased retirees' coinsurance, co-payments, deductibles, and out-of-pocket spending limits (see table 4).⁴⁶ In addition, data from the same survey indicated that in 2005, 42 percent of surveyed employers increased premium contributions for retirees age 65 or older at a rate that was higher than the reported increase in total premium costs, suggesting an increase in the share of premiums these retirees were required to pay. However, the survey researchers noted that this subgroup of employers tended to require retirees to contribute a lower share of premiums than other surveyed employers in that year.

Table 4: Percent of Surveyed Private-Sector Employers with 1,000 or More Workers That Made Cost-Shifting Changes to Their Retiree Health Benefits in the Previous Year

	Year surveyed		
	2003	2004	2005
Increased retiree coinsurance or co-payments	^a	45	34
Increased deductibles	34	37	24
Increased out-of-pocket limits	29	29	19

Source: Kaiser Family Foundation and Hewitt Associates Surveys on Retiree Health Benefits.

Notes: Data do not include public-sector employers. Comparable data for 2006 or prior to 2003 were not available.

^aIn 2003, 37 percent of large employers increased co-payments for physician office visits and 17 percent increased retirees' coinsurance.

Although few employers have terminated coverage for current retirees, many have done so for future retirees. The Kaiser/Hewitt survey found that among surveyed employers, 10, 8, and 12 percent dropped benefits for future retirees in 2003, 2004, and 2005, respectively. In contrast to employer-sponsored retirement plans, employer-sponsored health plans are not subject to ERISA's vesting rules that require plans to establish employee rights in certain benefits based on years of service. Therefore, retirees are generally not protected against the termination of health benefits unless those benefits are found to have been vested, such as through explicit contractual language included in the plan documents by

⁴⁶ Kaiser Family Foundation and Hewitt Associates Survey on Retiree Health Benefits. This survey has been conducted annually since 2002.

employers. Alternatively, employers may elect to include reservation of rights clauses in plan documents, which generally permit them to modify or terminate health benefits at any time. Terminations are more likely to affect new hires and workers who were hired after a specific date. Some experts believe the practice of terminating health benefits for future retirees will continue, and the Kaiser/Hewitt survey found that 10 percent of surveyed employers reported in 2006 that they are either very or somewhat likely to terminate retiree health benefits for future retirees in the next year. Some experts believe that this trend might be an indication that employers view these benefits as less important in attracting and retaining high-quality workers than offering health benefits for current workers.

Certain Recent Changes in Employer-Sponsored Health Benefits May Particularly Affect Low Income and Less Healthy Workers

Loss of health benefits and increased cost-shifting may particularly affect low-wage and less healthy workers. Decreasing rates of coverage among low-wage workers may be an indication that recent changes are disproportionately affecting these workers. A recent study found that, compared to their higher-wage counterparts, between 2001 and 2005, there were steeper declines in the percent of low-wage workers employed by firms that offered coverage and in the percent that enrolled in coverage when offered (see table 5).⁴⁷ In addition, the Agency for Healthcare Research and Quality reported that between 2001 and 2004, enrollment among eligible workers employed by large retail firms—which often employ low-wage workers—fell, while enrollment among all employers held steady.⁴⁸ Some experts believe that the recent drop in enrollment at the lowest income levels may be explained by the increasing cost of benefits to workers—such as higher premiums and increased cost-sharing requirements—which make them particularly difficult for low-wage workers to afford.

⁴⁷ The Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001-2005* (Washington, D.C. 2006).

⁴⁸ According to data from the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey-Insurance Component, enrollment among workers at large retail firms with 1,000 workers or more dropped from about 76 percent in 2001 to about 67 percent in 2004, while enrollment by eligible workers among all large employers held steady at about 81 percent over the same period.

Table 5: Percentage Point Change in Rates of Employer Sponsorship of Health Benefits, and Worker Eligibility, Enrollment, Coverage, and Uninsurance, 2001-2005, by Income Level, Based on the Federal Poverty Level (FPL)

	Income Level			
	Less than 100% FPL	100-199% FPL	200-399% FPL	Over 400% FPL
Worker's employer offers health benefits	-5.7 ^a	-4.1 ^a	-1.2 ^b	-1.1 ^a
Worker is eligible (when health benefits are offered)	0.0	-1.9 ^b	-1 ^a	-0.1
Worker enrolls (when health benefits are offered)	-7.2 ^a	-3.0 ^a	-1.4 ^a	-0.3
Worker has any employer-sponsored coverage	-6.4 ^a	-7.0 ^a	-3.9 ^a	-0.8 ^b
Worker is uninsured	7.4 ^a	5.2 ^a	2.6 ^a	0.4

Source: Urban Institute analysis of CPS data completed for the Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*.

Notes: The CPS is based on a sample of the civilian non-institutionalized population, which includes both private- and public-sector workers. The data represented in this table exclude self-employed workers, workers under the age of 19 or over 64, and workers who are full-time students under 23.

^aIndicates that the change between 2001 and 2005 in percent of people is statistically significant at the 95 percent confidence level.

^bIndicates that the change between 2001 and 2005 in percent of people is statistically significant at the 90 percent confidence level.

Similarly, experts are concerned that further cost-shifting of retiree health benefits may eventually lead some retirees—particularly those with lower retirement incomes—to drop this coverage, though the implications of this for some Medicare-eligible retirees might be mitigated by the recent introduction of Medicare Part D.⁴⁹ Less healthy workers may be more affected by increased cost-shifting than others, because those who are high utilizers of health care may spend a greater share of their income on the care they receive, and if they are unable to afford it, they may forgo needed care.

CDHPs may appeal to some workers, but may not benefit certain low-wage workers or those with chronic illnesses who face higher out-of-pocket expenses under these plans. We have previously reported, and others have also found, that those enrolled in CDHPs tended to have higher incomes

⁴⁹ Medicare Part D provides a voluntary prescription drug benefit to certain eligible Medicare beneficiaries. It was authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, and became available to beneficiaries in January 2006. Some retirees may have relied on employer-sponsored health benefits primarily to alleviate the cost of prescription drugs; therefore Part D might fully or partially replace lost employer-sponsored health benefits for some retirees.

than enrollees in other plans.⁵⁰ While lower premiums might make these plans more affordable for some and might encourage employers who previously did not offer health benefits to offer a CDHP, the increased financial risk associated with higher deductibles and cost-sharing may particularly affect low-income workers who may be less able to afford the upfront costs of care. Low-income workers enrolled in HSA-based plans may also be less likely to build their savings account balances because they have less disposable income and their tax benefit from making contributions would be small.⁵¹ This may be particularly true for those whose employers do not make contributions to their accounts. In addition, some early research indicates that CDHP enrollees may spend more of their annual incomes on health-related expenses than enrollees in other plan types.⁵² Those with high health care needs, such as those with a chronic illness, might be particularly affected by these plans as they may be more likely to use care and less able to accrue savings in their accounts from year to year. While some studies have found that CDHP enrollees were more likely to exhibit cost-conscious behavior than those in traditional insurance plans, one study found that they were also more likely to delay or skip needed medical care than were those with less cost-sharing, and this was more pronounced among those with low incomes.⁵³ In addition, one study found that CDHP enrollees believed they did not have the information they needed to make wise decisions about the cost

⁵⁰ See GAO, *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, [GAO-06-271](#) (Washington, D.C.: Jan. 31, 2006); and GAO, *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans*, [GAO-06-798](#) (Washington, D.C.: Aug. 9, 2006).

⁵¹ We previously reported that 51 percent of tax filers who reported an HSA contribution to the IRS in 2004 had an adjusted gross income of \$75,000 or more, compared to 18 percent of all tax filers under age 65 ([GAO-06-798](#)).

⁵² Employee Benefit Research Institute, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, Issue Brief No. 288 (Washington, D.C.: December 2005).

⁵³ Ibid. Other studies that have looked at some of these issues include: The Kaiser Family Foundation, *National Survey of Enrollees in Consumer-Directed Health Plans* (Washington, D.C.: November 2006) and McKinsey & Company, *Consumer-Directed Health Plan Report—Early Evidence Is Promising* (Pittsburgh, Pa.: June 2005). Both the Kaiser survey and the McKinsey study reported that CDHP enrollees appeared to be more cost conscious than those in traditional types of health plans. The Kaiser study also found that CDHP enrollees are more likely to skip needed medical care.

and quality of health care services.⁵⁴ Workers whose employers only offer CDHPs would be particularly affected by these potential implications.

Mini-medical plans may benefit certain low-wage workers who would have no coverage in the absence of such a plan, but health policy experts and industry representatives we spoke to expressed several concerns about the adequacy of these plans. Proponents of mini-medical plans believe they will extend benefits to workers who were not previously insured either because they could not afford coverage or it was not offered to them. If enrolled in mini-medical plans, these workers may be more likely to obtain routine and preventive care, which may lead to better health outcomes and lower overall health expenditures. Representatives we spoke to from a health policy research organization, a benefits consulting firm, and a labor group generally agreed that these plans could provide access to some health coverage for individuals who were previously uninsured. However, they also expressed concern that the limitations of these plans may be too restrictive. For example, an annual coverage cap of \$20,000 could be exceeded by a single hospitalization. In addition, there is concern that the limitations of these plans may not be clearly communicated to enrollees and that those who do not understand the coverage limitations may find themselves lacking coverage they need.⁵⁵ In addition, some labor and consumer advocacy groups are concerned that mini-medical plans will lead to reduced benefits for some workers, such as those whose comprehensive benefits are fully replaced by mini-medical plans.

Some workers' rights and consumer advocacy groups have expressed concerns about the privacy of workers' health information gathered through wellness programs and that employers might use these programs to attract or retain the healthiest workers. The privacy rule issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) places limits on health plans' use or disclosure of individually identifiable health information. However employers not acting as a health plan are not

⁵⁴ The Kaiser Family Foundation, *National Survey of Enrollees in Consumer-Directed Health Plans* (Washington, D.C.: November 2006).

⁵⁵ For example, in October 2006 a consumer advocacy group, Citizens for Economic Opportunity, filed a lawsuit in Connecticut against Aetna, its subsidiary Strategic Resources Company, and the state Department of Insurance claiming that consumers were misled into thinking their insurance coverage was more comprehensive than it was. *Citizens for Economic Opportunity v. Strategic Resources Company, et al.*, CV-06-4026380-S (Conn. Super. Ct. filed Oct. 30, 2006).

covered by the privacy rule. Concerning employers' use of health information obtained through a wellness program, HIPAA generally protects individuals from discrimination related to health coverage and benefits based on health status factors, such as their medical condition or history. Regulations issued by DOL, the Department of Health and Human Services, and the Internal Revenue Service in 2006 provide that employers may establish wellness programs without violating the prohibition against discrimination, provided the programs meet certain guidelines.⁵⁶ For example, if program rewards are given to participants who meet a health standard, such as achieving a cholesterol count below a set level, then a reasonable alternative standard must be made available to certain individuals, such as those who have a medical condition that makes it unreasonably difficult for them to meet the general standard.

The Ongoing Shift to Different Types of Employer-Sponsored Retirement Plans Continues to Affect Both Employers' and Workers' Roles in Retirement Planning

The trends in employer-sponsored pension benefits that have emerged over the last several decades have continued. Participation in DB plans continues to fall as employers continue to terminate existing plans or freeze benefits for active workers. Some employers choosing to retain their DB plans have converted them to hybrid plans that share characteristics of both DB and DC plans, a trend that may increase with the passage of the PPA. Conversely, participation in DC plans continues to rise as employers increase their offerings of these plans. In addition, some workers participate in both types of plans. Benefits experts stated that employers' decisions regarding the retirement plans they offer reflect their attempts to control retirement benefit costs and make them more predictable. Employers' decisions affect workers' roles in retirement planning. With DC plans, workers assume the responsibilities and risks for managing their retirement accounts; however, a growing number of employers are attempting to increase participation rates and retirement savings in DC plans by automatically enrolling workers, escalating worker contributions and offering investment funds that require less worker management.

⁵⁶ Proposed regulations were issued in 2001, and the agencies subsequently treated compliance with the proposed regulations as evidence of good faith compliance with HIPAA's statutory nondiscrimination requirements. The final regulations took effect on February 12, 2007, and will apply for plan years beginning on or after July 1, 2007. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (December 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 146).

Participation in Traditional Defined Benefit Plans Decreased as Some Employers Terminated or Froze Plans, and Others Converted to Cash Balance Plans

DOL analysis of DB plans shows the number of active participants and number of plans has decreased over the past several decades and recent data show that the trend is continuing. The number of active participants in DB plans can be an important indicator of the long-term decline of the DB system.⁵⁷ DOL analysis of Form 5500 data shows that the number of DB plans and the number of active participants in these plans have decreased since 1985 (see table 6).

Table 6: Employer-Sponsored Defined Benefit Plans and Active Participants, 1985, 1999, and 2003

	1985	1999	2003	Change between 1999 and 2003
Employer plans ^a	170,172	49,895	47,036	-2,859
Active participants	28.9 million	22.6 million	21.3 million	-1.3 million

Source: DOL analysis of Form 5500 filings for private-sector employers.

^aDefined benefit plans subject to ERISA.

More recently, data published in the National Compensation Survey shows that the percentage of private-sector workers with DB plans has remained steady around 20 percent between 2003 and 2006.

A number of active workers are participants in DB plans that have been “frozen.” Pension plans can be frozen in several ways. They can be closed to new entrants such that only those in the plan at a specific point in time continue to accrue benefits. Plans can be frozen for some, but not all participants, based on age, tenure, job classification, or location. Under a hard freeze, no participant accrues any additional benefits regardless of job tenure or compensation growth. Under a soft freeze benefits are generally not increased for additional tenure but are increased for compensation growth. Form 5500 data on DB plan freezes is available for only 2003 and shows that 9.4 percent of the single-employer DB pension plans insured by the PBGC were hard-frozen.⁵⁸ Most of these plans were

⁵⁷ The absolute number of participants (retirees, separated vested participants, and active participants) has increased over time. DOL 5500 reports show DB coverage increasing from 39.7 million in 1985 to 42.2 million in 2003. From 1999 to 2003, the number of individuals covered by DB plans increased from 41.4 million to 42.2 million. One reason for the long-term increase in number of covered persons is that retirees are living longer.

⁵⁸ The Form 5500 does not collect information that identifies whether plans were subject to a soft freeze.

small plans with fewer than 100 participants, representing about 2.5 percent of all participants in PBGC-insured DB plans. Benefit consultants, benefits researchers, and others stated that employers will continue to freeze or terminate DB plans in response to financial distress, insufficient plan funding, and other considerations. Surveys also report that additional employers are either considering or planning to freeze or terminate their DB plans.

Some employers that have retained DB plans have converted them from traditional plans to hybrid plans, such as cash balance plans. Form 5500 annual reports show that cash balance plans (as a percentage of all DB plans) increased from 2.7 percent in 1999 to 4.9 percent in 2003. Active participants in cash balance plans increased from 15.7 percent of all active participants to 22.9 percent over the same period. Some consider cash balance plans controversial because of the effect they may have on pension benefits of workers of different ages and years of service.⁵⁹ Some court decisions have found certain cash balance plans to be age discriminatory.⁶⁰ This has created some uncertainty about the legality of cash balance plans and their design features that may have affected some employers' decisions whether to convert to such plans. The PPA made changes intended to remove legal uncertainties, which may lead to additional conversions to cash balance plans.

⁵⁹ See GAO, *Private Pensions: Implications of Conversions to Cash Balance Plans*, GAO/HEHS-00-185 (Washington, D.C.: Sept. 29, 2000).

⁶⁰ See, e.g., *In re Citigroup Pension Plan ERISA Litigation*, –F.Supp.2d–, 2006 WL 3770504 (S.D.N.Y. 2006)(holding that the benefit accrual formula in Citigroup's cash balance plan violates ERISA's prohibition against age discrimination); and *In re J.P. Morgan Chase Cash Balance Litigation*, 460 F.Supp.2d 479 (S.D.N.Y. 2006)(holding that J.P. Morgan Chase's cash balance plan violates ERISA's age discrimination provision). But see *Register v. PNC Financial Services Group*, 477 F.3d 56 (3rd Cir. 2007)(affirming a lower court decision and holding that PNC's cash balance plan does not discriminate against older employees on the basis of age); *Cooper v. IBM Personal Pension Plan and IBM Corporation*, 457 F.3d 636 (7th Cir. 2006)(reversing a lower court decision and holding that IBM's cash balance plan does not violate ERISA's age discrimination provision); and *Finley v. Dun & Bradstreet Corp.*, –F.Supp.2d–, 2007 WL 196753 (D.N.J. 2007)(holding the Dun & Bradstreet's cash balance plan does not violate ERISA's age discrimination provision).

Participation in Defined Contribution Plans Continues to Increase as More Employers Offer Plans

The number of DC plans and the number of active participants in such plans have increased over the past several decades, continuing established trends. DOL analysis of Form 5500 data shows that the number of DC plans and active participants have increased since 1985 (see table 7). While the number of participants continued to increase during a more recent 5-year period, the number of plans decreased, largely as a result of a drop in the number of reported plans in 2003.⁶¹

Table 7: Employer-Sponsored Defined Contribution Plans and Active Participants, 1985, 1999, and 2003

	1985	1999	2003	Change between 1999 and 2003
Employer plans	461,963	683,100	652,976	-30,124
Active participants	33.2 million	50.4 million	51.8 million	1.4 million

Source: DOL analysis of Form 5500 filings for private-sector employers.

Notes: Because employers submit Form 5500 data for each retirement plan, the aggregate number of plans includes duplicate counts of employers when they offer more than one plan. Likewise, aggregate employee data include duplicate counts when employees participate in more than one plan. Within the 5-year period, the highest number of participants was in 2002 at 52.9 million, which decreased by approximately 1 million to 51.8 million in 2003.

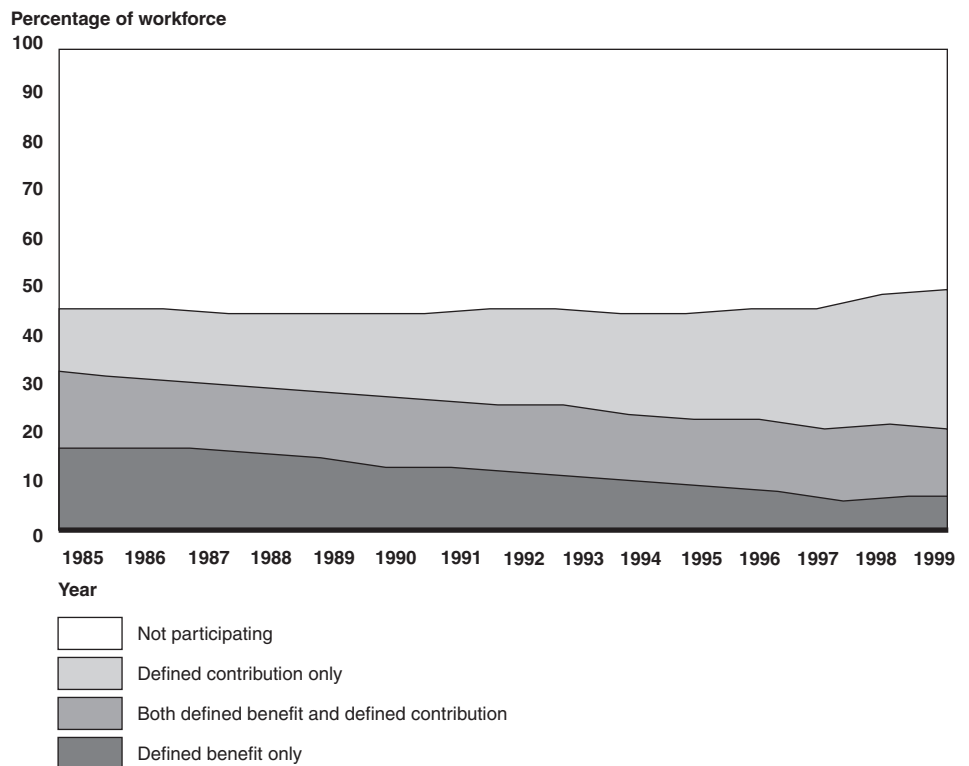
DOL officials and industry publications stated that the decrease in DC plans does not necessarily reflect a decrease in the number of employers offering DC plans or the number of workers participating in DC plans. Employers often offer several types of plans, and employers can drop plan offerings while continuing to offer other types of plans. More recent data from the National Compensation Survey shows an increase in the percentage of private-sector workers with DC plans—increasing from 40 percent in 2003 to 43 percent in 2006.

⁶¹ Form 5500 data show that the decrease in the number of plans is primarily the result of a decline in one type of plan—money purchase plans. The primary advantage of the money purchase plan over other types of DC plans was that it allowed higher contribution amounts; however, the Economic Growth and Tax Relief Reconciliation Act of 2001, raised the maximum contribution limits on some other types of DC plans.

Some Workers Participate in Both Defined Benefit and Defined Contribution Plans

Since the mid 1980s, a steady percentage of workers have participated in both DB and DC plans sponsored by their employers.⁶² Employers that offer a combination of a basic DB annuity and a DC plan can guarantee a certain minimum level of retirement benefits, while workers can choose the extent to which they participate in supplementary plans to increase their potential benefits upon retirement. Figure 3 shows the share of the private workforce that participated in some form of employer-sponsored retirement plan through 1999, including those that participated in both DB and DC plans.

Figure 3: Share of Workforce Participating in Employer-Sponsored Retirement Plans, by Type of Plan 1985-1999



Source: DOL analysis of Form 5500 for private-sector employers. The last year in which DOL performed this analysis was 1999.

Note: "Not participating" includes those workers that choose not to participate in such plans, those that are not eligible to participate, and those whose employers do not offer retirement plans.

⁶² These workers are also included in previous sections on DB plans and DC plans.

The percentage of the private-sector workforce participating in both types of plans has generally remained at about 15 percent since the mid-1980s. Although DOL stopped conducting its analysis of dual participation with the 1999 Form 5500 filings, others who have analyzed the data continue to show similar levels of dual participation through 2005.

Employers' Retirement Plan Decisions Reflect Their Preference for Retirement Benefit Cost Control and Predictability

While citing employer interest in obtaining greater control over benefit costs, benefits experts expressed various views on the relative costs associated with DB and DC plans. Several experts stated that companies can save money by changing from DB to DC plans; however, they added that it is difficult for employers to compare the relative costs of providing these plans because of the differences in the ways each type of plan is funded.⁶³ Employers' DB costs are based upon the amount of funding necessary to provide pension payments to current and future retirees and administrative costs, whereas DC costs are associated with employers' current contributions and administrative costs.⁶⁴ Nonetheless, several large companies that froze their DB plans and enhanced existing DC plans publicly stated that the actions would save their companies money.⁶⁵

Benefits experts also stated that employers are interested in making their benefits costs more predictable. According to the benefit consultants we interviewed, DB plan funding is subject to cost volatility from a variety of factors, including financial market conditions, investment performance, regulation, accounting requirements and changes in plan provisions. For example, DB plan funding requirements are affected by changes in interest

⁶³ In addition to other factors, experts stated that the age of the workforce affects employer funding for plans.

⁶⁴ GAO has previously reported that, while plan sponsors still pay some of the major types of fees in 401(k) plans, such as investment and recordkeeping fees, these fees are increasingly being paid by participants, see GAO, *Private Pensions: Changes Needed to Provide 401(k) Plan Participants and the Department of Labor Better Information on Fees*, [GAO-07-21](#) (Washington, D.C.: Nov. 16, 2006).

⁶⁵ For example, IBM reported that freezing its DB plan, while increasing 401(k) benefits, would save the company \$2.5 billion to \$3 billion for the period 2006-2010. Hewlett Packard announced that it was planning to take several cost-cutting actions, such as freezing its pension benefits, and that savings from this and other cost-cutting measures would result in savings of \$1.9 billion annually. Verizon Communications Inc. announced that it was freezing DB plans for active management employees and changing management employees' retiree medical benefits to save approximately \$3 billion over the next 10 years.

rates and changes in the value of plan assets.⁶⁶ In addition to interest rate and investment risks, employers are subject to legislative and accounting risk. For example, the PPA increases the required funding levels for DB plans and a new Financial Accounting Standards Board (FASB) rule requires companies to include pension obligations in their balance sheets, rather than reporting obligations in footnotes to a financial statement.⁶⁷ Some benefits experts indicated that the rule could have a negative effect on companies' financial statements. A survey of employers found that 82 percent of employers who froze or terminated their DB plans cited cost volatility as a significant factor.⁶⁸ In contrast to DB plans, benefits consultants stated that employers prefer the predictability of DC plan contributions that are based on established contribution rates or are tied to company profitability. They stated that employers seldom change their employee contribution match rates, while profit sharing contributions vary with the company's performance.

Despite their interest in greater benefit cost control and predictability, experts reported that many employers were not planning to make changes to their benefit plans. In fact, according to an employer survey, the majority of companies with DB plans do not expect to make changes to their plans.⁶⁹ Likewise, experts stated that employers with DC plans have not generally made changes to the level of their DC plan contributions in recent years; however, contributions tied to profitability have resulted in some companies changing the amounts of annual contributions.

Employer Decisions May Affect Worker Roles in Retirement Planning

To further encourage worker participation and increased retirement savings, a growing number of employers offering DC plans are automatically enrolling workers and investing retirement assets on their

⁶⁶ Some financial experts have suggested that employers can reduce volatility in funding DB plans using methods such as investing in asset types that have risks that match their pension liability risks.

⁶⁷ For public companies, FASB rule Statement of Financial Accounting Standards 158, *Employers' Accounting for DB Pension and Other Postretirement Plans*, becomes effective as of the end of the fiscal year after December 15, 2006, and as of the end of the fiscal year after June 15, 2007, for non-public companies.

⁶⁸ Other top reasons given by employers were cost (64 percent), not sufficiently valued or appreciated by workers (31 percent), and impact of funding rule changes (27 percent). Hewitt Associates LLC Survey Findings: *Hot Topics in Retirement, 2006*.

⁶⁹ Hewitt Associates LLC Survey Findings: *Hot Topics in Retirement, 2006*.

behalf. Most DC plans require workers to affirmatively enroll and elect contribution levels, but a growing number of plans automatically enroll workers and escalate the amount of the worker's contributions on a recurring basis.⁷⁰ An employer survey found that 16.9 percent of responding companies reported that their plans offered automatic enrollment in 2005, up from 8.4 percent in 2003.⁷¹ The survey also found that automatic enrollment is more common in large plans than small plans—the survey indicated that in 2005, 34.3 percent of the largest plans (i.e., greater than 5,000 participants) offered automatic enrollment while only 3.5 percent of the smallest plans (i.e., less than 50 participants) offered the feature. Benefits experts stated that most individuals are passive in making investment decisions and that automatic enrollment features increase active participation. They stated that 40 to 60 percent of active workers participate in plans when they must affirmatively join the plan, while plans offering automatic enrollment can increase participation rates to 80 to 90 percent. Minority, low-wage, and younger workers may benefit more with automatic enrollment because they tend to participate less than other groups of workers. However, it is unclear whether workers will continue to participate after being automatically enrolled, since many report that they cannot afford to participate or do not want to tie up their money. Some experts are concerned that employers may choose low-risk default investments—which may provide inadequate returns—to avoid fiduciary liability that might be related to higher-risk investments. The PPA directed the Department of Labor to issue regulations providing employers with guidance on developing appropriate default investments and employers' fiduciary responsibilities.⁷² Another technique employers are using in an attempt to increase workers' retirement savings is automatically escalating workers' 401(k) contributions. An employer

⁷⁰ Employers in some states have not chosen to use automatic enrollment because of concerns the practice was not legal under state laws prohibiting withholding of workers wages. The PPA preempts such state laws when the employer meets certain conditions.

⁷¹ Profit Sharing/401k Council of America: *49th Annual Survey of Profit Sharing and 401(k) Plans*.

⁷² Under rules proposed by DOL, a worker who participates in a DC plan will be deemed to have exercised control over assets in his or her account if, in the absence of investment directions from the participant, the plan invests in a qualified default investment alternative, such as a life-cycle or targeted retirement date fund. A fiduciary of a plan that complies with this proposed regulation, including requirements related to providing workers adequate notice of default investments, will not be liable for any loss, or by reason of any breach that occurs as a result of such investments. Default Investment Alternatives Under Participant Directed Individual Account Plans, 71 Fed. Reg. 56,806 (proposed Sept. 27, 2006)(to be codified at 29 C.F.R. pt. 2550).

survey found that, in 2003, only 1 percent of plans offered automatic escalation while 9 percent offered this feature in 2005.⁷³

Benefits experts are concerned about workers' retirement investment performance because workers do not always choose appropriate investments. For example, experts stated that workers can be too aggressive or too conservative in their investment choices, resulting in lower plan balances for retirement. Therefore, some employers are offering different types of funds, such as life-cycle funds, to help workers manage their investments.⁷⁴ An employer survey showed that, in 2004, 39.3 percent of participants offered life-cycle funds elected to invest some or all of their balances in these funds, up from 37.1 percent in 2003.⁷⁵ Some employers also provide financial education and investment advice with the objective of helping workers invest more wisely. An employer survey indicated that over 47 percent of plans offered investment advice such as one-on-one counseling, Internet-based information and tools, and telephone hotlines.⁷⁶ However, some experts stated that retirement studies have found that workers have little financial knowledge, despite the employer-provided courses and seminars. Other experts stated, however, that studies regarding the effectiveness of investment advice are inconclusive. Some employers choose not to offer investment advice due to concerns of fiduciary liability; however, the PPA provides additional protections for employers subject to certain conditions.

Employers' decisions to increasingly choose DC plans over DB plans require workers to make several key decisions about their retirement planning. With DB plans, employers enroll all eligible workers and are responsible for funding and managing investments to provide them with pensions upon retirement. With DC plans, workers have generally been responsible to elect to participate, determine the amount of their contributions, and choose and manage their retirement. However, if workers participate in DC plans through employers' automatic enrollment,

⁷³ Hewitt Associates LLC, *Trends and Experience in 401(k) Plans, 2005*.

⁷⁴ A highly diversified mutual fund that may contain a mix of stock, bonds, and cash, designed to remain appropriate for investors in terms of risk from their early career, through middle-age, and to retirement.

⁷⁵ Hewitt Associates LLC research report.

⁷⁶ Profit Sharing/401k Council of America: *49th Annual Survey of Profit Sharing and 401(k) Plans*.

automatic escalation, and default investments, then the workers' role through retirement is more similar to that under a DB plan.⁷⁷

Workforce Restructuring Can Result in Different Benefit Arrangements for Workers and May Affect Employer Benefit Costs

Workforce restructuring through the use of contingent workers may affect workers' benefits.⁷⁸ Contingent workers are not offered and do not participate in employer-provided pension and health care benefits to the same extent as full-time workers. The use of contingent workers can reduce the costs associated with providing these benefits for employers; however, benefits experts presented mixed views on whether employers have been changing the composition of their workforces for this reason.

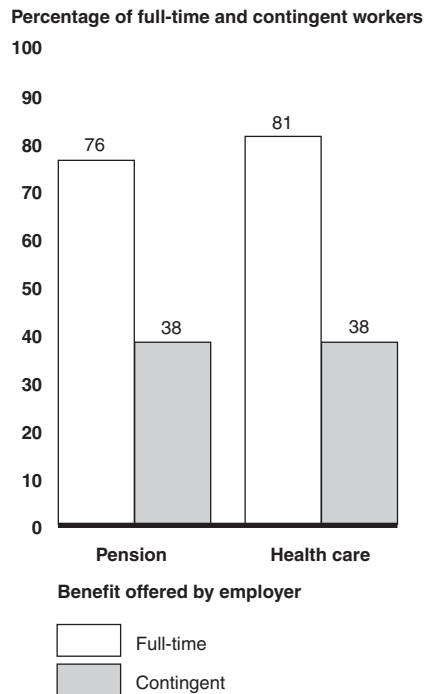
Fewer Contingent Workers Participate in Employer-Sponsored Benefit Plans, While Participation by Part-Time Workers Has Remained Stable

As we have previously reported, contingent workers do not participate in pension and health care benefits to the same extent as full-time workers. We consider contingent workers to include agency temporary workers, contract company workers, day laborers, direct hire temps, independent contractors, on-call workers, self-employed, and part-time workers; however, our analysis does not include self-employed or most independent contractors, because they do not have employers. Employers are permitted to exclude certain contingent workers from certain benefit plans, which may occur when employers think it is impractical or too costly to include them. Our analysis of BLS data shows that the proportion of contingent workers offered pension and health care benefits is much less than that for full-time workers (see fig. 4).

⁷⁷ At retirement, DB plans must offer participants an annuity, which is the normal form of benefit payment, but can also offer participants a lump-sum payment. DC plans are not required to provide an annuity option to participants and usually provide benefits in the form of a lump-sum distribution. Workers may roll-over or transfer lump-sum distributions into certain retirement plans free of taxes.

⁷⁸ Other types of workforce restructuring, such as offshoring, plant relocation, divestitures of corporate divisions or subsidiaries, increasing overtime work, alternative scheduling of work, etc., are not addressed in this report, because they were not generally raised by benefit experts as being current practices affecting employer benefit plans.

Figure 4: Percentage of Full-time and Contingent Workers Offered Employer-Provided Pension and Health Care Benefits, 2005



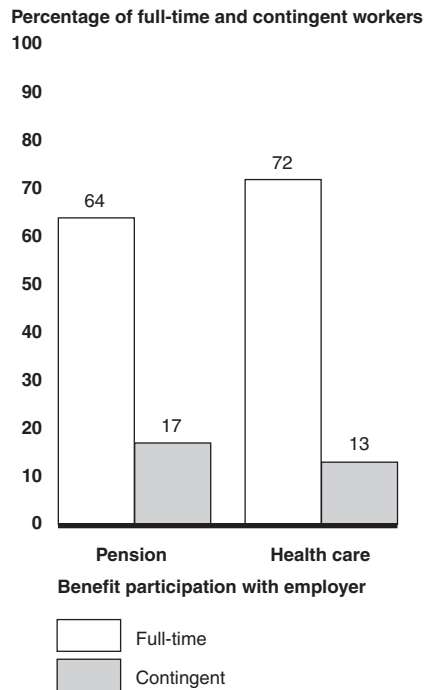
Source: GAO analysis of the BLS Current Population Survey, Contingent Work Supplement, February 2005.

Notes: Data include private- and public-sector workers. Workers in the self-employed category and most workers in the independent contractor category do not have employers; therefore, they are not included in this figure.

Also, significant differences exist in pension and health care participation rates between full-time and contingent workers. Our analysis of BLS data shows that in 2005, contingent workers' participation in employer-provided pension and health care plans is significantly lower than that of full-time workers (see fig. 5). When considering whether workers participate in benefits from any source—such as a spouse or government-sponsored plan—percentages increase and the difference between full-time and contingent workers narrows. For example, the percentage of workers with health care from any source is 87 percent for full-time workers and 73 percent for contingent workers.⁷⁹

⁷⁹ See GAO, *Employment Arrangements: Improved Outreach Could Help Ensure Proper Worker Classification*, [GAO-06-656](#) (Washington, D.C.: July 11, 2006).

Figure 5: Percentage of Full-time and Contingent Workers Participating in Employer-Provided Pension and Health Care Benefits, 2005



Source: GAO analysis of the BLS Current Population Survey, Contingent Work Supplement, February 2005.

Note: Data include private- and public-sector workers. Workers in the self-employed category and most workers in the independent contractor category do not have employers; therefore, they are not included in this figure.

Our analysis of BLS data shows that pension and health care participation rates for part-time workers—the largest component of contingent workers⁸⁰—have remained relatively constant between 1999 and 2005 (see table 8).⁸¹

⁸⁰ Part-time worker pension and health care participation rates are higher than the overall rates for contingent workers.

⁸¹ Other analyses also show little change in part-time worker participation in benefits during similar time periods from the BLS National Compensation Survey, Agency for HealthCare and Quality's Medical Expenditure Panel Survey, and The Iowa Policy Project's analysis of the BLS Contingent Work Supplement.

Table 8: Percentage of Part-time Workers Participating in Employer-Provided Pension and Health Care Benefits, 1999 and 2005

	1999	2005
Pension participation with employer	21	23
Health care participation with employer	17	19

Source: GAO analysis of data from the BLS Current Population Survey, Contingent Work Supplements, February 1999 and 2005.

Note: Data include private- and public-sector workers.

Some types of contingent workers do not have a specific single employer, such as the self-employed and most independent contractors, so they do not receive employer-sponsored benefits.⁸² Such workers may be able to factor in costs for these benefits in their fees that they charge their clients. Because the self-employed and most independent contractors do not have employers, they are more likely to participate in other types of tax deferred retirement accounts (such as IRAs and Keogh plans).⁸³ Our analysis found that in 2005, 45 percent of self-employed workers and 42 percent of independent contractors reported having such accounts, compared to 16 percent of full-time workers. Such workers may be able to deduct the amount paid for health insurance as an adjustment to income in determining their federal tax liability.

Employers' Use of Contingent Workers Can Affect Benefit Costs, but the Extent to Which This Leads Employers to Use Contingent Workers Is Uncertain

We previously reported that employers' retirement and health care benefit costs vary considerably between full-time and part-time workers. These differences in costs may be attributable to several factors, such as the extent to which employers offer benefits to full-time and part-time workers, worker participation in employer-sponsored benefit plans, and differences in the plans offered to each group (see table 9).

⁸² Some workers may be misclassified as independent contractors when they should be classified as employees, thus affecting their eligibility to participate in employers benefit plans, see GAO, *Employment Arrangements: Improved Outreach Could Help Ensure Proper Worker Classification*, [GAO-06-656](#) (Washington, D.C.: July 11, 2006).

⁸³ Keogh plans are retirement plans for self-employed workers, authorized by the Self-Employed Individuals Tax Retirement Act of 1962, Pub. L. 87-792.

Table 9: Hourly Cost of Retirement and Health Care Benefits for Full-time and Part-time Workers, 2005

	Full-time	Part-time
Retirement and savings	\$1.07	\$0.18
Health insurance	1.92	0.49

Source: GAO analysis of Bureau of Labor Statistics National Compensation Survey data.

Note: Data include private-sector employers.

Some benefits experts reported that while some employers choosing to restructure their workforces may be affecting the total amount that they spend on benefits, the decision to restructure their workforces is made for other strategic reasons. These strategic reasons may be to more efficiently meet changing production and service needs in order to be competitive both domestically and internationally. For example, an employer may hire the number of full-time workers it knows it will need at all times and then supplement that worker base with contingent workers depending on production demands—instead of a continuous cycle of lay-offs and new hiring. Other benefit experts reported that employers are restructuring their workforces to reduce benefits costs by reducing their numbers of full-time workers. To reduce benefit costs, some employers are employing only a core of full-time workers in key positions to whom they provide benefits, while other work is outsourced or done by workers who are not included in the employers' benefit plans.

Concluding Observations

The responsibilities of employers and workers in financing health and retirement benefits continue to evolve in an increasingly competitive global market. Employers have played a primary role in the financing of health benefits and retirement income for many workers for several decades; however, many are finding it increasingly challenging to provide these benefits. In responding to financial stresses, employers have changed the designs of both health and retirement benefits and shifted more of the cost, risk, and control to workers—reducing employers' responsibilities while increasing workers' responsibilities. These types of changes began with retirement benefits—with the shift from DB to DC plans—and were followed by similar changes to health benefits years later—such as through increased cost sharing and the more recent introduction of CDHPs. While DC plans have been widely adopted and their prevalence continues to grow, it is too early to tell if the shifting of health care costs and risks from employers to workers is sustainable or if CDHPs will take root in the same manner as DC plans.

Shifting some of the cost, risk, and control of health and retirement benefits from employers to workers, as well as the responsibility for managing them may help employers control their benefits costs and provide greater benefit choices for some workers, but such changes can also have other consequences. Workers participating in employer-sponsored benefits may not have or may perceive that they do not have sufficient financial resources, information, or knowledge to assume more of the costs and responsibility of these benefits. For example, a recent decline in health plan participation among lower-income workers may indicate that these workers are no longer able to afford the higher costs of these benefits. Similarly, although DC plans have grown in prevalence, recent employer changes to try to increase workers' participation and workers' investment returns—such as through automatically enrolling workers and offering life-cycle investment funds—may be an indication of growing concerns about workers' ability to adequately prepare financially for retirement when they are responsible for their participation in and management of these plans. The challenges workers face in assuming greater cost, risk, and control of their health and retirement benefits can make it more difficult for low-wage earners to afford health care coverage and save for retirement. Although these challenges may weigh most heavily on the less wealthy and less healthy segments of the workforce, they affect a broad spectrum of the American workforce and could prove challenging to many.

Employers, individuals, and government share the responsibility of finding long-term solutions with the goal of ensuring that individuals of varying economic and health backgrounds are prepared for their health and retirement needs. For employers this will involve balancing their need to attract quality workers and maintain a workforce that is healthy and prepared for retirement, all within their fiscal constraints. This may mean that solutions will differ for employers depending on factors such as their size, industry, profitability, and competition for labor. For individuals, this will involve balancing their demand for health care coverage and retirement savings vehicles with their ability to pay for them. It is becoming increasingly important for individuals to become actively engaged in planning for their health and retirement, and their decisions on these matters will be shaped in part by their income levels and health status. For government, this will involve balancing the need to promote both a healthy population and a healthy economy within its own budget constraints while facing the challenges posed by an aging population.

Agency Comments

We provided a draft of this report to DOL. DOL did not provide written comments, but did provide technical comments, which we incorporated as appropriate.

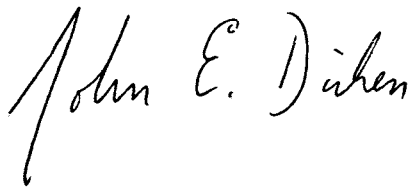
As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the date of this report. At that time, we will send copies of this report to the Secretary of Labor, relevant congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions concerning this report, please call Barbara D. Bovbjerg at (202) 512-7215 or John E. Dicken at (202) 512-7119. Contact points for our offices at Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,



Barbara D. Bovbjerg
Director, Education, Workforce,
and Income Security Issues



John E. Dicken
Director, Health Care Issues

Appendix I: Description of Survey Data Used in Our Analysis

To measure trends in employer-sponsored benefits, we relied primarily on data from three private-sector surveys of employer-sponsored health benefits and two federal surveys that address workforce characteristics and benefits costs and participation rates.

Private Surveys of Employer-Sponsored Health Benefits

We relied on data from two annual surveys of employer-sponsored health benefit plans conducted by private entities,¹ and one private-sector survey on retiree health benefits. For each of these surveys, we reviewed the survey instruments and discussed the data's reliability with the sponsors' researchers and determined that the data were sufficiently reliable for our purposes.

Kaiser Family Foundation and Health Research and Educational Trust Employer Health Benefits Annual Survey (Kaiser/HRET):

- Since 1999, Kaiser/HRET has surveyed a sample of employers each year through telephone interviews with human resource and benefits managers and published the results in its annual report—Employer Health Benefits.² Kaiser/HRET selects a random sample from a Dun & Bradstreet list of private and public-sector employers with three or more employees, stratified by industry and employer size. It attempts to repeat interviews with some of the same employers that responded in prior years. For the most recently completed annual survey, conducted from January to May 2006, 2,122 employers completed the full survey, yielding a 48-percent response rate. By using statistical weights, Kaiser/HRET is able to project its results nationwide. Kaiser/HRET uses the following definitions for employer size: (1) small—3 to 199 employees—and (2) large—200 and more employees. In some cases, Kaiser/HRET reported information for additional categories of small and large employer sizes. We used the Kaiser/HRET surveys to report on the changes in employer-sponsored health benefits.

¹ Year-to-year fluctuations or gradual changes in these employer benefit survey results need to be interpreted with caution. These surveys are based on random samples designed to be representative of a broader employer population and are used widely but may not have the precision needed to distinguish small changes in coverage from year to year because of their response rates and the number of firms surveyed.

² Kaiser/HRET has been conducting the survey of small and large employers since 1999. From 1991 through 1998, KPMG Consulting, Inc., conducted the survey using the same instrument.

Mercer National Survey of Employer-Sponsored Health Plans:

- Since 1993, Mercer has surveyed a stratified random sample of employers each year through mail questionnaires and telephone interviews and published the results in its annual report—National Survey of Employer-Sponsored Health Plans.³ Mercer selects a random sample of private-sector employers from a Dun & Bradstreet database, stratified into eight categories, and randomly selects public-sector employers—state, county, and local governments—from the Census of Governments. The random sample of private-sector and government employers represents employers with 10 or more employees. Mercer conducts the survey by telephone for employers with from 10 to 499 employees and mails questionnaires to employers with 500 or more employees. Mercer’s 2005 database contains information from 2,122 employers who sponsor health plans, yielding a response rate of 21 percent. By using statistical weights, Mercer projects its results nationwide and for four geographic regions. The Mercer survey report contains information for large employers—500 or more employees—and for categories of large employers with certain numbers of employees as well as information for small employers (fewer than 500 employees). We used the Mercer surveys to report on the changes in employer-sponsored health benefits.

Kaiser/Hewitt Survey on Retiree Health Benefits:

- Since 2002, The Kaiser Family Foundation and Hewitt Associates have jointly conducted an annual survey—Survey on Retiree Health Benefits—that is based on a nonrandom sample of private-sector employers. Kaiser/Hewitt conducted its most recent survey online from June 2006 through October 2006 and obtained data from 333 large (1,000 or more employees) employers. These employers included about one-third of the Fortune 100 companies with the largest retiree health obligations in 2005. Because the sample is nonrandom, the survey results cannot be generalized to all large employers. We used the Kaiser/Hewitt surveys to report on the changes in employer-sponsored retiree health benefits.

³ Foster Higgins, which later merged with Mercer Human Resource Consulting, began conducting the survey in 1986.

Private Surveys of Employer-Sponsored Pension Plans

We reviewed several major 2005 industry surveys of pension plan sponsors including surveys by the Profit Sharing/401k Council of America (PSCA) and Hewitt Associates LLC. Since the survey response rates are low, the data are not generalizable. To assess reliability of the survey data, we contacted the authors of each survey and collected information on the methodology that was used to complete it, and determined that the data were sufficiently reliable for our purposes.

Profit Sharing/401k Council of America Survey of Profit Sharing and 401(k) Plans:

- PSCA's 49th Annual Survey of Profit Sharing and 401(k) Plan reflects 2005 plan experiences of its members. PSCA's survey results are based on responses from 1,106 plan sponsors that have profit-sharing plans, 401(k) plans, or a combination of both and represent 1 to 5,000-plus employees. The survey was mailed or faxed to respondents and conducted from March 2006 to May 2006. The survey provides a snapshot as of the end of 2005. The survey response rate was 21 percent. PSCA is a national, nonprofit association of 1,200 companies and their 6 million plan participants. According to PSCA, it represents the interests of its members to federal policymakers and offers assistance with profit sharing and 401(k) plan design, administration, investment, compliance, and communication.

Hewitt Associates LLC Pension Surveys:

- Hewitt Associates biennial survey results are reported in 2005 Trends and Experience in 401(k) Plans. The survey results are based on responses from 458 employers with 1,000 employees or more. Nineteen percent of the respondents represented Fortune 500 companies. The survey was conducted from mid-March through April 2005. The survey and a link to a Web site were e-mailed to respondents whose e-mail addresses were available so that they could complete the survey on the Web or on paper. The other surveys were mailed with a stamped and addressed envelope. The survey had a 9-percent response rate. Hewitt Associates is a human resource outsourcing and consulting firm. Hewitt also analyzed 401(k) savings and investment behavior, in its research report, How Well Are Employees Saving and Investing in 401(k) Plans, 2005. The analysis includes more than 2.5 million eligible workers and more than 1.6 million active participants across 107 large employers. Further, Hewitt reported survey findings in, Hot Topics in Retirement, 2006, from responses from 227 employers in October and November 2005. Human resource professionals were surveyed to learn their likely areas of focus and action over the next year regarding their

defined contribution and defined benefit plans for active salaried workers.

Federal Surveys

Current Population Survey:

- The CPS is designed and administered jointly by the Bureau of the Census (Census) and BLS. It is a source of official government statistics on employment and employment-based benefits in the United States. The survey is based on a sample of the civilian, noninstitutionalized population of the United States. Using a multistage stratified sample design, about 60,000 households are selected on the basis of area of residence to be representative of the country as a whole and of individual states. A more complete description of the survey, including sample design, estimation, and other methodology, can be found in the CPS documentation prepared by Census and BLS. We used the Annual Social and Economic Supplement of the CPS to estimate the overall percent of the U.S. workers and retirees covered by employer-sponsored health benefits and the Contingent Worker Supplement to estimate the number of different types of contingent workers and their access and participation in employer provided health and retirement benefits.

National Compensation Survey:

- The National Compensation Survey (NCS) is conducted by the U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor. The estimates provided are for private nonagricultural industries. The NCS benefits survey obtains data on private-industry nonagricultural establishments and their workers. The survey provides data on access to and participation in selected benefits, such as employer health care and retirement benefits. We used the survey data to report increases in employer benefit expenses and to show workers' participation in employer retirement plans.

Appendix II: GAO Contacts and Staff Acknowledgments

GAO Contacts

Barbara D. Bovbjerg (202) 512-7215 or bovbjergb@gao.gov

John E. Dicken (202) 512-7119 or dickenj@gao.gov

Acknowledgments

In addition to the contacts named above, Randy DiRosa, Assistant Director, and David Lehrer, Assistant Director; Joseph Applebaum; Gerardine Brennan; Laura Brogan; Richard Burkard; Susannah Compton; Sharon Hermes; John Larsen; Sheila McCoy; Daniel Meyer; Michaela M. Monaghan; Tovah Rom; Dayna Shah; and Eric Wenner made key contributions to this report.

Related GAO Products

Private Pensions: Changes Needed to Provide 401(k) Plan Participants and Labor Better Information on Fees. [GAO-07-21](#). Washington, D.C.: November 16, 2006.

Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans. [GAO-06-798](#). Washington, D.C.: August 9, 2006.

Employment Arrangements: Improved Outreach Could Help Ensure Proper Worker Classification. [GAO-06-656](#). Washington, D.C.: July 11, 2006.

Employee Compensation: Employer Spending on Benefits Has Grown Faster Than Wages Due Largely to Rising Costs for Health Insurance and Retirement Benefits. [GAO-06-285](#). Washington, D.C.: February 26, 2006.

Federal Workers Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts. [GAO-06-271](#). Washington, D.C.: January 31, 2006.

Private Pensions: Information on Cash Balance Pension Plans. [GAO-06-42](#). Washington, D.C.: November 3, 2005.

Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act. [GAO-05-205](#). Washington, D.C.: February 14, 2005.

Private Pensions: Implications of Conversions to Cash Balance Plans. [GAO/HEHS-00-185](#). Washington, D.C.: Sept. 29, 2000.

Contingent Workers: Incomes and Benefits Lag behind Those of the Rest of the Workforce. [GAO/HEHS-00-76](#). Washington, D.C.: June 30, 2000.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548