

Better Health for Mothers and Children: Breastfeeding Accommodations under the Affordable Care Act

By Robert Drago, Ph.D., Jeffrey Hayes, Ph.D., and Youngmin Yi



INSTITUTE FOR
WOMEN'S POLICY RESEARCH

About This Report

This study examines new workplace protections for nursing mothers under federal law. We report current patterns of breastfeeding, and provide the first estimates of coverage rates under the law, as well as the first projections of the likely effect of the new protections on increasing rates of breastfeeding in the United States. The research represents part of a broader body of work undertaken by the Institute for Women's Policy Research on balancing work and family commitments. The research was made possible by grants from the Annie E. Casey Foundation, the Ford Foundation, the Kellogg Foundation, and the Rockefeller Foundation.

About the Institute for Women's Policy Research

The Institute for Women's Policy Research (IWPR) conducts rigorous research and disseminates its findings to address the needs of women, promote public dialogue, and strengthen families, communities, and societies. The Institute works with policymakers, scholars, and public interest groups to design, execute, and disseminate research that illuminates economic and social policy issues affecting women and their families, and to build a network of individuals and organizations that conduct and use women-oriented policy research. IWPR's work is supported by foundation grants, government grants and contracts, donations from individuals, and contributions from organizations and corporations. IWPR is a 501 (c) (3) tax-exempt organization that also works in affiliation with the women's studies and public policy programs at The George Washington University.

Acknowledgments

Many people facilitated this research and provided significant insight into issues surrounding breastfeeding, employment, and relevant legal issues, including Melissa Bartick of the Harvard Medical School and Laurie Bonjo of Old Dominion University. We thank them and we are responsible for any inadvertent errors.

IWPR B292

\$10.00

© Copyright 2010 by the Institute for Women's Policy Research, Washington, DC.

All rights reserved.

Printed in the United States of America.

Board of Directors

Lenora Cole, Chair

University of Maryland University College

Esmeralda O. Lyn, Vice Chair

Hofstra University

Carol Greene Vincent, Treasurer

Pricewaterhouse Coopers LLP

Cynthia Lloyd, Secretary

Population Council

Bill Baer

Bloomingdale's

Mariam Chamberlain

National Council for Research on Women

Bob Corti

Avon Foundation

Ellen Delany

Delany, Siegel, Zorn & Associates, Inc.

Holly Fechner

Covington & Burling LLP

Lynn Gitlitz

Business Development Consultant

David A. Goslin

American Institutes for Research

Ellen Karp

Anerca

Susan Meade

Phillips Oppenheim

Emily van Agtmael

Van Agtmael Interiors

Sheila W. Wellington

New York University

Marcia Worthing

Heidi Hartmann, President

Institute for Women's Policy Research

Barbara Gault, Vice President

Institute for Women's Policy Research

Institute for Women's Policy Research

1200 18th Street NW, Suite 301

Washington, DC 20036

202/785-5100 • 202/833.4362 fax

www.iwpr.org

Table of Contents

List of Figures	i
Executive Summary	iii
Background	1
Breastfeeding, Infant Formula, and Breast Milk Expression.....	1
Employment Is a Barrier	2
Interventions Can Raise Rates of Breastfeeding.....	4
The Affordable Care Act Will Help	4
Rates of Breastfeeding Prior to the Health Care Reform	5
ACA Coverage by Income, Education, Age, and Race/Ethnicity	8
Projected Effects of the ACA on Breastfeeding Rates	12
Further Considerations	14
References	16
Appendix: Data and Methodology	19

List of Figures

Figure 1. Infants Ever-Breastfed, Selected Nations.....	3
Figure 2. Poverty and Breastfeeding.....	6
Figure 3. Education and Breastfeeding	6
Figure 4. Age and Breastfeeding	7
Figure 5. Race/Ethnicity and Breastfeeding	7
Figure 6. ACA Coverage Among Employed Women.....	9
Figure 7. Poverty and ACA Coverage	10
Figure 8. Education and ACA Coverage	10
Figure 9. Age and ACA Coverage.....	11
Figure 10. Race/Ethnicity and ACA Coverage.....	11
Figure 11. Breastfeeding Effects of ACA Coverage Among Employed Mothers.....	13

Executive Summary

Given a choice between breastfeeding and using infant formula, most new mothers select breastfeeding. Employment, however, has often constrained this choice, obliging mothers to use formula. In recent decades, an additional option has emerged: expressing breast milk in the workplace and storing it for later use. This option spares new mothers from having to choose between breastfeeding and employment.

Although no hard numbers are available on the extent of breast milk expression, indirect evidence suggests that the practice is increasingly recognized as viable and valued. Most recently, the U.S. Congress passed, and President Obama signed, the Affordable Care Act of 2010 (ACA), which provides for nursing breaks and a private, sanitary place for most mothers employed on an hourly basis to express breast milk (PPACA 2010).

The new ACA breastfeeding provisions raise several questions that are answered below:

- How many women breastfeed? How is breastfeeding affected by employment? How do levels of breastfeeding and employment differ among mothers across lines of income, education, age, and race/ethnicity?
- How many employed women of childbearing age are covered by the new ACA provisions? Who among the different demographic groups are covered?
- How many mothers are likely to breastfeed an infant through six months of age as a result of the provisions?

Our analysis shows that:

- Women in a relatively weak position in the labor market, including those who are poor, young, do not hold a college diploma, and who are African American, are those who historically have had low rates of breastfeeding, according to data from the U.S. Centers for Disease Control and Prevention (CDC) (National Center for Health Statistics 2010).
- Mothers in similar groups, including those who are poor, young, do not hold a college diploma, or are Hispanic or African American, are most often covered by ACA workplace breastfeeding protections. This first estimate of coverage is based on an analysis of the 2009 Annual Social Economic Supplement (ASEC) to the Current Population Survey (CPS).
- The ACA provisions therefore appropriately target mothers who are most likely to benefit from the provisions.
- An estimated total of almost 19 million employed women of childbearing age are covered by the ACA provisions. That figure is likely an underestimate of effective coverage, given that many salaried women who are not formally covered by this provision in the ACA work alongside hourly workers who are.
- Based on an analysis of the 2009 ASEC data, a first cautious projection of the effects of the ACA on rates of breastfeeding is that an additional 165,000

mothers annually will breastfeed until an infant is at least six months old. Although the estimate represents only a four percentage point increase in rates of breastfeeding among all mothers of infants, more than one million mothers and their children will be affected over the course of the next six years, with attendant health benefits for both mothers and infants. Longer-term effects due to any reduced stigma attached to breastfeeding and breast milk expression could raise these figures.

- Results from an earlier study suggest that slightly more than 25,000 mothers living in poverty do not breastfeed their infants through six months because of stringent work requirements under the Temporary Assistance to Needy Families (TANF) program (Haider, Jacknowitz, and Schoeni 2003, p. 492). Our estimates suggest that an overlapping group of 16,500 mothers living in poverty will likely breastfeed as a result of the ACA provisions, partly redressing some of the effects of welfare reform.

Additional policy options for reducing remaining constraints on the choice to breastfeed are also discussed:

- legalizing breastfeeding in public places,
- introducing health and safety standards for breast pumps, and
- subsidizing breast pumps and breastfeeding counseling and education.

Breastfeeding, Infant Formula, and Expressing Breast Milk

The rise of the infant formula market in the early part of the 20th century provided new mothers with a choice between breast and bottle feeding.¹ In the United States, popular portrayals of infant formula in the 1960s and 1970s cast it as “liberation in a can,” partly because it facilitated a more equal division of household labor between mothers and fathers but also because it made it easier for new mothers to be employed (Galtry 2000, p. 301).

Effectively, there was, and to some extent still is, a line between breastfeeding and employment, as documented below. That line, however, was already breaking down during the 1990s, and perhaps earlier, due to the emergence of a third option: expressing breast milk in the workplace and storing the milk for later use. Although no hard numbers are available on the extent of expressing breast milk, indirect evidence suggests the practice is increasingly recognized as viable and valued. In 1997, the American Academy of Pediatrics (AAP) issued a policy statement that, in part, urged employers to support expressing breast milk at work. A year later, Representative Carolyn Maloney introduced a bill in the U.S. Congress explicitly supporting the practice (Galtry 2000). By 2000, the International Labour Organization (2000) issued a Maternity Protection Convention, which included a provision for paid nursing breaks or reduced work hours to allow new mothers to breastfeed. According to National Survey of Employer data from the Families and Work Institute, the percentage of U.S. employers providing a private space or lactation room for this purpose rose from 37 percent in 1998 to 53 percent in 2008 (Galinsky, Bond and Sakai 2008). Most recently, the U.S. Congress passed, and President Obama signed, the Affordable Care Act of 2010 (ACA), which provides for nursing breaks and a private, sanitary place for many employed mothers to express breast milk.

Recent studies documenting the benefits of breast milk for children, for mothers, and for society at large are central to understanding the ascendance of breastfeeding in general and breast milk expression. Researchers have estimated that if 80 percent of U.S. infants were breastfed exclusively for six months, health care expenditures would decline by \$10.5 billion, and 741 annual infant deaths would be prevented (Bartick and Reinhold 2010). According to the AAP, breastfeeding helps to protect infants from asthma, obesity, diabetes, childhood leukemia, sudden infant death syndrome, and diarrhea, and may lead to better health later in life (AAP 2005). Nursing also improves mothers’ ability to recover from childbirth, and may decrease mothers’ risk of breast cancer, ovarian cancer, type II diabetes, (Ip et al. 2007) and cardiovascular disease (Schwarz et al. 2009). These studies and related public health initiatives motivated

¹ We ignore wet nursing in this report for brevity.

many new mothers to switch from infant formula to breastfeeding, including expressing breast milk at work and storing it to feed her infant at later times.

There is uncertainty regarding the importance of exclusive breastfeeding as opposed to augmenting breast milk with water, baby food, formula, juice, cow's milk, or sugar water. The cost-benefit study mentioned above restricted its analysis to exclusive breastfeeding as part of a careful scientific approach because it is difficult to parcel out health effects when various amounts or degrees of breastfeeding are involved (Bartick and Reinhold 2010). Additionally, the World Health Organization (2002) and the AAP (2005) recommend exclusive breastfeeding as a standard for the care of all infants.

The signature public health initiative in the United States addressing breastfeeding, the Healthy People 2010 (HP2010) initiative from the U.S. Department of Health and Human Services (HHS) (DHHS 2000), initially focused on the value of *any* breastfeeding, regardless of supplementation. Starting from a 1998 baseline wherein 64 percent of new mothers initiated breastfeeding post-partum, 29 percent continued for at least six months, and 16 percent continued for one full year, the HP2010 target for the year 2010 was to raise these rates to 75 percent, 50 percent, and 25 percent, respectively. Partly due to related campaigns to promote breastfeeding, one of the HP2010 targets was met by mid-decade: the percentage of infants who were ever breastfed rose from 60 percent in 1993–1994, to 77 percent in 2005–2006 (CDC 2007). Nonetheless, only 43.5 percent of infants in the United States were at least partially breastfed² for the first six months of life among children born in 2006, and 23 percent were partially or exclusively nursed for an entire year (CDC undated).³ As a practical matter, the original HP2010 emphasis on any breastfeeding is sensible: only one-third of mothers nursing through six months do so with no supplementation.⁴

Employment Is a Barrier

Although the HP2010 goal of raising the proportion of infants ever breastfed was met successfully, it failed to achieve two of the three objectives. One set of reasons for this failure has to do with physical difficulties and health risks involved in establishing or maintaining breastfeeding (DHHS).⁵ For women who confront these issues, breastfeeding may be neither desirable nor possible.

² Exclusive breastfeeding implies that no other foods or liquids are provided to the infant during this period. Note that expressing and storing breast milk is consistent with exclusive breastfeeding.

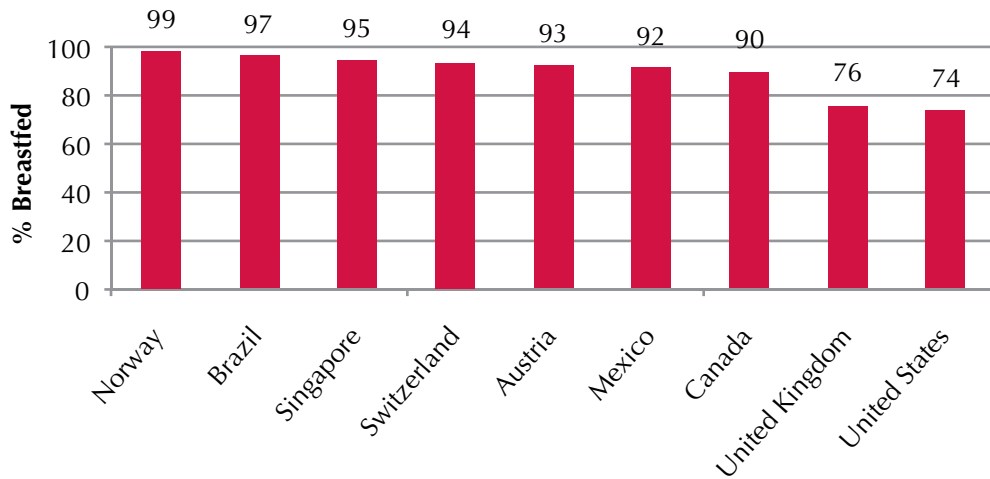
³ Only 22.7 percent of the infants were breastfed for an entire year.

⁴ The CDC figure for any breastfeeding at six months is above 43 percent, whereas the WHO Global Data Bank on Infant and Young Child Feeding reports a figure of only 13.6 percent of U.S. infants being exclusively breastfed through six months. See <http://www.who.int/nutrition/databases/infantfeeding/countries/usa.pdf>. Note that the HHS introduced exclusive breastfeeding targets in 2007, and the target for six months as of 2010 was only 25 percent, half the size of the target for any breastfeeding at six months (CDC 2007).

⁵ Some new mothers may be unable to produce breast milk. The presence of certain health conditions, including HIV or other infectious diseases, might also warrant that the mother not breastfeed.

Nonetheless, the United States exhibits one of the lowest rates of breastfeeding in a sample of nations providing comparable data on whether infants are ever breastfed (Figure 1). It seems unlikely that physical difficulties establishing or maintaining breastfeeding are so different in the United States, implying that some other barrier is relatively unique to the United States.

Figure 1: Infants Ever-Breastfed, Selected Nations



Source: World Health Organization Global Data Bank on Infant and Child Feeding, most recent years available. <<http://www.who.int/nutrition/databases/infantfeeding/countries/en/index.html>>

Research suggests that a key reason for low U.S. rates lies in employment. All of the nations listed in Figure 1 provide paid maternity leave, except for the United States. American mothers who plan to continue their jobs are therefore forced to make a relatively rapid return to employment (McGill Institute for Health and Social Policy 2010). Studies specific to the United States show that rapid return to employment is correlated with stopping nursing. One study found that women employed four months after childbirth breastfed for an average of 18 weeks, compared to a figure of almost 26 weeks for nonemployed mothers (McKinley and Hyde 2004). Another study found that stringent work requirements for mothers of infants under Temporary Assistance to Needy Families (TANF), a welfare-to-work program introduced in 1996, affected 2.6 percent of new mothers and, as a result, almost half of these mothers (1.2 percent of all new mothers) abandoned breastfeeding by the time their infant was six months old (Haider, Jackowitz and Schoeni 2003). Using 2006 birth rates (presented below), this yields an estimate of more than 25,000 infants who are not breastfed each year because their mothers are poor and subject to work requirements under TANF.

Interventions Can Raise Rates of Breastfeeding

As the rise of expressing breast milk at work implies, breastfeeding and employment are not inherently incompatible. New mothers with part-time as opposed to full-time jobs are more likely to continue breastfeeding once employment resumes (Fein and Roe 1998), as are mothers who perform at least some work at home under telecommuting arrangements (Jackowitz 2008). In both of these cases, work arrangements may facilitate the scheduling of breastfeeding around time devoted to the job.

Other mothers express breast milk in the workplace. As mentioned earlier, employers have increasingly provided relevant accommodations in recent years (Galinsky, Bond and Sakai 2008).

More generally, workplace supports can improve the fit between employment and breastfeeding. Although the availability of schedule adjustments and lactation rooms have been found to encourage breastfeeding, according to a recent study, new mothers with flexible work schedules also tend to breastfeed longer, and continue to do so after returning to work (Guendelman et al. 2009). A study of 462 new mothers employed across five corporations found that an intervention involving breastfeeding education and counseling in tandem with a private lactation room and a breast pump raised rates of breastfeeding initiation to 98 percent, with 58 percent of the mothers continuing at least partial breastfeeding for six months or longer—well above the HP2010 target (Ortiz, McGilligan and Kelly 2004).

Other aspects of the aforementioned study are noteworthy. First, 94 percent of the women returned to their original jobs after the baby was born. Second, of that group, 79 percent attempted to express breast milk at work, and almost all of those who tried succeeded (98 percent). Among those who succeeded and did not stop working, the mean duration of breastfeeding was more than nine months. That group represented 76 percent of the women who had returned to the job after childbirth.

The Affordable Care Act Will Help

Employment can be made compatible with breastfeeding, and targeted legislation could facilitate that process. One relevant response lies in the Breastfeeding Promotion Act, introduced by Representative Carolyn Maloney in each session of Congress since 1998. In 2010, two related provisions were included in the Affordable Care Act (ACA): the right for new mothers to have reasonable break times and the right to a private place to express breast milk at work until the child is one year of age. The law applies only to “nonexempt” employees, or those covered by the overtime provisions of the Fair Labor Standards Act (FLSA). U.S. Department of Labor rules regarding the ACA were issued in July 2010, and specify that employers with fewer than 50 employees can be exempted from the ACA requirements if “compliance with the provision would

impose an undue hardship” on the employer (2010).⁶ The rules also specify that employers with multiple worksites must count all employees across the sites as a single group. This requirement implies that employees in many small establishments will also be covered by the ACA protections.

In conducting this study, we hypothesize that the ACA will promote nursing among mothers who have been least likely to breastfeed in the past. The law covers employees in hourly as opposed to salaried jobs (see Appendix), and these jobs are typically low-wage, are those for which time-cards are still used, where supervision is often strict, and where too many breaks for any reason can result in dismissal. Therefore, it is expected that women holding these positions have faced extreme difficulties in attempting to combine breastfeeding and employment. Similarly, the overtime protections provided to workers by the FLSA when it was passed in 1938 were intended to restrain employers from abusing workers who were disadvantaged relative to high-wage managers and professionals. Both the original purpose of the FLSA and that underlying the new ACA breast milk expression provisions may serve to protect employees who are most in need of protection. In what follows, we use poverty, education, age, and race/ethnicity as proxies for socioeconomic status (SES), and assume that women of low SES are those facing the most severe barriers to breastfeeding, and hence are those who will benefit most from the new protections. Following those analyses, we project the effect of the ACA on increasing rates of breastfeeding.

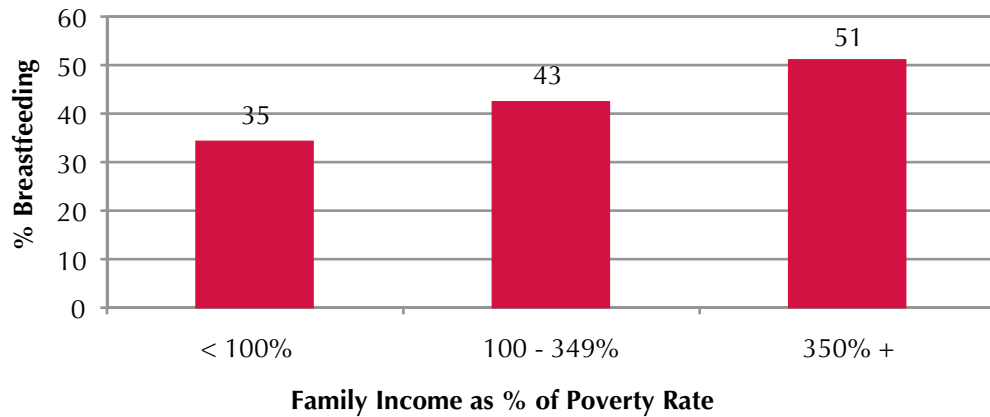
Rates of Breastfeeding Prior to the Health Care Reform

The most recent estimates for rates of breastfeeding are provided in a CDC analysis of National Immunization Survey data covering children born in 2006 (undated). The estimates are for women who breastfed infants the first six months of the child’s life, regardless of whether breast milk is supplemented with other foods or liquids, and whether or not the mother was employed.

Figure 2 describes the relationship between family income and rates of breastfeeding. It shows that new mothers living in poverty are only around two-thirds as likely to breastfeed relative to their counterparts in families with income at or above 350 percent of the poverty line. Breastfeeding is a practice tied to households with high family income.

⁶ The Department of Labor intends to issue additional guidance regarding the breast milk expression provisions of the ACA. Until further guidance is released, we will not know for certain whether small employers will need to apply for any exemption or can instead assume the exemption applies unless an employee files a complaint with the Wage and Hour Division.

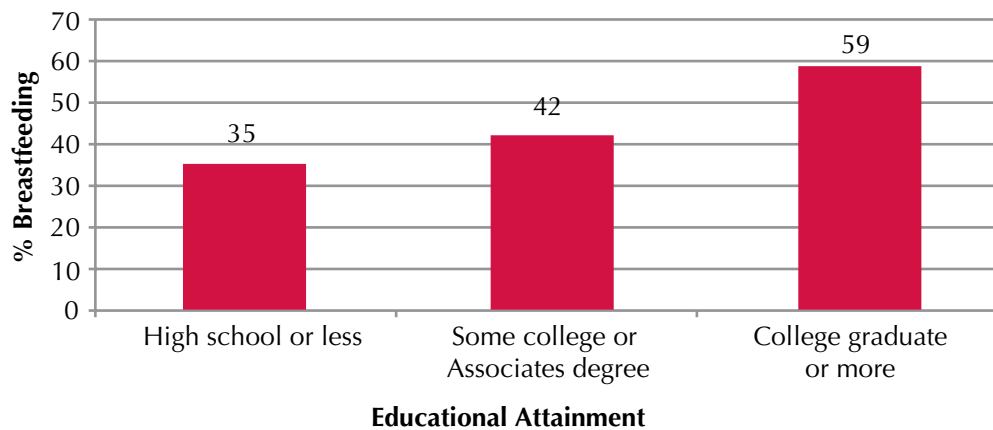
Figure 2: Poverty and Breastfeeding



Source: Figures for mothers of children born in 2006 from CDC analyses of the National Immunization Survey (undated).

Figure 3 provides information on educational attainment and rates of breastfeeding. New mothers who hold degrees from a four-year college or university are almost twice as likely to breastfeed as those with education levels equivalent to or less than a high school diploma. Breastfeeding is linked to high levels of education.

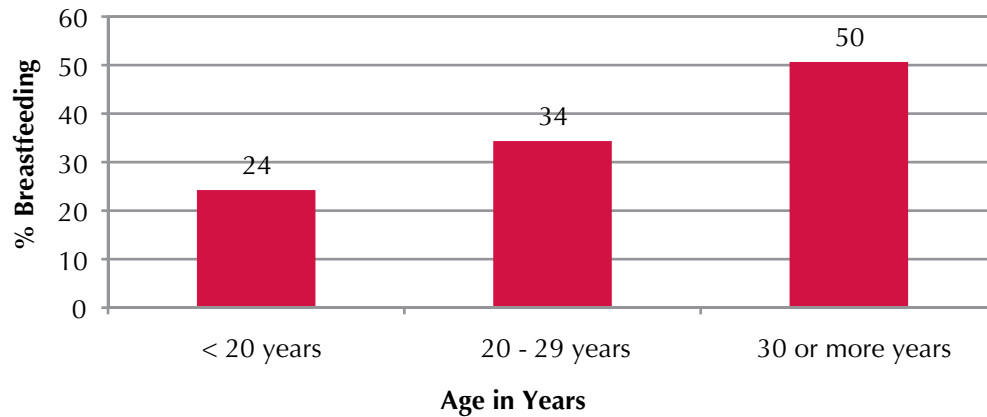
Figure 3: Education and Breastfeeding



Source: Figures for mothers of children born in 2006 from CDC analyses of the National Immunization Survey (undated).

Figure 4 links breastfeeding to the age of the mother at childbirth. New mothers under the age of 20 years are less than half as likely to breastfeed compared with the group 30 years and older. Breastfeeding and age are positively correlated; older women breastfeed more.

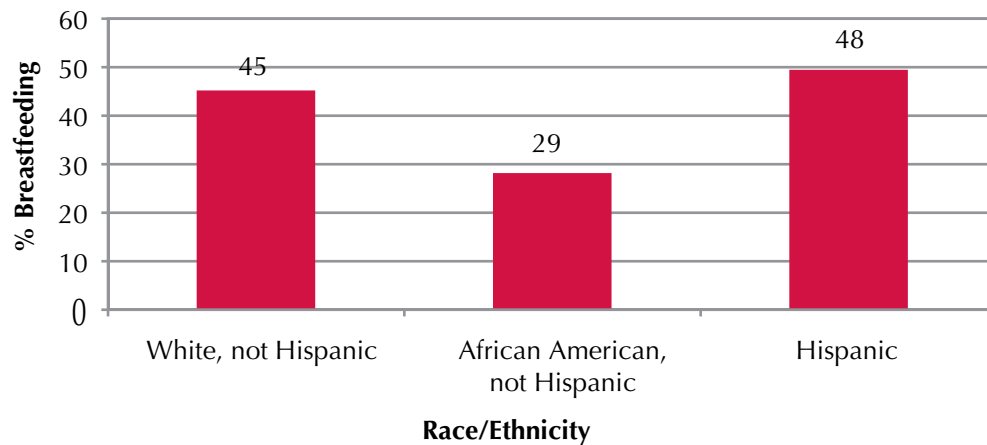
Figure 4: Age and Breastfeeding



Source: Figures for mothers of children born in 2006 from CDC analyses of the National Immunization Survey (undated).

Figure 5 provides information on breastfeeding and the race/ethnicity of the mother. For simplicity, the categories for whites and for African Americans are restricted to non-Hispanics. Rates are relatively high for whites, and even higher for Hispanics, but are at least 16 percentage points lower for African American mothers. Breastfeeding is linked to race and ethnicity.

Figure 5: Race/Ethnicity and Breastfeeding



Source: Figures for mothers of children born in 2006 from CDC analyses of the National Immunization Survey (undated).

In general, these patterns support Galtry's (2000) finding that breastfeeding in the United States is largely reserved for women of high SES, as reflected in high rates for new mothers living in high-income families, and among new mothers with high levels of education, and among those who are white. The age result is also consistent with

this interpretation because highly educated women with managerial and professional careers are those who are most likely to delay childbirth until later in life (Drago 2007). High rates of breastfeeding among Hispanic mothers do not fit this claim, and may reflect either cultural influences on rates of breastfeeding or the fact that Hispanic mothers of infants are less often employed than those who are white or African American (Han et al. 2008).

There are at least three possible explanations for the linkage between high SES and breastfeeding. First, highly educated women may more often be exposed to public health initiatives regarding the benefits of breastfeeding, and hence more likely to breastfeed in response. If this is true, then equity concerns suggest that we direct relevant public health initiatives to focus on low-income families, new mothers with low levels of education, young mothers, and women of color. Second, critics argue that breastfeeding has become stylish among women of high SES, generating intense levels of peer pressure in support of breastfeeding among “upper-class women” in the United States (Rosin 2009). If this is so, then the breastfeeding choices of mothers of low SES more accurately represent rational behavior. Third, it is possible that the resources available to mothers of high SES serve to reduce or alleviate constraints on the breastfeeding choice (e.g., if they can more readily afford to work reduced hours or delay any return to employment, or if employees with managerial or professional careers are more likely to have a flexible schedule or a private office for expressing breast milk). The crossnational comparison of rates of breastfeeding presented earlier imply that the first explanation, exposure to public health information, may have some salience, but that the second explanation concerning peer pressure can only hold if high rates of breastfeeding in other nations reflect a fad of worldwide proportions. The third explanation, regarding constraints on breastfeeding, strikes us as the most powerful, particularly given the relatively rapid return to employment found among mothers in the United States.

ACA Coverage by Income, Education, Age, and Race/Ethnicity

Although the breastfeeding figures above cover all mothers of infants, the ACA protections are relevant only to employed mothers with infants under one year of age. As of 2001, around 60 percent of all U.S. mothers returned to employment by the time the infant reached that age (Han et al. 2008). We analyze coverage rates only for women who are employed as wage and salary workers and are of childbearing age (i.e., between 16 and 44 years, inclusive). Although some births may occur at or beyond the age of 45 years, the absolute number is likely very small, making the group less relevant for analysis here.

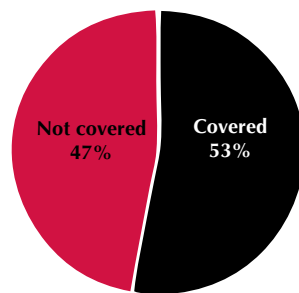
In this first study of coverage rates, the 2009 Social and Economic Supplement (ASEC) to the Current Population Survey is used to generate coverage estimates (U.S. Census Bureau 2010). To provide a cautious estimate, we assume that only hourly workers

are covered by the ACA provisions, with salaried employees excluded. This assumption likely yields a substantial understatement of ACA coverage, partly because the overtime provisions of the FLSA cover some salaried workers (see Appendix). In addition, many and perhaps most lactation rooms provided to hourly workers will be located in workplaces that also employ salaried workers. It seems reasonable to believe that the rooms would only rarely be restricted to hourly workers, effectively expanding facilities coverage (if not breaks per se) to a proportion of salaried employees. There is also a hardship exemption for small establishments, but the language on what constitutes a hardship exemption is vague. In order to approximate the effect the exemption could have on women, we exclude establishments of 10 or fewer employees (see Appendix).

According to an analysis of these data, we estimate that among the women between 16 and 44 years old employed as wage and salary workers in 2009, 53 percent are now covered by the ACA workplace breastfeeding protections (Figure 6). In other words, 18.7 million of 35.4 million employed women of childbearing age are covered by the breastfeeding protections under the recent health care reform.

Almost 19 million women are now covered by the breastfeeding provisions of health care reform. Millions of salaried workers will likely benefit as well.

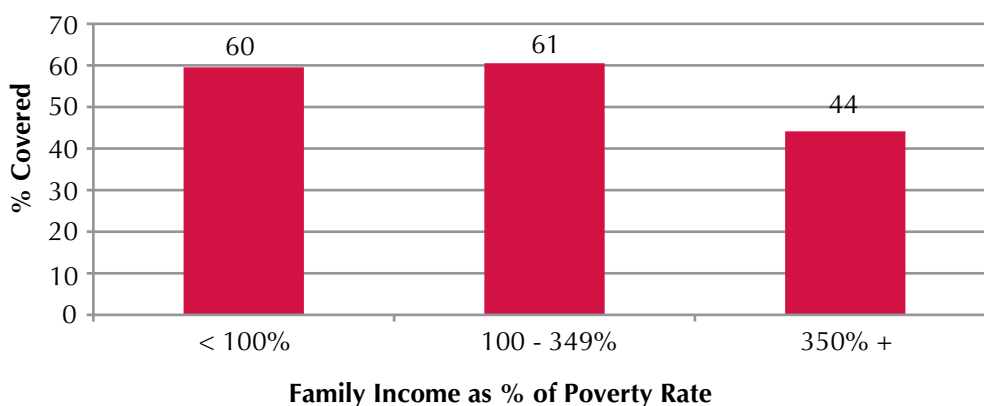
Figure 6: ACA Coverage Among Employed Women



Source: IWPR estimates from the 2009 ASEC (U.S. Census Bureau 2010).

First-ever estimates of ACA coverage among employed women across lines of income, age, education, and race/ethnicity are provided in Figures 7 through 10. The provisions cover most employed women living in families below 350 percent of the government poverty line. Indeed, a full three-fifths of these employees are estimated to be covered, compared with only 44 percent of employees in higher-income families (Figure 7).

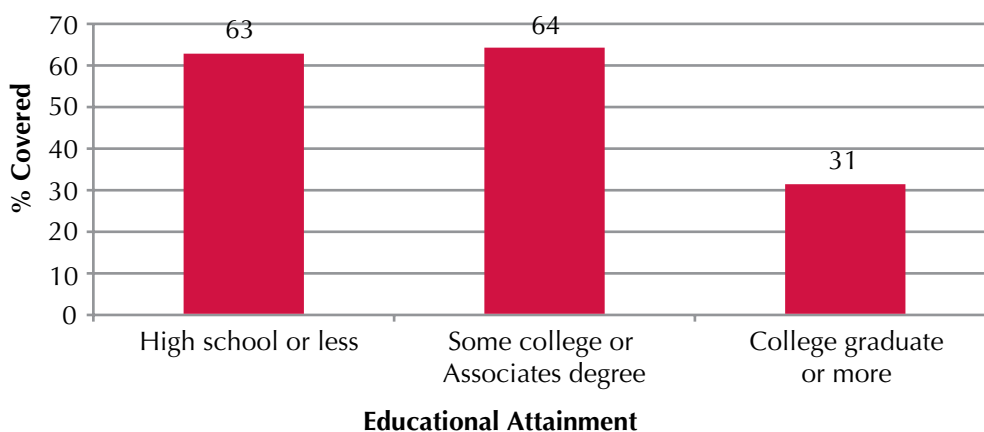
Figure 7: Poverty and ACA Coverage



Source: IWPR estimates from the 2009 ASEC, women below age 45, wage and salary workers only. (U.S. Census Bureau 2010)

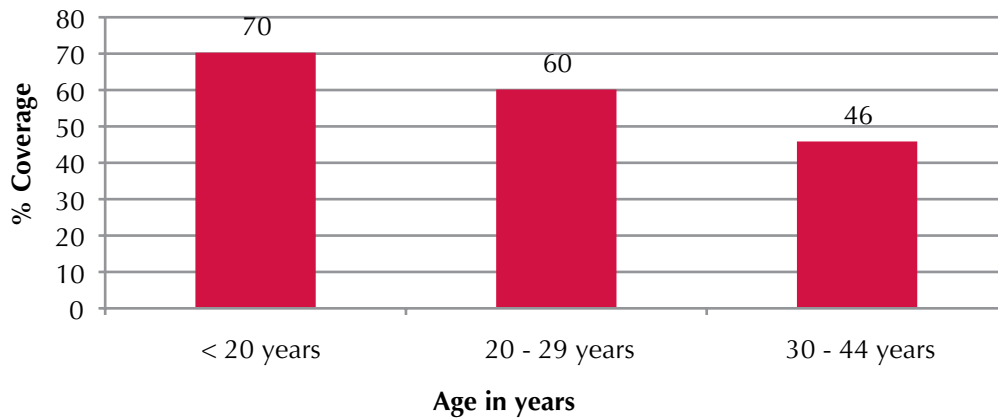
As shown in Figure 8, breastfeeding protections in the ACA mainly cover women with lower levels of education. Over three-fifths of women with some college or less education are covered, while just under one-third of college graduates are covered. The age distribution of coverage favors young women, with coverage extending to almost three-quarters of those under 20 years of age, three-fifths of those in the age range 20–29 years, and 46 percent of employed women in the 30–44 year age group (Figure 9). Finally, coverage rates by race are relatively low for white women (51 percent), with higher rates for Hispanic women (57 percent), and the highest rates for African American women (61 percent, Figure 10).

Figure 8: Education and ACA Coverage



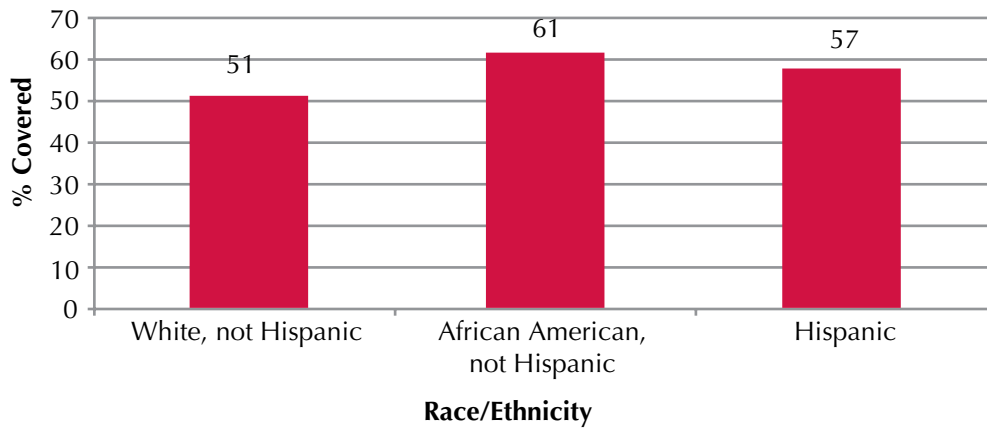
Source: IWPR estimates from the 2009 ASEC, women below age 45, wage and salary workers only. (U.S. Census Bureau 2010)

Figure 9: Age and ACA Coverage



Source: IWPR estimates from the 2009 ASEC, women below age 45, wage and salary workers only.

Figure 10: Race/Ethnicity and ACA Coverage



Source: IWPR estimates from the 2009 ASEC, women below age 45, wage and salary workers only. (U.S. Census Bureau 2010)

These differences in coverage rates under health care reform uniformly suggest that, as hypothesized, mothers of low SES are those who are most likely to be covered.

ACA protections for expressing breast milk in the workplace will serve to equalize opportunities for breastfeeding across lines of socioeconomic status. Employment and breastfeeding will be more complementary for those who historically have faced the greatest challenges combining these activities.

Projected Effects of the ACA on Breastfeeding Rates

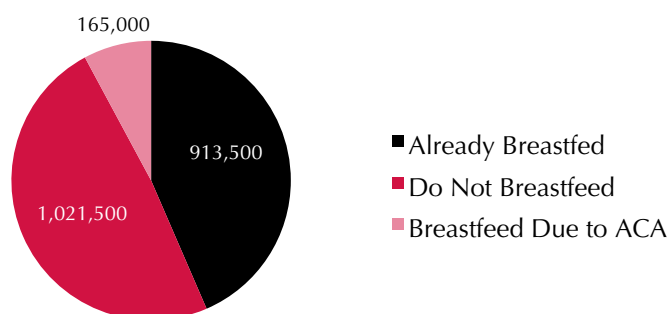
The translation of coverage into projected effects on breastfeeding rates at six months requires several steps. As of 2006, the Census Bureau estimated that 4.2 million American women gave birth (Dye 2008). A conservative estimate is that 2.1 million of those mothers (50.4 percent) were employed by the time the infant was six months old, and that 1.1 million of the employed mothers (52.9 percent), the average rate we estimated above, would have been covered by ACA breastfeeding provisions, had they pertained in 2006 (see Appendix).

Employed mothers breastfeed at a rate approximately 15 percent below that of nonemployed mothers, so we estimate that the rate of breastfeeding among employed mothers was 36 percent prior to the ACA, and the figure for nonemployed mothers was 51 percent in 2006 (see Appendix). Relative to the hourly employees now covered by the ACA, the 36 percent estimate is overstated, given it includes numerous women who are employed on a salaried basis and hence more likely to breastfeed (consistent with results above).

To the best of our knowledge, only one published study, the research covering an intervention to promote expressing breast milk across five corporations referenced earlier, distinguishes the effects of the intervention on hourly as opposed to salaried employees (Ortiz, McGilligan and Kelly 2004). That study reported that 79 percent of salaried employed mothers, but only 66 percent of hourly employed mothers attempted to express breast milk in the workplace. ACA protection is a less extensive intervention than that used for the 2004 study. That intervention also involved providing information, counseling, and breast pumps to mothers. Therefore, we estimate that ACA coverage will yield half the effect of the more extensive intervention, or raise the rate of breastfeeding at six months among covered mothers from 36 to 51 percent (i.e., half the increase involved in moving from 36 to 66 percent).

Combining our coverage estimates and our review of breastfeeding rates in the existent literature allows us to project the net effect of the ACA for the first time. We project that an additional 165,000 mothers will breastfeed through six months each year (Figure 11), or more than one million additional mothers and their children in the next six years will benefit from the health gains due to breastfeeding. As a result, the rate of breastfeeding at six months will rise from 44.5 to 47.5 percent, or by four full percentage points, and come closer to the HP2010 goals.

Figure 11: Breastfeeding Effects of ACA Coverage Among Employed Mothers



Source: IWPR estimates of average of rates for any breastfeeding at six months from various sources (see Appendix).

By way of comparison, the study of work requirements under TANF estimated that almost 50 percent of new mothers subject to stringent work requirements abandoned breastfeeding by six months as a result, a behavioral shift affecting more than 25,000 mothers each year. We estimate that an additional 15 percent of new mothers covered by the ACA provisions will respond by breastfeeding through six months. The net effect of the ACA provisions is much larger because it covers almost one-quarter of all mothers of infants, while stringent work requirements under TANF affected less than 3 percent of new mothers.

Digging a little deeper, we estimate from the ASEC data that 10.2 percent of women covered by the ACA provisions live in poverty. Therefore, if the provisions lead 165,000 new mothers to breastfeed annually, it is reasonable to infer that 16,500 of these women will be living in poverty. This shift will in part reverse the adverse effects of TANF work requirements (although it is important to note that most mothers living in poverty are not currently receiving income from TANF, so are not subject to related work requirements; Henrici et al. 2010).

We believe that this projection is both reasonable and cautious. We project that the behavior of only 4 percent of all new mothers will be influenced by ACA coverage. However, it seems likely that the behavior of many other new mothers is also likely to be affected by the law, so that we are likely underestimating the probable behavioral shift that will ultimately result from the ACA. In part, the understatement follows from the fact that numerous salaried women will enjoy the benefits of lactation facilities mandated for hourly employees. The understatement also flows from the fact that many salaried women are in fact covered by the overtime provisions of the FLSA and hence the new ACA provisions. Most importantly, it seems likely that the stigma currently attaching to breastfeeding in general and especially to expressing and storing breast

milk at the workplace⁷ will be attenuated by the provision in the ACA. It is difficult to imagine a young woman in the United States being stigmatized for wearing pants to school or work today, even though that was true in the not-too-distant past. The ACA may help us to achieve a similar level of social acceptance for breastfeeding.

Further Considerations

Another benefit of the ACA provisions relates to cost-savings for employers resulting from reduced labor turnover. By improving the ability of mothers of infants to both breastfeed and maintain employment, it seems likely that a significantly increased fraction of women will remain with a given employer following childbirth. Many women who sought to provide breast milk to their infants have encountered barriers in the workplace in the past, so have either left one employer to seek employment with another more family-responsive one, or quit employment entirely. The ACA protections will make existing jobs more attractive to these women. For employers, any resulting reduction in employee turnover will reduce labor costs associated with replacing and training new employees.

The new ACA provisions for expressing breast milk will expand the opportunities available to many working mothers. Much of the evidence presented here supports the claim that work has often served as a barrier to breastfeeding. The ACA will reduce, although not eliminate, those barriers and will serve to help equalize breastfeeding opportunities across lines of income, age, education, and race/ethnicity.

The ACA breastfeeding protections will help to reduce workplace constraints and may help ameliorate the stigma currently associated with breastfeeding and expressing breast milk. But this is not enough. Even with the ACA protections, we will not achieve the HP2010 objective of 50 percent of new mothers breastfeeding through six months—much less the new, higher HP2020 objective of 60.5 percent (DHHS undated). More could and should be done, including:

- legalizing breastfeeding in public places,
- introducing health and safety standards for breast pumps, and
- subsidizing breast pumps and breastfeeding counseling and education, particularly for low-income mothers.

⁷ Using ethnographic research, Boswell-Penc and Boyer (2007) uncover evidence suggesting that the stigma associated with expressing breast milk is likely more severe than that associated with nursing an infant directly.

The first two possibilities are included in provisions of the proposed Breastfeeding Promotion Act. The latter supports are already available on a limited basis to mothers participating in the Women, Infants, and Children (WIC) program.⁸

It is unfair that the health benefits of breastfeeding have been disproportionately available to mothers and children of high socioeconomic status. The ACA breastfeeding protections, as well as the additional policies discussed in this report, can help to rectify this situation, and make breastfeeding less a matter of privilege and opportunity and more a matter of unconstrained individual choice for new mothers.

⁸ See Collins, Rappaport, and Burstein (2010) for counseling provisions and their effects, and page 14 of the document for evidence regarding providing breast milk pumps through the WIC program.

References

- AAP (American Academy of Pediatrics). 2005. "Policy Statement: Breastfeeding and the Use of Human Milk." *Pediatrics* 115 (February): 496–506.
- Bartick, Melissa, and Arnold Reinhold. 2010. "The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis." *Pediatrics* 125 (May): 1048-56.
- BLS (Bureau of Labor Statistics). 2009. "Women in the Labor Force: A Databook." <<http://www.bls.gov/cps/wlf-databook2009.htm>> (accessed August 26, 2010).
- Boswell-Penc, Maia and Kate Boyer. 2007. "Expressing Anxiety? Breast Pump Usage in American Workplaces." *Gender, Place & Culture* 14(5): 551–67.
- CDC (Centers for Disease Control and Prevention). 2007. "Breastfeeding Trends and Updated National Health Objectives for Exclusive Breastfeeding—United States, Birth Years 2000–2004." *Morbidity and Mortality Weekly Report* 56 (August): 760-763.
- CDC. Undated. "Final Breastfeeding Rates by Socio-Demographic Factors, among Children Born in 2006." <http://www.cdc.gov/breastfeeding/data/NIS_data/2006/socio-demographic_any.htm> (accessed July 27, 2010).
- Collins, Ann, Catherine Dun Rappaport, and Nancy Burstein. June 2010. *WIC Breastfeeding Peer Counseling Study, Final Implementation Report*, WIC-10-BPC. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis.
- DHHS (U.S. Department of Health and Human Services). 2000. *Healthy People 2010: Understanding and Improving Health*, 2nd ed. November. Washington, DC: U.S. Government Printing Office. <<http://www.healthypeople.gov/publications>> (accessed October 13, 2010).
- DHHS. 2010. "Breastfeeding: Common Challenges." <<http://www.womenshealth.gov/breastfeeding/common-challenges>> (accessed August 20, 2010).
- DHHS. Undated. "Healthy People 2020 Topics and Objectives, Maternal, Infant, and Child Health." <<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=26>> (accessed December 6, 2010).
- Drago, Robert. 2007. *Striking a Balance: Work, Family, Life*. Boston, MA: Dollars & Sense.
- Dye, Jane Lawler. 2008. "Fertility of American Women: 2006," *Current Populations Reports*, No. P20-558. Washington, DC: U.S. Census Bureau.

- Fein, Sara B., and Brian Roe. 1998. "The Effect of Work Status on Initiation and Duration of Breastfeeding," *American Journal of Public Health* 88 (July): 1042–46.
- Galinsky, Ellen, James T. Bond, and Kelly Sakai. 2008. *The National Study of Employers*. New York: Families and Work Institute. <<http://familiesandwork.org/site/research/reports/2008nse.pdf>> (accessed October 13, 2010).
- Galtry, Judith. 2000. "Extending the 'Bright Line': Feminism, Breastfeeding, and the Workplace in the United States," *Gender and Society* 14(2): 295–317.
- Golden, Lonnie, and Helene Jorgensen. 2002. "Time After Time: Mandatory Overtime in the U.S. Economy," Briefing Paper, No. 120. Washington, DC: Economic Policy Institute.
- Guendelman, Sylvia, Jessica Lang Kosa, Michelle Pearl, Steve Graham, Julia Goodman, and Martin Kharrazi. 2009. "Juggling Work and Breastfeeding: Effects of Maternity Leave and Occupational Characteristics." *Pediatrics* 123(1): e38–e46.
- Haider, Steven J., Alison Jacknowitz, and Robert F. Schoeni. 2003. "Welfare Work Requirements and Child Well-Being: Evidence from the Effects on Breastfeeding." *Demography* 40(3): 479–97.
- Han, Wen-Jui, Christopher J. Ruhm, Jane Waldfogel, and Elizabeth Washbrook. 2008. "The Timing of Mother's Employment after Childbirth," *Monthly Labor Review* 131: 15–27.
- Henrici, Jane M., Allison Suppan Helmuth, Frances Zlotnick, and Jeff Hayes. 2010. "Women in Poverty During the Great Recession," Briefing Paper, No. D493. Washington, DC: Institute for Women's Policy Research.
- International Labour Organization. 2000. "C183 Maternity Protection Convention, 2000." Geneva, Switzerland: International Labour Organization. <<http://www.ilo.org/ilolex/cgi-lex/convde.pl?C183>> (accessed August 24, 2010).
- Ip, Stanley, Mei Chung, Gowri Raman, et al. 2007. *Breastfeeding and Infant and Maternal Health Outcomes in Developed Countries*. Evidence Report/Technology Assessment No. 153. Rockville, MD: Agency for Healthcare Research and Quality.
- Jacknowitz, Alison. 2008. "The Role of Workplace Characteristics in Breastfeeding Practices," *Women and Health* 47(2): 87–111.
- McGill Institute for Health and Social Policy. 2010. "The Work, Family, and Equity Index((WFEL): Measuring governmental performance around the world." <<http://raisingtheglobalfloor.org/policies/single-country-1.php?country=United+States+of+America>> (accessed August, 20, 2010).

- McKinley, Mary Nita, and Janet Shibley Hyde. 2004. "Personal Attitudes or Structural Factors? A Contextual Analysis of Breastfeeding Duration." *Psychology of Women Quarterly* 28 (December): 388–99.
- National Center for Health Statistics. 2010. *Health, United States, 2009 with Special Feature on Medical Technology* (DHHS Publication No. 76-641496). Hyattsville, MD.
- National Bureau of Economic Research. Undated. "CPS Merged Outgoing Rotation Groups." <<http://www.nber.org/data/morg.html>> (accessed July 28, 2010).
- Ortiz, Joan, Kathryn McGilligan, and Patricia Kelly. 2004. "Duration of Breast Milk Expression Among Working Mothers Enrolled in an Employer-Sponsored Lactation Program." *Pediatric Nursing* 30(2): 111–19.
- (PPACA) Patient Protection and Affordable Care Act, 2010. H.R. 3590, 111th Congress. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.pdf> (accessed July 28, 2010)
- Rosin, Hanna. 2009. "The Case Against Breast-feeding." *The Atlantic*, April. <<http://www.theatlantic.com/magazine/archive/2009/04/the-case-against-breast-feeding/7311>> (accessed August 23, 2010).
- Schwarz, Eleanor B., Roberta M. Ray, Alison M. Stuebe, Matthew A. Allison, Roberta B. Newss, Matthew S. Freiberg, and Jane A. Cauley. 2009. "Duration of Lactation and Risk Factors for Maternal Cardiovascular Disease." *Obstetric Gynecology* 113(5): 974–82.
- U.S. Census Bureau. 2010. "Poverty Data" <<http://www.census.gov/hhes/www/poverty/data/index.html#cps>> (accessed October 13, 2010).
- U.S. Department of Labor, Wage and Hour Division. 2010. "Fact Sheet #73: Break Time for Nursing Mothers under the FLSA." <<http://www.dol.gov/whd/regs/compliance/whdfs73.pdf>> (December 14, 2010).
- World Health Organization. 2002. *The Optimal Duration of Exclusive Breastfeeding. Report of an Expert Consultation*. Paper presented from consultation, Geneva, March 28–30, 2001.
- World Health Organization. Undated. "Infant and young child feeding data by country." <<http://www.who.int/nutrition/databases/infantfeeding/countries/en/index.html>> (accessed December 14, 2010).

Appendix: Data and Methodology

The 2009 ASEC data are used for ACA coverage estimates. Hourly status serves as a proxy for nonexempt as opposed to exempt status under the FLSA overtime provisions. Although the correlation between hourly and nonexempt status is not perfect, as a practical matter most employees and employers associate hourly status with payment for overtime hours beyond 40 per week. As an empirical matter, Golden and Jorgensen (2002) report a U.S. Department of Labor Wage and Hour Division estimate that 66.8 percent of wage and salary workers were covered by the overtime provisions of the FLSA in 1999. The 1999 Merged Outgoing Rotation Group data from the Current Population Survey, provided by the National Bureau of Economic Research (NBER), shows 58 percent of wage and salary workers being paid on an hourly basis. The difference suggests that the hourly proxy understates the extent of ACA coverage, perhaps by as much as nine percentage points.

The ASEC does not provide data on employer ownership of multiple worksites, while the Department of Labor rules for the ACA protections use the sum of employment at all or multiple sites to establish whether 50 individuals are employed. Therefore, many individual establishments with fewer than 50 employees will be covered by the ACA protections. Further, many small employers will not seek an exemption, implying that even more employees in small establishments will be covered. We therefore estimate that, on average, women employed hourly in establishments with more than 10 employees will be covered by the breastfeeding protections of the ACA.

The ASEC data are weighted by the population weights provided by the U.S. Census Bureau to estimate mean rates of ACA coverage for the various demographic groups.

To estimate the number of women covered by the ACA, we constrain the ASEC estimates to the number of employed women, ages 16 to 44 years, yielding a figure of 35,386,345. Of that population, the proportion of women paid hourly and employed in establishments with at least 10 employees, is 52.9 percent, as calculated from the ASEC data, so an estimated 18,706,175 women are covered by the ACA provisions.

U.S. Census Bureau estimates from the American Community Survey for 2006 show 4,182,942 women giving birth during the 12 months prior to survey administration, noting that twins and high-order births count as a single birth event (Dye 2008). A subsample of 2,109,291 women (50.4 percent) was estimated to be employed at the time the survey was administered. That figure represents an average employment rate for all mothers of infants. The analysis here, however, requires information on mother's employment at any time up to the point where the child reaches six months of age, and a recent study suggests that the 50.4 percent figure understates employment at that point because so few women are employed during the first (7 percent) or second (26 percent) month after childbirth (Han et al. 2008). Consequently, some of the employed women are in fact self-employed, and should be excluded from the estimates. In 2008,

only 5.2 percent of all employed women were self-employed (BLS 2009). We assume the sources of under- and over-estimation roughly cancel each other out.

Of the 2.1 million employed mothers of infants, we estimate that 1.1 million (52.9 percent) will be covered by the breastfeeding provisions in the ACA, assuming that 2006 birth rates are indicative of future fertility. The evidence from the research literature reported in the first two sections of the report suggests that rates of breastfeeding through six months for women employed on an hourly basis have historically fallen below rates for the general population (43.5 percent). A study of new mothers in California found that employment is associated with a 15 percentage point lower rate of breastfeeding (Guendelman et al. 2009, p. e43). Given that around half of all mothers are employed, it is reasonable to view the 43.5 percent national figure as an average of 36 percent among employed mothers and 51 percent among nonemployed mothers (reflecting the 15 percentage point difference). The 36 percent figure is probably overstated as an estimate for hourly workers, given salaried workers are more likely to breastfeed. Nonetheless, we use this information as the best available figure to represent the proportion of new mothers who are employed hourly and would breastfeed through the six-month period absent the ACA provisions. If the rate for hourly employees is even lower without the ACA protection, then the projected effect of the ACA provision would be even larger.

Regarding the extent to which the ACA protections will raise the rate of breastfeeding, the study of an intervention in five corporations found that, among employed mothers, those paid on a salary basis reported expressing breast milk at a rate of 79 percent, whereas those employed on an hourly basis reported a rate of only 66 percent (Ortiz, McGilligan and Kelly 2004); the latter is relevant to the likely behavior of the population covered by the ACA provision. Even the 66 percent figure, however, is likely an overestimate of ACA effects given that it resulted from a more extensive intervention than that flowing from the ACA (e.g., it included counseling and providing a pump). It therefore seems reasonable to assume that the rate of breastfeeding at six months in the relevant population would rise from 36 percent to 51 percent, or traverse half the distance from 36 percent to the 66 percent figure. Assuming that 51 percent of hourly employed mothers, 51 percent of nonemployed mothers, and 36 percent of salaried mothers will breastfeed as a result of the ACA protections, projections yield an average rate of breastfeeding of 47.5 percent at six months.

IWPR Program Advisory Committee

Barbara Bergmann
American University

Nancy Duff Campbell
National Women's Law Center

Joe Cordes
The George Washington University

Nikki Daruwala
American Rights at Work

Cynthia Deitch
The George Washington University

David Fasenfest
Wayne State University

Sarah Gotbaum
SCG Associates

Caren Grown
American University

Cindy Hall
Women's Policy, Inc

Cynthia Harrison
The George Washington University

Rufina Hernandez
National Education Association

Catherine Hill
American Association of
University Women

Lisalyn Jacobs
Legal Momentum

Joan Kuriansky
Wider Opportunities for Women

Sara Meléndez
Savage/Meléndez & Associates LLC

Christine Owens
National Employment Law Project

Elena Silva
Education Sector

Deborah Weinstein
Coalition on Human Needs

Nancy Zirkin
Leadership Conference on Civil Rights

Become a Member

(Benefits vary according to membership level)

Student: \$35

- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- Special IWPR conference rate

Friend: \$75

Regular subscription to the IWPR Information Network

- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- 20% discount on one registration for an IWPR conference

Sustainer: \$175

Enhanced subscription to the IWPR Information Network

- Research News Reporter Online
- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- 20% discount on one registration for an IWPR conference

Partner: \$250

Comprehensive subscription to the IWPR Information Network

- Complimentary copies of all IWPR major reports
- Research News Reporter Online
- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- 20% discount on one registration for an IWPR conference

Affiliate: \$350

Organizational subscription to the IWPR Information Network
(\$200 for nonprofits with operating budgets under \$500,000)

- Complimentary copies of all IWPR major reports
- Research News Reporter Online
- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- 20% discount on three registrations for an IWPR conference

Corporate Affiliate: \$1,000

Corporate subscription to the IWPR Information Network
(\$500 for corporations with revenue under \$1 million)

- Complimentary copies of all IWPR major reports
- Research News Reporter Online
- Quarterly newsletter, fact sheets, and Research-In-Briefs
- 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**
- 20% discount on IWPR publications
- 20% discount on five registrations for an IWPR conference

Eleanor Roosevelt Policy Council

Members of IWPR's premier giving circle receive a comprehensive subscription, special acknowledgement in select IWPR publications, a 50% discount off an annual subscription to the *Journal of Women, Politics & Policy**, and exclusive invitations to IWPR events across the country.

- Community Council, \$500-\$999
- Institute Council, \$1,000-\$2,499
- Leadership Council, \$2,500-\$4,999
- President's Council, \$5,000 and up

For more information contact Membership Services.

The Institute for Women's Policy Research is a 501(c)(3) charitable organization. Donations and membership fees are tax-deductible to the extent allowed by law.





Institute for Women's Policy Research
1200 18th Street NW, Suite 301
Washington, DC 20036
202/785-5100 • 202/833.4362 fax
www.iwpr.org