



PAID FAMILY AND MEDICAL LEAVE PROGRAMS: STATE PATHWAYS AND DESIGN OPTIONS

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SUMMARY

Time off to provide care for the health and well-being of a family member or for a worker's own illness or injury is a near-universal need of workers from all backgrounds. Paid family and medical leave offers protection against financial hardship for employees requiring such time away from work to provide or receive care. The United States is an extreme outlier in its lack of a national paid leave program. In the absence of a national program, several states have established paid leave programs for medical and family caregiving needs. States have taken different pathways to creating their paid leave programs, and have pursued different design options in terms of structure, funding, and program administration. States considering developing new paid leave programs can learn much from the study of existing programs.

All workers face the risk of needing time away from work at some point during their careers, regardless of their age, sex, health, or family status. During their adult years, most working people will have a child through birth or adoption, need to provide care for a family member, and/or experience their own serious health condition that temporarily prevents them from working. Yet, most workers do not have access to paid leave to cover these common, serious life events. Given the tenuousness of many families' economic security—with 44 percent of adults reporting they could not easily manage an unexpected \$400 emergency expense—access to paid rather than unpaid leave is critically important.¹ This challenge is becoming more acute as changes in society and the labor market reduce the number of families with stay-at-home caregivers, and as the population ages. Broader access

to paid leave could also offset the decline in labor force participation experienced since 2000.²

Social insurance programs pool risk across a large group of individuals and/or employers, making the coverage of that risk as efficient and affordable as possible. In the case of paid family and medical leave, social insurance programs pool the risk of lost wages from needing to take time off from work to care for a family member or one's own illness. This risk can be pooled across workers in a state or a nation. Several states have had programs in place since the 1940s that provide paid *medical* leave, commonly referred to as temporary disability insurance (TDI). Over the past two decades, all of these states but one have incorporated paid *family* leave into their TDI programs. Other states seeking to implement paid family and medical leave in the future face



a range of program design choices with regard to system structure, funding, and administration. This brief discusses the growing need for paid leave, the pathways to existing paid leave programs in the U.S. and abroad, and design options and challenges facing states seeking to adopt new systems in the coming years.

Paid Leave Coverage in the United States

There is no national program in the United States to support workers with paid time off when they need to care for a new child or a seriously ill or injured family member, or to recover from their own short-term but serious health condition. The Family and Medical Leave Act (FMLA) provides up to 12 weeks of *unpaid*, job-protected leave, but only about 59 percent of workers are eligible for it.³ The United States is the only advanced economy that does not have a national program for paid maternity leave, and is one of only a few to not provide paid parental leave to fathers.⁴ Additionally, unlike most peer nations, the U.S. does not guarantee workers the right to paid temporary disability leave,⁵ paid family caregiving leave, or to any form of paid leave at all.⁶

Paid sick leave to care for an acute illness, injury, or safety concern (i.e., receiving care or services related to domestic violence, sexual assault or abuse, or stalking) is a more common benefit offered to employees, but nearly one-third of workers do not have access to it and there is no federal mandate that employers offer it.⁷ For a non-work-related illness or injury, or for pregnancy-related medical conditions and recovery from childbirth, some workers have access to short- to medium-term disability benefits either through state-based programs, employer-based insurance, or privately purchased policies. For a long-term disability, workers who have contributed for a sufficient number of years (which varies based on age) are generally insured by Social Security Disability Insurance. Finally, for work-related injuries or illnesses, state-based Workers' Compensation systems provide both short-term and long-term disability benefits.

At the state level, there have been increasing legislative efforts over the past decade to ensure access to paid leave for the health and caregiving needs of workers. Five states have longstanding programs to provide paid leave for temporary disability (i.e., paid medical leave): California, New Jersey, Rhode Island, New York, and Hawaii. These temporary disability insurance programs replace a portion of wages, up to a cap, when a worker faces a serious but short-term health need. All of these states except Hawaii have subsequently added paid family leave to their TDI systems. In addition, Washington state and the District of Columbia have enacted new laws establishing combined paid family and medical leave programs.



Several states and many localities require at least some employers to offer some amount of paid sick leave. This leave is intended to cover short-term illnesses and injuries, while TDI programs are generally intended to cover more serious and longer-term medical conditions. As of September 2017, seven states (Arizona, California, Connecticut, Massachusetts, Oregon, Vermont, and Washington), the District of Columbia, 28 cities, and two counties (Montgomery County, MD and Cook County, IL) have enacted laws mandating paid sick leave, and other states and localities are continuing to pursue sick leave legislation.⁸

What are the different types of paid leave for illness, injury, parental leave, and family caregiving?

Paid Sick Leave—Sick leave is time off from work to care for an acute personal illness, injury, or safety concern (i.e., receiving care or accessing services related to domestic violence, sexual assault or abuse, and stalking). While paid sick leave is not mandatory under federal law, a growing number of state and local laws require it, and many employers decide to voluntarily provide this benefit to some or all of their employees. Slightly more than two-thirds of workers in the United States have access to paid sick days. These workers typically receive 100 percent of their wages for a certain number of days, depending on the worker's job tenure and hours worked that year, although the exact benefit varies by employer and location. Paid sick leave is generally administered and funded by employers, but is enforced by state or local agencies in regions where legislation mandates paid sick leave. In addition, some labor unions have sick pay programs for their members.

Temporary Disability/Paid Medical Leave—Several states have Temporary Disability Insurance (TDI) programs, also known as State Disability Insurance (SDI) or paid medical leave. TDI is a statutory program that provides partial wage replacement for workers taking time off to recover from a non-work-related injury or sickness, or from pregnancy. State TDI programs are implemented through either a state social insurance fund or an employer mandate, whereby the employer can purchase insurance from a private carrier, a state fund (if one exists), or self-insure. The duration of benefits, compensation rate, restrictions on eligibility, and the share of program funding borne by employers versus workers all vary by state (see Table 1 on page 10).

Short-Term Disability—Short-term disability insurance (STD) is similar to TDI, but employers offer this coverage voluntarily as part of their employee benefit package in states and regions where TDI coverage is not required. Employers electing to provide STD coverage can do so by purchasing private insurance plans or self-insuring. Individual employees also may purchase short-term disability insurance from a private insurance carrier. STD policies offer partial wage replacement for workers who need to take time off from work for their own health-

related need, including pregnancy. Long-term disability insurance is also provided by some employers, or purchased by some workers.

Paid Family Leave—Paid Family Leave (PFL) is a statutory program, typically funded by employee and/or employer contributions, that enables workers to take time off from work for the birth or adoption of a child or to provide care for a close family member such as a spouse, domestic partner, parent, or child. Some programs also cover caregiving for grandparents, grandchildren, siblings, or in-laws. In the U.S., there is no national PFL program; state programs have either been added to a pre-existing TDI program or created from scratch as part of combined paid family and medical leave programs. In addition to the state programs, some employers provide such leave voluntarily.

Social Security Disability—Employees who have a qualifying history of work, and who have contributed to Social Security, can become eligible for Social Security Disability Insurance (SSDI) benefits if they experience a long-term disability. Generally, to be eligible for SSDI, a worker needs 10 years of work, five of which occurred in the last 10 years, although younger workers may qualify with fewer credits. SSDI is funded by employee and employer contributions. Only individuals who have a medically determinable physical or mental impairment that precludes them from continuing gainful employment for at least one year and/or will result in death are eligible for benefits.

Workers' Compensation—Workers' Compensation provides funding for medical care, rehabilitation, and cash benefits for workers who are injured on the job or who contract work-related illnesses. It is funded almost entirely by employers. Each of the 50 states, the District of Columbia, and the U.S. territories has their own Workers' Compensation program (as does the federal government for federal employees). There is consistency across states in central features of the programs, but there is substantial variation in terms of which injuries and illnesses are compensable and the level of benefits provided.



Inequality in Access to Paid Leave by Income, Disability, and Family Structure

Due to the lack of a national paid leave system, access to paid leave is most often decided by employers, with the exception of the few existing state programs. This leads to highly unequal access. Only 14 percent of civilian workers nationally have paid family leave provided by their employers, and 38 percent have access to paid short-term disability leave.⁹ Moreover, there are wide differences by income between workers who have access to paid leave and those who do not, and voluntary plans offered by employers may cover only a portion of their workforce. Those who are least able to afford unpaid leave are the least likely to have access to paid leave.¹⁰ Among workers in the lowest earnings quartile for their respective occupations, only 6 percent have access to paid family leave,¹¹ and only 18 percent have access to short-term disability insurance.¹² Even in the highest earnings quartile, only 22 percent of workers have access to paid family leave,¹³ while 53 percent are offered short-term disability for a personal health need.¹⁴

Access to paid sick leave is also unequal, along similar lines. For workers in the private sector nationwide, 64 percent have access to paid sick leave to address an acute health condition, and 90 percent of state and local government workers have access to paid sick leave.¹⁵ However, workers of lower socio-economic status are still significantly less likely to have access to paid sick leave; while 87 percent of private industry workers in the highest decile of average

wages have access to paid sick time, only 27 percent of those in the lowest decile do.¹⁶

Individuals with disabilities face acute challenges in accessing family and medical leave, both paid and unpaid. Most policies at the state, federal, and even employer levels favor individuals who work full-time and are employed in higher-wage positions. Workers with disabilities are disproportionately represented in low-wage and part-time employment, for a variety of reasons.¹⁷ Additionally, what is considered a qualifying event for triggering paid family and medical leave benefits has often excluded the range of needs experienced by individuals with disabilities.

Some workers also face unequal access to both paid and unpaid family leave due to the nature of their family structure. The definition of who is considered eligible under the term “family” varies across employer, federal, state, and local policies, and is often centered on the so-called nuclear family of parent(s) and children. Some states have expanded upon this definition of family to include siblings, grandparents, and adult children. However, there are still many caregiving situations left uncovered by existing leave laws. Broader extended family (e.g., aunts and uncles, cousins, non-cohabitating partners) and “chosen family”—informal support networks of close relationships developed outside of blood, marriage, or other legal status ties—often play a critical role in caregiving, and in some cases represent the sole individual willing and available to provide care.¹⁸ Chosen families are particularly important to certain marginalized communities, including LGBTQ+ individuals or people with disabilities.¹⁹

Inadequate Paid Leave Infrastructure Weakens the Economic Security of Working Families

Lack of access to paid family and medical leave has manifold implications for families’ economic security. Most parents lack access to paid parental or family caregiving leave, and cannot afford to take unpaid time off to care for a new baby for the length of time appropriate for promoting the health of children and parents alike.²⁰ Furthermore, more and more adults struggle to provide unpaid care or afford quality professional support for their parents and other aging family members while maintaining labor force

attachment.²¹ On average, caregivers of individuals 50 and older spend 24 hours a week providing care, and more than one in five (22 percent) spend more than 40 hours a week.²² These caregiving responsibilities can negatively affect their employment, earnings, retirement savings, and Social Security benefits.²³ A MetLife report based primarily on analysis of the 2008 panel of the Health and Retirement Study found women 50 or older who left the labor force early due to elder care demands suffered forgone wages averaging \$142,693, as well as a reduction in lifetime Social Security benefits averaging \$131,351; for men, forgone wages and Social Security benefits averaged \$89,107 and \$144,609, respectively.²⁴

The challenges of balancing work and caregiving result in a number of workers, particularly women, being pushed into part-time work or out of the workforce entirely due to family care needs. Women of color, who on average are among the lowest-paid workers, often face the most acute challenges because they tend to have fewer economic resources and are more likely to work in jobs that lack work-family supports.²⁵ Additionally, when workers are unable to take paid leave to recover from their own serious health concern or childbirth, they may find themselves choosing between following their doctors' recommendations and maintaining their income, which can have deleterious health effects for those who return to work too quickly,²⁶ as well as for their children.²⁷



Changes in Family Structure, the Labor Market, and Demography Exacerbate Need

In previous generations, women were less likely to work for pay and were more likely to provide unpaid care within the home for children, the elderly, and those with medical needs.²⁸ Today, in the majority of families with children, all of the adults in the family work for pay.²⁹ Although women's labor force participation lags behind men's, the majority of mothers (both married and unmarried) are in the labor force.³⁰ Most families do not have an adult who stays at home full-time; approximately one in five children are raised with a stay-at-home parent, while the rest are raised by either a single working parent or married parents who are both employed.³¹ Therefore, ready access to family-provided care is limited for many of those who need care.

People work for a variety of different reasons and may find personal fulfillment and satisfaction in their jobs, but for most, engaging in paid labor is an economic necessity. Two-thirds of mothers bring home at least a quarter of the family's total earnings, and low-income mothers tend to account for a larger share of their family's earnings.³² Women of color are especially likely to be responsible for supporting their families economically; black mothers are nearly twice as likely as white mothers to be the primary breadwinner for their families.³³ As wages have stagnated for most workers, one of the only opportunities for working families to increase their incomes has been to increase their labor supply—and this has occurred primarily through the increased labor force participation and work hours of women.³⁴ The families that have seen real (inflation-adjusted) income growth since the 1970s are married couples where both spouses work.³⁵ As the share of families with all of their adult household members working has increased, the need for public policies facilitating balancing work and family caregiving obligations has intensified.

Women have made tremendous gains in the labor market, but have not reached equality. They still are paid less than men in almost all occupations, and are less likely to have upward mobility at work than their male colleagues.³⁶ Women, and women of color in particular, are more likely to work in low-wage jobs, earn the minimum wage or barely above it, and stay in entry- or low-level positions.³⁷ While labor market discrimination contributes to this



state of affairs, women's higher likelihood of being the primary caregiver for children and aging relatives, even when married and/or living with their partners, is also an important factor. Adult daughters are more likely than sons to care for elderly parents, and are increasingly caring for in-laws as well.³⁸

It is important to stress that while women bear the brunt of caregiving work, work-family issues are not restricted solely to working women. In some surveys, working fathers report even more work-family conflict than mothers,³⁹ and research consistently shows that men desire to be more involved with their families⁴⁰ and spend more time caregiving than generations past,⁴¹ and are often penalized for doing so in their workplaces because of outdated gender norms and a lack of supportive policies.⁴² Gender stereotypes regarding who works for pay and who provides care can limit the wealth-building and caregiving potential of individuals, families, and our economy and society.

A key demographic factor exacerbating the need for paid leave is the aging of the Boomer generation. Changing demographics will reduce the number of caregivers

available for each frail older person, and hence heighten the caregiving burden on families.⁴³ Seniors typically require higher levels of care as they get older, but will have access to ever fewer working-age family members to provide that care. For the particularly high-risk population of seniors over age 80, there will be a drastic reduction in the availability of potential family caregivers. In 2010, there were roughly seven potential caregivers (i.e., people aged 45-64, mostly adult children) for each person aged 80 or older. That ratio is projected to drop to 4:1 by 2030, and to 3:1 by 2050.⁴⁴ Unless policymakers make it easier in the coming years for workers to balance work and family caregiving, it is likely that either adult children of aging parents will reduce their labor market participation in order to provide needed care or that many frail elders will receive insufficient care.

Pathways to Existing State Paid Leave Systems

There is no national paid family and medical leave program in the United States, but there are multiple state programs (see Figure 1 on page 9). Federal law does provide access to job-protected *unpaid* leave for some workers. The Family

and Medical Leave Act (FMLA) of 1993 allows qualifying workers access to up to 12 weeks of unpaid, job-protected leave annually. FMLA leave can be taken to care for a new child (biological or adopted), to care for a seriously ill immediate family member, to address a worker's own serious health condition, or to address contingencies that arise out of military deployment.⁴⁵ Due to restrictive eligibility requirements (see Table 1 on page 10), roughly 40 percent of all workers are excluded from FMLA coverage.⁴⁶ Additionally, nearly half of workers who reported an unmet need for FMLA-type leave said they could not afford to take unpaid leave.⁴⁷

Five states currently guarantee access to paid *medical* leave, commonly referred to as temporary disability insurance (TDI) coverage, and all but one have subsequently added paid *family* leave to their TDI programs. These systems are not all the same, however; they have different institutional origins and designs that can be described broadly in four types: social insurance with an exclusive state fund (Rhode Island), social insurance with limited options for employers to use private coverage (California and New Jersey), a state fund with highly regulated private options (New York), and an employer mandate (Hawaii).⁴⁸

The first type was created in Rhode Island, which became the first state to adopt TDI in 1942. Rhode Island was seeking to provide unemployment-style benefits to those



unable to work; the law's drafters saw temporary disability as a special case of unemployment—unemployment due to sickness. Hence, they utilized their state's legal and administrative infrastructure for Unemployment Insurance (UI) as the foundation for their temporary disability program. Rhode Island also imitated the UI system's use of a single public insurance fund to collect contributions and pay benefits statewide, creating an exclusive TDI fund. Rhode Island was also one of only nine states at the time that had not only employer but also *employee* contributions to UI. As the economy recovered from the Great Depression in the 1940s and state UI coffers swelled, proponents of TDI saw an opportunity to replace most (two-thirds) of the employee contribution to UI with an equivalent employee contribution to the new disability fund. This 'painless' approach to financing paved the way to passage. While Rhode Island's TDI system was inspired by and built upon its UI program, it was *not integrated into* its UI program. This is because it is legally prohibited from using UI revenues for purposes other than those outlined in federal law.

California and New Jersey followed Rhode Island in enacting TDI systems in 1946 and 1948, respectively. They emulated Rhode Island's experience in that they built their TDI systems on top of their UI legal and administrative architectures. Like Rhode Island, they were among the few states in the country that had employee contributions to UI, and they, too, opted to eliminate these and introduce new employee contributions to TDI of a similar or lesser payroll tax rate, giving their programs a politically painless funding stream.⁴⁹ California's Senator Knowland took this a step further by introducing an amendment to the Federal Unemployment Tax Act, passed by Congress in 1946, that allowed states with employee contributions to UI to transfer previously accumulated employee contributions from UI to TDI.⁵⁰ This was utilized by California, New Jersey,



and Rhode Island to provide their TDI programs with a significant infusion of start-up funding.⁵¹ California and New Jersey diverged from the Rhode Island model in one key respect, however: they allowed employers to cover their workers outside of the state fund with the consent of their employees, either by purchasing short-term disability insurance from a private insurer or by self-insuring. This key alteration to the structure of TDI created a second type of design architecture: a social insurance program with additional employer options outside of the state system. Within this model, there are two subtypes: California made it very hard to opt out of the state fund; New Jersey made it easier, but still strongly regulated private plans.⁵² California allows employers to opt out of the state plan as long as their coverage meets the minimum requirements set by the state program and offers at least one benefit that is more generous, with equal or lesser costs for employees.⁵³ New Jersey permits companies to opt out if they provide coverage through an approved private plan with equal or greater benefits, and equal or lesser costs, for employees.⁵⁴

New York was the fourth state to enact TDI, which occurred in 1949. It utilized a third type of system architecture: a state fund with highly regulated private options.⁵⁵ The state did not have the benefit of an employee UI tax to potentially rededicate to TDI. Perhaps for this reason, it sought a different institutional pathway than the first three states; rather than building on UI's legal and administrative infrastructure, it built on its Workers' Compensation system. New York's Workers' Compensation system was and remains structured as an insurance marketplace with the New York State Insurance Fund (NYSIF) functioning as a competitive state fund. The NYSIF is a state-run not-for-profit, and is required to set premiums at the lowest

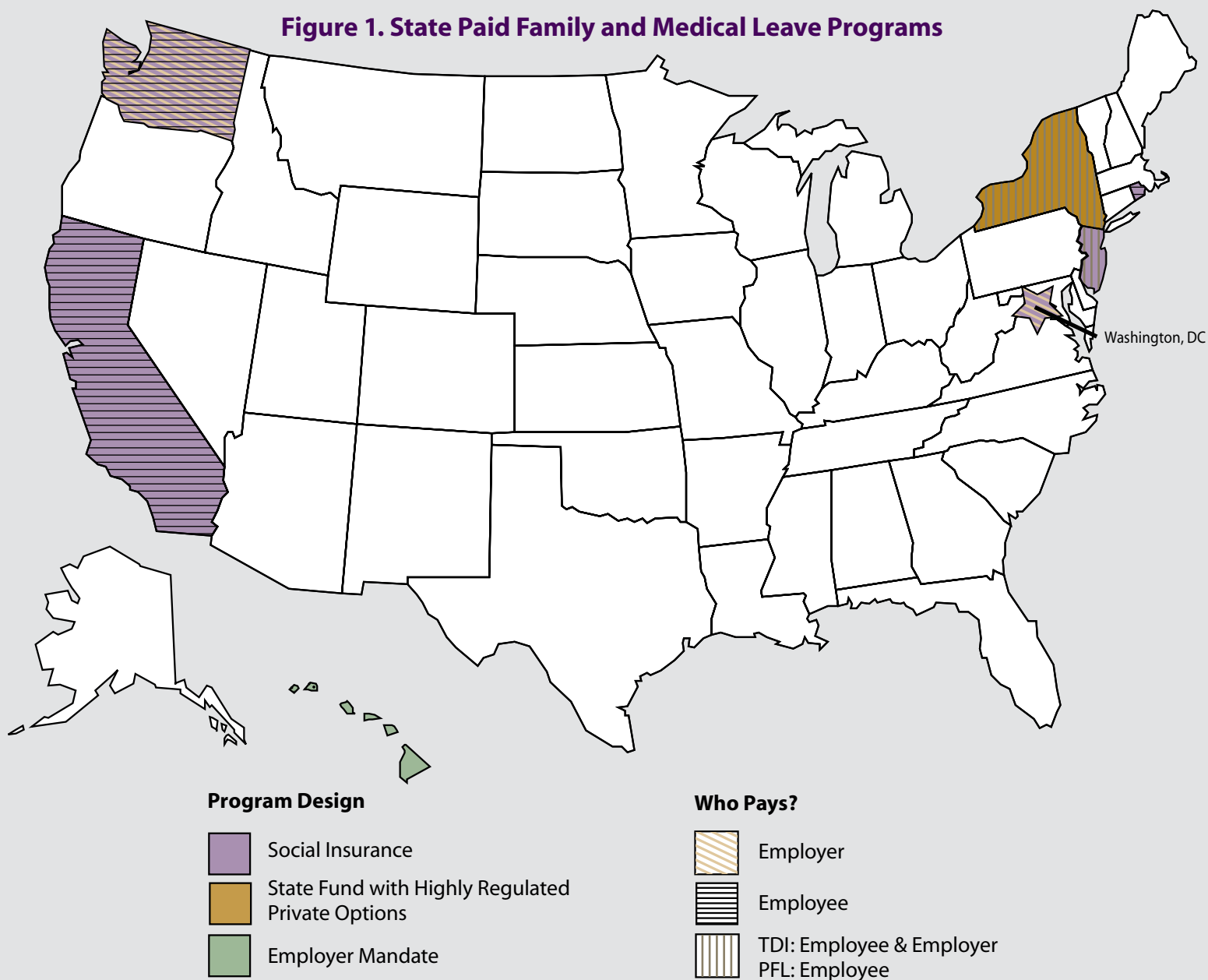
possible rates that allow for fund solvency.⁵⁶ The state fund provides TDI coverage that meets the minimum statutory standards, in addition to enriched state plans that offer higher levels of wage replacement.⁵⁷ Employers can choose whether to purchase coverage from a private insurer (which the majority of employers currently do), self-insure, or purchase coverage from the state fund. While New Jersey and California require a majority of employees to agree to adopt a private plan, New York allows employers to make this choice without employee consent.⁵⁸ Although New York makes it easy for employers to choose private insurance, the state has a strong enforcement agency and offers a state-run appeals process.⁵⁹

Hawaii adopted temporary disability insurance in 1969, much later than the previous four states. It utilized a fifth, much more laissez-faire type of system architecture: an employer mandate. This requires employers either to purchase state-approved private coverage for their employees, or to self-insure by paying partial wages directly during the time of an employee's personal medical leave. Most employers in the state, regardless of size, are required to provide temporary disability insurance for their workers. All costs of the plan must be funded either in full by the employer or through permitted levels of cost sharing with employees.⁶⁰

There is a clear contrast between the systems of New York and Hawaii. In New York, employers can choose between a state fund, a private insurer, or self-insurance (if they meet statutory requirements), but are subject to strict regulation and enforcement mechanisms to ensure workers have equitable access to statutory leave. New York's system is thus designed to achieve similar goals as social insurance systems in other states, albeit via a different program structure (rooted in the state's century-long history with Workers' Compensation and TDI). In Hawaii, TDI is entirely private and the state plays a much smaller role with significantly less oversight and regulation of the process, such as determining the rates that insurers can charge.⁶¹ Additionally, New York not only mandates coverage, but also offers employers a state fund as an alternative, whereas Hawaii has no competitive state fund⁶² (although the state does maintain a Special Disability Fund to provide benefits to workers whose employers are not in compliance with the law or who become disabled while unemployed).⁶³



Figure 1. State Paid Family and Medical Leave Programs



In 2002, California became the first state to add paid family leave to its TDI program. New Jersey did so in 2008, followed by Rhode Island in 2013. New York added paid family leave to its TDI program in 2016, effective 2018. Its paid family leave premiums are community rated, meaning that all employees are treated similarly and are not subject to cost variations based upon age, gender, geographic location, or any other demographic factor.⁶⁴ The law also gives the state's regulatory authorities the discretionary power to apply a risk-adjustment mechanism, which would

pool risk across insurers by loss ratio (the ratio of claims paid to premiums collected).⁶⁵ Hawaii is the only state with TDI that has not adopted paid family leave.

The District of Columbia and Washington state both passed comprehensive family and medical leave laws in 2017, effective 2020. The District of Columbia adopted the Rhode Island model of a social insurance system with an exclusive state fund, but the DC program will be financed through an employer rather than employee contribution.

Table 1. Key Features of Existing Family

Jurisdiction	Structure and Funding		Administrative Agency	Cost	
	Temporary Disability Insurance (TDI)	Paid Family Leave (PFL)		TDI	PFL
United States (Family and Medical Leave Act)	Unpaid		United States Department of Labor	n/a	
California	Social insurance with limited private options; Funded through employee payroll tax		California Employment Development Department	0.9% of taxable wages, up to a maximum of \$998.12	
New Jersey	Social insurance with limited private options; Employers may request approval to opt out of state plan to self-insure or provide insurance through private carrier; Funded through employee/ employer payroll tax	Funded through employee payroll tax	New Jersey Department of Labor and Workforce Development	Employee: 2017 – 0.24% up to wage base of \$33,500; 2018 – 0.19% up to \$33,700; New employers: 0.5%; All other employers: experience rated, 2017 wage limit – \$33,500; 2018 wage limit – \$33,700	2017: 0.10% of employee's wages up to the wage base of \$33,500; 2018: 0.09% of employee's wages up to \$33,700
Rhode Island	Social insurance with exclusive state fund; Funded through employee payroll tax		Rhode Island Department of Labor and Workforce Development	1.2% of the first \$68,100 in earnings	
New York (PFL: Enacted in 2016, effective 2018)	State fund, with highly-regulated private options; Employers must provide coverage either through private insurance or the state plan, or request approval to self-insure; Employers may wave the employee contribution to fully fund coverage; Funded through employee/ employer payroll tax	Funded through employee payroll tax	New York State Workers' Compensation Board	Employee: 0.5% of wages paid, up to \$0.60 per week Employer: all additional costs	0.126% of employee's weekly wage up to the state average weekly wage (AWW)
Hawaii	Employer mandate	n/a	Hawaii Department of Labor and Industrial Relations	Employee: up to 0.5% of weekly wages, up to \$5.12 Employer: all additional costs	
District of Columbia (Enacted 2017, effective July 2020)	Social insurance with exclusive state fund; Funded through employer payroll tax		To be determined	0.62% of the annual wages of each covered employee	
Washington (Enacted 2017, effective 2019 (premiums) / 2020 (benefits))	Social insurance with limited private options; Funded through an employee/ employer payroll tax		Washington State Employment Security Department	0.4% of wages, with a minimum of 37.5% paid for by employers and the remaining amount, up to 62.5%, by employees	

Sources: Family and Medical Leave Act of 1993; State of Rhode Island, 2017; State of Hawaii, 2017a; State of California, 2017; State of New Jersey, 2017; New York State Paid Family Leave, 2017; District of Columbia, 2016; State of Washington, 2017.

and Medical Leave Programs

Length of Leave Available		Wage Replacement	Eligibility Requirements*	
TDI	PFL			
Up to 12 weeks		None	Worked at current job for at least 12 months & logged at least 1,250 hours in previous year AND Work for an employer with at least 50 employees within a 75-mile radius	U.S.
Up to 52 weeks	Up to 6 weeks	55%, weekly max of \$1,173; In 2018, benefit increases to 70% for those earning <1/3 of state average weekly wage (AWW), & 60% for all others, up to benefit cap	Earned at least \$300 in base period	CA
Up to 26 weeks	Up to 6 weeks	66%, weekly max of \$633	Earned at least \$8,400 in base year OR Earned at least \$168 per week for a minimum of 20 weeks	NJ
Up to 30 weeks	Up to 4 weeks	60%, weekly maximum of \$817, plus dependent benefits	Earned at least \$11,520 in base or alternate base period** OR Earned at least \$3,840 in base period & at least \$1,920 in a quarter & have total base period earnings of at least 150% of highest quarter's earnings	RI
Up to 26 weeks	Up to 8 weeks in 2018, 10 weeks in 2019, 12 weeks in 2021	TDI: 50%, with a weekly maximum of \$170 PFL: 50% up to 50% of state AWW in 2018, 55% up to cap of 55% of state AWW in 2019, 60% up to cap of 60% of state AWW in 2020, 67% up to a cap of 67% of state AWW in 2021	TDI: worked at least 4 consecutive weeks for a covered employer OR Work for an employer who provides voluntary coverage OR Work at least 40 hours per week for one employer as a domestic or personal employee PFL: currently employed by a covered employer & worked at least 26 consecutive weeks for a covered employer OR Worked at least 175 days for a covered employer if part-time	NY
Up to 26 weeks	n/a	58%, with a weekly maximum of \$594	Worked at least 20 hours per week for at least 14 weeks AND Earned at least \$400 in the 52 weeks prior to the claim date AND Be in current employment	HI
Up to 2 weeks	Up to 8 weeks of parental leave; Up to 6 weeks of family caregiving leave; No more than 8 weeks of total leave in a 52-week period	For workers with weekly earnings <150% of DC min wage (\$690 in 2017), 90% of AWW; For workers with weekly earnings >150% of DC min wage, 90% of earnings up to 150% of DC min wage, plus 50% of earnings above this threshold, with weekly max of \$1,000	Worked more than 50% of the time for a covered private-sector employer in DC AND Worked for a covered employer for at least some time in last 52 weeks; OR Self-employed with self-employment income for work performed more than 50% of the time in DC AND Opted into paid leave program & paid appropriate taxes into system	DC
Up to 12 weeks, OR up to 14 for serious pregnancy-related complications resulting in incapacity	Up to 12 weeks; Combined family/medical leave may not exceed 16 weeks; OR 18 in case of serious pregnancy-related complication	For workers with earnings at <50% of state AWW, 90% of worker's AWW; For workers earning over 50% of state AWW, 90% AWW up to 50% of state AWW, plus 50% of employee's AWW for all earnings above 50% of statewide AWW, with weekly max of \$1,000	Worked at least four out of five completed quarters prior to application AND Worked for at least 820 hours in the qualifying period	WA

* Coverage exclusions may apply in individual states, and coverage for public sector workers varies by state.

** In Rhode Island, the base period is defined as the first four of the last five completed calendar quarters before the starting date of a new claim. If an individual is not eligible due to insufficient earnings using the base period, the state will recalculate earnings from an alternate base period consisting of the last four completed calendar quarters before the starting date of a claim. While the same earnings requirements must be met to qualify for this alternate base period, it allows for wage replacement to be set based on more recent earnings when the employee might have been earning higher wages that would permit them to qualify for benefits.



Washington state first passed legislation to implement a paid leave program in 2007, but the process of developing a functioning system has taken over a decade since no source of funding for the program was initially established. In 2017, the state enacted a new and comprehensive paid family and medical leave law, funded through an employee and employer payroll contribution. The state adopted a social insurance approach with limited employer options to privately insure. Employers will be permitted to opt out of the state plan if they already offer a program of equal or greater generosity. It will begin collecting funds in 2019 and paying out benefits in 2020.

Current Landscape of State Paid Leave Systems

Rhode Island, California, New Jersey, the District of Columbia, and Washington state all structure their paid family and medical leave programs as social insurance, with near-universal statutory coverage and a high degree of risk pooling through a state fund, financed by dedicated employer and/or employee contributions. New York requires employers to choose between a state plan and highly-regulated private plans to cover paid leave for workers, and sets community-rated premiums for its paid family leave program. Rules for eligibility, coverage, and job protection vary by state, but all these paid family and medical leave programs provide workers with partial wage replacement when they need leave to care for themselves, a family member with a serious health condition, or a new biological, adoptive, or foster child.⁶⁶ Hawaii offers

temporary disability leave, but not family leave, through an employer mandate.

Rhode Island workers can access up to 30 weeks of temporary disability and up to four weeks of family leave per year (for details on state provisions, see Table 1). These benefits are paid at 60 percent of normal wages, up to a weekly maximum of \$817. In California, workers are eligible for up to 52 weeks of temporary disability leave and up to six weeks of family leave per year. Leave benefits are currently paid at 55 percent of average weekly wages, and will increase in 2018 to 70 percent for those earning less than one-third of the state average weekly wage and 60 percent for higher earners. Benefits are capped at a maximum of \$1,173 per week in 2017. Both California and Rhode Island adjust their maximum allowable benefits annually. In New Jersey, workers can qualify for up to 26 weeks of temporary disability leave and six weeks of family leave, paid at 66 percent of normal wages up to a maximum of \$633 per week. New York currently provides up to 26 weeks of temporary disability benefits at 50 percent of a workers' average wages, up to a cap of \$170 per week. Starting in 2018, the New York paid family leave program will provide up to eight weeks of family leave paid at 50 percent of a worker's normal wage, up to a cap of 50 percent of the state average weekly wage. The length of leave and wage replacement level will increase over time until 2021, when workers will be eligible for up to 12 weeks of family leave paid at 67 percent of normal wages, up to a cap of 67 percent of the state average weekly wage. In Hawaii, employees are eligible for up to 26 weeks of time per year to care for a personal medical need, paid at 58 percent of the individual's average weekly wages, up to a current maximum of \$594. Hawaii does not currently have a paid family leave program. Beginning in 2020, the District of Columbia will provide up to eight weeks of paid leave for individuals caring for a new child, six weeks for individuals caring for a seriously ill family member, and two weeks for one's own serious personal medical needs. Also in 2020, Washington state will provide up to 12 weeks of temporary disability benefits (with up to 14 weeks for serious pregnancy-related complications resulting in incapacity) and up to 12 weeks of paid family leave benefits. The total combined leave taken by a worker in a year cannot exceed 16 weeks (or 18 weeks in case of serious pregnancy-related complications).

Design Options for New Paid Leave Systems

Policymakers and advocates around the country are in the process of designing paid family and medical leave systems for their states. As they do so, they will have choices to make in terms of system architecture, funding, and administration.

System Architecture

As discussed above, existing systems of paid leave in the U.S. are structured in one of four types of system architecture: social insurance with an exclusive state fund (RI/DC), social insurance with limited private options (CA/NJ/WA), state insurance funds with highly-regulated private options (NY), or an employer mandate (HI). The choice of system architecture has strong implications for risk pooling, coverage, administration, and costs.

The majority of paid leave programs in the United States, and the vast majority of those in other advanced economies, are structured as social insurance. In these programs, workers and/or their employers make payroll contributions into a dedicated insurance fund (although in some countries the government may contribute as well). When a worker qualifies for leave, they receive partial wage replacement from the insurance pool. This is a benefit



administered by the government rather than by employers. Because risk and resources are pooled in social insurance programs, and because the events that trigger paid family and medical leave are infrequent over the course of most workers' lives, paid leave can be provided universally at a low per-person cost.

Social insurance with an exclusive state fund: A social insurance system utilizing an exclusive state fund, as in Rhode Island, achieves maximum risk and resource pooling. Pooling risk across an entire state's workforce allows the higher costs caused by those who need to take longer periods of leave—e.g., an individual undergoing treatment for cancer, parent caring for a newborn child, or person caring for a parent with dementia—to be offset by the lower costs of those who need to take little or no leave in a given year. In general, the larger the risk pool, the more predictable and stable the premiums can be. In a larger risk pool, there is less uncertainty about the rate at which the insured event will transpire, so premiums are likely to be lower. And because contributions to a state fund are typically community rated, employers do not experience variance in their premiums based on their claims experience, making the costs predictable.

A social insurance system with an exclusive state fund is more streamlined to administer than a system with both a state fund and well-regulated private options. A major reason for this is that premium collection is administratively simpler and less expensive when collected through payroll deduction.⁶⁷ Moreover, when a significant share of employers have private plans, the state must hire staff





to approve, regulate, and supervise them, in addition to running the state fund. Exclusive state funds also eliminate the costs associated with underwriting, advertising, and profit of private insurers, as well as the costs of litigation, resulting in lower overhead expenses.

Social insurance with limited private options: A social insurance system with employer opt-outs can maintain many of the advantages of an exclusive state fund if it has a strong regulatory apparatus and keeps opt-outs to a modest level, as in the cases of New Jersey and particularly California. A state allowing employer private options could experience higher premiums or benefit costs in their state fund, however, if the employers opting out were selecting against the fund—that is, if they had employee populations that were, on average, less likely to take temporary disability and/or family leave. Moreover, if a system were to allow opt-outs, strong regulations and enforcement would be required to make sure that employers who self-insure have sufficient assets to cover costs and that employers offering

private insurance plans provide coverage of equal or better quality than the state fund to their workers.

State fund with private options: New York’s system architecture of a state fund with private options is a product of the legacy structure of its Workers’ Compensation program. It was efficient to add TDI to this architecture in 1949, and then paid family leave in 2016, but it would be far less efficient for other states to create such a system without a similar legacy structure in place. Beyond the administrative costs of developing and running a state fund, such a system would require extensive staffing for compliance audits, an appeals process, and enforcement of private coverage. A highly regulated version of an employer mandate system, as in New York, is only possible in a state with a strong regulatory infrastructure. Most states do not already have comparably rigorous regulatory requirements, supervision, and enforcement as is the case in New York. Without sufficient enforcement, a state fund with private options could potentially compromise access to leave.

Employer mandate: States pursuing paid leave systems could also choose to forgo a social insurance approach and instead adopt an employer mandate, as in Hawaii. Outside the United States, this approach is more common in emerging economies, particularly in the Middle East, but also among Asian and African nations.⁶⁸ In this type of model, employers are required by the government to provide paid leave benefits directly to their workers. This can be achieved through an employer directly self-financing a paid leave program or by purchasing private market insurance products.

A social insurance approach to the provision of paid leave has a number of advantages over an employer mandate. It renders the coverage much more portable, avoiding job lock. In the same vein, a social insurance approach provides better coverage than an employer mandate for workers who become disabled or assume family responsibilities between jobs—people who were looking for work, but now temporarily cannot (although Hawaii does make provisions for some unemployed workers). Social insurance also provides better coverage for contingent or part-time workers.

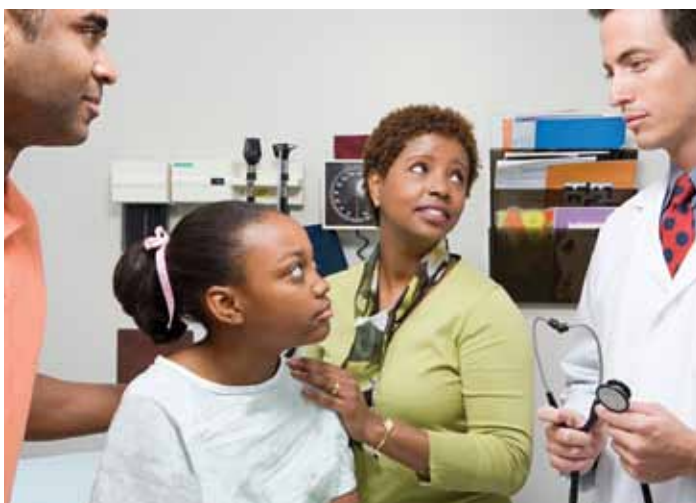
Mandating that employers provide paid leave may result in unintended consequences.⁶⁹ There is some evidence to suggest that an employer mandate to provide paid maternity leave, when coupled with a requirement that employers self-finance such coverage, may lead to



employment discrimination against women, although this effect may be tempered when employees also contribute to funding the program.⁷⁰ Furthermore, claiming paid leave benefits from one's employer—which could potentially drive up their insurance costs—may incur stigma, particularly for hard-to-observe medical conditions like lower back pain or psychological conditions. In cases where an employer chooses to self-insure, workers may be required to provide sensitive medical information directly to their employer and supervisors—something many employees may be reticent to do. Moreover, employers and for-profit insurers have an incentive to interpret eligibility criteria restrictively. Removing the employer or the employer's insurer from decisions about the existence and duration of disability avoids this problem. Even when employers do not discriminate, there may be a disproportionate economic impact of mandating employer self-financing of paid family and medical leave where the labor force is comprised primarily of women of childbearing age or older workers who are more likely to need temporary disability leave, or for small businesses.

Direct government provision: A handful of countries provide paid leave through government programs that are funded through general revenues, but this remains an uncommon approach abroad, and no state in the U.S. has done so as of yet. In this program structure, leave-takers typically receive flat-rate or modest benefits (rather than replacement of a share of prior wages) from the government, and the program is financed through general revenues (rather than payroll contributions to a dedicated





fund).⁷¹ Australia, which implemented its paid parental leave program in 2011, pays a flat-rate parental leave benefit equal to the minimum wage.⁷² New Zealand and the United Kingdom are the only two other major countries that utilize a direct government provision approach exclusively; they pay largely income-related benefits (up to a cap in New Zealand). In some other countries, a direct provision component is used as a social-assistance complement to a social insurance or employer mandate program to meet the needs of workers who fail to meet the qualifying conditions, and/or to provide benefits for low-income women or new mothers who are in an informal work arrangement.⁷³

Employee opt-out: In addition to these system architecture options, a specific design feature recently considered in some states, such as New Hampshire, is an employee opt-out provision. This would allow any worker to opt out of contributing, thus rendering themselves ineligible for benefits. Such a provision would likely lead to a strong selection bias among workers. Those who plan to become parents and those who have reason to anticipate either a personal or family health care crisis requiring paid time away from the workplace to receive or provide care would have a stronger incentive to participate than those who are at a lower self-perceived risk needing to take family or medical leave. As a result, the proportion of workers paying into the system would be smaller, and their costs would be higher, raising contribution levels for those who do participate,⁷⁴ while those who opt out of the program would be exposed to risk in the event of an unanticipated personal or family health need.

Funding: Employer, employee, or matching contributions?

A key decision point in designing paid leave programs is the source of funding. Employees finance the cost of leave either in whole or in part in all paid leave social insurance programs except the District of Columbia, where a payroll tax will be levied solely on employers, for reasons unique to the District.⁷⁵ However, it is possible that some portion of employer contributions is ultimately transferred to workers through a reduction in future wages.

The paid leave programs in California and Rhode Island are solely funded by employee contributions, and the rate is set depending on the health and solvency of the state fund. Employers in California who choose private options may shoulder the entire cost themselves or require employee contributions, but these cannot exceed the rate set by the state social insurance fund. Employers share the cost with employees in Washington state's paid leave system, and in the temporary disability insurance component of the paid leave systems in New York and New Jersey. In New York, because the employee contribution to TDI is capped at only \$0.60 per week, in practice employers pay the majority of the cost for TDI, although paid family leave is entirely employee-funded.⁷⁶ In New Jersey, employer contributions vary because the program is largely experience rated.



Under Hawaii's employer mandate, employers may cover the entire cost or require contributions from employees, which cannot exceed 0.5 percent of their taxable weekly earnings up to a maximum of \$5.12 in 2017.⁷⁷

Administration: A new agency or integration into existing authorities?

States seeking to enact a paid family and medical leave system will need to choose or create an institutional vehicle for administering the program. Establishing administration for a new program that is as efficient and cost-effective as possible often means building upon other processes and procedures already in place within other state programs. A paid family and medical leave administrative body needs to be able to meet four core functions: (1) determining eligibility for leave based on evaluating whether or not a worker is experiencing a qualifying life event, such as the birth of a child or a temporary disability; (2) determining eligibility based on program rules for prior earnings and/or labor force attachment; (3) calculating and processing the appropriate level of wage replacement; and (4) addressing appeals if a claim for leave is initially denied.

In order to administer paid leave, states must either develop an entirely new agency or create a new department within an existing agency. Ideally, paid leave administration should be coordinated with other state agencies that already collect data on wages and labor force attachment, as these data are necessary to make eligibility determinations and to calculate wage replacement. Administering paid leave through an existing agency that already has wage and labor force attachment data has the added advantage of reducing the reporting burden on employers.

California, New Jersey, and Rhode Island administer their paid leave programs through their employment security agencies, which also administer UI, and Washington state and the District of Columbia have similar plans for their paid leave programs.⁷⁸ Although a paid leave program cannot be administered by a state's Unemployment Insurance system or result in new costs to that system, states can issue memorandums of understanding (MOUs) that allow wage data collected by the UI program to be shared. Another option is for a state to administer its paid leave program in coordination with its Workers' Compensation program. The state of New York has

housed administration of its paid leave program within its Workers' Compensation Board, and the New York State Insurance Fund provides both Workers' Compensation and temporary disability insurance (and will soon provide paid family leave insurance, as well).



A key consideration in administrative design is maximizing efficiency and minimizing costs. States that allow employers to opt out of the state-run social insurance infrastructure must oversee the privately offered plans, in addition to running the state fund. This adds an additional layer of administrative functions and requires additional staffing. For example, California has a Voluntary Plan Administration Section with two managers and 11 staff to oversee all employer-provided voluntary plans, which currently cover approximately 2,500 employers in the state.⁷⁹ California's Voluntary Plan Administration Section has recommended that other states not allow employer opt-outs, as it would add additional complexity and administrative functions in the already complex process of forming a new state program.⁸⁰

Economic and Health Impact of Paid Leave Programs

Paid leave programs have been found to increase labor market participation, improve the financial security of working families, and improve child and maternal health outcomes. From 1990 to 2010, the U.S. ranking among OECD countries in terms of female labor-market participation declined from sixth to seventeenth. A major reason for this relative decline was the lack of

family-friendly employment policies in the U.S.⁸¹ The U.S. Department of Labor estimates that if women in the U.S. aged 25-54 participated in the labor force at the same rates as their counterparts in Canada or Germany, 5.5 million more women would have been in the labor force in 2014, increasing GDP by 3.5 percent.⁸² Moreover, initial evaluations of the state-based paid leave programs implemented over the past two decades in the U.S. suggest positive economic impact. Despite prior concerns from the business community, findings from California⁸³ and Rhode Island⁸⁴ show that the effects of paid family leave overall have been neutral or even beneficial for employers there.

Strengthening the financial security of working families is a primary motivation for any paid leave policy, and these policies have indeed been shown to improve outcomes. Access to paid maternity leave makes mothers more likely to return to paid employment after giving birth, and paid leave is associated with higher wages and a lower gender wage gap.⁸⁵ Mothers with access to paid leave in California were not only more likely to return to work, they were also more likely to return to their same employers.⁸⁶ Similar effects have been found in New Jersey, where paid leave has increased married mothers' employment probability—an effect that persists for three years after giving birth.⁸⁷ When workers with medical conditions have access to paid leave, it helps them to maintain employment and return to work more quickly when they need time off. For example, research on



women who experienced myocardial infarction or angina found that those with access to paid leave were more likely to return to work compared to women without paid leave.⁸⁸

Health outcomes are another important metric in assessing paid leave policy. Babies whose parents have access to paid leave are more likely to be breastfed⁸⁹ and receive vaccinations on the medically recommended schedule, and paid leave is associated with lower infant mortality rates.⁹⁰ Benefits also extend to mothers; women who had less than eight weeks of paid maternity leave, as well as those who took under 12 weeks of unpaid leave, experienced an increase in depressive symptoms and had a lower health status overall after childbirth than those who had access to and took advantage of longer periods of paid leave.⁹¹

Access to paid parental leave has also been shown to have a positive effect in improving gender equity in the balancing of work and caregiving. Fathers are more likely to take parental leave when it is paid, likely because families can often better afford for fathers to take time off and the stigma of leave-taking is reduced when leave is paid.⁹² Fathers who take parental leave show higher levels of parental involvement, and these effects persist as children age.⁹³ In contrast, in countries where paid parental leave is not gender neutral and is largely restricted to birth mothers, there is some evidence that women pay a wage penalty and may face employment discrimination.⁹⁴



International Experience with Paid Leave

On a global level, the United States is an extreme outlier in its lack of a national paid leave program. The U.S. is the only developed economy that does not guarantee any paid maternity leave. Among developed economies, 88 percent of nations fund maternity leave through a social insurance program, with the remaining nations relying on some combination of social insurance and employer mandate.⁹⁵ The International Labour Organization notes that the use of a social insurance system, in contrast to a system where employers bear the entire costs of paid leave, is important to mitigating employment discrimination, particularly against women who may become mothers.⁹⁶ Paid paternity leave of varying duration is guaranteed as an entitlement in 27 out of the 35 OECD countries,⁹⁷ and 26 provide at least some duration of paid leave for working family members to care for a sick child, spouse, and/or close family member.⁹⁸

It is important to recognize that the goals behind the development and implementation of paid leave policies in other countries may differ from those prioritized in the United States. For example, many “work-family” policies

implemented in Europe after WWII were not originally intended to help workers manage their competing needs at work and home, but rather to help push women back to the domestic sphere as men returned from the battlefields. In some countries, such policies were developed to help to increase birthrates. The intended goals of paid leave programs have differed across countries and over time, and the specifics of the policies—eligibility, level of benefit, length of leave—differ depending on their desired outcomes. These policies have evolved over the decades to match the needs of the contemporary workforce, and these updates have often been explicitly intended to help promote gender equity and women’s labor force attachment.⁹⁹

There is some evidence that women workers in countries with employer mandates for maternity leave may experience negative employment effects, likely contributing to the gender wage gap.¹⁰⁰ Relatively long (by U.S. standards) maternity leaves of more than 6 months have been associated in some studies with reduced wages for women.¹⁰¹ Some have argued that the creation of a paid family and medical leave program would be likely to result



in reduced labor force participation for women and could cause an increase in employment discrimination. These are concerns worth addressing by further studying what has and has not worked in other countries.

Questions for Future Study

A robust body of research makes the case for how and why a national paid family and medical leave program would positively impact children, family economic security, labor force participation, and the U.S. economy.¹⁰² There are, however, fundamental policy questions that warrant further study.

First, additional research is needed to assess specific policy choices such as length of leave, ideal level of wage replacement, and whether creating a uniform policy for parental leave, family care, and personal medical leave has the greatest benefits for gender equity and efficiency. Questions also remain about the most appropriate source of funding, in particular the pros and cons of contributions by employees, employers, or both—or, alternatively, general revenue funding. Further research on the impacts of even these modest payroll tax increases on low-income workers, and whether the Earned-Income Tax Credit (EITC) should be increased to alleviate some of the burden, would also advance the policy design debate. Moreover, how would the program work for employees currently entitled to benefits from their employer? Would the public plan be the primary or secondary payer?

There are also remaining questions about the appropriate scope of a paid leave program, in particular with regard to the definition of family members for whose care a worker can qualify for leave, and with regard to how paid leave policies can better address the needs of people with disabilities and their families.¹⁰³ A question of increasing urgency is how paid leave programs can ensure the coverage of contingent workers, as well as ensure that benefit contributions are affordable and portable for workers without a formal or consistent employer.

Perhaps the most pressing research need is to compare how the different system architectures discussed above affect administrative efficiency and equity. As noted in the discussion of pathways to existing state paid leave systems, the states that chose to allow employer opt-outs

or private options did so in large part to remain consistent with their legacy TDI policies, all of which were originally created in the 1940s. Further research is needed to assess whether it would be administratively efficient for states not confined by the same path dependency to pursue this system architecture. Moreover, how do the costs of paid leave and worker experiences with the program vary among an exclusive social insurance fund (like Rhode Island's), a system allowing employer opt-outs from state funds (as is currently possible to a limited extent in California and New Jersey, and to a greater extent in New York), and a loosely regulated employer mandate (as in Hawaii)? How does the experience of workers in private plans compare to that of workers in state plans?

Finally, more analysis is needed on the pros and cons of administering a paid leave system in coordination with a state's Unemployment Insurance system (although by law paid leave cannot be administered directly by—or integrated into—a state's UI system), a Workers' Compensation system, or some other state agency. On the national level, legislation is under consideration to utilize the Social Security Administration's existing data and infrastructure to also provide paid family and medical leave. More research is needed to determine which agency of the federal government and/or state governments would be best suited to administer a paid leave program.



CONCLUSION

All people—men and women, young and old, parents and those without children—face the risk of experiencing a period of time in their working lives when they need time off to care for a family member or themselves. In spite of the dramatic shift in work and family life over the last 40 years, national policies have been slow to change in response. Yet, policies to help families cope with the conflicts between work and caregiving are necessary to promote family economic security, combat income inequality, strengthen intergenerational mobility, increase labor market participation, and bolster economic growth. As ever more states consider enacting a paid family and medical leave program for their workforce, they can draw on the lessons from existing programs in the United States and abroad. With many new systems created in the past five years alone, more research is needed to study the implications of their design choices with respect to system architecture, funding, and administration.

ENDNOTES

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- 2 Federal Reserve Bank of St. Louis, 2017.
- 3 Family and Medical Leave Act of 1993. The FMLA will be discussed in more detail further below.
- 4 The Organization for Economic Co-operation and Development (OECD), 2015.
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- 7 Bureau of Labor Statistics, 2016a.
- 8 Kurani, Ranji, Salganicoff, and Rae, 2017.
- 9 Perez and Groshen, 2016.
- 10 Bureau of Labor Statistics, 2016a.
- 11 Ibid.
- 12 Bureau of Labor Statistics, 2016c.
- 13 Bureau of Labor Statistics, 2016a.
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- 15 Bureau of Labor Statistics, 2016b.
- 16 Ibid.
- 17 Grant, Sutcliffe, Dutta-Gupta, and Goldvale, 2017.
- 18 Bowman, Durso, Gruber, Kocolatos, Krishnamurthy, Make, McGovern, and Gallagher Robbins, 2016.
- 19 See forthcoming analysis by Gallagher Robbins and Durso, 2017.
- 20 The Pediatric Policy Council (PPC) and the American Academy of Pediatrics (AAP) have endorsed legislation that would provide up to 12 weeks of paid parental leave, while former AAP President Dr. Benard Dreyer has publicly recommended 6 to 9 months of leave for parental leave. For more information on the official stance of the PPC and AAP, see: American Academy of Pediatrics, 2015. For Dr. Dreyer's comments, see: National Public Radio, 2016.
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- 33 Ibid.
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- 37 Wingfield, 2009; Belman, Wolfson, and Nawakitphaitoon, 2015.
- 38 Smith, 2004.
- 39 Aumann, Galinsky, and Matos, 2011.
- 40 Rehel, 2014.
- 41 Parker and Wang, 2013.
- 42 Vandello, Hettinger, Bosson, and Siddiqi, 2013.
- 43 Dastur, et al., 2017.
- 44 Redfoot, Feinberg, and Houser, 2013.
- 45 Family and Medical Leave Act of 1993.
- 46 Klerman, Daley, and Pozniak, 2012a.
- 47 Ibid.
- 48 Williamson, 2017, distinguishes three TDI models: a monopolistic state fund, a default state fund with private options, and an employer insurance mandate.
- 49 Ibid.
- 50 Social Security Administration, 2017.
- 51 Williamson, 2017.
- 52 Ibid.
- 53 State of California, n.d.
- 54 State of New Jersey, n.d.
- 55 Washington state was the fourth state to enact a TDI program earlier in 1949, but it was repealed by referendum in 1950. See: Williamson, 2017.
- 56 New York State Insurance Fund, 2016.
- 57 New York State Insurance Fund, 2017.
- 58 Williamson, 2017.
- 59 Ibid.
- 60 State of Hawaii, 2017b.
- 61 Ibid.
- 62 Williamson, 2017.
- 63 State of Hawaii, 2013.
- 64 New York State Department of Financial Services, 2017.
- 65 New York State Register, 2017.
- 66 National Partnership for Women and Families, 2015b.
- 67 Woolhandler, Campbell, and Himmelstein, 2003.
- 68 Ibid.
- 69 Mathur, Sawhill, et al., 2017.
- 70 Addati, Cassirer, and Gilchrist, 2014.
- 71 Esping-Andersen, 1990.
- 72 Australian Government Department of Social Services, 2016.
- 73 Addati, Cassirer, and Gilchrist, 2014.
- 74 Hayes and Berlan, 2017.
- 75 The DC government is not legally able to tax workers who are employed in the District but live in surrounding states (commuters), therefore the decision was made to tax DC employers to fund the program in order to avoid unequal access to paid leave between employees in the same businesses.

- 76 State of New York, n.d.
- 77 State of Hawaii, 2017c.
- 78 U.S. DOL, 2014.
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- 80 Glynn et al., 2015.
- 81 Blau and Kahn, 2013.
- 82 U.S. DOL, 2015a.
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- 84 Bartel, Rossin-Slater, Ruhm, and Waldfogel, 2016.
- 85 Waldfogel, Yoshio, and Masahiro, 1999; Australian Government Productivity Commission, 2009; Washbrook, Ruhm, Waldfogel, and Han, 2013; U.S. Census Bureau, 2011; Boushey, 2008.
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