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# Healthy Pregnancy and Healthy Children: Opportunities and Challenges for Employers

## The Business Case for Protecting and Promoting Child and Adolescent Health

This issue brief provides the business case for protecting and promoting child and adolescent health. It includes an overview of children’s key health issues, information on the economic and workplace burden of children’s illness, and important prevention opportunities. It also provides guidance on how employers can support improved family health.

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## Introduction

In 2006, there were 73.7 million children in the United States between 0 and 17 years of age, accounting for 25% of the U.S. population.<sup>1</sup> Approximately 9.3 million of these children—12.8% of all children under the age of 18—have a chronic and severe health problem that requires more intensive or specialized care than children normally require.<sup>2</sup>

Employers are concerned about child health and health care for several reasons.

**1. Employers provide healthcare coverage to more than half the children in the United States.**

Almost all large employers provide dependent healthcare coverage. Most large employers provide healthcare coverage for qualifying dependents from birth through age 19, and many provide coverage for young adults aged 20 to 25, so long as the dependent is enrolled in school.<sup>3</sup> In 2005, 57.8% of children had employer-sponsored health coverage through a parent or legal guardian.<sup>4</sup>

**2. A substantial proportion of employee lost work time can be attributed to child health problems.**

Employees who have access to innovative work/life benefits such as on-site childcare and flexible working arrangements, may be able to minimize lost productivity when their children are ill. Research also shows that when the parents of chronically ill children receive help and support from their employers, they are better able to concentrate on their jobs and remain with their companies longer.

**3. Many common and costly child health problems, including injuries, substance abuse, unintended pregnancy, and sexually transmitted infections, are preventable.**

**There is a strong business case for both comprehensive child health benefits and innovative work/life benefits that help parents balance work and home responsibilities.**

Improving the health of children will likely benefit an employer's bottom line by reducing both direct healthcare costs and indirect costs, such as lost productivity.

The following sections highlight the most critical issues in child and adolescent health, and present opportunities employers have to improve the health of these beneficiaries and reduce healthcare costs.

## Child and Adolescent Illness and Injury: Direct and Indirect Costs for Employers

### Healthcare Costs

In 2000, **national healthcare expenditures** for children and adolescents totaled \$67 billion.<sup>5</sup> Among children who used any type of healthcare service in 2000, the average medical expense was \$1,115 per child.<sup>5</sup> Among children with a special health care need, the average medical expense was more than double that amount: \$2,498 per child. 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 2006, the median expense was only \$316.<sup>5</sup>

### Workplace Burden

Child and adolescent illness and injury are a major cause of employee absence.

- Working parents with young children in childcare typically miss 9 days of work annually due to child illness.<sup>6</sup>

- The parents of elementary-school-aged children miss up to 13 days of work annually due to child illness.<sup>6</sup>
- 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 doctor or emergency department visits, and 1.7 hospitalizations.<sup>7</sup>

These missed work days result in lost productivity costs for employers.

- Employee absences due to childcare breakdowns cost businesses in the United States approximately \$3 billion dollars every year.<sup>6</sup> Many childcare breakdowns are a result of illness or injury: schools, childcare centers, nannies, and other care providers typically do not accept children when they are ill, so parents must stay home from work in order to care for their child.
- Costs are highest among the parents of children with special health care needs. One study found that mothers of children who had a developmental delay or disability (e.g., cerebral palsy, autism) lose around 5 hours of work weekly, which totals 250 hours per year and results in lost productivity costs of \$3,000 to \$5,000 a year (assuming an hourly employee cost of \$12 to \$20, including fringe benefits).<sup>8</sup>

In addition to absenteeism, child illness can result in parents being late to work, reduced concentration at work (lost productivity), and in extreme cases, an early exit from the workforce.<sup>9</sup>

An **acute illness** is characterized by signs and symptoms that are of rapid onset and short duration (a week or less). Examples of acute illnesses include colds, flu, and ear infections.

A **chronic illness** impacts a child's health for 3 months or longer. Examples of chronic illnesses that affect children include asthma, diabetes, juvenile rheumatoid arthritis, cystic fibrosis, spina bifida, emotional or behavioral disorders, and congenital heart diseases.

## Family-Friendly Benefits

Employees with sick children who receive help and support from their employers are usually better able to concentrate on their jobs, and remain with their companies longer. Employee retention is a key driver of customer retention, which in turn is a key driver of company growth and profits.

Access to quality childcare at the worksite is very important to employees. Employers benefit from this arrangement because it: (a) increases employee productivity, (b) lowers absenteeism, (c) reduces the number of employees who leave the job, and (d) increases company profits and value. For example:

- Sixty-three percent (63%) of employees with sick children state that their productivity improves when they use the childcare program at their company.<sup>6</sup>
- Fifty-four percent (54%) of employers state that childcare services reduce missed workdays by as much as 20% to 30%.<sup>10</sup>
- Childcare programs can reduce employee turnover by 37% to 60%.<sup>11</sup>

Most large employers also offer **employee assistance programs (EAP)** and work/life benefits. These programs may provide services at the worksite, via phone, or contract with providers in the community. Examples of EAP and **work/life benefits** include<sup>12</sup>:

- Childcare referrals.
- Counseling services.
- Education programs.
- Legal services.
- Referrals to mental health providers for ongoing care.
- Wellness programs for employees and sometimes family members.

The **Family Leave and Medical Leave Act (FMLA)** of 1993 applies to employers with 50 or more employees. FMLA provides employees with up to 12 weeks of unpaid leave annually, and covers a broad spectrum of health-related problems. Employees may take leave for the birth or adoption of a child; to care for a seriously ill parent, spouse, or child; or to address their own health needs. Throughout the duration of the leave, the employee's job and healthcare benefits are protected.

Although FMLA is of great benefit to employees, it is also very costly for employers. According to the United States Department of Labor, 50 million Americans took FMLA leave in 2000.<sup>13</sup> A study by the Employment Policy Foundation (EPF) reported that costs for companies with employees who took leave under FMLA in 2004 totaled nearly \$21 billion dollars.<sup>13</sup> These financial losses were caused by costs for labor replacement, lost productivity, and continued funding of employees' healthcare benefits.<sup>13</sup>

## Child Health Promotion and Disease Prevention

Children pass through an identifiable sequence of physical, cognitive, and emotional stages as they grow and develop.<sup>14</sup>

The major **stages of development** are:

- Infancy: birth to 11 months
- Early childhood: 1 to 4 years
- Middle childhood: 5 to 10 years
- Adolescence:
  - Early: 11 to 14 years
  - Middle: 15 to 17 years
  - Late: 18 to 21 years

**The PlanBenefit Model (provided in Part 2) was specifically designed for children aged 0 to 12 years, and adolescents aged 13 to 21 years.**

### Well-Child Care

**Well-child care** is preventive care for children and adolescents. *The Bright Futures Guidelines* for promoting health in infants, children, and adolescents recommend that children visit a primary care provider during<sup>15</sup>:

- Infancy—newborn; within 1 week; 1, 2, 4, 6, and 9 month visits.
- Early Childhood—1 year; 15 months; 1.5, 2, 2.5, 3, and 4 year visits.
- Middle Childhood—annually.
- Adolescence—annually.

Some children may require more frequent well-child visits for preventative health care.<sup>16, 17</sup>

Regular well-child visits help to ensure that a child is growing and developing normally.

During preventive healthcare visits, a primary care provider should:

- Assess a child's growth and development.
- Administer immunizations according to the recommended schedule for the child's age.
- Refer the child to a specialist if the child is experiencing physical or developmental problems.
- Instruct parents about the nutritional needs of the child at each stage of life.
- Discuss how the child is performing in school.
- Provide surveillance and screening for developmental delays, behavioral problems, and mental health issues, and note if the child's behavior is typical for his or her age.
- Counsel parents with children who are experiencing minor behavioral problems, or who are not getting along with other children. Refer parents to mental health specialists if their child is exhibiting serious behavioral problems, or their child has become withdrawn or depressed.
- Provide anticipatory guidance—the discussion of age-appropriate strategies to ensure good health.

**Well-child visits are essential to prevent, detect, and manage problems before they develop into more serious or chronic conditions.**

### *The Economic Benefit of Prevention and Early Detection*

One of the primary purposes of well-child care is to identify children affected by a physical, mental, or developmental problem as early in life as possible. Approximately 16% to 18% of children in the United States are diagnosed with disabilities that include speech-language impairments, mental retardation, learning disabilities, and emotional/behavioral disturbances.<sup>18</sup> Yet, only 20% to 30% of children with disabilities are diagnosed and start treatment before beginning school.<sup>18</sup>

Children with disabilities who enter early intervention programs prior to starting kindergarten are more likely to complete high school; enter and remain in the workforce; and avoid teen pregnancy, delinquency, and violent crimes. Research has shown for every dollar spent on early intervention services for children with disabilities, \$13.00 are saved.<sup>18</sup>

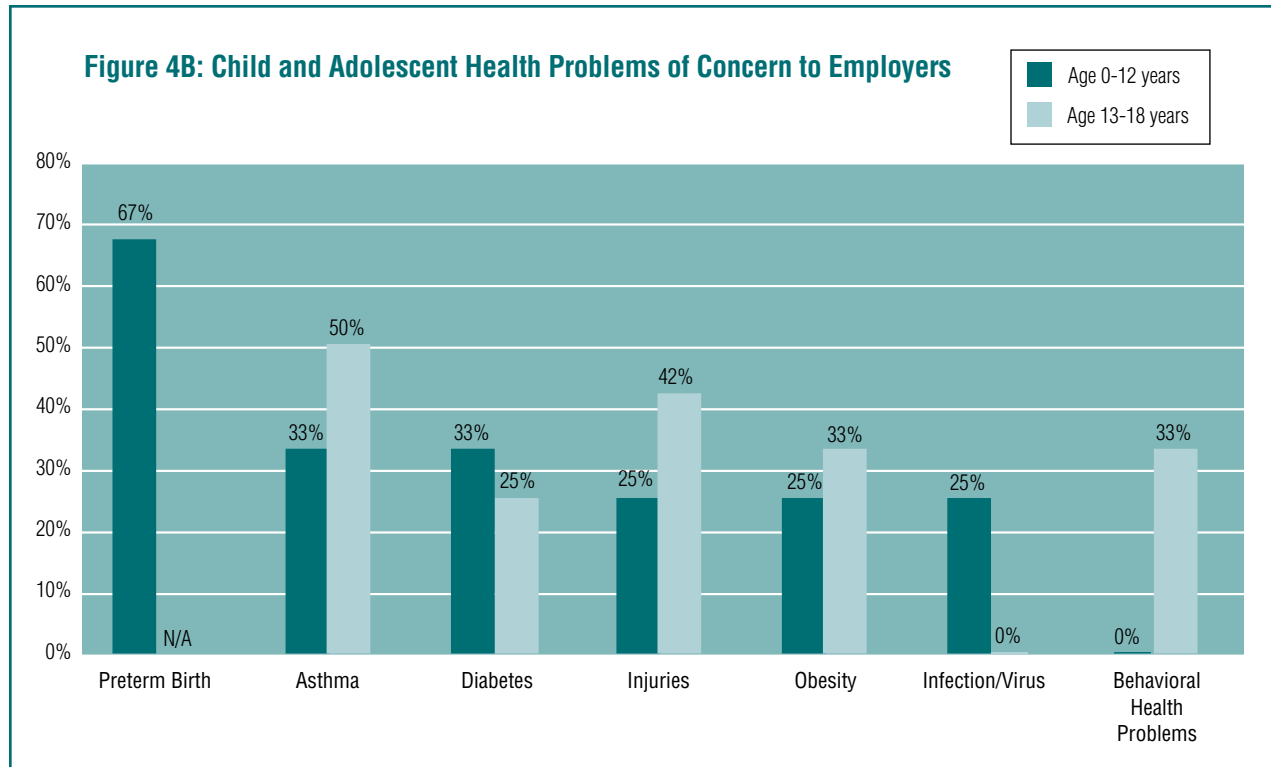
Employers also benefit from the early detection of child health problems. Children who receive early intervention services are better able to function later in life. Improved functionality can help to lower employee absenteeism and reduce turnover because children who are able to care for themselves, attend school, and perform developmentally-appropriate tasks require less care from their parents.

Well-child visits are also designed to help parents learn how to care for their children and address common problems. For example, healthcare providers teach parents about nutritional requirements, how to prevent injuries, and how to properly discipline children with behavioral problems.<sup>19</sup> Such guidance may reduce parental stress, improve productivity, and reduce lost work days due to child illness.

In addition, well-child visits can benefit the health of parents (employees). Recently, well-child care visits have been used to detect intimate partner abuse (the new term for domestic violence), and screen for maternal depression.<sup>20</sup> Parents may also personally benefit from health education and injury-prevention counseling conducted during well-child visits (e.g., motor vehicle safety, food safety).

### **Children: Key Health Risks**

While most children are generally healthy, all children face health risks. Business Group membership surveys show that large employers are particularly concerned with child health risks that are serious (i.e., they result in long-term or permanent problems) and costly to treat or manage. In 2005, the Business Group asked its large-employer members to name the most “problematic” health conditions that affected their child and adolescent beneficiaries (refer to Figure 4B on page 24). Respondents reported that for children aged 0 to 12 years preterm birth, asthma, diabetes, injuries, and infections were the most problematic conditions; for adolescents aged 13 to 18 years, the most problematic conditions were asthma, behavioral health problems, injuries, and obesity.<sup>3</sup>



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

### Vaccine Preventable Diseases

#### Health Impact

Immunizations have a powerful positive impact on the overall health of children. Childhood immunization<sup>19</sup>:

- Is generally safe;
- Protects children from a number of potentially serious and even deadly childhood diseases;
- Prevents outbreaks of infectious diseases and the spread of epidemics; and
- Is one of the only defenses against many childhood infections, such as chicken pox, polio, and measles.

**Childhood immunizations have eliminated or nearly eliminated many infectious diseases that affected children in the past.**

Clinical studies demonstrate that immunization has produced a dramatic decline in the incidence of childhood infections. For example:

- During the first 6 years of use, the influenza vaccine reduced the incidence of invasive *Haemophilus influenzae* disease by 95% in children under 5 years of age.<sup>21</sup>
- Before the varicella (chicken pox) vaccine was available, 4 million cases, 11,000 hospitalizations, and 100 deaths were caused by chicken pox each year. Typically a child with chicken pox misses 5 to 6 days of school, and their employed caretaker loses 3 to 4 days of work.<sup>22</sup>

The immunization rate for children of all ages in the United States is high. However, certain groups of children, such as racial and ethnic minorities and those who live in low-income families, have lower rates.<sup>23</sup>

Further, many children, from all types of backgrounds, delay their immunizations and are therefore susceptible to disease – and a risk to other children – for a period of time. For example, more than 24% of toddlers in the United States are missing one or more recommended immunizations. These children are vulnerable to serious illnesses, including polio, measles, mumps, rubella, diphtheria, tetanus, pertussis, invasive *Haemophilus influenzae* type b infection, hepatitis B, and varicella because they have not completed the recommended vaccination series.<sup>24</sup>

**It is critically important to maintain a high vaccination rate in order to prevent a resurgence of potentially deadly infectious disease. For example, if the measles vaccine was no longer available in the United States, 3 to 4 million measles cases would develop every year, which could result in more than 1,800 deaths, 1,000 cases of encephalitis, and 80,000 cases of pneumonia.<sup>22</sup>**

### Economic Burden

Society benefits when all children receive recommended immunizations. Vaccines are **cost-effective**, and most routine child vaccines are **cost-saving**. The routine childhood vaccination program saves nearly \$10 billion in direct medical costs and \$43 billion in societal costs for every **birth cohort** immunized.<sup>25</sup> Many cost-benefit analyses indicate that vaccination against most common childhood diseases results in large returns on investment: For every dollar spent on vaccination, between \$10 and \$18 are saved in medical and indirect costs.<sup>21, 26</sup>

Most important to payers is the fact that the introduction of new vaccines has led to a substantial and immediate decline in medical spending for some conditions. For example, in 1995, a vaccine to protect against varicella (chickenpox) was added to the routine childhood immunization schedule. Between 1994 and 1995, the year before the vaccine was introduced, the total estimated direct medical cost of varicella hospitalizations and ambulatory visits reached \$85 million. By 2002, the cost of varicella declined to \$22.1 million.<sup>25</sup>

### Prevention Opportunities

To encourage timely immunization, employers should provide coverage for all recommended vaccines at no cost to beneficiaries (i.e., no copays or coinsurance). The Advisory Committee on Immunization Practices (ACIP) provides national recommendations on immunizations. These recommendations change from time to time. For the most up-to-date set of recommendations, visit the ACIP website at: <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.

**All 50 states have some form of school-based immunization requirement. These crucial requirements have greatly contributed to the success of immunization programs in the United States. School-based immunization programs have also reduced racial, ethnic, and socioeconomic disparities in immunization rates.**

### SIDS

Sudden infant death syndrome (SIDS) is defined as the sudden unpredictable death of an apparently healthy infant under 1 year of age, with no detectable cause after a thorough case investigation.<sup>27</sup> SIDS is the leading cause of infant death between 1 month and 1 year in the United States; most deaths happen when infants are between 2 months and 4 months of age.<sup>28</sup>

Infants born to mothers who smoked during pregnancy are twice as likely to die of SIDS than infants whose mothers did not smoke. Approximately 14% of SIDS deaths are caused by prenatal tobacco use; and in 2001, 299 infants died as a result of smoking-induced SIDS.<sup>29</sup> Infants who are exposed to tobacco smoke following birth are also at a greater risk of developing SIDS than other infants.

### Health Impact and Economic Burden

An infant death that leaves unanswered questions causes intense grief for parents and families. Parents may require counseling to overcome feelings of guilt and grief, and they may require extended time off in order to recover from the loss.

### Prevention Opportunities

Employers can help prevent SIDS deaths by educating employees on risk factors for SIDS, including sleeping positions and tobacco use.

- The American Academy of Pediatrics (AAP) recommends positioning infants in the supine position (laying on their back) during the first few months following birth. Placing infants in the prone position (laying on their tummy) is associated with an increased incidence of SIDS. Deaths from SIDS have decreased by more than 40% since 1992, which is when the American Academy of Pediatrics (AAP) recommended that caretakers place infants on their backs.<sup>14, 30</sup>
- Tobacco use treatment is critical for preconception, pregnant, and postpartum women. Approximately 21% of childbearing-age women smoke in the United States; and, depending on demographic factors, between 11% and 14% of pregnant women smoke.<sup>31</sup> Tailored smoking cessation programs are proven to help women reduce or eliminate their tobacco use, and tobacco cessation treatment for pregnant women is considered one of the most cost-saving preventive services. Clinical trials have shown that \$6 are saved in healthcare costs for every \$1 invested in treatment.<sup>32</sup>

**Employers should offer comprehensive tobacco use treatment benefits (screening, counseling, and medication); and instruct their health plans to actively educate pre-conception and pregnant women on the dangers of tobacco use and available treatment services.**

### Asthma

Asthma is a chronic inflammatory disorder of the large and small airways. It is classified in four ways: mild intermittent, mild persistent, moderate persistent, and severe persistent. Nobody knows exactly why some children develop asthma. It may be inherited, and it is usually associated with allergies.<sup>14</sup> Asthma affects approximately 6.3 million children in the United States and is the most frequent underlying cause of chronic disease in children.<sup>22</sup> The rate of asthma is increasing population wide, and the death rate among children with asthma under the age of 19 has increased 80% since 1980.<sup>33</sup>

## Health Impact and Economic Burden

Asthma is one of the most common and expensive chronic diseases of childhood: chronic asthma is the leading cause of missed school days in the United States, and it is the most common reason for hospitalization among children aged 3 to 12 years.<sup>22</sup>

- Approximately 2.52 million school-aged children were treated for asthma in 1996. Direct medical costs totaled \$1009.8 million dollars (\$401 per child).<sup>34</sup>
- Asthma is responsible for approximately 14 million lost school days each year.<sup>22</sup>
- In 1996, children with asthma experienced an average of 2.48 missed school days. Parents' loss of productivity due to their child's asthma-related absence was \$719.1 million (\$285 per child).<sup>34</sup>

## Prevention Opportunities

Many asthma-related hospitalizations and emergency department visits are avoidable.<sup>22</sup> Appropriate medication and treatment regimens can help children avoid asthma flare-ups and crises. To encourage the appropriate management of childhood asthma, employers should<sup>35</sup>:

- Remove financial barriers to care by reducing or eliminating copays and coinsurance on controller medications and asthma-related office visits.
- Provide comprehensive tobacco use treatment benefits. Women who smoke during pregnancy are more likely to deliver infants with respiratory problems, including asthma, and parents who smoke in their homes are more likely to have children that suffer from asthma.
- Consider providing coverage or subsidizing non-medical devices and equipment that are important for asthma management, such as mattress and pillow covers, air vent filters, and dehumidifiers.
- Educate employees on asthma and asthma management at health fairs or as part of health promotion programs.
- Develop innovative incentives to reward treatment compliance.

**As a group, asthma, pneumonia, and acute bronchitis are responsible for nearly \$3 billion dollars in healthcare expenditures each year.<sup>22</sup>**

## Upper Respiratory Infections

The most common types of upper respiratory tract infections (URIs) in children are: nasopharyngitis, pharyngitis, tonsillitis, influenza, and otitis media.<sup>14</sup>

- Respiratory infections are the most common reason for acute illness in children.<sup>36</sup>
- Children from age 3 months to 18 years develop approximately six to ten colds a year.<sup>22</sup>
- Infants and young children, particularly children from 6 months to 3 years of age, develop more severe respiratory tract infections than older children.<sup>14</sup>

## Health Impact

Respiratory infections cause pain and discomfort for children, result in restricted activity days or missed school days, and are easily transmitted to other children and adults. Children who develop respiratory infections during infancy are also at greater risk of developing bronchial obstruction during their first 2 years, and asthma at 4 years of age.<sup>37</sup>

## Economic Burden

In addition to direct medical costs, URIs result in lost productivity and absenteeism costs for employers. Studies suggest that parents lose 1.2 hours of work each time their child under the age of 12 gets a cold.<sup>38</sup> In total, children's colds are responsible for \$230 million dollars of lost productivity each year.<sup>38</sup>

### Prevention Opportunities

Children with URIs are frequently treated with antibiotics, despite the fact that antibiotics are not indicated for such infections. Treating children with URIs with antibiotics can be harmful because it<sup>22</sup>:

- Decreases the effectiveness of currently prescribed antibiotics against bacterial respiratory organisms.
- Increases the child's risk of developing a drug-resistant URI.

Despite the known dangers of using antibiotics to treat URIs, \$227 million dollars were spent in 1998 for antibiotics used to treat 7.4 million patients (children and adults) with URIs.<sup>22</sup> Employers should educate their beneficiaries on the appropriate use of antibiotics, and should work with their health plans and pharmacy benefit managers (PBMs) to develop strategies to curb inappropriate prescription patterns.

Employers also have opportunities to help prevent the spread of URIs through employee education. For example, employers could provide prevention information in new parent classes, in existing health promotion programs, at health fairs, in open enrollment materials, or at the worksite. These materials should remind parents to teach their children to<sup>14</sup>:

- Thoroughly wash their hands.
- Use a tissue to cover their noses and mouths when coughing and sneezing.
- Put soiled tissues into a wastebasket.
- Avoid sharing cups, spoons, dishes, and towels with other children and adults.
- Avoid other children who are ill.

### Injuries (Children and Adolescents)

#### Childhood Injuries

**Unintentional injury** is the leading cause of death for children 1 to 4 years of age. In 2000, unintentional injury caused nearly 41% of all deaths among children aged 5 to 9 years. Fifty-six percent (56%) of these injuries resulted from motor vehicle crashes.<sup>39, 40</sup>

#### Adolescent and Young Adult Injuries

Unintentional injury is also the leading cause of death for children 10 to 24 years of age.<sup>40</sup> Among young people aged 10 to 24 years, 16,989 died as a result of unintentional injuries in 2004, representing 45.5% of all deaths in this age group. Seven out of 10 of these deaths resulted from motor vehicle crashes. Other unintentional injuries included poisoning, drowning, fires/burns, and falls.

#### Health Impact and Economic Burden

Injuries seriously impact the lives of children and their families. Injuries can result in long-term health problems, severe disabilities, and even death. In addition, childhood injuries cause enormous economic losses for families, employers, and society as a whole. Lost productivity is a major cost of injury. When children and adolescents are injured, parents may be forced to stay home from work to care for their child. This affects both the family's income and the employers' profit. Children, disabled from an injury, may be unable to work in the future.

**Over 780,000 youth aged 10 to 24 were treated in emergency rooms for injuries sustained from violence in 2004.**<sup>41</sup>

Injury costs can be separated into resource and productivity costs.

- Resource costs relate to caring for injury victims and managing the aftermath of injury incidents. They are dominated by the medical costs of injuries.
- Productivity costs value wage work and housework that children and adolescents will be unable to do because of their injury, as well as the work that parents or other adults forego to care for injured children.

Unintentional injuries to children aged 0 to 19 years that occurred during 1996 imposed \$81 billion in lifetime resource and productivity costs. Children who experienced injuries in this year lost approximately 2.6 million quality-adjusted years of life. Economic losses averaged \$1,060 per person and were highest among adolescents.<sup>42</sup> Similarly, injuries experienced by children aged 0 to 14 years in 2000 resulted in total lifetime costs of more than \$50 billion.<sup>43,44</sup> These estimates include medical expenses and lost productivity costs.

Five injury causes account for nearly 80% of lifetime resource and productivity costs.<sup>42</sup>

- Falls.
- Motor vehicle crashes on public roads.
- Other motor vehicle or cycle crashes.
- Victims struck by or against something.
- Cutting or piercing.

### Prevention Opportunities

Fortunately, most injuries among children can be prevented if parents and caretakers follow simple guidelines for each age group. For example, the consistent use of car seats in automobiles is essential for the safety of young children. Many adolescent injuries can be prevented through education and risk-reduction counseling. Employers have opportunities to educate parents on safety guidelines. Employers also have the opportunity to support injury prevention guidance in the healthcare setting through benefit design and communication.

## Adolescents

As children grow into adolescents they experience rapid physical, cognitive, and emotional changes. In fact, the rate of growth in adolescence is second only to the rate of growth in infancy. Due to rapid physical and mental changes, many health-damaging behaviors (e.g., smoking) and health problems first emerge during adolescence. For these reasons, preventive healthcare is particularly important during adolescence.

### Well-Child Care for Adolescents

Annual preventive healthcare visits (well-child care) are recommended for adolescents aged 11 to 21 years.<sup>15</sup> Despite the recommendation that older children and adolescents should have one preventive visit per year, only 68.3% of children aged 10 to 14 years and 63.8% of children aged 15

**Approximately 25% to 30% of adolescents are considered at risk of adverse health outcomes based on the reported prevalence of health-damaging or risk-taking behaviors (e.g., smoking, driving without a seatbelt, binge drinking).**

to 17 years received a well-child visit in 2005.<sup>45</sup> In fact, only three quarters (73%) of adolescents see a primary care provider at least once a year for any reason.<sup>46</sup> Adolescents who miss preventive healthcare visits may go untreated for health and developmental problems, delay necessary immunizations, and miss opportunities to receive risk-reduction and healthy lifestyle counseling.<sup>47, 48</sup>

Risk-reduction and healthy lifestyle counseling is particularly important for adolescents because the behaviors adolescents practice can have a profound effect on their current and future health. Experimenting with tobacco, alcohol, or drugs, or engaging in risky sexual behaviors can create long-term or even permanent health problems.<sup>49</sup> Positive health behaviors such as taking precautions to prevent injury, choosing healthy foods, and getting regular exercise can help an adolescent set the stage for a lifetime of good health.

The American Medical Association (AMA), American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) all recommend that adolescents receive health education and risk-reduction counseling services during the course of well-child care. Health education counseling can help adolescents<sup>50</sup>:

- Prevent injuries (through seat belt use);
- Reduce their risk of heart disease and diabetes later in life (through tobacco cessation, good nutrition, and adequate exercise); and
- Prevent or reduce certain risky behaviors (such as unsafe sexual behaviors).

### ***The Cost of Adolescent Health Problems***

Each year in the United States, at least \$33.5 billion is spent on preventable adolescent health problems. This estimate only includes direct medical costs associated with six adolescent health problems: unintended pregnancy, sexually-transmitted infections, alcohol and other drug use, motor vehicle injuries, other unintentional injuries, and outpatient mental health visits. When the long-term costs of preventable adolescent health problems are included, the estimate increases to over \$700 billion a year.<sup>46, 51</sup> Long-term costs include:

- The value of lost productivity and workdays due to illness.
- Disability.
- Premature death.
- Legal costs associated with crime and risky behaviors.
- The cost of treating pelvic inflammatory disease and infertility due to sexually transmitted infections (STIs).
- Societal costs associated with adolescent pregnancy and childbirth.

These analyses do not include the costs of treating many other preventable conditions such as measles or tuberculosis; nor do they account for the costs of failing to diagnose health problems such as dental caries, asthma, depression, or diabetes until they develop into much larger, more costly problems.

The most serious, costly, and widespread adolescent health problems – unintended pregnancy, sexually transmitted infections, violence, suicide, unintended injuries, and the use of alcohol, tobacco, and other drugs – are potentially preventable. In fact, nearly three quarters of adolescent mortality is due to preventable causes.<sup>46</sup>

Cost-effectiveness studies that document the savings associated with well-child care and clinical preventive services for adolescents are limited. However, many experts believe that risk identification and behavior change counseling have a significant effect on adolescent health and healthcare costs. For example, the American Academy of Pediatrics (AAP) estimated that it would have cost \$4.3 billion to provide comprehensive clinical preventive services to all 10- to 24-year-olds in 1998. If these services could prevent just 1% of the \$700 billion in preventable long-term costs explained above (i.e., \$7 billion), the provision of preventive care would “save” more than \$2.7 billion in healthcare costs, even after subtracting the amount required to provide preventive services to all adolescents.<sup>51</sup>

## Adolescents: Key Health Risks

### *Mental Health*

Research studies suggest that between 14% and 20% of children and adolescents - about 1 in every 5 - have a diagnosable mental, emotional, or behavioral disorder. An estimated 10% of children have a disorder severe enough to cause some form of impairment and 5% to 7% of children have a severe emotional disturbance (SED) that causes extreme functional impairment.<sup>53</sup>

**Most mental illnesses begin in childhood or adolescence. Half of all individuals who have a mental illness during their lifetime report that the onset of symptoms occurred by age 14, and three fourths report that symptoms appeared before they turned 24.<sup>52</sup>**

Anxiety disorders, mood disorders (such as depression), and disruptive disorders (such as attention-deficit/hyperactivity disorder) are the most common mental or behavioral disorders among children and adolescents. Depression affects 1% to 2% of school-aged children and 3% to 8% of adolescents.<sup>54</sup> Eating disorders and substance abuse disorders also affect adolescents.

Children and adolescents from all backgrounds experience mental health problems.

Adolescents are at greater risk for developing mental health problems when certain factors occur in their lives or environments, these factors include:

- Alcohol and other drug use.
- Discrimination.
- Emotional abuse or neglect.
- Exposure to violence.
- Frequent relocation.
- Harmful stress.
- Loss of a loved one.
- Physical abuse.
- Poverty.
- Trauma.

### **Eating Disorders**

Teens' food choices are often influenced by social pressures to be thin, the desire to gain peer acceptance, or to assert independence from parental authority. A teenager with an eating disorder diets, exercises, and/or eats excessively as a way of coping with physical and emotional changes. The three most common types of eating disorders are anorexia, bulimia, and binge eating.

Treatment for adolescent mental health problems typically includes individual or family talk therapy (psychotherapy), and psychotropic medication. The use of psychotropic medications has dramatically

increased over the past two decades, and medication has become the predominant form of treatment for both adults and children with mental illness. The rate of antidepressant use among children under the age of 18 increased 66% between 1998 and 2002.<sup>55</sup>

### Health Impact

Mental, emotional, and behavioral disorders are common problems that adversely affect the lives of millions of American children and their parents. These disorders disrupt a child's family life, decrease his/her ability to learn, and impede making friends and social contacts. Resulting problems can include:

- Poor peer relationships.
- Increased risk of substance abuse.
- Increased risk of suicide.
- Increased risk of delinquency and violence in adolescence and adulthood.

### Teen Suicide

Suicide, the third leading cause of death for adolescents in the United States, accounts for 11.2% of all adolescent and young adult deaths. In 2003, 4,232 youth aged 10 to 24 years took their own lives. Eighty-six percent (86%) of these suicides occurred among males, and 54% involved a firearm. For every teen suicide death, there are 10 other teen suicide attempts.<sup>57</sup>

Unless properly diagnosed and consistently treated, children and adolescents with mental health and behavioral problems are at risk for more serious disorders or co-occurring disorders that can become disabling in adulthood.<sup>56</sup> Untreated mental illness is also a major risk factor for suicide.

### Economic Burden

The economic burden of mental, emotional, and behavioral disorders among youth includes direct medical costs (e.g., prescription antidepressants, counseling visits, hospitalization); and indirect costs such as lost productivity, disability and work loss, special education, and criminal justice system costs. Mental, emotional, and behavioral disorders among youth also result in lost work time for parents. Such disorders can lead to stress, **work cut-back**, absenteeism, and in certain instances, an early exit from the workforce.

Each year an estimated \$11.8 billion is spent on treating mental illness, behavior problems, and emotional disturbances among children aged 1 to 18 years. Roughly half of this cost (\$6.9 billion) is for the treatment of adolescents aged 13 to 18 years.<sup>58</sup>

Children with mental, emotional, and behavioral disorders have higher medical claims than their peers, even peers with other serious health problems. For example, children with depression average \$3,795 in healthcare expenditures, more than five times the amount of children without a mental illness (\$754). Children with depression also use significantly more emergency room and inpatient care services than their peers.<sup>59</sup>

### Prevention Opportunities

Mental, emotional, and behavioral disorders are most effectively treated when they are addressed early. Unfortunately, two-thirds of young people with mental health problems do not get the help they need.<sup>60</sup>

Employers can assist employees who are parents of children with mental, emotional, and behavioral disorders by providing robust mental health benefits; providing employee assistance services; offering education opportunities; and providing flexible work arrangements, when feasible.

**Two-thirds of young people with mental health problems do not get the help they need. Untreated mental health problems can lead to school failure, family conflicts, substance abuse, violence, and even suicide.**

To address the needs of families, employers should:

- Provide comprehensive mental health benefits, including inpatient and outpatient care, prescription medications, and specialty services for the seriously mentally ill. Mental health benefits should be equal to physical health benefits (i.e., there should not be day or visit limits on mental health services).
- Consider adding specialty mental health services for children with serious emotional disturbance, such as therapeutic nursery care.
- Consider adding early intervention services for mental health and substance abuse problems. This typically includes health plan coverage for the treatment of sub-clinical conditions and DSM-IV V-code conditions. Please refer to the Plan Benefit Model (Part 2) for additional information.
- Provide employee assistance services and educate beneficiaries on the services available. Most EAPs provide short-term counseling services. Other helpful benefits include:
  - Childcare referrals.
  - Referrals to family network or support group organizations.
  - Referrals to mental health providers for ongoing specialized care.
- Consider adding information on child and adolescent mental health to existing health promotion, wellness, and health education programs. Discussing mental health issues reduces stigma, helps link families with care services, and provides support for families struggling with mental health problems. For example, find a way to recognize national mental health and substance abuse awareness days and months (i.e., National Depression Screening Day or National Alcohol & Drug Addiction Recovery Month).

### Substance Use and Abuse

Substance abuse refers to the abuse of alcohol, illicit or prescription drugs, or both. Approximately 22.5 million Americans aged 12 years and above experienced a substance abuse or substance dependence disorder in 2004. In 2005, 1.5 million youth (5.8%) aged 12 to 17 years had a drug or alcohol problem severe enough to require specialized treatment; yet only 119,000 (8.1%) received treatment.<sup>61</sup>

Substance	Rate of Use by Age, 2005			
	12-13 years	14-15 years	16-17 years	18-20 years
Alcohol use	4.2%	15.1%	30.1%	51.1%
Binge drinking	2.0%	8.0%	19.7%	36.1%

**Source:** Substance Abuse and Mental Health Services Administration. *Results From the 2005 National Survey on Drug Use and Health: National Findings*. Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006.

### Health Impact

Substance abuse contributes to a wide range of health problems, including HIV, hepatitis C, suicide and depression, motor vehicle-related injuries, birth defects, and many other problems. For adolescents, it is also a particular risk factor associated with sexual activity and unintended pregnancy. Due to their developing bodies and brains, children and adolescents are also particularly susceptible to some of the negative effects of alcohol and substance abuse.

- Alcohol use contributes to the three leading causes of death for 15- to 24-year-olds: motor vehicle-crashes, homicides, and suicides.<sup>62</sup>
- Alcohol abuse is the third leading preventable cause of death in the United States (4% of the total deaths in 2000); and it is a factor in approximately 41% of all deaths from motor vehicle crashes.<sup>63</sup>
- In 2005, an estimated 8.3% of 16- to 17-year-olds, 19.8% of 18- to 20-year-olds, and 27.9% of 21- to 25-year-olds reported driving under the influence of alcohol at least once during the past year. Males were nearly twice as likely as females (17.1% vs. 9.2%) to report drunk driving.<sup>61</sup>

Mental illness and substance abuse are intertwined. Many people with undiagnosed mental or emotional disorders ‘self-medicate’ with alcohol or drugs in order to control or escape their thoughts or feelings.<sup>64-66</sup> Some researchers and clinicians also believe that mental health and substance abuse problems have common underlying genetic and environmental causes.<sup>64</sup>

Substance	Rate of Use by Age, 2003	
	12-17 years	18-20 years
Any illicit drug	11.2%	23.3%
Marijuana	7.9%	
Prescription drugs	4.0%	
Inhalants	1.3%	
Hallucinogens	1.0%	
Cocaine	0.6%	

**Source:** Substance Abuse and Mental Health Services Administration. *Results From the 2003 National Survey on Drug Use and Health: National Findings.* Office of Applied Studies, NSDUH Series H-25, DHHS Publication No SMA 04-3964. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004.

### Substance Use: Quick Facts<sup>57</sup>

- Initiation of substance use most often occurs between grades 7 and 10.
- Alcohol is the most commonly used substance among students.
- One in five 12th graders smokes cigarettes daily.
- Marijuana is the most widely-used illicit drug among adolescents.

### Economic Burden

The economic burden of adolescent substance abuse is significant for employers, families, and communities. Employers pay for the direct medical costs associated with substance abuse, they also bear the lost productivity costs that result when parents take time off work to care for an affected child. Much of the direct cost of adolescent substance abuse results from injuries. For example, in 2004, 142,701 alcohol-related emergency department visits were made by patients aged 12 to 20 years.<sup>67</sup>

### Prevention Opportunities

Employers can help address adolescent drinking and drug use through benefit design, employee education, and support services.

- Employers should provide substance abuse treatment benefits for all beneficiaries, including coverage for inpatient detoxification and outpatient drug and alcohol programs.

- Employee education can help parents learn how to raise a drug-free child. EAP, health promotion, or wellness programs can provide a venue for speaking to employees about healthy parenting techniques. Research shows that parents and siblings are a major influence in a teen's decision to start or increase drug or alcohol use. In fact, teen perceptions of immorality, parental disapproval, and harm to health are far more powerful deterrents to teen smoking, drinking, and drug use than legal restrictions on the purchase of cigarettes and alcohol, or the illegality of using drugs like marijuana, LSD, cocaine, and heroin.<sup>68</sup>
- Existing EAP services can help employees cope with the stress of adolescent substance abuse. Employers should consider working with their EAP to better communicate existing services (e.g., legal advice, family counseling services) that are available to help families struggling with substance abuse.
- If support services aren't feasible internally, consider developing a list of community resources that could help employees cope with substance abuse and the effects it has on families.

### **Obesity and Physical Activity**

Data from the National Health and Nutrition Examination Survey (NHANES 2003-2004), indicates that 17% of children and adolescents aged 2 to 19 years in the United States are overweight or obese. Obesity is an epidemic in the United States: between 1976 and 2002 the proportion of children (aged 6 to 11 years) classified as obese doubled and the proportion of overweight adolescents (aged 12 to 19 years) tripled.<sup>69</sup> Adolescents are considered overweight when their BMI is at or above the 95th percentile on a sex-specific age/growth chart.

### **Health Impact**

Poor eating habits during the teen years may lead to both short- and long-term health consequences including obesity, osteoporosis, and sexual maturation delays.<sup>70</sup> Sustained obesity puts adolescents and young adults at high risk for several chronic diseases including hypertension, type II diabetes, and cardiovascular disease.

**Poor eating habits during the teen years may lead to both short- and long-term health consequences including obesity, osteoporosis, and sexual maturation delays.**

Poor diet/physical inactivity is overtaking tobacco as the leading cause of death in the United States. The Centers for Disease Control and Prevention (CDC) estimates that 15.2% of all deaths in the United States are caused by poor diet and a lack of physical activity: in 2002, 365,000 deaths were attributable to overweight and obesity.<sup>71</sup>

### **Economic Burden**

The economic burden of obesity in the United States is substantial. In 1998, 9.1% of all medical expenditures could be attributed to obesity.<sup>43</sup> The annual cost of obesity (direct and indirect costs) is estimated to range from \$69 billion to \$117 billion in year 2000 dollars.<sup>72</sup> These costs include healthcare expenditures for children, adolescents, and adults.

### **Prevention Opportunities**

Employers have many opportunities to help their employees raise healthy-weight children. Some ways your company can address child and adolescent obesity are listed below.

### *Education and Health Promotion*<sup>73</sup>

- The most important overweight prevention for babies and toddlers is breastfeeding.<sup>74</sup> Include the benefits of breastfeeding in prenatal programs and support new mothers in breastfeeding when they return to work.
- Encourage employees to engage in healthier eating habits and more active lifestyles. When parents set good examples, it will be easier for children to reach their health goals.
- Increase awareness of unhealthy behaviors and environmental factors that can stimulate overeating. Provide information on healthy eating habits that can help parents monitor and control the type and amount of food children are eating.
- Distribute nutrition and physical activity educational materials during open enrollment.
- Reimburse employees for gym memberships or facilitate participation in on-site programs
- Offer family-centered weight loss and maintenance classes.
- Fund or provide subsidies through health reimbursement accounts (HRAs) for employees who achieve weight goals.

For more information on tailoring health promotion and disease management programs to meet the needs of children and adolescents, please refer to Fact Sheet #2 in Part 5.

### *Health Benefit Coverage*<sup>73</sup>

- Provide coverage for obesity screening, counseling, and treatment.
- Provide coverage for nutrition counseling.
- Ensure that network providers screen children and adolescents for overweight and obesity during well-child care. Screening can help identify children who are at risk for becoming overweight and can help identify those who may need further assessment or treatment for a weight problem.

### *Unintended Pregnancy*

In the United States, one out of every eight women aged 15 to 19 years becomes pregnant each year. Eighty-five percent (85%) of these pregnancies are unintended, meaning that they are either unwanted or mistimed.<sup>75</sup> Despite a declining teen pregnancy rate, more than four in 10 adolescent girls become pregnant at least once before reaching 20 years of age.<sup>49</sup>

### **Health Impact**

Approximately 51% of adolescent pregnancies end in live births, 35% end in induced abortion, and 14% result in miscarriage or stillbirth.<sup>75</sup> Pregnancies that are carried to term are at-risk for poor outcomes due to a variety of factors, including:

- **Age.** Very young girls are at risk for a host of pregnancy-related complications.
- **Baseline health status.** Women of all ages who experience an unintended pregnancy are less likely to practice healthy preconception behaviors (e.g., eliminating alcohol use, taking folic acid) and are thus at an increased risk for birth defects and other problems.
- **Co-occurring risks.** Girls who experience an unintended pregnancy are also at a higher risk of substance abuse and STIs, both of which are risk factors for poor pregnancy outcomes.

## Economic Burden

The social and economic consequences of teenage pregnancy are substantial. Each year unintended pregnancy among adolescents costs more than \$1.3 billion in direct healthcare expenditures. Induced and spontaneous abortions among teenagers cost more than \$180 million each year.<sup>75</sup>

Unplanned pregnancies, compared to planned pregnancies, often result in higher total medical claims because women whose pregnancies are unintended are less likely to take folic acid supplements or to breastfeed, and are more likely to continue smoking during pregnancy. The poor health outcomes associated with these behaviors lead to higher obstetric claims.<sup>76,77</sup>

Parents may also lose work time in order to care for their pregnant child and/or their grandchild after it is born. The stress of an unplanned adolescent pregnancy may also reduce an employee's productivity, and lead to stress or depression.

## Prevention Opportunities

In order to reduce unintended pregnancy, employers should provide comprehensive contraception coverage for employees and dependents. Employers should also consider removing cost barriers by eliminating cost-sharing requirements on contraceptive medications, devices, procedures, and office visits. Expanding coverage and removing cost barriers is particularly important for adolescents because many can not afford to pay for contraceptives out-of-pocket.

All methods of contraception are cost-saving from the societal perspective and most are also cost-saving from the private-payer perspective. For example, after one year of use, private-sector savings from adolescent contraceptive use range from \$308 (implant) to \$946 (male condom).<sup>75</sup>

## Sexually Transmitted Infections

Each year, approximately 4 million teens in the United States - one in four sexually active teens - get a sexually transmitted infection (STI).<sup>60</sup> Many STI's can be cured; others have treatable symptoms, but cannot be cured.

- Genital chlamydia is the most common bacterial STI in the United States, and 46% of newly reported infections occur in sexually active 15- to 19-year-old girls.<sup>78</sup>
- Human papillomavirus (HPV), previously termed genital or venereal warts, is a sexually transmitted viral infection. Treatment of genital warts does not eradicate the disease. An estimated 24 million Americans are infected with HPV, and as many as 1 million new infections occur annually. A vaccine to prevent HPV was recently released in the United States and is recommended for all women aged 9 to 26 years.<sup>79</sup>
- Other STIs include: gonorrhea, syphilis, herpes simplex virus, and hepatitis B.

## Health Impact

STIs can cause pain and discomfort, and some can lead to long-term health problems. Young women who go untreated for an STI are two to five times more vulnerable to long-term diseases such as sterility and certain cancers that may not appear until years after the initial infection.<sup>80</sup> Infection with some STIs also increases a person's susceptibility to other STIs, including HIV.

### Economic Burden

In 2000, 9 million new STI infections occurred among adolescents and young adults; these infections resulted in \$6.5 billion in direct healthcare costs. HIV and HPV were the most costly STIs, and accounted for 90% of the total economic burden of all STIs.<sup>81</sup>

### Prevention Opportunities

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians routinely screen all sexually active females age 25 and younger for chlamydia, all sexually active at-risk women for gonorrhea, and all men and women at risk for HIV and syphilis.<sup>82</sup> The Centers for Disease Control and Prevention (CDC) recommends that all people between the ages of 13 and 64 be screened at least once during their lifetime for HIV.<sup>83</sup>

Screening for STIs is particularly important because many STIs do not cause detectable symptoms until the disease is advanced. Despite the importance of screening, screening rates remain unacceptably low: Only one-third to one-half of primary care physicians report regularly screening sexually-active young women for STIs.<sup>84-86</sup>

In general, screening at-risk adolescents and adults for STIs is either cost-saving or cost-effective.<sup>82</sup>

Employers can support STI prevention, early detection, and treatment by offering robust clinical preventive service benefits, reducing cost barriers, and educating beneficiaries on the importance of sexual health.

- Health benefits should include primary care counseling to prevent STIs, screening to detect STIs, and treatment.
- Employers should instruct their health plans to actively educate providers on the importance of screening at-risk adolescents. The benefits of screening should be regularly communicated to plan participants.

**The USPSTF and the CDC recommend that all sexually active women under the age of 25 be screened for chlamydia annually. Yet seven out of 10 sexually active 16- to 20-year-old females enrolled in managed care plans did not receive a test for chlamydia or other genital infection in the past year.<sup>60</sup>**

## Children with Special Health Care Needs

**Children with special health care needs (CSHCN)** are children “who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”<sup>2</sup> CSHCN have a wide range of physical, mental, emotional, or behavioral disorders including congenital anomalies, severe physical disabilities, complex organ system disease such as cystic fibrosis, sickle cell anemia; and more common conditions, including depression and severe asthma.

Nationwide, more than 9.3 million children—12.8% of all children under the age of 18—have a special need.<sup>2</sup> One in five households with children in the United States includes at least one child with a special health care need and, in any given company, it is estimated that 8.6% of employees care for a child with a special need.<sup>12</sup>

The prevalence of special health care needs increases with age. Only 8% of children under the age of 5 years have an identified special need, whereas 14.6% of children aged 6 to 11 years and 15.8% of adolescents aged 12 to 17 years have a special need.<sup>2</sup>

**The majority of children with special needs (61.6%) are covered by employer-sponsored health plans.<sup>87</sup>**

### **Healthcare Costs**

In 2000, national healthcare expenditures for children and adolescents totaled \$67 billion. Although children with special health care needs make up less than 20% of the population, they account for 41% of all child health expenditures.<sup>5</sup> In fact, medical expenses for children with special needs are over double the cost of children without chronic problems.<sup>5</sup>

### **Unique Problems and Concerns**

Children with special health care needs are an important part of an employer's beneficiary population because they:

- 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 and require additional office visits and hospitalizations than other children, which results in lost productivity and absenteeism for their parents.

### **Healthcare Concerns**

Access to adequate health care is critical for families caring for a child with a special need. By definition, CSHCN require healthcare services of a different type, intensity, or scope than their peers. Children with chronic conditions enrolled in employer-sponsored health coverage programs typically face high deductibles and cost-sharing (due to their increased service use). Many also face annual or lifetime limits on their benefits. Further, many traditional employer plans use a definition of "medical necessity" that excludes treatment for congenital anomalies, rehabilitation for developmental delays, and other services critical for CSHCN.<sup>87</sup> These barriers prevent children with special needs from accessing necessary care. In order to maximize the range of covered services and minimize out-of-pocket costs, some families of CSHCN pursue a strategy of double coverage, or joint private-public coverage.<sup>12</sup>

**The Maternal and Child Health Benefits Advisory Board developed a new definition of "medical necessity" that addresses the unique needs of children, including those with special needs. For more information, please refer to the Plan Implementation Guidance Document in Part 2.**

### **Work-Life Balance Concerns**

Most employed parents worry at times about their children, and thus are sometimes less efficient on the job. However, employed parents of children who are very ill or disabled deal with constant and often intensive stress, both at work and at home. Such pressures can limit parents in their ability to function at work. In extreme cases, parents may be forced to cutback their hours or leave the workforce altogether in order to provide full-time care for their child.

Some of the stresses that cause parents to lose productive work-time, cut back on their hours, or leave the workforce include the following<sup>12</sup>:

- Physically caring for a sick child, which can cause exhaustion, illness, and higher medical claims.
- Worrying about the well-being of the child, which may result in a mental health problem such as depression.
- Finding quality childcare services.
- Making numerous telephone calls to healthcare providers for appointments or guidance; taking the child to appointments with care providers and for various procedures.
- Consulting with the child's teachers about the child's educational needs.
- Assisting the child through hospitalizations and following discharge.
- Working with other family members to provide the child with as much support as possible.

### **The Business Case for Work/Life Benefits**

Research has shown that work/life supports on the job are related to positive work outcomes for parents of children with special needs. Positive work outcomes include: increased job satisfaction, a stronger commitment to the employer, and improved retention.<sup>12</sup>

**Parents of children with chronic health conditions experience greater financial hardship, reduced employment, poorer mental health, and increased stress compared to the parents of children without special needs.<sup>12</sup>**

Key components of a supportive workplace for employees with CSHCN include an understanding and supportive supervisor, comprehensive health coverage, work schedule flexibility, an employee assistance program (EAP), and access to childcare.<sup>12</sup>

Health and work/life benefits can assist employees dealing with special needs issues. Benefits important to employees who have children with special needs include<sup>12</sup>:

- Comprehensive and affordable health insurance.
- Flexible work arrangements and use of leave time.
- Supportive work environments.
- Clear and accessible information about company benefits and how to access them.
- Information about community resources and services and public benefit programs.

### **Employer Actions** 6, 12, 88

What can employers do to assist employees who care for children with special needs? Below is a summary of some important steps that companies can take to support families with CSHCN.

**Supporting families caring for CSHCN can be accomplished without adding new benefits. Programs and benefits exist in many companies that can be adapted for families at no cost, or very low cost – such as flexible work arrangements.**

### **Provide comprehensive healthcare benefits:**

- Services that may be particularly important to CSHCN include:
  - Durable medical equipment and medical foods.
  - Home health services.
  - Mental health services.
  - Dental care.
  - Vision care.
  - Laboratory and diagnostic testing.
  - Prescription drugs.
  - Educational testing/screening and interventions.
- Review your company's cost-sharing, flex benefit, and case management policies and programs and make sure they support children with special health care needs. If cost barriers are a problem in your population, consider reducing or eliminating copays/coinsurance on essential care services, prescription drugs, etc.
- If your company doesn't already offer child-tailored disease management programs, ask your vendors how they can better address the needs of children and adolescents in existing programs.

### **Clearly communicate benefits and solicit input from employees:**

- Have health plan customer service agents or member services representatives teach employees with children who are ill about healthcare benefits that apply specifically to their situation.
- Provide all employees with information on relevant benefits such as FMLA, sick leave policies, and health benefits.
- Establish an employee resource or a company-wide diversity council that regularly meets to give input on policies and benefits.
- Consider including parents of special needs children in benefit design discussions for particular topics (e.g., autism benefits).

### **Provide flexible work environments:**

Flexibility is essential for employees struggling with the unpredictability of multiple medical conditions and numerous healthcare appointments. Flexibility is possible in most jobs; however, it may require employees and managers to work together to find the right solution.

- Develop policies that allow emergency time off, shift trades, and flexible hours.
- Allow employees to use paid time off (PTO), paid sick time, or incidental absence days to care for their child.
- When flexible work arrangements are possible, allow employees with ill children to work from home or even from a child's hospital room if necessary.
- Start a childcare program at the workplace, if feasible. Remember that childcare programs can reduce job turnover by 37% to 60%. If your company already provides on-site childcare, consider offering special needs education and training to company-sponsored childcare staff.
- Provide employees with a quiet room they can use during breaks to contact healthcare providers, teachers, and childcare providers.

### **Tailor EAP and health promotion programs:**

- Provide childcare resource and referral services to employees either through an internal or outsourced EAP or partnership with nonprofit referral agency in the community. Ensure that

your company's resource and referral vendor offers access to a childcare database of providers with special needs expertise.

- Consider adding special needs issues to existing health promotion and wellness programs.
- Provide information to employees on your State's Title V Children with Special Health Care Needs Program.

### **Educate management on the issue:**

- Provide executives, supervisors, and human resources staff with information about: (a) CSHCN, (b) the physical and emotional impact of caregiving on parents, and (c) the special problems employees with very sick children face as they juggle home and work responsibilities.

### **Provide education and support, when feasible:**

- Create opportunities for employees who have children with special needs to gain support from each other.
- Provide employees with information on local support groups. If there is sufficient demand at the worksite, consider launching a support group by providing meeting space at a company location.
- Conduct seminars in the workplace (after hours) for families of children with special needs on topics such as financial planning, finding appropriate childcare, and managing stress, or refer families to community resources.

## **Summary Points**

- Well-child care is preventive health care for children and adolescents. One of the primary purposes of well-child care is to identify children affected by a physical, mental, or developmental problem as early in life as possible.
- All children face health risks; yet, many child health problems are preventable.
- Child and adolescent illness and injury are a major cause of employee absence and lost productivity. Employers have opportunities to reduce preventable health problems through benefit design, communication, and employee education.
- Children with special health care needs are an important part of an employer's beneficiary population. These children experience complex, chronic, and severe health problems, which can be difficult to manage; they use more healthcare services than other children and thus have higher overall healthcare expenditures; and they experience more sick days than other children, which results in lost productivity and absenteeism for their parents.
- Employees with sick children who receive help and support from their employers are usually better able to concentrate on their jobs, and remain with their companies longer. Employee retention is a key driver of customer retention, which in turn is a key driver of company growth and profit.
- Improving the health of children will likely benefit an employer's bottom line by reducing both direct healthcare costs and indirect costs, such as lost productivity.

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