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DISCUSSION

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DISCUSSION PAPER

// STEFAN PICHLER AND NICOLAS ZIEBARTH

Sick Leave and Medical Leave in the United States: A Categori- zation and Recent Trends

Sick Leave and Medical Leave in the United States: A Categorization and Recent Trends *

Stefan Pichler[†] Nicolas R. Ziebarth[‡]

January 16, 2024

Abstract

This article reviews the current debate about sick pay mandates and medical leave in the United States. The United States is one of three industrialized countries that do not guarantee access to paid sick leave for all employees. We first provide a categorization of the different paid leave concepts such as sick leave, medical leave, or temporary disability insurance, both in a domestic and an international context. Then we use data from the National Compensation Survey to sketch employee coverage rates by type of job. We also document changes since 2010, focusing on paid sick leave. Although gaps in access have decreased over the past decade, we still find large inequalities in access to paid sick leave: While overall coverage increased to 78% in 2023 from 64% in 2015, about half of all part-time employees, employees in the bottom quarter of the wage distribution, and employees in the accommodation and food industry still have *no* access to paid sick leave benefits. In the last part, we discuss implications of the lack of access to paid sick and medical leave benefits. Moreover, building on international research findings and experiences, we discuss what a possible integration, coordination, and expansion of the co-existing programs could look like.

Keywords: sick pay mandates, sick leave, medical leave, paid leave, inequality, employer mandates, fringe benefits, moral hazard, unintended consequences, labor costs, National Compensation Survey (NCS)

JEL classification: I12, I13, I18, J22, J28, J32

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Introduction

All but three Organisation for Economic Cooperation and Development (OECD) countries guarantee universal access to paid sick leave for all employees (Heymann et al., 2010; OECD Policy Responses to Coronavirus, 2020). The United States has traditionally let employers decide whether to offer paid sick leave benefits to their employees. Until recently, the only existing federal law was the *Family and Medical Leave Act of 1993 (FMLA)*. This act provides *unpaid* leave of up to 12 weeks a year for of pregnancy, own illness, or illness of a family member to full time employees in firms with at least 50 employees (cf. Ruhm, 1997; Waldfogel, 1999; Tominey, 2016). Broadly speaking, “sick leave” implies that employees can take days off from work due to a short-term sickness such as the common cold or the flu, whereas “medical leave” (called “long-term sick leave” outside the U.S.) implies coverage for a longer-term more serious sickness of several weeks.

In the U.S., former Senator Edward M. Kennedy (D-MA) introduced the first legislation for a federal sick pay mandate—the *Healthy Families Act*—to the U.S. Congress in 2005. After several failed attempts to pass and enact it, the bill was reintroduced in 2023 (S.1664 - *Healthy Families Act*, 2023). The *Healthy Families Act* would enable every employee to earn one hour of sick time for every 30 hours worked, up to 56 hours per year, whereby unused days carry over to the next year. Employers with more than 15 employees would have to provide paid sick time, whereas small employers would have to provide unpaid sick time (S.1664 - *Healthy Families Act*, 2023). The bill explicitly stipulates that paid sick time can be taken for own sickness or medical care or “caring for a child, a parent, a spouse, a domestic partner, or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship [...] (Section 3, (b) (3)).”

Although no bipartisan consensus on passing the *Healthy Families Act* has been reached, as of writing, dozens of cities and 15 states, plus D.C., have passed sick pay mandates that largely follow the structure of the *Healthy Families Act*. Table A1 in the Appendix provides an overview. For example, California covers all workers, including part-time, and covers all firms, independent of size. Nine of the states that passed sick pay mandates also passed “ceiling or floor” preemption laws, preventing local governments from en-

acting more or less generous mandates than at the state-level (Pomeranz, 2022). Further 17 state-level preemption laws in (primarily red) states without a state-level mandate prevent local governments from enacting *any* sick pay mandate (Economic Policy Institute, 2023).

Moreover, in response to the COVID-19 pandemic, in March of 2020, Congress passed a bipartisan Families First Coronavirus Response Act (FFCRA) that contained up to two weeks of emergency sick leave for employees in private firms with up to 500 employees (Department of Labor, 2020). Although this emergency provision was effective in preventing the spread of COVID-19, it has expired (National Partnership for Women and Families, 2020; Pichler et al., 2020a; Andersen et al., 2023). States additionally enacted emergency sick leave legislation during COVID-19, some of which was expanded and made permanent, e.g. the Colorado Healthy Families and Workplace Act Colorado Healthy Families & Workplace Act (2020).

This article reviews and discusses recent trends of access to paid leave in the United States. Although we also categorize and discuss other programs for health-related work absences (such as medical leave or disability insurance) we deliberately focus on policy changes and discussions of short-term sick leave in the spirit of the *Healthy Families Act*. Specifically, we use representative data from the National Compensation Survey (NCS) by the U.S. Bureau of Labor Statistic (BLS) to sketch the most important trends in sick leave access for American employees from 2010 to 2023. We also discuss changes by type of job and provide suggestive evidence on how the recently passed mandates and the intensified policy discussion may have contributed to the observed increase in employee access to short-term sick leave.

A Categorization of Health-Related Paid and Unpaid Leave

This section classifies existing federal and state-level programs that cover health-related work absences in the United States of America. Besides FMLA, employees are universally covered by a state-level insurance system that provides sick and medical leave for *work-related* diseases or accidents: Workers Compensation. Most Americans are also covered

by the federal disability insurance (DI) program, which provides disability benefits for the *permanently* work disabled. Moreover, for decades, five states have been running so-called “temporary disability insurance (TDI)” programs, providing wage replacement benefits for longer, but temporary, work disability. The more recent versions of these programs are no longer called TDI but “medical leave” or state-level FMLA programs, following the federal FMLA language. See [Ben-Shalom \(2020\)](#) for further details on TDI programs.

Figure 1 provides a categorization of existing federal or state-level programs that cover temporary or permanent health-related work disability in the United States.

Figure 1: Categorization of Health-Related Paid Leave Benefits

| | <i>in labor force</i> | | <i>out of labor force</i> |
|-----------------------|---|---|--|
| <i>work-unrelated</i> | <i>short-term sick leave</i> | Sick and Medical Leave <i>medical leave, TDI, long-term sick leave</i> | Disability Insurance Federal programs: SSDI, SSI |
| | Employer mandates (18 states + DC, dozens of cities) | Temporary Disability Insurance (5 states) FMLA state-level programs (12 states + DC) | |
| <i>work-related</i> | | Private employer group insurance ("short-term disability") Private individual insurance | Private employer group insurance ("long-term disability") Private individual insurance |
| | | Workers' Compensation (WC) all U.S. states except Texas | |

Notes: Own illustration.

Work-Related Medical Leave (“Workers’ Compensation”)

Workers’ Compensation is a mix of health insurance and medical leave. It pays for work-related accidents and diseases and covers medical care costs and wage replacements for employees ([Powell and Seabury, 2018](#)), see Figure 1. Worldwide, the first “Workers’ Accident Insurance” was implemented in Germany in 1885 ([Deutsche Gesetzliche Unfallversicherung, 2019](#)). In the United States, Workers’ Compensation has been the oldest and most comprehensive health-related social insurance program. The first viable workers’ compensation statute, the Federal Employers Liability Act, was first signed into law by Theodore Roosevelt in 1908 ([Boggs, 2015](#)). In the United States, WC is a state-level program and all states but Texas require employers to have worker’s compensation coverage ([Cabral et al., 2022](#)).

The relevance of this social insurance program has decreased over the last century—because of improvements in workplace safety, worker training, and shifts in the industry structure away from manufacturing toward service sector jobs in OECD countries. Between the 1950s and 1980s, the workplace fatality rate per 100,000 workers decreased from above 20 to below 10 in several OECD countries (OECD, 1989). In the United States, 2.8 million non-fatal occupational injuries and illnesses were counted in 2022 (Bureau of Labor Statistics, 2023a). Fortin and Lanoie (2000) and Butler and Gardner (2011) provide excellent literature overviews and Kangas (2001) provides an institutional overview of statutory accident insurance schemes in 18 OECD countries.

Short-Term Sick Leave

We define “short-term sick leave” as full or partial wage replacements for work absence due to sickness *for the first days of sickness*. The exact number of days covered by this benefit depends on the institutional framework, which differs from country to country. For example, for the United States, we define sick leave in the spirit of the *Healthy Families Act* and the many recently enacted state-level sick pay mandates as listed in Table A1 (Appendix).

As sick pay mandates have been enacted only recently, suitable data are scarce, as is empirical evidence from the U.S.¹ Gilleskie (1998) and Gilleskie (2010) are notable exceptions from the U.S. prior to the current policy debates. Gilleskie (1998) exploits 1987 Medical Expenditure Panel Survey (MEPS) data to structurally model work absence behavior and simulate the effects of alternative policies. She finds that a quarter of all male employees would not take sick leave when ill if sick leave were unpaid.

Moreover, several reports document select employer experiences with sick pay mandates. For example, Boots et al. (2009) conclude that “[...] by and large, most employers

¹The European literature on sick leave is much older and richer: These studies find that employees adjust their intensive labor supply in response (Johansson and Palme, 2005; Ziebarth and Karlsson, 2010, 2014; De Paola et al., 2014; Dale-Olsen, 2014; Fevang et al., 2014). Other papers on sick leave investigate the role of probation periods (Ichino and Riphahn, 2005), culture (Ichino and Maggi, 2000), gender (Ichino and Moretti, 2009; Herrmann and Rockoff, 2012), income taxes (Dale-Olsen, 2013), union membership (Goerke and Pannenberg, 2015), and unemployment (Nordberg and Røed, 2009; Pichler, 2015). There is also research on the impact of sick leave on earnings (Sandy and Elliott, 2005; Markussen, 2012), the role of compulsory dialogue meetings (Alpino et al., 2022) or gatekeeping through physician certification (Markussen and Røed, 2017) as well as interaction effects with long-term sick leave (Markussen et al., 2018).

were able to implement the paid sick leave ordinance with minimal to moderate effects on their overall business and their bottom line (page 8).”

Other papers document inequality in access to paid sick leave, unawareness or emphasize relevant statistical correlations. For example, [Susser and Ziebarth \(2016\)](#) find that up to three million U.S. employees work sick every week and that women and low-income earners are more likely to work sick. In almost half of all cases, the reasons were directly related to a lack of sick leave. [DeRigne et al. \(2016\)](#) report that employees without access to paid sick leave are more likely to forgo medical care. [Peipins et al. \(2012\)](#) find that employees without access to sick pay are less likely to undergo mammographies, pap tests, and endoscopies at recommended intervals. Finally, [Hall et al. \(2018\)](#) report that 30% of all employees in New York City were unaware of their recently enacted rights.

Recent economic research exploits variation in sick pay mandates across U.S. regions over time to conduct causal inference. For example, [Pichler and Ziebarth \(2020\)](#) use employment and wage data at the county level to conclude that sick pay mandates did not significantly disrupt labor markets and produce job losses or weaker wage growth. [Ahn and Yelowitz \(2015\)](#) come to a similar conclusion for Connecticut.² Several papers use ([Ahn and Yelowitz, 2016](#); [Callison and Pesko, 2022](#)) retrospectively reported National Health Interview Survey (NHIS) data to estimate that the sick pay mandates increased sick leave utilization by about one day per year in the short-run. [Pichler and Ziebarth \(2017\)](#) theoretically model these behavioral reactions and the decrease in “contagious presenteeism” behavior. They also show empirically that flu rates decreased significantly because of the first city level mandates. In line with this finding, [Stearns and White \(2018\)](#) find significant decreases in the aggregate illness-related leave taking after the introduction of sick pay mandates.³ And [Schneider et al. \(2021\)](#) report that the share of workers working sick decreased after Olive Garden expanded sick leave during COVID-19.

[Maclean et al. \(2022\)](#) use NCS data to show that state-level mandates increased coverage rates by 13 percentage points, and that newly covered employees took two additional

²[Colla et al. \(2017\)](#) do not find evidence that the 2008 employer health benefit mandate for non-small employers had a substantial effect on employment and wages in San Francisco.

³These findings are in line with [Marie and Vall Castelló \(2023\)](#), who exploit a Spanish reform that cut sick pay. The cuts decreased the number of spells which, however, was offset by increases in duration due to relapses and a higher rate of work accidents.

sick days in the first year.⁴ This finding is consistent with complementary economic research (Ahn and Yelowitz, 2016; Chen et al., 2019; Callison and Pesko, 2022). Interestingly, do not find evidence that the mandated benefits crowd-out non-mandated benefits. Further, Slopen (2023) finds that mandating access to paid sick leave improves women’s health, employment and economic security. Further, studies exploiting variation in U.S. mandates find a higher employee productivity and firm profitability as well as reduced firm bankruptcy (Chunyu et al., 2022; Miller, 2022). Using a model of optimal sick pay and empirical causal estimates as sufficient statistics, Maclean et al. (2022) conclude that mandating sick pay is welfare improving under a range of plausible parameter assumptions.

Finally, note that—while related under the umbrella term “paid leave”—paid sick leave differs from paid vacation and parental leave in both aim and scope (Rossin-Slater et al., 2013; Lalive et al., 2014; Baum and Ruhm, 2016; Ahammer et al., 2020). Although paid sick time in the spirit of the *Healthy Families Act* can be used to take care of sick children or family members, its focus has always been on health issues and the short-run. However, “family leave” usually (but not always) refers to longer-term leave for family reasons, for example, parental leave. In addition, the employer cost implications are much different and significantly higher for parental leave, as take-up among employees of childbearing age is relatively high and the work absence durations relatively long. Consequently, basically all countries outside the United States run separate and separately funded parental leave programs (Adema et al., 2016; Raub et al., 2018; Chzhen et al., 2019; Hemmings and Prinz, 2020). Moreover, the labor market consequences of parental leave programs likely differ substantially from those for traditional short- and long-term sick leave programs. For example, Bartel et al. (2018) find that the California’s Paid Family Leave program has increased the share of fathers who take parental leave. However, there is also evidence that parental leave mandates may reduce the labor supply of women and job promotions (Bailey et al., 2019). On the other hand, Rossin-Slater et al. (2013) find that weekly work hours of employed women have *increased* because of the law, and Waldfogel (1999) finds no impact on women’s wages or employment. Anand

⁴Colla et al. (2014) find that, in San Francisco, 73% of all firms offered sick pay voluntarily before the mandate in 2006, and that this share had increased to 91% by 2009.

[et al. \(2022\)](#) find that access to paid family leave can avoid reductions in labor supply after spousal health shocks.

TDI, Medical Leave and Long-Term Sick Leave

As [Figure 1](#) shows, the bridge between short-term sick leave and permanent work disability and withdrawal from the labor force is “medical leave (outside the U.S. typically called long-term sick leave, cf. [Ziebarth, 2013](#); [Andr en, 2007](#); [Fevang et al., 2017](#)).” We define medical leave as leave from work due to prolonged sickness of more than six days and before permanent work disability is diagnosed. Usually, patients are still employed while on medical leave but only a share of them will recover and return to work, whereas another share will be permanently work disabled and potentially qualify for long term disability insurance. A classic example for medical leave is cancer treatments. The section “Implications for Implementing Medical Leave Systems in the United States” and another chapter of this volume [Smalligan \(2020\)](#) discuss medical leave more extensively. [Ben-Shalom \(2020\)](#) discuss TDI in more detail.

(Long-Term) Disability Insurance

Public disability insurance (DI) is an integral part of social insurance in OECD countries ([OECD, 2010](#)). Although institutional details vary over time and across countries, disability insurance mainly aims to provide a safety net in case of permanent work disability (), but it clearly provide value in addition to insuring health risk ([Deshpande and Lockwood, 2022](#)). Benefits typically replace a fraction of former gross wages. For the U.S., the income-mortality elasticity has been estimated to lie between -0.6 and -1.0 ([Gelber et al., 2023](#)).

The empirical disability insurance literature in economics is very rich, in terms of both empirical methods and published papers. It contains structural life-cycle models ([Low and Pistaferri, 2015](#)) and standard reduced-form evidence ([Kostol and Mogstad, 2014](#)). It includes research on the United States, Australia and European countries ([McVicar et al.,](#)

2022), the large majority of which focuses on the labor market consequences of public disability insurance.⁵ However, private insurance also exist for work disability.

Private Insurance

The United States has traditionally relied on voluntary provisions of paid sick leave, medical leave, and health insurance benefits. Because of their large risk pool, big employers can purchase and offer insurance policies at modest costs, as they do for medical leave or long-term disability insurance. However, small employers may not be able to afford such policies. Compared to other countries⁶, individually underwritten disability policies represent a small market in the United States (Duggan et al., 2014).

In the Section “Access to Paid Sick Leave in the United States”, we discuss who has access to paid vacation, paid sick leave and paid family leave in the United States. We also provide access rates for short- and long-term group disability insurance, by types of jobs.

U.S. Sick Pay Mandates

Table A1 (Appendix) provides a detailed summary of U.S. state-level mandates passed to date.⁷ While the details of the mandates differ in each state, all mandates are employer mandates. Several mandates exclude small employers or have other exemptions. Employees “earn” a paid sick leave credit; typically 1 hour per 30 to 40 hours worked with a maximum of about 7 days per year. If unused, the sick leave credit rolls over to the next calendar year. Because employees must accrue the credit, most mandates explicitly state a 90 day accrual period (in addition to waiting periods for new employees). Several

⁵See Autor and Duggan (2006) for the U.S., Staubli et al. (2023) for Austria, Oshio and Shimizutani (2011) for Japan, García-Gómez et al. (2012) for Spain, Burkhauser et al. (2016) for Germany, Banks et al. (2015) for the UK, McVicar and Wilkins (2013) for Australia, Dahl et al. (2014) for Norway, as well as Koning and Lindeboom (2015) for the Netherlands

⁶for example, see Fischer et al. (2022) for Germany

⁷Whenever state and city laws coexist, legal complexities arise. When states pass mandates, existing city laws are typically preempted, as in the case of the 13 existing New Jersey city laws that existed prior to the state law (Title 34. Chapter 11D. (New) Sick Leave §§ 1-11). See for the detailed bill https://www.njleg.state.nj.us/2018/Bills/AL18/10_.HTM However, this is not always the case, especially not when city laws are passed *after* the state law and are more comprehensive.

mandates that exempt small employers compel them to provide *unpaid* sick days ([Massachusetts Attorney General's Office, 2016](#)).

Employers have to post employee rights such as minimum wage laws, harassment and discrimination protection and sick pay rights at the workplace. Figure A1a shows an earned sick time notice for Massachusetts that employers could post to comply with the Massachusetts workplace poster requirements ([Commonwealth of Massachusetts, 2019](#)). Alternatively, posters such as those in Figure A1b (here for Arizona) list *all* employee rights that employers must post to comply with the respective state laws ([Industrial Commission of Arizona, 2019](#)).

An institutional point is worth mentioning. In several cases, laws were challenged in court, mostly by business groups. For example, Pittsburgh's paid sick leave ordinance was approved on August 3, 2015. Shortly after, business groups sued, and lower courts ruled against the law (because of unique language in the state's home rule charter). However, the city appealed the decision in Pennsylvania's Supreme Court, which upheld the law in 2019 ([Moore, 2018](#)). In various other lawsuits, airline carriers have sued states citing federal protections for airlines that would trump state-level paid sick-leave mandate. ([Bloomberg BNA - Workplace Law Report, 2018](#))

Access to Paid Sick Leave in the United States

This section uses NCS data by the Bureau of Labor Statistics (BLS) to document access to paid leave in the United States, particularly short-term sick leave. In addition to documenting inequalities in access as of 2023, we also discuss *changes* in access since 2010.

While the public NCS data are high quality government data well suited to documenting access and employer costs, they are not well-suited to measuring *take-up* of sick leave benefits. [Maclean et al. \(2022\)](#) find that that employees who gain access to sick leave as a result of the state-level mandates take about two days of paid sick leave in the first post-mandate years. However, because employees accumulate more sick days the longer they work, the long-term take-up rate is likely higher—despite regulations that allow employers to cap the number of hours that can be accrued and carried forward, see Table A1.

In addition, because access to sick and medical leave is still not the social norm, there may be take-up barriers even for employees who are formally covered by the benefits, e.g., fear of negative job consequences. For long-term projections, other countries may provide evidence on take-up. For example, Germany provides universal and low-barrier access to both sick and medical leave. In Germany, in a given year, about 50% of all employees take paid sick leave, and about 5% of all employees take medical leave ([Ziebarth, 2013](#); [Ziebarth and Karlsson, 2014](#)).

National Compensation Survey

The NCS is a nationally representative dataset at the establishment-occupation level. The U.S. Census Bureau defines establishments as “a single physical location where business is conducted or where services or industrial operations are performed ([Bureau of Labor Statistics, 2023d](#)). Because the NCS is designed to provide official government statistics on a wide range of compensation and labor cost items, it includes information on access to paid sick leave and other paid leave and fringe benefits.

While the NCS is a quarterly survey, we focus on the March responses of the first quarter interview below because the BLS only provides information from this interview for many benefits (including access to paid sick leave). In the survey, human resource administrators of the establishment provide detailed information on a range of offered benefits. We use the public version of the NCS ([Bureau of Labor Statistics, 2023b](#)).

Note that the NCS solely yields evidence on benefits offered by *the employers*. However, the data include neither WC, nor TDI nor medical leave coverage through systems that are independently run by the government. See [Smalligan \(2020\)](#) for details on medical leave and alternative databases.

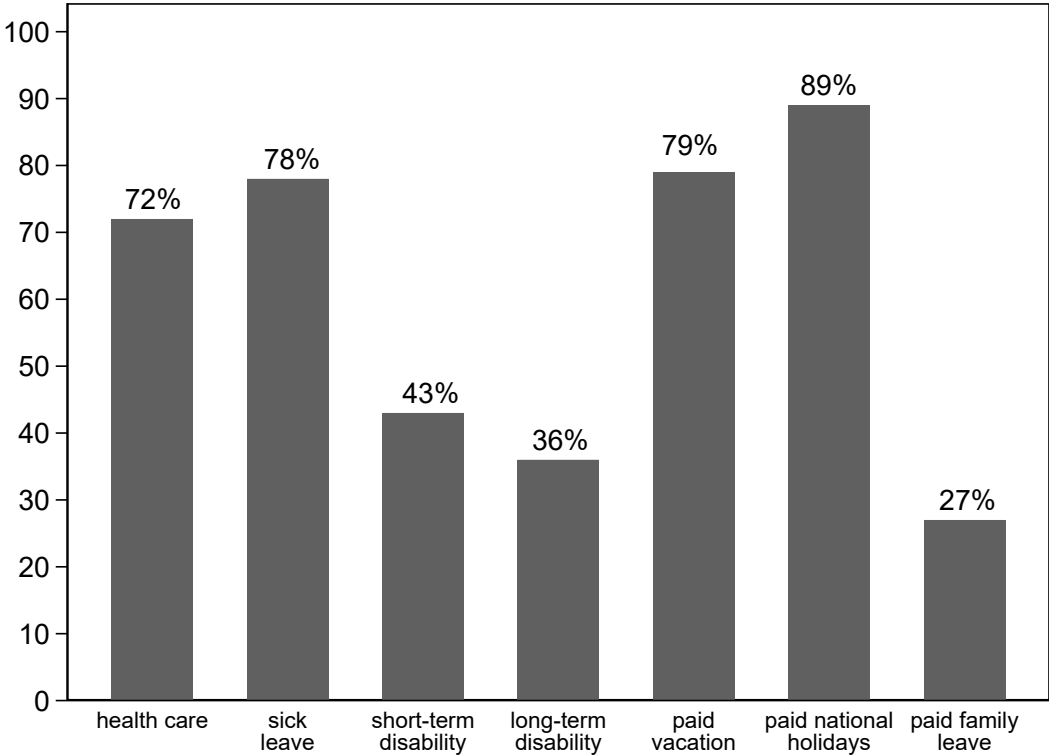
Access to Paid Leave in 2023

Figure 2 uses the March 2023 wave of the NCS. It shows the share of employees who have access (through their employer) to (a) health insurance, (b) short-term sick leave, (c) short- and long-term disability insurance, (d) paid vacation and holidays, and (e) paid family

leave. All these benefits have traditionally been provided voluntarily by U.S. employers.⁸ Figure 2 shows that, as of March 2023, 72% of all employees were offered health insurance and 78% were offered short-term sick leave. As seen, 43% of jobs come with short-term disability benefits (i.e. private medical leave plans), 36% with private long-term disability benefits and 27% with paid family leave.

The following figures exclusively focus on access to short-term sick leave.

Figure 2: Access to Health Insurance, Types of Paid Leave and Disability Benefits in 2023



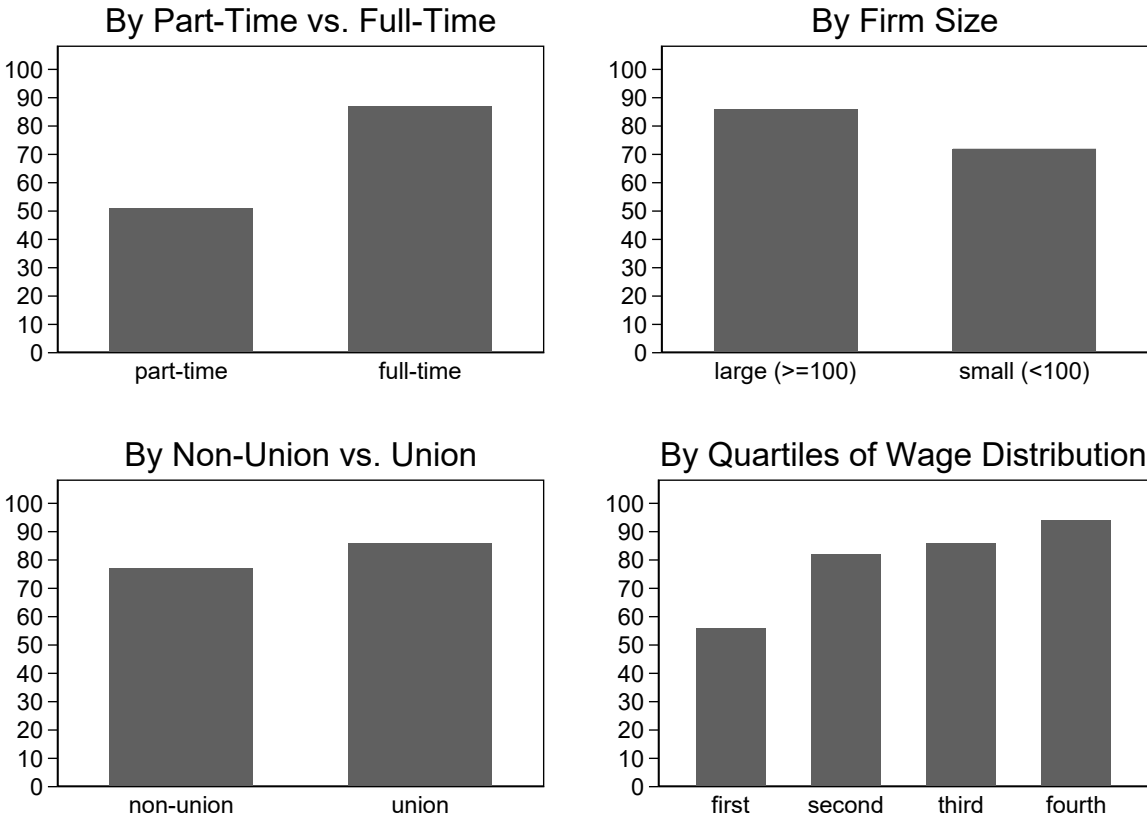
Notes: Own illustration based on NCS data 2023.

Figure 3 investigates sick leave access rates by type of job. Thirteen percent of full-time employees have no access to paid sick leave. Moreover, 49% of part-time employees do not have access to paid sick leave in their job (Figure 3a). Fourteen percent of firms with more than 100 employees do not offer paid sick leave (Figure 3b), whereas this share is 28% in firms with fewer than 100 employees. Moreover, 14% of jobs with union representation come without paid sick leave (Figure 3c). Finally, we observe a clear gradient when plotting out coverage rates by the quarter of the wage distribution. While 6% of employ-

⁸However, the ACA introduced a health insurance employer mandate for companies with 50 full-time employees or more at the federal level. Under this mandate, employers have to provide health insurance to their employees or pay a penalty. [Kaiser Family Foundation \(2019\)](#)

ees in the highest income category lack access to paid sick leave, 44% in the lowest income category lack access to paid sick leave.

Figure 3: Access to Short-Term Sick Leave by Type of Job in 2023

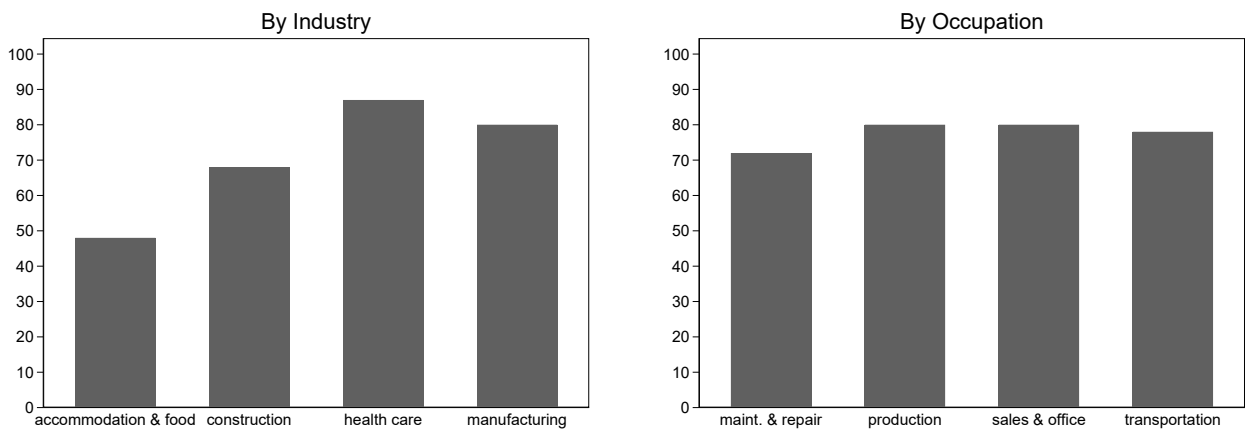


Notes: Own illustration based on NCS data 2023.

Figure 4 stratifies coverage rates by industry and occupation. The industry with the lowest coverage rate is the “accommodation and food industry” (48%). Given the high degree of customer contact, such low coverage rates are particularly worrisome from a public health perspective. Research has shown that employees without access to paid sick leave are much more likely to work sick and spread diseases. (cf. Pichler and Ziebarth, 2017; Piper et al., 2017; Pichler et al., 2020a,b; Schneider et al., 2021).

In summary, across all types of jobs, access to short-term sick leave is generally far from universal in the United States. Moreover, access to paid sick leave is highly unequal. In low-wage and part-time jobs as well as the accommodation and food industry roughly half of all jobs provided no access to paid sick leave. It is estimated that, across the United States, 28 million employees have no access to paid sick leave (A Better Balance, 2023d).

Figure 4: Access to Short-Term Sick Leave by Industry and Occupation in 2023



Notes: Own illustration based on NCS data 2023.

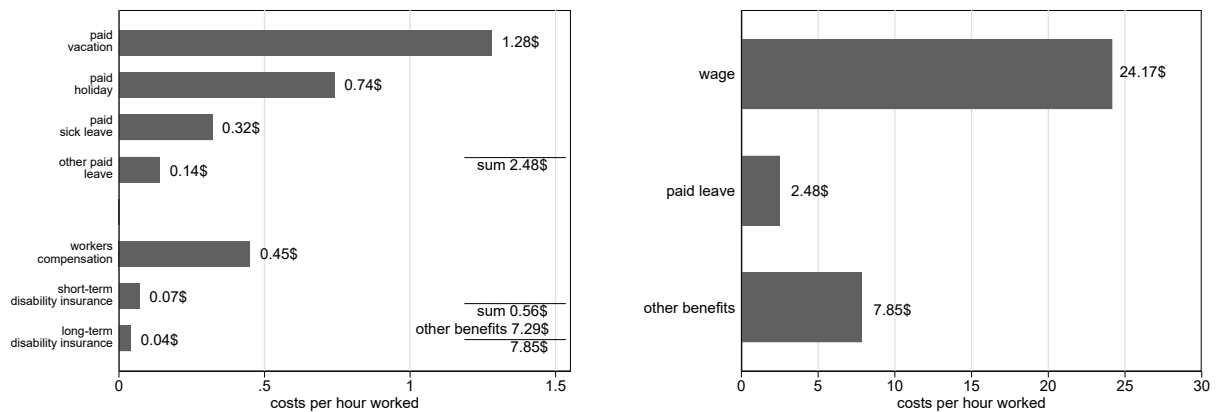
Employer Costs of Providing Paid Leave Benefits in 2023

This subsection uses NCS data to provide evidence on labor costs for different types of paid leave. To put them into perspective, we compare them to costs for wages and other fringe benefits. Figures 5a and b provide corresponding overviews for 2023, normalized to costs per hour worked. Of course, the average cost estimates depend on how common it is to provide the benefits, as well as on their generosity. For example, paid sick leave costs \$0.32 per hour worked on average. However, as coverage rates are 78% (Figure 2), the average costs for workers *with* paid sick leave are \$0.41 or 1.7% of gross hourly wages. Under a 100% replacement rate and assuming 220 working days per year, a back-of-the-envelope calculation suggests that each worker with access to paid sick leave takes on average 2.8 sick days per year.

As seen in Figure 5a, the labor costs for paid vacation days (\$1.28 per hour worked), paid national holidays (\$0.74 per hour worked) and Workers' Compensation (\$0.45 per hour worked) exceed the costs for paid sick leave (costs for paid family leave are not available in the NCS). Private short- and long-term disability policies only cost \$0.07 and \$0.04 per hour worked, respectively.

Figure 5b sums up all costs for paid leave and compares the total sum to the costs for wages and other fringe benefits (which includes health insurance benefits of \$3.08 and retirement benefits of \$1.98). As can be seen, the total costs for all forms of paid leave

Figure 5: Employer Costs of Providing Paid Leave Benefits in 2023



Notes: Own illustration based on NCS data 2023.

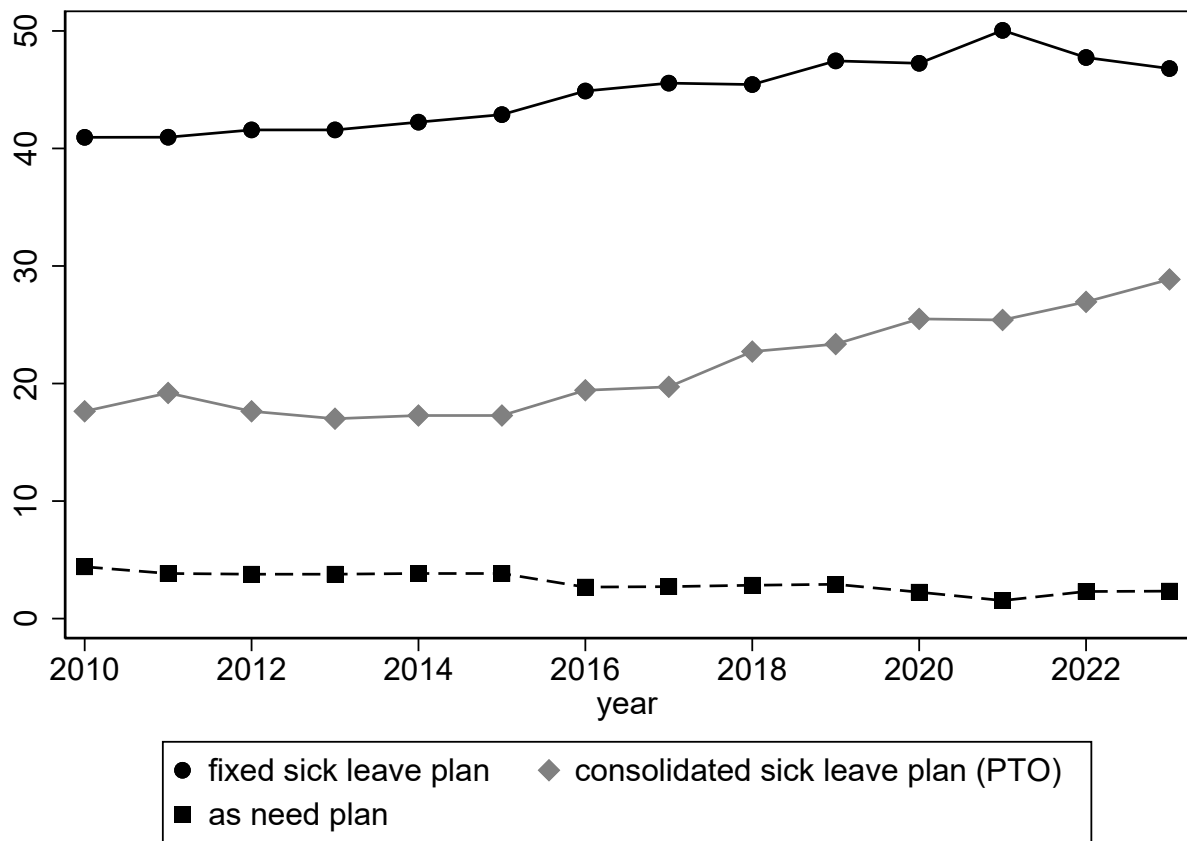
“only” sum up to \$2.48 per hour worked, where paid vacation and national holidays make up by far the largest share of \$2.02. Costs for wages are \$24.17, and for all other fringe benefits jointly \$7.85.

Changes in Access to Sick Paid Leave from 2010 to 2023

Next, we analyze how sick leave is offered in Figure 6. Most sick leave is offered as a fixed plan, where employees earn up to a fixed number of sick days per year. The second most common plan is a “consolidated leave plan”, often also referred to as Paid Time Off (PTO) bank. Finally, only few employers offer plans without yearly limits (“as need plans”).

As seen in Figure 6, PTO plans have become increasingly popular among U.S. employers, increasing from 17% to 29% between 2015 and 2023. Under a PTO plan, employers do not provide a *separate* number of days for sick leave, vacation, or parental leave, and instead aggregate or “consolidate” the total number of paid leave days per year, independent of reason (Lindemann and Miller, 2012). For instance, the BLS reports that the average consolidated PTO plan has accumulated 18 days of available paid leave after five years of service with the employer (Bureau of Labor Statistics, 2023c). Paid sick leave mandates are in compliance with such PTO plans as long as they are at least as generous as the sick leave mandated by the law (ADP, 2016). Maclean et al. (2022) find clear evidence that sick pay mandates induced employers primarily to set up *separate* sick

Figure 6: Composition of Sick Leave



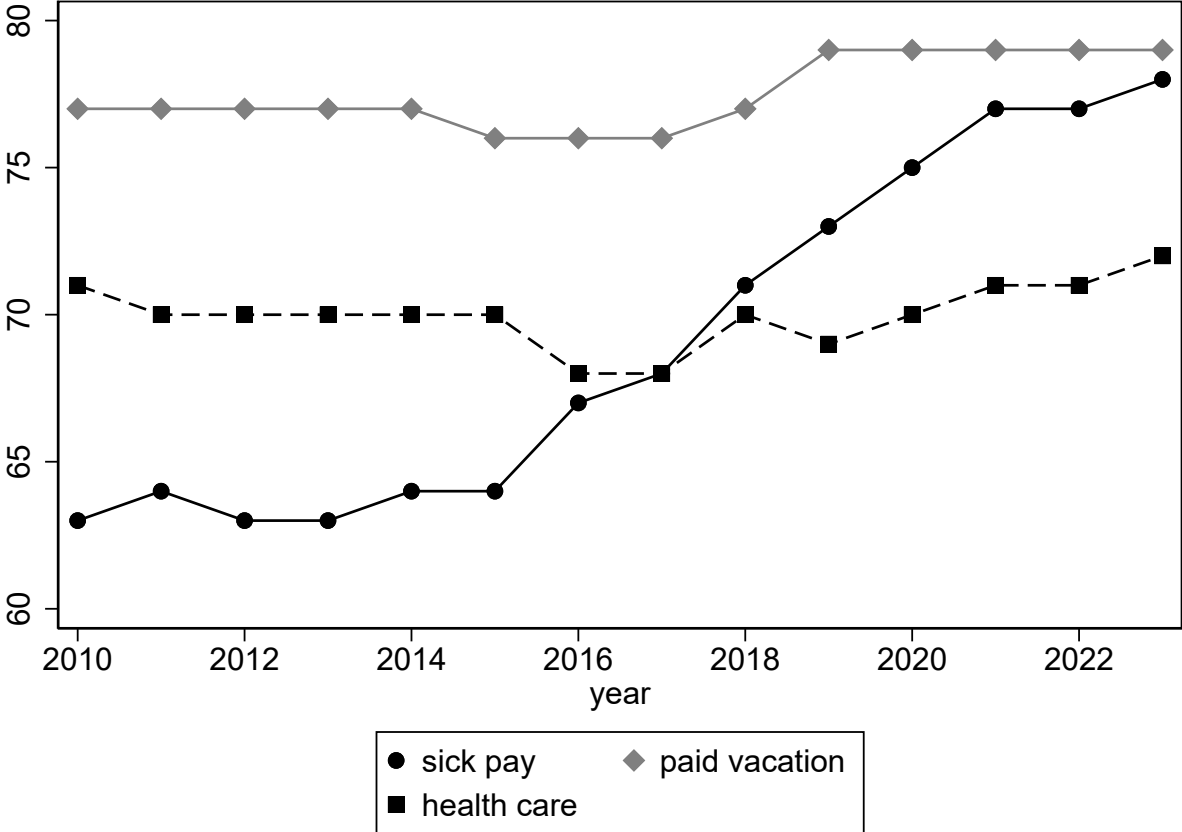
Notes: Own illustration based on NCS data 2023.

leave plans, and neither crowded-out nor increased the provision of PTO banks. The authors suggest that this was the case for employers to avoid uncertainty as to whether their consolidated PTO plan would comply with the law (Miller, 2015). As of writing, three states—Maine, Nevada and Illinois—have passed PTO mandates instead of sick pay mandates; another variant in the already fragmented U.S. paid leave landscape (A Better Balance, 2023b)

Figure 6 shows an increase in the provision of paid sick leave by firms. Comparing changes over time to changes for other benefits can help us to assess the impact of the recently enacted sick pay mandates in 15 states (plus D.C.), such as California, Massachusetts and Oregon. Figure 7 compares changes in coverage rates for short-term sick leave to changes for health insurance and paid vacation from 2010 to 2023. The latter two benefits are approximate “control groups” when trying to eyeball a causal impact of the recently enacted sick pay mandates. As seen, coverage rates for paid vacation have been

stable at around 77% since 2010, and only increased slightly in 2018 and 2019. This relatively flat trend is in line with the absence of state or federal mandates for paid vacation days.

Figure 7: Changes in Access to Short-Term Sick Leave vs. Health Insurance and Paid Vacation



Notes: Own illustration based on NCS data 2023.

Moreover, the share of jobs with health insurance coverage has also been very stable over time. In 2016 and 2017, we observe a temporary decline by two percentage points from 70 to 68%. However, in 2023, the share of employees with access to health insurance coverage rebounded to 72%.

Clearly, sick leave benefits have increased the most since 2010. While coverage rates remained stable around 64% until 2015, they increased strongly between 2015 and 2023. The beginning of this upward trend coincides exactly with the enforcement of the mandates in California (July 1, 2015), Massachusetts (July 1, 2015) and Oregon (Jan 1, 2016), see Table A1 in the Appendix. While many relevant cities had enacted mandates before

2015, the number of newly covered employees was too small to move the needle in coverage rates as measured at the federal level. This obviously changed with the three big states California, Massachusetts and Oregon, and further continued with the mandates in Vermont (2017), Arizona (2017), Washington (2018), Maryland (2018), Rhode Island (2018), New Jersey (2018) and Michigan (2019). When COVID-19 hit the world at the beginning of 2020, it became apparent how a lack of paid sick leave coverage would potentially severely reinforce the spread of the disease. After various emergency sick leave provisions at the federal and state level ([A Better Balance, 2023a](#)), New York (2020), Colorado (2021), New Mexico (2022) and Minnesota enacted permanently sick pay mandates, further driving up the share of covered jobs as seen in Figure 7, together with an increase in voluntarily provided sick pay or PTO banks.

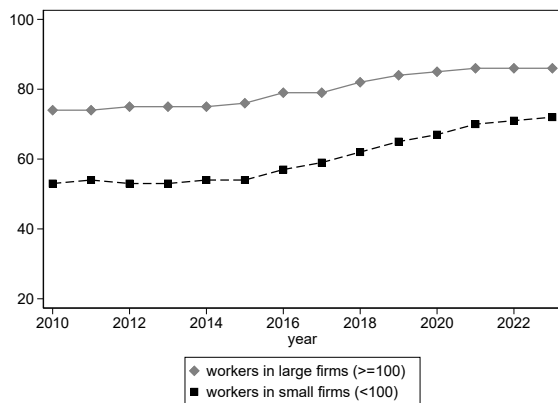
Figure 8 decomposes the strong increase in sick leave coverage rates by (a) firm size, (b) industry, (c) occupation, and (d) wage quartile. With regard to firm size, both small and large firms saw substantial increases; similarly coverage not only increased in industries with historically low coverage rates like *accommodation and food* (from 30% in 2010 to 48% in 2023), but also in industries with high coverage rates in the pre-mandate era such as *health care* (from 79% in 2010 to 87% in 2023).

Coverage also increased *before* 2015 for some occupations such as *maintenance and repair* (Figure 8c). Finally, stratifying the trends by wage levels, employees in the lowest wage quarter experienced particularly strong increases in access to short-term sick leave up from 33% in 2010 to 56% in 2023. Figure A2 (Appendix) further illustrates that the increase was especially driven by part-time and non-unionized jobs.

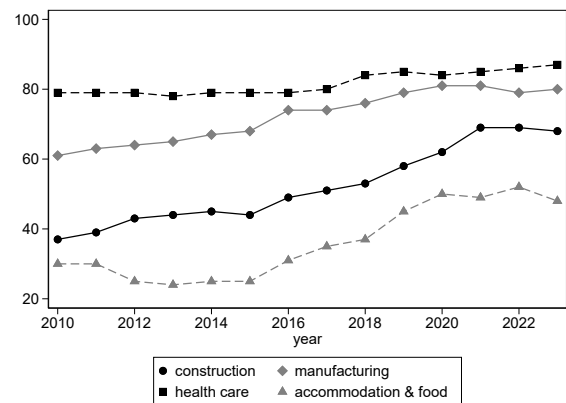
Implications for Implementing Medical Leave Systems in the United States

In the spirit of the 1993 federal FMLA law, 13 states and D.C. have passed state-level FMLA laws over the past years. Although the more recent laws use the FMLA terminus explicitly and exclusively, California was the first state to essentially extend their TDI system to take care of sick relatives or bond with a newborn child in 2004 (often called

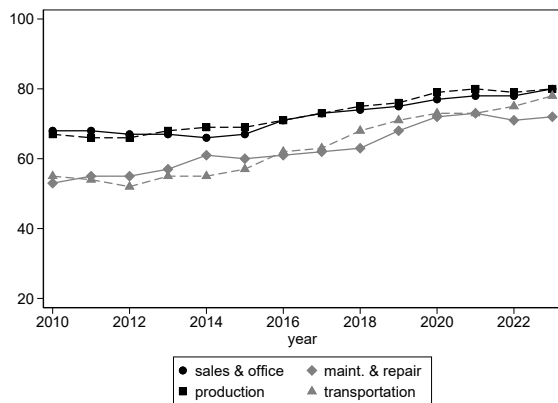
Figure 8: Changes in Employee Access to Short-Term Sick Leave by Type of Job



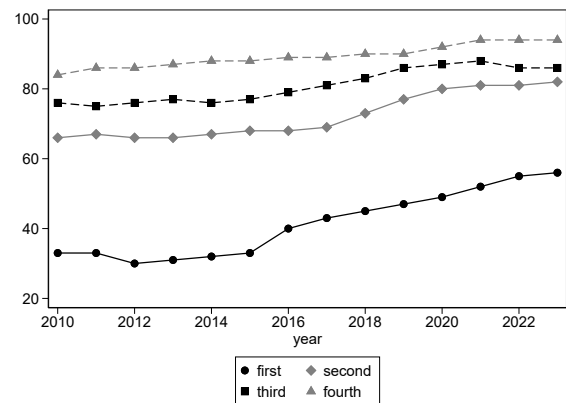
(a) By Firm Size



(b) By Industry



(c) By Occupation



(d) By Wage Quartile

Notes: Own illustration based on NCS data 2000-2023.

Paid Family Leave and sometimes called Family Temporary Disability Insurance) [Bartel et al. \(2014\)](#). The latest states to pass FMLA state laws were Maryland (2022), Delaware (2022), Minnesota (2023) and Maine (2023) but benefits can only be withdrawn starting 2026.

Basically, although being institutionalized under a variety of state-level legal frameworks and names, all these laws essentially provide paid leave for (a) taking care or bonding with a new child, (b) taking care of a family member with a serious health condition, (c) taking care of one's own disability or serious health condition. In that sense, in an international context, they represent a mix of parental leave, eldercare, and own long-term sick leave. The benefit duration typically depends on the specific reason for leave-taking

and ranges for family leave and own sickness from 6 weeks within 24 months (DE) to 12 weeks within 12 months (most other states). Like California, four other states (Rhode Island, New Jersey, Pennsylvania, and Puerto Rico) have run separate “Temporary Disability Insurance” programs for decades that mainly cover own work unrelated extended work disability.⁹

In general benefits are between 60 and 90% of a worker’s average weekly wages, but states differ in how they cap the maximum amount. Funding occurs basically through employee-employer payroll deductions of between 0.17 and 1.1% of employees base wages (National Partnership for Women & Families, 2019; A Better Balance, 2023c), up to a certain cap. States also differ in their eligibility criteria and work requirements. Further, some states have unpaid waiting periods, whereas others do not.

In the following, we summarize findings from the economic literature and the literature in related fields that broadly relate to paid family and medical leave. These findings may hold lessons for the implementation of FMLA laws at the state level. In particular, we focus on the lessons from long-term sick leave programs outside the United States as well as TDI programs within the United States. In other words, we focus on insurance programs that cover own health conditions and disability—the “medical leave” aspect of the while FMLA programs—and ignore the broad literature on parental leave.

First of all, there is consensus in the economics literature that the labor supply elasticity of paid leave programs is different from zero (Gruber, 2000; Johansson and Palme, 1996, 2002, 2005; Ziebarth and Karlsson, 2010; De Paola et al., 2014; Fevang et al., 2014). The rich DI literature surrounds the question: “How much higher would the employment rate be without the existence of a DI system?” The standard approach to answering this question is to exploit quasi-random variation in assignment of DI cases to examiners; the findings show that employment rates are 15 to 30 percentage points higher

⁹Note that California, New Jersey, Rhode Island, and New York have laws for “Temporary Disability Insurance” and paid family leave. The paid family leave laws focus on care of other family members pregnancy or childbirth, while employees who are unable to work due to non-work-related illness or injury, are eligible for temporary disability insurance (more details available here www.edd.ca.gov/disability/ for California, here <https://www.nj.gov/labor/myleavebenefits/> for New Jersey, here <https://paidfamilyleave.ny.gov/paid-family-leave-and-other-benefits> for New York, here <http://www.dlt.ri.gov/t di/> for Rhode Island, and here <https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/PaidLeaveFinalRuleComparison.pdf> for a comparison of the different laws).

among “marginally rejected” DI applicants, relative to marginally accepted DI applicants (Bound, 1989; Chen and van der Klaauw, 2008; von Wachter et al., 2011; Maestas et al., 2013; French and Song, 2014; Kostol and Mogstad, 2014). Other studies find strong evidence for peer effects in the Norwegian context (Dahl et al., 2014) and that stricter application screening reduces the number of applications and improves targeting efficiency in the Dutch context (de Jong et al., 2011; Staubli et al., 2023).

As medical leave programs have precisely the objective of providing longer-term wage replacement benefits while keeping people *employed* and providing job protection, one implication is that medical leave programs keep sick people employed. Thus they potentially prevent a (permanent) exit from the labor force. Whether and by how much medical leave programs decrease disability insurance applications and rolls is, however, an open question. Maybe surprisingly, Stepner (2019) finds that employer-provided short-term disability insurance *increases* long-term disability insurance take-up in the long-run. That implies a negative fiscal externality on the government budget.

Studying the underlying reasons for the take up of medical leave benefits, findings from other countries suggest that around five percent of the employed population would take up long-term sick leave programs due to cancer, back-pain or mental illnesses (Ziebarth, 2013). It is clear that medical leave leads to take-up, utilization and program costs. However, while rising program costs are almost certainly a consequence of implementing new social insurance programs, the crucial question for most economists is whether new programs are cost-effective and welfare improving. Although costs are relatively easy to measure, benefits may not be because they manifest in the long-run and indirectly, for example, through higher labor productivity, higher labor supply, or higher life satisfaction.

One lesson from research on European systems is that when replacement rates and funding between short-term sick leave and long-term medical leave are not well adjusted, unintended consequences will result at their intersection. For example, Fevang et al. (2014) show that employers discourage workers on (social security funded) long-

term sick leave to return to work, because the direct financial costs of relapses associated with short-term sick leave would have to be carried by employers.¹⁰

Another lesson from Europe is that whenever direct benefit costs of sick and medical leave have to be carried by employers, it could lead to discrimination against workers and applicants with characteristics that are associated with higher sickness rates, such as age, women in childbearing ages or body weight. For example, [Ziebarth and Karlsson \(2014\)](#) find evidence that German employers became reluctant to hire sicker workers after the government increased the mandated wage replacement rate for the first six weeks of sick leave in 1999. Moreover, because sick workers took more sick days in response to more generous benefits, healthy workers had to work more overtime hours to compensate for the lost labor at the firm level.

However, because the U.S. short-term sick leave systems are funded through individual sick leave accounts which minimize moral hazard on the employee side, we do not expect shirking behavior to play a major role. Also, recall that mandated sick pay enables workers to earn and budget two to three percent of their work time as sick time, which can be taken when needed. [Pichler and Ziebarth \(2020\)](#) find no evidence that sick pay mandates hurt employment or wages growth, and employer surveys indicate that these mandates are not perceived as a major issue and threat to employers' bottom lines ([Boots et al., 2009](#); [Drum Major Institute for Public Policy, 2010](#)). However, the case for longer-term medical leave might be different as the perceived (and real) risks for disruptions at the firm level might be significant. This is simply a consequence of the much longer leave spells for medical leave. Hence, discrimination against workers may be a concern for medical leave programs.

The question of how to finance medical leave is another crucial question. As medical leave in the U.S. is largely funded through general employee payroll taxes, it exacerbates the risk of discrimination against high risk workers. Moreover, economists have long debated the question of whether payroll taxes hurt employment or wage growth. Although [Kramarz and Philippon \(2001\)](#) find negative employment effects, others hardly find such

¹⁰In most European countries, employers bear the costs of short-term sickness, while the long-term sick workers are financed by health and social insurance funds. As shown in [Fevang et al. \(2014\)](#) this can lead to a "sick pay trap."

effects ([Anderson and Meyer, 2000](#); [Benmarker et al., 2009](#)). [Fuest et al. \(2018\)](#) find that roughly half of firm taxes are passed through to employee wages.

Medical leave is related to rehabilitation programs and therapies, for which a rich literature outside of economics exist, see, for example, [Hoefsmit et al. \(2012\)](#) for a general review or [Tamminga et al. \(2010\)](#) for a review on cancer and [Nieuwenhuijsen et al. \(2014\)](#) for a review on depression. In one of the few empirical economic studies on rehabilitation programs, [Frölich et al. \(2004\)](#) use Swedish register data and find that rehabilitation programs for the long-term sick are not effective in improving their labor market outcomes. [Ziebarth \(2010\)](#) exploits a doubling of copayments for rehabilitation treatments and finds that demand is more elastic than for acute medical treatments. Finally, [Laun and Skogman Thoursie \(2014\)](#) evaluate a randomized field experiment by the Swedish government and do not find evidence that private providers for vocational rehabilitation treatments outperform public providers in terms of costs and labor market outcomes.

Towards an Integrated and Evidence-Based Paid Sick and Medical Leave System

What can we learn from the description of the status-quo, recent trends in the paid leave systems of the United States as well as international research findings? What are the lessons and the outlook for the next decades? Given the highly polarized and divided Congress, what are the chances for a bipartisan and political agreement on a coherent federal paid leave reform?

After more than a decade of experiences with the ACA, one might be tempted to conclude that the outlook would be grim. However, the silver lining in the paid leave debate is that, unlike the ACA, it is not (yet) tied to a specific polarizing figure, leader, or administration. Representatives of both parties have expressed support for various forms of paid sick leave, medical leave, or family leave. Likewise, while being at the top of the agenda of Democrats for years ([Parsons, 2019](#); [Calfas, 2019](#)), even former President Trump has repeatedly expressed support for a (permanent) federal leave reform [The White House \(2019\)](#). He signed FFCRA in 2020. In addition, and maybe most importantly, the gen-

eral public strongly supports measured and modest (local) reforms such as the wave of recent sick pay mandates. Approval ratings are above 70% and high across party lines ([National Paid Sick Days Study, 2010](#)). According [National Partnership for Women and Families \(2020\)](#) 82% favor permanent sick days. In a recent Pew poll, 62% of workers say it would be extremely important to them to have a job that offered paid time off for vacations, routine doctor's appointments or to deal with minor illnesses ([Pew Research Center, 2023](#)).

Currently, several proposals for federal sick and medical leave systems have been introduced into Congress. First, there is the *Healthy Families Act* which has been under discussion for two decades and reintroduced to Congress in 2023 ([S.1664 - Healthy Families Act, 2023](#)). The *Healthy Families Act* has served as the blue print for the 15 state-level sick pay mandates (plus in D.C.) and similar mandates in dozens of U.S. cities. The experiences in these localities have been largely positive. Research has demonstrated that the relatively light mandates do not disrupt labor markets and reduce employment or wage growth ([Pichler and Ziebarth, 2020](#)). Moreover, various studies find consistent evidence that city-level ([Pichler and Ziebarth, 2017](#)) and state-level [Pichler et al. \(2020b\)](#) mandates reduced influenza-like illness (ILI) rates. Further, the bipartisan Families First Coronavirus Response Act (FFCRA) which contained two weeks of emergency sick pay due to COVID-19 reduced the spread of the disease [Pichler et al. \(2020a\)](#).

[Maclean et al. \(2022\)](#) find that sick pay mandates in the spirit of the *Healthy Families Act* are effective in increasing sick leave access. Because labor cost effects seem to be modest and much smaller than employees' valuation of the benefit, the authors conclude that they most likely lead to an increase in welfare—even when ignoring the public health benefits. Hence, the authors of this article strongly support the implementation of sick pay mandates in the spirit of the enacted state-level mandates and the *Healthy Families Act*. These mandates are reasonable, mild, incentive compatible, and can be run efficiently without much government bureaucracy.

In 2013, The Family and Medical Insurance Leave Act of 2013, or FAMILY Act, was first introduced in Congress. In was reintroduced again by Senator Gillibrand in 2021 ([S.248 - FAMILY Act, 2021](#)). The FAMILY Act foresees the implementation of a federal

family and medical leave system for all workers, including part-time workers and in small firms. This system would be run by the Social Security Administration (SSA) and funded through employee and employer payroll taxes. Everyone who is eligible for SSDI would be eligible to receive a wage replacement benefit of two thirds of the monthly wage for up to 12 weeks—where the monthly benefit would be capped from below and above at \$580 and \$4,000. Eligibility criteria would be taking care of a newborn child, recovering from one’s own serious illness, or taking care of a sick family member including parents, children and spouses. While the main parameters of such a system appear to be reasonable in an international comparison, it should be noted that few state-level FMLA systems have been fully implemented yet. This implies a lack of empirical evidence regarding the functioning and possible unintended consequences of such a system in the United States. The authors of this chapter are thus more careful in their (immediate) support for the implementation of such a federal social insurance system.

Moreover, while the *Healthy Families Act* and the *FAMILY Act* have primarily secured support among Democrats, one Republican initiative is the *The Strong Families Act*, introduced by Senators Deb Fischer (Republican) and Angus King (Independent) in 2017 ([S.344 - Strong Families Act, 2019](#)). The act foresees a 25% percent tax credit for employers of any size for family and medical leave benefits provided for their employees.¹¹ While the authors of this chapter view this tax credit suggestion as a step forward, they note that it is neither a bold nor an innovative suggestion. It would not ensure that workers who are currently without coverage will be covered. How many additional workers would be covered depends on the employer elasticity in providing paid leave benefits with respect to costs. Essentially, the proposal provides a taxpayer-funded subsidy for paid family and medical leave. The economics literature does not provide directly applicable elasticity estimates but, given the experiences with subsidies for employer-provided health insurance, the coverage effect of such a proposal is likely small ([Heim and Lurie, 2009](#); [Krueger and Kuziemko, 2013](#); [Moriya and Simon, 2016](#)). Moreover, firms that already provide paid family and medical leave could claim the tax credit and generate windfalls gains. On the plus side, the proposal is not very bureaucratic, has realistic

¹¹The allowable amount of such a credit is limited to \$3,000 per employee for any taxable year.

chances of securing enough votes in Congress, and foresees a “study on the effectiveness of the tax credit for paid family and medical leave (S.344 - Strong Families Act, 2019).”

Although all current reform proposals represent a step forward, none alone would lead to an efficient, well-coordinated and integrated social insurance system of paid sick and medical leave. On the other hand, envisioning a holistic, well-integrated, and coordinated paid leave reform that considers all concerns and demands is certainly wishful thinking. Realistically seen, it is unlikely that any of the federal bills discussed above will pass in the near future. The more realistic outcome is a continuation of what we have seen over the past decade—grassroots-driven incremental changes, first through city laws, then state laws, and then *maybe* federal laws. The upside of this bottom-up “organic” and decentralized approach is that local stakeholders typically have a much better assessment of the problems and desires of local populations and industries. The downside of this approach, however, is the continuation of a fragmented paid leave landscape.

Nevertheless, we believe that it is crucial to implement paid leave reforms in such a bottom-up, consensus-oriented, policy approach where politicians, employees, employers, unions and industry representatives *work together* in committees and *jointly* implement incremental reforms that a majority can agree on. Only if employers can be convinced that moderate mandates or payroll taxes are no threat to their businesses, but may actually foster employee productivity and job satisfaction, will they take a pro-active, less confrontational position. Social norms and opinions change slowly over time. Past experiences tell us that employers in states that passed sick pay mandates have reported very positive experiences and gained confidence in measures that they may have viewed very skeptically at the beginning. At the same time, it is crucial not to kill all efforts and modest achievements with a top-down overreach that could further polarize Americans.

A bottom-up, decentralized reform approach has the appeal that states and cities can experiment with alternative approaches and models. It would be helpful, though, if policymakers and all stakeholders could agree on a systematic scientific evaluation of their policies. Such evidence-based evaluations of policy reforms are already standard in other countries, see for example the OECD Best Practice Principles on the Governance of Regulators (OECD, 2014). Currently, data availability—or rather a lack thereof—especially at

the firm and local level, is the crucial bottleneck in producing more scientific evidence, and moving towards an evidence-based paid leave system. For this purpose, it is crucial to collect high-quality, linked employer-employee data which allows researchers to precisely study benefit take-up at the individual level and also how different systems interact. Empirical research has made great progress in the past decades. State-of-the-art statistical methods allow researchers to measure possible positive and also unintended consequences of mandating paid leave.¹²

Whenever there is evidence that new policies produce more negative effects than intended, they should be abolished or altered. Whenever there is evidence that policies work and enhance welfare, policymakers should proudly promote them, and neighboring regions should carefully consider adopting similar policies. However, without a systematic, evidence-based evaluation, instead of evidence, ideology prevails—on the political right and the political left.

The question of how to coordinate and best integrate the different paid leave systems remains a crucial one. While researchers can make recommendations based on empirical evidence, best practices in other countries, or theoretical considerations, it has to be seen how the implementation works in practice. We believe that the rule “don’t fix unless it’s broken” applies in this context. First of all, Workers’ Compensation, as the oldest of all U.S. based systems, has a long tradition and is run by many experienced leaders. Similarly, the SSDI system is a decades-old institution, which is appreciated by the population and policymakers alike. It will be very hard—and politically fatal—to radically change the SSDI system in the short-run although there is a clear need for reforms. These two paid leave systems resemble disability insurance systems, and “accident insurance”, in other countries.

In our opinion, the United States should not fundamentally reform WC or SSDI, but try to build and integrate new paid leave systems around them using the described bottom-up approach (if no agreement can be found for a major federal reform). Just focusing on health-related paid leave, the major difference between the United States and other OECD countries is the lack of universal access to sick and medical leave.

¹²See, [Bailey et al. \(2019\)](#) for example, who find that the Californian paid leave mandates have hurt women in the labor market.

As outlined, substantial improvements in access to short-term sick leave have been made since 2010. It is important that states continue in their efforts to implement and strengthen state-level sick leave mandates. There will be a time when a broad societal consensus will allow Congress to pass a federal law, such as the *Healthy Families Act*. It may happen sooner than some may think.

That leaves us with the missing piece in the puzzle: “Paid Medical and Family Leave.” The authors of this chapter believe that mixing different types of leave such as short-term disability insurance, parental leave and eldercare is not helpful in making the case. Similar conclusions have been drawn by [AEI-Brookings Working Group on Paid Family Leave \(2018\)](#). Moreover, a systematic coordination and integration into the other (health-related) paid leave systems is more difficult if several different types of leave are lumped together. Finally, this also hinders a systematic evaluation of the causes and consequences of new policies.

One can hypothesize that the lack of access to short and long-term medical leave results in a long-term decline in the health and labor market prospects of affected individuals. It could be a driving force of the costly increase in permanent work disability and SSDI caseloads. Many experts would agree that a well-functioning medical leave system could prevent such a long-term decline in work capacity. However, to implement an effective medical leave system, it must be closely integrated with existing short-term sick leave and DI systems and explicitly focus on preventing permanent work disability. Hence, medical and vocational rehabilitation services must be an integral part of it. When employees experience a health shock—for instance cancer—doctors, employers, and patients should closely work together and communicate openly about the expected leave of absence, possible workplace accommodation, and part-time work options. The objective for the employer would be to reduce uncertainty about a possible return of a highly qualified and productive worker. Ideally employees become healthy, prevent permanent work disability, keep their job, and eventually return to work fully recovered.

Some readers may find such an approach overly optimistic and unrealistic to implement. However, many European countries have managed to integrate their short-term and long-term sick leave systems with their disability insurance systems; they have case-

workers and doctors assigned to long-term sick individuals; see for example [OECD \(2010\)](#) and [Hemmings and Prinz \(2020\)](#). A description of systems in other countries can also be found in [Burkhauser et al. \(2016\)](#) and [McVicar et al. \(2022\)](#) as well as the references therein. Sweden, the Netherlands, Switzerland, and Norway have a comprehensive support system with relatively high replacement levels [Hemmings and Prinz \(2020\)](#). However, these countries are also characterized by very high use and take-up. In order to rectify this, these countries implemented various reforms over the past years. For example, the Dutch reform experience demonstrated that employer incentives can substantially reduce claims. In this spirit, [Autor and Duggan \(2010\)](#) and [Burkhauser and Daly \(2012\)](#) propose similar reforms for the U.S. DI system. The core of these proposals seeks to provide monetary incentives to employers to accommodate those who become work disabled.

The United States need not invent from a whole cloth an integrated sick and medical leave system. Many countries around the world provide examples of social insurance systems that work well in practice and could help the United States to support a healthier, happier, and more productive workforce in the long-run.

Conclusion

This article describes existing paid leave systems for health such as Workers' Compensation, short-term sick leave, medical leave and disability insurance in the United States. After classifying them, we briefly sketch empirical evidence with a focus on research in economics. Then, we use consistently collected, high-quality government data to analyze whether and how often employees had access to paid leave *through their employer* in 2023. Next, we investigate trends in access over the past decade with a particular focus on short-term sick leave, which has been mandated by dozens of city legislatures and 15 states plus D.C.

While employer provisions for medical leave and long-term disability have been very stable since the Great Recession, access to short-term sick leave has increased by 15 percentage points from 64% in 2015 to 78% in 2023. This increase first gained momentum

at the time when California, Massachusetts and Oregon enacted their sick leave mandates in 2015; it was then reinforced by the COVID-19 pandemic and the obvious need to reduce presenteeism behavior. Although the 15 percentage point increase is observable throughout small and big firms and across occupations and industries, the largest coverage gains happened in the construction, food and accommodation industry, among low income earners and in part-time and non-unionized jobs.

In the last two section, we discuss the current policy landscape and the pathways for creating a coordinated and integrated paid leave system covering short-, medium- and long-term work disabilities. An ideal system would minimize inefficiencies and coverage gaps. It would require coordinated and cost-effective actions between patients, employers, and doctors. It could lead to a happier, healthier, and more productive workforce in the long-run. While this system may be wishful thinking given the current polarization in Washington D.C., we point out some silver linings and the progress that has been made in the last 15 years. Moreover, while the United States lacks a comprehensive and coordinated leave system for work disabilities, experiences from other countries and certain U.S. states can help in building and improving the existing support network.

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Appendix

Figure A1: Examples of Legally Required Employee Right Notifications

EARNED SICK TIME

Notice of Employee Rights

Beginning July 1, 2015, Massachusetts employees have the right to earn and take sick leave from work.

WHO QUALIFIES?

All employees in Massachusetts can earn sick time. This includes full-time, part-time, temporary, and seasonal employees.

HOW IS IT EARNED?

- Employees earn 1 hour of sick time for every 30 hours they work.
- Employees can earn and use up to **40 hours per year** if they work enough hours.
- Employees with unused earned sick time at the end of the year can **rollover up to 40 hours**.
- Employees **begin earning** sick time on their first day of work and **may begin using** earned sick time 90 days after starting work.

WILL IT BE PAID?

- If an employer has 11 or more employees, sick time must be paid.
- For employers with 10 or fewer employees, sick time may be unpaid.
- Paid sick time must be paid on the same schedule and at the same rate as regular wages.

WHEN CAN IT BE USED?

- An employee can use sick time when the employee or the employee's child, spouse, parent, or parent of a spouse is sick, has a medical appointment, or has to address the effects of domestic violence.
- The smallest amount of sick time an employee can take is one hour.
- Sick time cannot be used as an excuse to be late for work without advance notice of a proper use.
- Use of sick time for other purposes is not allowed and may result in an employee being disciplined.

CAN AN EMPLOYER HAVE A DIFFERENT POLICY?

Yes. Employers may have their own sick leave or paid time off policy, so long as employees can use at least the same amount of time, for the same reasons, and with the same job protections as under the Earned Sick Time Law.

RETALIATION

- Employees using earned sick time cannot be fired or otherwise retaliated against for exercising or attempting to exercise rights under the law.
- Examples of retaliation include: denying use or delaying payment of earned sick time, firing an employee, taking away work hours, or giving the employee undesirable assignments.

NOTICE & VERIFICATION

- Employees must **notify** their employer before they use sick time, except in an emergency.
- Employers may require employees to use a **reasonable notification system** the employer creates.
- Employees out of work for 3 consecutive days **OR** using sick time within 2 weeks prior to leaving their jobs, may be required by their employer to provide documentation from a medical provider.

DO YOU HAVE QUESTIONS?

Call the Fair Labor Division at 617-727-3465 E-Mail us at EarnedSickTime@state.ma.us
 Visit www.mass.gov/ago/earnedsicktime

The Attorney General enforces the Earned Sick Time Law and regulations. It is illegal to violate any provision of the Earned Sick Time Law. Violations of any provision of the Earned Sick Time Law, M.G.L. c. 149, § 14B, or these regulations, 940 CMR 33.00 shall be subject to paragraphs (1), (2), (4), (6) and (7) of subsection (b) of M.G.L. c. 149, § 17C(6) and to § 150. This notice is intended to inform. Full text of the law and regulations are available at www.mass.gov/ago/earnedsicktime.

The right figure is a collage of multiple workplace posters. Key posters include:

- EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT**: A poster from the U.S. Department of Labor, Wage and Hour Division, detailing FMLA rights.
- EMPLOYEE RIGHTS POLYGRAPH PROTECTION ACT**: A poster regarding the use of lie detector tests in the workplace.
- WORK EXPOSURE TO BODILY FLUIDS**: A poster detailing safety protocols for handling bodily fluids.
- STATE AND FEDERAL LABOR LAW**: A poster with a map of Arizona, listing various labor laws.
- ARIZONA CONSTRUCTIVE DISCHARGE NOTICE**: A notice regarding constructive discharge in Arizona.
- EMPLOYEE SAFETY AND HEALTH PROTECTION**: A poster detailing OSHA safety rights.
- EMERGENCY NUMBERS CALL 911**: A poster listing emergency contact numbers.
- PAY DAY NOTICE**: A poster regarding wage and hour regulations.
- NOTICE TO EMPLOYEES**: A poster regarding unemployment insurance.
- WORK EXPOSURE TO METICULIN-RESISTANT BIPHIDOCOCCUS AERIS (MRSAL SPINAL MENINGITIS OR TUBERCULOSIS (S))**: A poster regarding a specific biological hazard.

Left figure shows an Earned Sick Time poster from Massachusetts (Commonwealth of Massachusetts, 2019). Right figure shows a general workplace poster that is compliant with notification requirements in Arizona (Industrial Commission of Arizona, 2019). The Arizona poster includes all labor laws that employers are required to post at the workplace in Arizona.

Table A1: Overview of State-Level Sick Pay Mandates in the U.S.

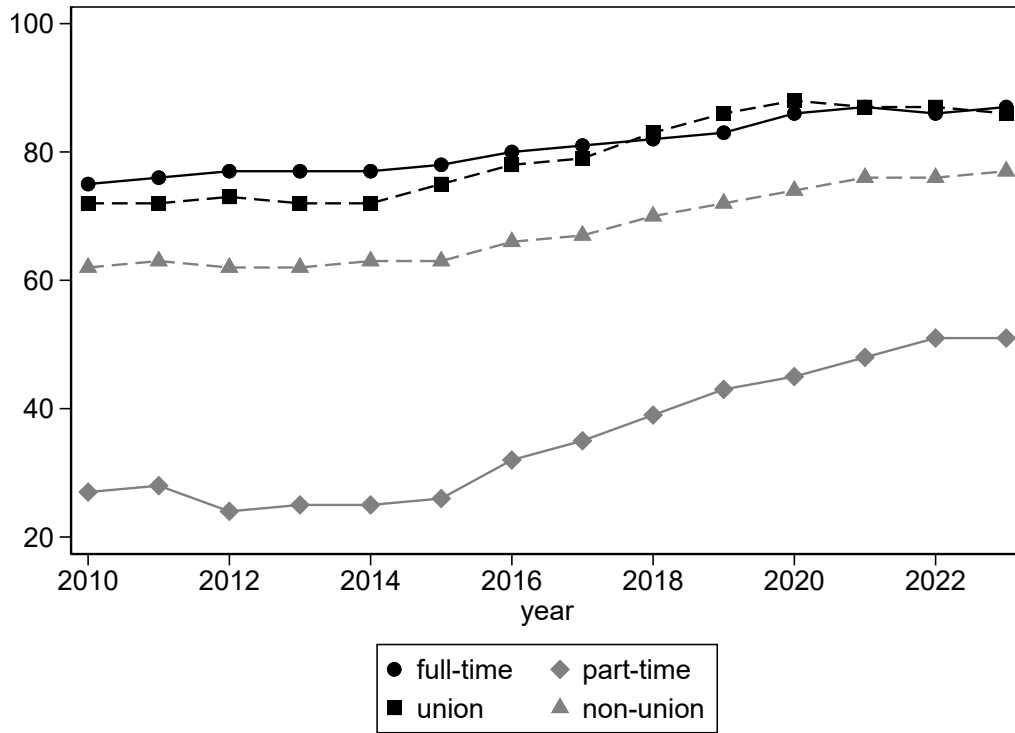
| Region (1) | Law Passed (2) | Law Effective (3) | Content (4) |
|-----------------|---|------------------------------|---|
| Washington D.C. | May 13, 2008 Dec 18, 2013 | Nov 13, 2008 Feb 22, 2014 | 'qualified employees'; 1 hour of paid sick leave for every 43 hours, 90 days accrual period; up to 3 to 9 days depend. on Firm size; own sickness or family; no health care or restaurant employees extension to 20,000 temporary and tipped employees (retrosp. in Sep 2014) |
| Connecticut | July 1, 2011 | Jan 1, 2012 | full-time service sector employees at firms with >49 employees (20% of workforce); 1 hour for every 40 hours; up to 5 days; own sickness or family member, 680 hours accrual period (4 months) |
| California | September 19, 2014 | July 1, 2015 | all employees; 1 hour of paid sick leave for every 30 hours; minimum 24 hours; own sickness or family member; 90 days accrual period |
| Massachusetts | Nov 4, 2014 | July 1, 2015 | all employees at firms with >10 employees; 1 hour for every 40 hours; up to 40 hours; own sickness or family member; 90 days accrual period |
| Oregon | June 22, 2015 | Jan 1, 2016 | all employees at firms with >9 employees; 1 hour every 30 hours; 90 days accrual period; up to 40 hours; own sickness or family member |
| Vermont | March 9, 2016 | Jan 1, 2017 | employees w/ 18 hours/week & >20 weeks/year at firms with > 5 employees; 1 hour every 52 hours; up to 24 hours in 2017, 40 hours thereafter; own sickness or family member; underage employees and firms in first year exempt; some state employees & per diem employees in health care or long-term care facility exempt |
| Arizona | November 8, 2016 | July 1, 2017 | all employees; 1 hour for every 30 hours; up to 40 hours at firms with >14 employees, up to 24 hours <15 employees; own sickness or family member; firms can impose 90 day accrual period for new employees |
| Washington | Nov 8, 2016 | Jan 1, 2018 | all employees except those who are exempt from minimum wage law; 1 hour for every 40 hours; no cap but no more than 40 hours carry over; own sickness or family member; 90 day accrual for new employees |
| Maryland | Jan 12, 2018 (override veto by Governor) | Feb 11, 2018 | employees w/ 12 hours/week at firms with > 14 employees (<15 employees 40 hours unpaid); 1 hour for every 30 hours; firms can cap at 64 hours accrual and 40 hours carry over; own sickness or family member, also for parental leave; certain groups exempt (e.g. temp. agency employees) |
| Rhode Island | Sept 28, 2017 | July 1, 2018 | All employees; 1 hour for every 35 hours; 24 hours in firms >17 (2018, 2019); 40 hours in firms >17 (2020+) own sickness or family member; 90-day accrual period; |
| New Jersey | May 2, 2018 | Oct 28, 2018 | all employees; 1 hour for every 30 hours up to 40 hours/year; per diem health care employees exempt own sickness or family member; 120 day accrual for new employees; preempts city laws |

Overview of Employer Sick Pay Mandates in the U.S. (II)

| Region (1) | Law Passed (2) | Law Effective (3) | Content (4) |
|---------------|--|---|---|
| Michigan | Dec 13, 2018 (weakened in lame duck session) | March 28, 2019 | employees w/ 25 hours/week employed for 25 weeks at firms with > 49 employees; 1 hour for every 35 hours; government employees, certain railway and air carrier employees exempt; own sickness or family member; 90 day accrual for new employees |
| New York | April 3, 2020 | Sep 30, 2020 (accrue) Jan 1, 2021 (take) | employees at firms with > 100 employees; up to 56 hours; <100 employees 40 hours (unpaid if <5 employees & < \$1M in earnings); own sickness or family member; 1 hour per 30 hours of work; independent contractors and public employees exempt; accrual, use and bank can be limited to 48 hours |
| Colorado | July 14, 2020 | immediately (covid-19) Jan 1 2021, Jan 1, 2022 | all employees; 1 hour for every 30 hours; up to 48 hours p.a. supplemental sick leave when public health emergency; own sickness or family member; accrual, use and bank can be limited to 48 hours |
| New Mexico | April 1, 2021 | July 1, 2022 | all employees; some airline, railroad, government, tribe workers exempt; 1 hour for every 30 hours; own sickness or family member; use up to 64 hours p.a. |
| Minnesota | May 24, 2023 | Jan 1, 2024 | all employees with 80 hours/year; independent contractors exempt; building/construction exempt if covered by a CBA and clear waiver of requirements; 1 hour for every 30 hours; accrue and carry forward up to 80 hours; own sickness or family member |

Source: several sources, own collection, own illustration. Note: Nevada (Jan 1, 2020), Maine (Jan 1, 2023), and Illinois (Jan 1, 2024) passed paid time off mandates, requiring employers to allow employees to accrue general paid time off, without specific reason.

Figure A2: Changes in Employee Access to Sick Pay



Notes: Own illustration based on NCS data 2000-2023.



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