

Investing in Maternal and Child Health: A Business Imperative

The Business Case for Investing in Maternal and Child Health

Ever-increasing **healthcare costs** are forcing companies to explore alternative benefit designs and **health promotion** strategies for employees and their dependents. To reduce costs, employers are asking beneficiaries to manage their healthcare expenses and take on a consumer role in healthcare decision-making. Employers are also focusing on particular sub-groups of their overall beneficiary population to identify opportunities to improve health status and reduce cost. One important, yet commonly overlooked sub-group, is child and adolescent dependents and pregnant women.

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Maternal and child health is important to business. Maternal and child healthcare services (e.g., labor and delivery, childhood immunizations) account for \$1 out of every \$5 large employers spend on healthcare.¹ Furthermore, a substantial proportion of employee's lost work time can be attributed to children's health problems. And pregnancy is a leading cause of short- and long-term disability and turnover for most companies.²

Improving the health of women and children, and improving the quality of the care they receive, will benefit an employer's bottom line.

Improving the health of children, adolescents, and childbearing-age women benefits employers in at least four ways:

- 1. Lower healthcare costs.** Healthy women and children use fewer costly healthcare services (such as hospitalization) and thus have lower total healthcare costs.
- 2. Increased productivity.** Parents of healthy children miss fewer workdays than those with ill children. As such, they are less likely to take family medical leave, personal sick leave, or paid time off due to a child's health problem. They may also be more productive at work because they do not suffer stress related to caregiving.
- 3. Improved retention/reduced turnover.** Women who have healthy pregnancies (pregnancies without complications) are able to work longer during their pregnancy and return to work sooner after delivery as compared to women who suffer complications. Similarly, parents with healthy children and adolescents are less likely to leave the workforce or cutback their work hours compared to the parents of children with chronic illnesses or severe disabilities.
- 4. A healthier future workforce.** The children and adolescents of today are the workforce of tomorrow. Many chronic diseases, for example obesity and mental illness, put children at risk for a lifetime of health problems. Employers benefit (from lower healthcare costs and improved productivity) when the people in the community or region where they recruit are healthy.

Investing in Maternal and Child Health includes information, resources, and tools employers can use to improve the health of their beneficiaries. This toolkit includes:

- Recommendations on evidence-informed, comprehensive health benefits to support child, adolescent, and pregnancy health. It also includes a cost-impact assessment of the recommended benefit changes (Part 2).
- Data on the cost of maternal and child healthcare services (Parts 2 and 4).
- The business case for investing in child and adolescent health, healthy pregnancies, and primary care services for all beneficiaries (Part 4).
- Tools employer can use to develop a maternal and child health strategy, communicate the value of their maternal and child health benefits, and link maternal and child health outcomes to organizational performance (Parts 3 and 7).
- Strategies employers can use to effectively communicate with beneficiaries, and tailor existing health programs and policies to the unique needs of children, adolescents, and pregnant women (Part 5).
- Health education information specifically developed for beneficiaries (Part 6).

Improving Maternal and Child Health

Maternal and child health refers to the health and health care of:

- Preconception women (women of childbearing-age prior to conception);
- Pregnant women;
- Postpartum women (women who were pregnant in the previous year);
- Children (birth to 12 years) and adolescents (aged 13 to 21 years), including those with special health care needs.

Benefit Design Opportunities

Benefit managers, charged with selecting and implementing health benefits, struggle with complex and sometimes contentious resource allocation decisions. Each year, benefits department staff must decide which healthcare services to cover in their plan(s) and at what level. Typically, these decisions were a function of cost, employee and/or union negotiations, and tradition.

Over the past 15 years, “evidence of effectiveness” has emerged as a key factor in health benefit investment decisions. Employers interested in “smart purchasing” have developed benefit plans that support and incentivize **evidence-based** or **evidence-informed** services. Many evidence-based benefit guidelines have been developed for adult care; far fewer are available to inform the design of **maternal and child health benefits**. Increasing healthcare costs, stagnating quality, and pressure from globalization have also led employers to shift their focus from budget-based allocation decisions to **value-based purchasing** strategies. Employers are beginning to see health benefits as an investment, not merely a cost.

The provision of evidence-informed, high-value maternal and child health benefits, and innovative, **family-friendly work/life benefits** may help employers improve the health of children, adolescents, and pregnant women, and the productivity of employees.

For additional information on evidence-informed benefits, refer to Part 2.

The Maternal and Child Health Plan Benefit Model

The Maternal and Child Health Plan Benefit Model (Plan Benefit Model) is the core component of this toolkit. The Plan Benefit Model is an evidence-informed, standardized, equitable, and comprehensive health benefits package created specifically for children, adolescents, and pregnant women. It emphasizes prevention and early detection, aims to reduce employee cost barriers to essential care services, and strives to balance employee affordability with employer sustainability.

The Plan Benefit Model is the National Business Group on Health’s (Business Group’s) recommendation on minimum health, pharmacy, vision, and dental benefits. It includes guidance on cost-sharing arrangements and other information pertinent to plan design and administration.

Concepts of evidence and value have helped balance health benefit decisions in recent years. However, the cost impact of benefit modification remains a critical factor in employers’ resource allocation decisions. Furthermore, the potential cost-offsets of investing in prevention and early

detection are frequently overlooked. To address these issues, the Business Group sponsored an actuarial meta-analysis of the Plan Benefit Model. This analysis estimated the cost impact of the Plan Benefit Model recommendations on typical large-employer PPO and HMO plan types. The analysis, presented in Part 2, provides cost-impact assessments for (a) the entire Plan Benefit Model, (b) each service category (e.g., preventive services), and (c) each recommended benefit (e.g., immunizations). Employers can use this information to estimate the cost implications of adopting the Plan Benefit Model recommendations for their own covered population.

Variation in Benefits

While virtually all large employers provide health benefits, there is wide variation in the structure of benefits and coverage levels. While tailoring can be used to meet diverse needs, variation can also lead to fragmentation, beneficiary confusion, and administrative costs. The extreme cost, quality, and access variation seen in the marketplace today suggests that employers are not maximizing their investment in health benefits. Employers may be able to improve their return on investment in health benefits by improving the alignment between health benefits, organizational strategy, and internal operations. Part 3 includes tools to help employers evaluate the relationships between maternal and child health outcomes and organizational performance, implement and track Plan Benefit Model recommendations, and design and evaluate other maternal and child-focused health and work/life benefits.

Beneficiary Engagement Opportunities

Experience has shown employers that providing comprehensive health benefits is not sufficient to ensure good health for any population: engagement, appropriate utilization, and quality are necessary factors as well. In order for beneficiaries to become engaged in health promotion and healthcare decision-making, they need education on the importance of these activities, resources and tools, appropriate incentives, and employer support.

The idea behind **engagement** is simple. Beneficiaries will make better healthcare decisions if they are equipped with:

1. The knowledge necessary to understand their personal (or their child's) health needs and unique health risks; and
2. The information required to make effective healthcare decisions, for example information on cost and quality.

Many employers have successfully developed strategies to engage employees; few have effectively engaged dependent beneficiaries. Parts 4, 5, and 6 present strategies employers can use to engage dependent beneficiaries in health promotion and healthcare decision-making.

Overlooked Benefits: Child, Adolescent, and Maternity Care

Employer-sponsored medical benefit plans were originally developed to protect employees from the catastrophic costs of unplanned illness and injury. Over time, these “health insurance” plans evolved into “health coverage” programs as they began to provide access to basic healthcare services, preventive services, and ancillary services such as medical equipment, dental care, and vision care.³

Today, most large employers offer a robust benefits package that typically includes:

- Healthcare coverage (general medical; prescription drugs; specialty services such as behavioral health, dental, and vision care; and disease management services).
- Disability benefits.
- Employee assistance services.
- Wellness programs.

These programs are designed to provide health or health-related services that address specific employee and employer needs.

Employer-sponsored health coverage programs, past and present, have focused mainly on the needs of working-age adults. Benefit plans were structured to provide care to adults, and the unique health care needs of children were largely ignored. Consider the following examples regarding care for children and pregnant women:

- Children generally receive care in different settings than adults; they are more likely to need provider office visits, home health services, and school-based care, and less likely to need prescription drugs or hospitalization.
- The type and intensity of required care differs as well. For example, comprehensive well-child care, (essential preventive care), requires 26 provider office visits and at least 37 immunizations during the first 21 years of life.^{4,5} These critical healthcare services are a long-term investment: they set the stage for a lifetime of good health.
- One in five households with children in the United States includes at least one child with special health care needs. Nationwide, more than 18.5% of all children under the age of eighteen have a special healthcare need.⁶ These children suffer from complex problems that are often best addressed by a **healthcare team** that can integrate necessary health, education, and social services.
- Research shows that preconception health affects pregnancy health and the health of infants and children. Therefore, child health requires a long-term perspective and an investment in women's health and well-being.

Typical employer-sponsored plans do not adequately account for these differences in either plan design or cost-sharing strategies.

Due to cost differences, a lack of visibility, and other issues, maternal and child health has been given less attention than health care for adults. Children, adolescents, and pregnant and postpartum women are a unique and important segment of an employer's beneficiary population. As a group they:

- **Require specific health interventions and healthcare services that are different in scope, intensity, duration, or setting from that of the general population.**
- **Have a different disease and condition profile.**
- **Often rely on others to access health coverage and services.**

Opportunities exist to improve existing benefits by tailoring them to better meet the unique needs of women and children.

Employer-Sponsored Health Coverage Pertinent to Maternal and Child Health

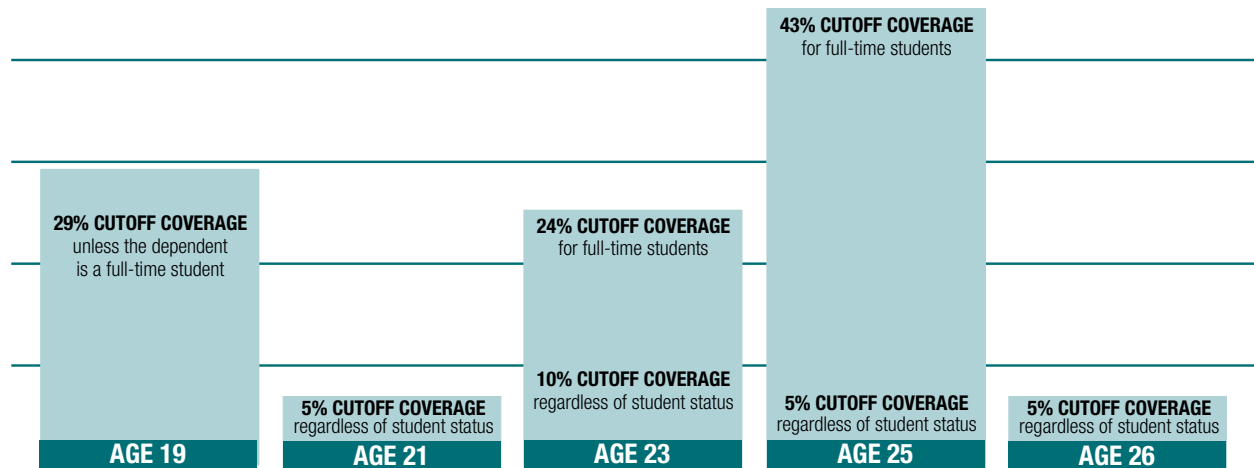
Dependent Coverage

Typically, employer-sponsored plans are open to qualifying employees under the age of 65, their dependents (children, and spouses or domestic partners), and occasionally retirees. Virtually all large employers provide maternity benefits (i.e., coverage for prenatal care, labor and delivery, and postpartum care). Dependent coverage for children varies by age, school status, and other factors. Most large employers provide child dependent coverage from birth, though adolescence, and into young adulthood. In fact, 43% of Business Group member survey respondents provide healthcare coverage to dependent children through age 25, as long as the child remains a full-time student.⁷

The content of dependent coverage and the way it is made available to employees has a significant impact on access to care for children.

Gary L. Freed, MD, MPH,
Child Health Evaluation and Research Unit
University of Michigan Health System, 2006

Figure 1A: Child Dependent Age Cutoffs for Large Employers



Source: National Business Group on Health. *Maternal and Child Health Benefits Survey* Washington, DC: National Business Group on Health; January 2006.

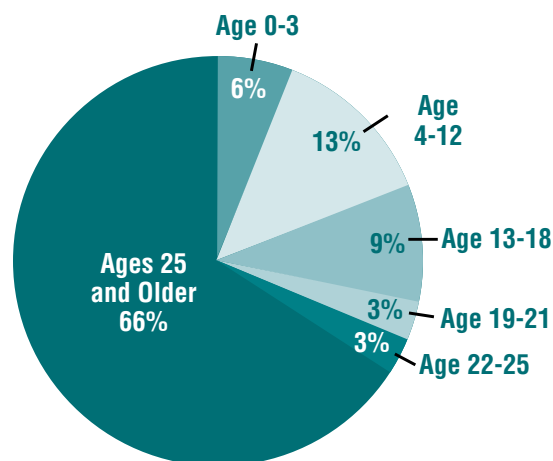
Demographics

Pregnant Women

According to the Census Bureau's 2008 American Community Survey, 61.7% of women who had a baby in the previous 12 months were in the labor force.⁸ In 2009, employer sponsored insurance covered almost 2/3 of women between the ages of 18 and 64.⁹

Children and Adolescents

In 2008, there were 73.9 million children in the United States between the ages of 0 and 17 years, accounting for 25% of the total population.¹⁰ In 2007, 54.2% of children had employer-sponsored health coverage.¹¹ According to Business Group surveys, child and adolescent dependents (through age 25) generally comprise about one-third of a large employer's total beneficiary population.⁷



Children with Special Health Care Needs

Approximately 18.5% of children under the age of 18 in the United States have a special health care need (a chronic and severe health problem that requires more intensive or specialized care than children normally require).⁶ **Children with special health care needs** are only slightly less likely than their peers to have employer-sponsored healthcare coverage. Children with special health care needs are an important part of an employer's beneficiary population because they:

Researchers estimate that 8.6% of employees provide care to a child with a special need.¹²

- Experience complex, chronic, and severe health problems, which can be difficult to manage.
- Use more healthcare services than other children and thus have higher overall healthcare expenditures.
- Experience more sick days than other children and require additional office visits and hospitalizations, which results in lost productivity and absenteeism for their parents.

Pregnancy-Related Healthcare Costs: An Overview

In 2006, 90.5% of women had at least one health care expenditure.¹³ Pregnancy is a major cause of health expenditures among women of childbearing-age.¹⁴

The total cost of a pregnancy includes physician/provider services for prenatal care and labor and delivery; hospital or birth-center fees for labor and delivery; laboratory and diagnostic testing costs; medication; and postpartum care. The total cost of a pregnancy is difficult to estimate due to different provider payment methods (e.g., capitation); extensive regional differences; and variance in the procedures, medications, and screening services women and their newborns receive. According to a recent study of women with employer-sponsored health coverage who delivered a baby in 2004, prenatal care and maternity-related hospital payments *combined* averaged \$7,737 for a vaginal delivery and \$10,958 for a **cesarean delivery** (these figures include patient out-of-pocket costs).¹⁵

Pregnancy and childbirth account for nearly 25% of all hospitalizations in the United States.¹⁵

In 2000, the average hospital charge for labor and delivery was \$6,200 (this figure does not include for the newborn's care). Other types of obstetric hospital stays included antepartum care (average charge \$6,900), care related to

pregnancy loss (average charge \$8,200), and postpartum care (average charge \$8,900).¹⁶ Among women in the U.S. with large employer sponsored plans, the average cost of having a baby in 2004 was more than \$8,000.

Preterm birth is a serious health problem that costs the United States more than \$26 billion every year, according to the Institute of Medicine. In 2007, the average medical costs for a preterm baby were more than 10 times as high as they were for a healthy full-term baby. The costs for a healthy baby from birth to his first birthday were \$4,551. For a preterm baby, the costs were \$49,033.¹⁷

The medical costs for both mother and her preterm baby in 2007, were four times higher than when a mother delivered a healthy full-term infant. The costs for a full-term infant were \$15,047; while the costs for the preterm infant were \$64,713.¹⁷

Healthcare Costs for Children and Adolescents: An Overview

In 2004, children accounted for 26 percent of the population and 13 percent of the primary health care spending.¹⁸ Among children who used any type of healthcare service in 2000, the average medical expense was \$1,115.¹⁹ As is common in adult populations, a relatively small proportion of children are responsible for the bulk of total medical expenditures. For example, while the average per-child healthcare expenditure was \$1,115 in 2000, the median expense was only \$316.¹⁹

By definition, children with special health care needs use more healthcare services than their peers. For example, children with special needs have twice as many outpatient care visits as other children.¹⁹ The increased service use results in additional healthcare costs. Among children with a special health care need, the average medical expense was \$2,498 in 2000, more than double the average for all children.

Although children with special health care needs make up less than 15% of the population, they account for 41% of all child health expenditures.¹⁹

Healthcare Services Used	Children with Special Health Care Needs	All Children
Outpatient office visit	83.3%	67.4%
Emergency department visit	16.3%	11.1%
Inpatient hospital stay	6.0%	2.4%
Dental visit	50.3%	44.2%
Prescription medication	78.7%	45.8%

Source: Chevarley FM. *Utilization and Expenditures for Children with Special Health Care Needs*. Research Findings No. 24. Rockville, MD: Agency for Healthcare Research and Quality; 2006.

Special needs status is only one demographic variable that affects healthcare use and healthcare costs. For example, children living in the Northeast and the Midwest are more likely to use healthcare services and have higher healthcare expenses than children in other areas of the country. White children are more likely to incur medical expenses than either Hispanic or black children.¹⁹ Age is also an important factor: very young children (0 to 5 years) are more likely to have healthcare expenditures than older children (6 to 11 years) or adolescents (12 to 17 years).¹⁹

For additional information on healthcare costs for children and adolescents, refer to Part 4

More than 4 million hospitalizations per year could be prevented by improving primary care, increasing access to quality treatment, and encouraging Americans to live a healthier lifestyle.

“In 2006, nearly 4.4 million hospital admissions totaling \$30.8 billion in hospital costs were potentially preventable with timely and effective ambulatory care or adequate patient self-management of the condition. Hospital costs for potentially preventable hospitalizations represented about one of every 10 dollars of total hospital expenditures in 2006.”

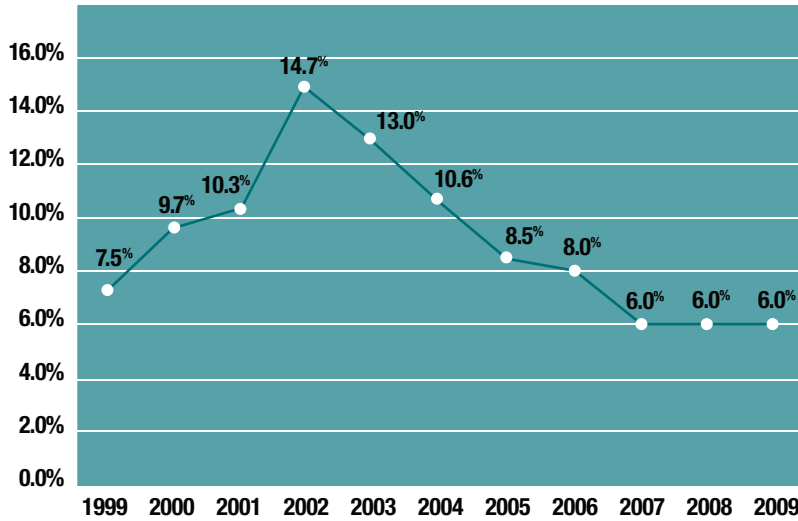
- Children accounted for about 276,000 potentially preventable hospitalizations, totaling \$737 million in hospital costs.
- Among children, pediatric asthma was the most costly potentially preventable condition (\$293 million), but pediatric gastroenteritis accounted for the highest number of potentially preventable hospitalizations (133 million admissions, or 183 admissions per 100,000 population).²⁰

Employer-Sponsored Healthcare Coverage Costs

The cost of employer-sponsored health plans increased dramatically through the late 1980s and 1990s. Healthcare cost increases peaked in 2002, when the cost trend reached 14.7%²¹(refer to Figure 1B). Since 2002, costs have stabilized; yet large employers still face steep annual increases.²¹

In 2005, large employers, on average, paid \$6,658 per employee enrolled in an HMO plan and \$6,518 per employee enrolled in a PPO plan (refer to Figure 1C) (note that prescription drug, mental health, vision and hearing benefits are included here if part of the plan, but dental is not).²² By 2008, that cost increased to \$8,106 per employee enrolled in an HMO plan and \$7,861 per employee enrolled in a PPO plan (refer to Figure 1C). Additionally, employee contribution to an HMO plan for individual coverage averaged \$1,104.²²

Figure 1B: Large-Employer Healthcare Cost Increases, 1999-2009



Source: National Business Group on Health, Watson Wyatt Worldwide. *The Keys to Continued Success: Lessons Learned From Consistent Performers*. 2009 14th Annual Employer Survey on Purchasing Value in Health Care. Washington DC: Watson Wyatt Worldwide; 2009.

Figure 1C: Large-Employer Healthcare Costs* by Plan Type, 2005-2008

Plan Type	Average Cost* Per Employee			
	2008	2007	2006	2005
HMO	\$8,106	\$7,486	\$7,004	\$6,658
PPO	\$7,861	\$7,429	\$7,029	\$6,518

Note: *Total gross annual cost for medical plan only, for active employees and dependents, divided by the number of active covered employees. Includes employee contributions (payroll deductions) if any, but not employee out-of-pocket expenses such as deductibles and copays. Prescription drug, mental health, vision and hearing benefits for all active employees and their covered dependents are included if part of the plan. Dental benefits, even if a part of the plan are not included in these costs.

Source: Mercer Health & Benefits Consulting, National survey of Employer-Sponsored Health Plans: 2008 Survey Report, Mercer Health & Benefits Consulting; 2009.

For years employers have used employee cost-sharing to contain healthcare costs. In fact, growth in healthcare premiums has consistently outpaced both inflation and growth in workers' earnings for the past 20 years.²³

Family out-of-pocket costs for medical care are also on the rise. In 2003, 18.2% of families covered by employer-sponsored health benefits spent 10% or more of their annual income on medical

The growth in healthcare costs has become a central women's health issue. A sizable share of women are falling through the cracks, either because they don't have insurance or even with insurance can't afford to pay for medical care or prescription drugs.

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expenses (premiums and copayment/coinsurance), compared to 14.2% in 1996. This represents a 28% increase over 8 years.

While employee cost-sharing is an effective cost-containment strategy, many experts believe that employers have maximized the financial benefit of cost-sharing.²⁴ High cost-sharing, specifically high premiums, can price some families out of the market. Similarly, high deductibles, copayment/coinsurance requirements, and out-of-pocket maximum amounts may force families to delay or forgo care. One of the primary purposes of the Plan Benefit Model is to balance employer sustainability and employee affordability. The Plan Benefit Model aims to ensure beneficiary access to essential care services by removing beneficiary cost barriers wherever possible, all without increasing employer costs.

Employer-Sponsored Maternal and Child Health Benefit Costs¹

To provide data on the cost of maternal and child healthcare services for a typical large employer in the United States, PricewaterhouseCoopers (PwC) developed a cost projection model. This model included data from PwC’s proprietary health insurance cost model and the Medstat database.

The Medstat database used in this analysis included information on the experience of 3 million members covered by large-employer healthcare benefit plans during 2004. This data set represents a typical distribution of enrollment by plan type (HMO, PPO, POS, and indemnity plans) and average cost-sharing provisions (deductible, coinsurance, and copayment). The data was normalized to reflect the typical level of costs for a hypothetical population of 120,000 beneficiaries (refer to Figures 1D, 1E, and 1F).

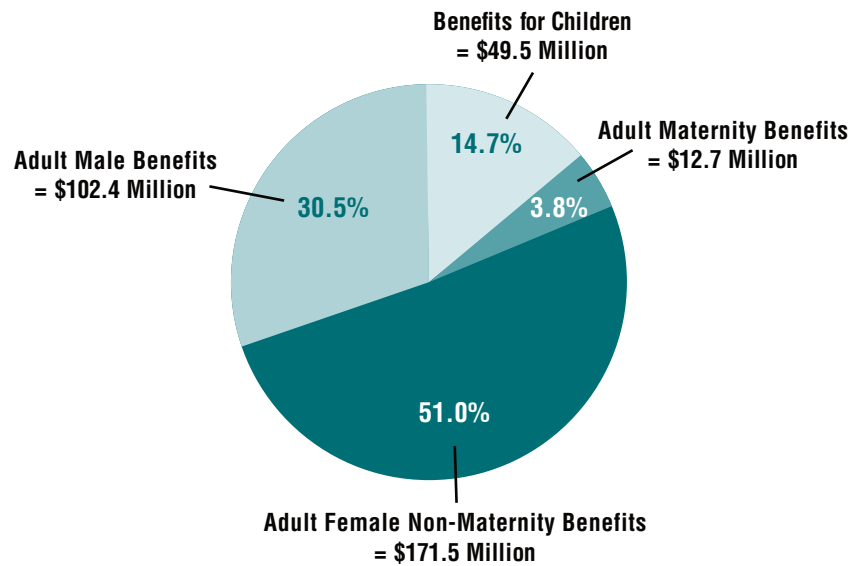
Children and adolescents comprised 33% of the beneficiary population included in the Medstat data and were responsible for 14.7% of total costs (\$49.5 million) (refer to Figure 1D). Children and adolescents’ use of healthcare services, and the associated costs, were

Average Annual Cost of Benefits For Covered Children and Adolescents	
Newborns (0-1 year)	\$4,629
Children (1-12 years)	\$872
Adolescents (13-18 years)	\$1,125
All Children (0-18 years)	\$1,258

highest in the first year of life (including birth) and during late adolescence. Healthcare services for children and adolescents were responsible for 16% of inpatient costs, 12% of outpatient costs, 18% of professional services/office visit costs, 10% of prescription drug costs, and 24% of ancillary service costs.

Females comprised 54.6% of the adult beneficiary population and were responsible for 64.3% of adult-related costs. Maternity benefits, including prenatal and postpartum care services, were responsible for 3.8% (\$12.7 million) of total plan costs.

Figure 1D: Health Plan Benefits for Large Employers, Average Benefits for a Plan with 120,000 Beneficiaries, 2004



Notes: The plan enrollment for this data includes active employees, retirees under 65, and COBRA participants. Dental benefits are not included. Benefits for retirees 65 and over are not included.

Source: PricewaterhouseCoopers LLP. *Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model*. Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.

Figure 1E: Beneficiary Healthcare Costs for Children and Adolescents, by Age, 2004

Age Group (Years)	Average Number of Beneficiaries	Inpatient Hospital Services	Outpatient Hospital Services	Professional Services	Prescription Drugs	Ancillary Services
00-00	1,664	\$2,708	\$242	\$1,537	\$67	\$74
01-04	5,199	\$177	\$235	\$569	\$107	\$58
05-09	7,613	\$99	\$154	\$309	\$135	\$61
10-14	9,450	\$126	\$156	\$307	\$183	\$71
15-19	10,099	\$249	\$279	\$412	\$249	\$94
20-25	5,342	\$367	\$357	\$493	\$383	\$110
Total	39,367	\$301	\$228	\$446	\$203	\$79

Figure 1F: Total Plan Costs, by Age, 2004

Age Group	Average Number of Beneficiaries	Inpatient Hospital Services	Outpatient Hospital Services	Professional Services	Prescription Drugs	Ancillary Services	Total
Children	39,367	\$11,860,067	\$8,992,537	\$17,572,525	\$7,979,406	\$3,101,806	\$49,506,342
Adults	80,633	\$62,093,331	\$64,069,727	\$81,467,397	\$68,911,505	\$10,021,403	\$286,563,363
All Beneficiaries	120,000	\$73,953,399	\$73,062,264	\$99,039,922	\$76,890,911	\$13,123,210	\$336,069,705
Distribution of Benefits		22.0%	21.7%	29.5%	22.9%	3.9%	100%
Children's % of Total	33%	16%	12%	18%	10%	24%	15%

The 2004 data shown above was one of the primary sources used to project the average health plan costs for 2007. The updated 2007 plan costs were used to estimate the impact of the Plan Benefit Model's recommended changes in plan design. For more information on the cost impact of recommend plan design changes, refer to Part 2.

Health-Related Costs for Employers

In addition to health plan expenditures, employers pay for specialty services such as dental, vision, and mental health care; disease management services; short- and long-term disability; and costs associated with absenteeism, lost productivity, and turnover.

Workplace Burden

A substantial proportion of employee's **lost work time** can be attributed to child health problems. Research shows that child illness and injury result in absenteeism, tardiness, leaving work early, and significant work interruptions.²⁵ Working parents with young children in childcare typically miss 9 days of work annually due to child illness; the parents of elementary-school-aged children miss up to 13 days of work annually due to child illness.²⁶ These missed work days result in **lost productivity** costs for employers. In fact, employee absences due to childcare breakdowns cost businesses in the United States approximately \$3 billion dollars every year.²⁶

The parents of children with special health care needs are particularly vulnerable to lost work time. When asked about their experience during the previous year, parents of special needs children report an average of 20 missed school/childcare days, 12 provider office or emergency department visits, and 1.7 hospitalizations.²⁸ One study found that the mothers of children with a developmental delay or disability (e.g., cerebral palsy, autism) lose around 5 hours of work each week, totaling 250 hours per year. This translated into lost productivity costs of \$3,000 to \$5,000 a year (assuming an hourly employee cost of \$12 to \$20, including fringe benefits).²⁹

Approximately 26% of the time, employees who call in sick are actually staying home to care for an ill family member, usually a child.²⁷

The **workplace burden** of childhood illness is highest among the parents of young children, due to the increased rate of illness among young children and their inability to care for themselves.³¹ Illness, injury, and disability among adolescents also result in lost productivity for parents and subsequent costs for employers. Adolescent injuries are the most expensive injuries of any age group and require a significant amount of care. The parents of these adolescents often lose work time in order to care for their child in the hospital and during the rehabilitation process. Unique issues of adolescence such as serious mental illness, substance abuse, and unintended pregnancy can cause in significant parental stress.

The impact of children's special healthcare needs on families is substantial: 20.9% of parents report that their child's health care needs caused them financial difficulties and 29.9% reduced their hours or quit their job because of their child's needs.³⁰

Both child and adolescent health problems can result in **work cutback** or, in extreme cases, an **early exit from the workforce**. Research shows that work/life benefits can support families struggling with acute or chronic illness or injuries.¹² These benefits can reduce turnover and improve productivity.^{26,27}

There is considerable evidence that child health affects parents' work lives. Poor child health can present substantial challenges to parents' effort to manage their work and caregiving roles. Child health, however, is more than just a personal concern for parents. Owing to healthcare costs, lost time, and other employment implications, child health is also a relevant consideration for business organizations.

Debra Major, Carolyn Allard
Journal of Occupational Health Psychology, 2004

Family-Friendly Benefits

Employer sensitivity to family issues is strongly associated with increased job satisfaction and loyalty. A 2000 America @ Work survey found that several **family-friendly benefits** were independently related to organizational commitment. Employees who had access to (a) flexible work schedules, (b) preventive medical care, and/or (c) childcare for sick children, even when they did not personally use these benefits, showed a stronger commitment to their organization and a significantly lower intention to quit than employees without access to these benefits.³²

Family-friendly benefits are also a means of recruiting employees and promoting productivity (refer to Figure 1G). In a recent study, researchers evaluated the impact of four types of family-friendly benefits: prenatal programs, worksite lactation programs, sick childcare, and flexible working arrangements. All four benefit types were found to increase employer attractiveness. Furthermore, flexible working arrangements were found to improve productivity, and prenatal programs and lactation programs were found to reduce overall healthcare costs.³¹

Figure 1G: Family-Friendly Benefits Offered by Large Employers, 2009

Type	Family-Friendly Benefit	Percentage of Large Employers who Offer Benefit
Flexible Work Schedule	Flextime	54%
	Bring child to work in an emergency	29%
Leave Programs	Paid family leave	25%
	Family leave above and beyond that required by Federal FMLA	25%
	Parental leave above and beyond that required by Federal FMLA	17%
Other	Lactation program/designated area	25%

Source: Society for Human Resources Management. *2009 Employee Benefits: Examining Employee Benefits in a Fiscally Challenging Economy*.

Summary

Employers have a unique opportunity to improve the health of women and children through health benefit design, beneficiary education and engagement, and health promotion programs and policies. This toolkit provides employers with the information and tools they need to design and implement evidence-informed, comprehensive health benefits; effectively communicate benefit offerings to beneficiaries; educate beneficiaries on the importance of health promotion and disease prevention; and link these activities to organizational success.

References

1. PricewaterhouseCoopers LLP. *Actuarial analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model*. Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.
2. Leopold R. *A Year in the Life of a Million American Workers*. New York, NY: Met Life Group Disability; 2004.
3. Starr P. *The Social Transformation of American Medicine*. New York, NY: Basic Books; 1984.
4. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007.
5. Centers for Disease Control and Prevention. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians. *MMWR*. 2006;55(No. RR-15):1-48.
6. Tu H, Cunningham P. Public coverage provides vital safety net for children with special health care needs. *Center for Studying Health System Change*. 2005(98):1-4.
7. National Business Group on Health. *Maternal and Child Health Benefits Survey*. Washington, DC: National Business Group on Health; January 2006.
8. U.S. Census Bureau. *2008 American Community Survey: Table B13012: Women 16 to 50 years who had a birth in the past 12 months by marital status and labor force status*. Suitland, MD: U.S. Census Bureau; 2008.
9. Henry J. Kaiser Family Foundation. Women's health insurance coverage. Menlo Park, CA: Henry J. Kaiser Family Foundation; October, 2009. Available at: <http://www.kff.org/womenshealth/upload/6000-08.pdf>. Accessed on March 22, 2010.
10. U.S. Census Bureau. *Current population reports: estimates of the population of the United States by single years of age, color, and sex*. July, 2008

11. Roberts M, Rhoades JA. *Health insurance status of children in America, first half 1996-2007: Estimates for the U.S. civilian noninstitutionalized population under age 18*. Statistical Brief #216. Rockville, MD: Agency for Healthcare Research and Quality; 2008.
12. Perrin J, Kuhthau K, Fluet C. *Children with Special Needs and the Workplace: A Guide for Employers*. Boston, MA: Center for Child and Adolescent Health Policy at the MassGeneral Hospital for Children; 2004.
13. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Women's Health USA 2009*. Rockville, Maryland: U.S. Department of Health and Human Services, 2009. Available at: <http://mchb.hrsa.gov/whusa09/hsu/pages/307hce.html>. Accessed on March 22, 2010.
14. U.S. Department of Health and Human Services, Health Resources and Services Administration. *Women's Health USA 2006*. Rockville, Maryland: U.S. Department of Health and Human Services, 2006. Available at: http://mchb.hrsa.gov/whusa_06/healthservutiliz/0406hce.htm. Accessed on August 21, 2007.
15. Thomson Healthcare. *The Healthcare Costs of Having a Baby*. Santa Barbara, CA: Thomson Healthcare; June 2007.
16. Jiang HJ, Elixhauser A, Nicholas J, et al. *Care of Women in U.S. Hospitals, 2000*. Rockville (MD): Agency for Healthcare Research and Quality; 2002. HCUP Fact Book No. 3; AHRQ Publication No. 02-0044.
17. March of Dimes. *About prematurity: cost to business*. Available at: http://www.marchofdimes.com/prematurity/21198_15349.asp. Accessed March 22, 2010.
18. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. National health expenditure data by age, 2004. Available at: http://www.cms.hhs.gov/NationalHealthExpendData/04_NationalHealthAccountsAgePHC.asp#TopOfPage. Accessed on March 22, 2010.
19. Chevarley FM. *Utilization and Expenditures for Children with Special Health Care Needs. Research Findings No. 24*. Rockville, MD: Agency for Healthcare Research and Quality; 2006.
20. Jiang HJ, Russo CA, Barrett, ML. Nationwide Frequency and Costs of Potentially Preventable Hospitalizations, 2006. HCUP Statistical Brief #72. April 2009. U.S. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.pdf>. Accessed on March 22, 2010.
21. Mercer Health & Benefits Consulting. *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report*. Mercer Health & Benefits Consulting; 2006.
22. Mercer Health & Benefits Consulting. *National survey of Employer-Sponsored Health Plans: 2008 Survey Report*. Mercer Health & Benefits Consulting; 2009.
23. Henry J. Kaiser Family Foundation. *Health Care Costs: A Primer. Key Information Health Care Costs and Their Impact*. Menlo Park, CA: Henry J. Kaiser Family Foundation; August 2007.
24. Bantlin JS, Bernard DM. Changes in financial burdens for health care: national estimated for the population younger than 65 years, 1996-2003. *JAMA*. 2006;296:2712-2719.
25. Major DA, Allard CB. Child health: a legitimate business concern. *J Occup Health Psychol*. 2004;9(4):306-321.
26. Shellenback K. *Child Care and Parent Productivity: Making the Business Case*. Ithaca, NY: Cornell Department of City and Regional Planning; 2004.
27. LoJacono SA. Reducing employee absenteeism through sick child day care. *Journal of Compensation and Benefits*. 1999;14(6):60-63.
28. Chung PJ, Garfield CF, Elliott MN, Carey C, Eriksson C, Schuster MA. Need for and use of family medical leave among parents of children with special health care needs. *Pediatrics*. 2007;119:e1047-e1055.
29. Powers ET. Children's health and maternal work activity: Estimates under alternative disability definitions. *J Hum Resour*. 2003;38(3):522-556.
30. van Dyck PC, Kogan MD, McPherson MG, Weissman GR, Newacheck PW. Prevalence and characteristics of children with special health care needs. *Arch Pediatr Adolesc Med*. 2004;158:884-890.
31. Major DA, Cardenas RA, Allard CB. Child health: a legitimate business concern. *J Occup Health Psychol*. 2004 Oct;9(4):306-21.
32. Lineberry J, Trumble S. The role of employee benefits in enhancing employee commitment. *Compensation & Benefits Management*. 2000;16:9-14.