



Two Proposals to Strengthen Paid-Leave Programs

Invest in Return-to-Work Services and Test a Longer Benefit

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Existing state paid family and medical leave programs do not currently include services aimed at assisting workers who have difficulty returning to their jobs after experiencing a new serious illness or injury. These return-to-work services are also not included in the most widely sponsored federal paid leave bill, the Family and Medical Insurance Leave (FAMILY) Act. However, they are a feature of many private short-term disability benefits offered by employers and many paid medical leave programs in other countries. High-quality versions of these programs help firms retain employees, improve worker employment and health outcomes, and reduce costs to businesses. Further, temporary disability benefits for workers who need longer leaves but are not eligible for Social Security disability have not been tested and evaluated. A national strategy on paid leave that supports worker attachment to the labor force and positive health outcomes would be strengthened by investments in evidence-based return-to-work services. It would also explore and evaluate the potential benefits and costs of a longer temporary disability benefit for workers whose conditions require longer leaves.

In this brief, we discuss the evidence base for expanding investment in return-to-work services and propose pairing a paid medical-leave benefit lasting 12 weeks with grants to states to provide evidence-based interventions targeted to workers who struggle to get back on the job following a new serious illness or injury. We discuss how a tiered-evidence approach to funding and evaluating interventions could be used to scale up investments over time, similar to the model used for funding nurse home-visiting programs. Second, we propose testing a longer paid medical-leave benefit for workers at risk of negative employment and health outcomes and discuss the importance of rigorous evaluation and testing of such a benefit outside the context of the Social Security Disability Insurance program.

Helping Workers After a New Illness or Injury

The United States does little to assist workers who have difficulty returning to their job after taking leave to address a new serious health condition. As we discuss in an earlier brief, existing federal and state programs are not designed to assist this group of workers (Smalligan and Boyens 2018). For example, some worker's compensation programs provide return-to-work supports in addition to benefits, but only in cases where the illness or injury is work related. Some workers who develop long-term or permanent disabilities can turn to the Social Security Disability Insurance (SSDI) program. However, SSDI was not designed to help workers with shorter-term, temporary disabilities, and it does not provide an opportunity to intervene as early as possible after the onset of a new condition, which research suggests is critical to increasing the likelihood that a worker can return to their job and to supporting other positive health and employment outcomes (Smalligan and Boyens 2018; Christian, Wickizer and Burton 2016). Vocational rehabilitation programs can provide similar services but are limited by funding and statute to assisting only individuals with the most severely disabling conditions. This prioritization makes sense, but it creates a gap for many workers.

Unlike in many other high-income countries, employers in the United States are also not required to provide return-to-work assistance to struggling employees. For example, in some European countries, employers are required to provide paid sick days and temporary disability benefits, along with return-to-work services for workers who struggle after experiencing a new serious condition. Absent federal or state mandates, some employers provide these services voluntarily. Many employers do so in the context of disability management programs aimed at helping employers manage employee absences and supporting worker retention. These programs often employ occupational health staff and consultants to coordinate services and communication across homes, workplaces, health care settings, and social environments. These programs are most common in industries with higher rates of workers' compensation claims or where the workforce is highly compensated and high skilled.

Taken together, the gaps in federal and state programs and reliance on voluntary, employer-based programs mean that millions of workers whose employment is derailed by a new serious medical condition are often left to navigate the consequences of their condition on their own. This is concerning because millions of workers experience health shocks every year. In an analysis using six waves of the Panel Study of Income Dynamics, Mudrazija and Smalligan (2019) found on average, each year, 4.2 percent of workers age 18 to 62 reported a new work-limiting health condition or a new major health shock. These workers were found to be three times as likely to leave the labor force and twice as likely to have fallen into poverty within two years of experiencing such a condition. After six years, they were 22 percentage points more likely to leave the labor force, and of those who did leave, over one-third did not receive government income assistance of any kind, including SSDI.

The onset of a new serious medical condition is especially threatening to older workers, women, and people of color. The analysis of data from the Panel Study of Income Dynamics found that these workers all faced a higher risk of leaving the labor force. Further, older workers frequently report having to retire prematurely because of health conditions (Smalligan and Boyens 2020). Older workers

who leave the workforce prematurely experience significant reductions in income that continue into their retirement (Johnson and Gosselin 2019).

Intervening early and successfully with workers at risk of having a short-term, temporary disability turn into a longer-term disability or lead to job loss could provide significant benefits to individual workers, employers, and government assistance programs. These benefits include increased employment rates, better health outcomes, reduced absences, and delayed or reduced take-up of SSDI. In the next section, we describe what is known about the design of effective interventions and their impact on these key outcomes.

Evidence-Based Return-to-Work Programs

Return-to-work services are aimed at supporting continued employment for workers who develop a new potentially disabling illness or injury or who experience the worsening of a chronic condition that could limit their ability to work. Return-to-work services can take many forms, but the most effective approaches emphasize intervening as early as possible after the onset of a condition and when potential delays and complications to returning to work become apparent.

The timeliness of the intervention is important for several reasons. First, intervening early, while a person is still connected to an employer (e.g., while on paid sick or medical leave), preserves his or her best chance at staying employed and potentially secures a workplace accommodation based on his or her functional abilities. The worker's current employer has the greatest incentive to provide accommodations, especially for workers with firm-specific human capital and in jobs with significant training costs. Second, returning to work as early as possible is critical. Prolonged time away from the job can lead workers to become disconnected from the workplace, erode their skills, and deteriorate their emotional and psychological well-being (Waddell and Burton 2006). A person who experiences long-term unemployment, on top of the personal and financial costs of a medical condition, may find it even more difficult to navigate the hurdles involved in finding new employment.

In addition to a timely intervention, the most effective return-to-work strategies are characterized by a focus on improving coordination, communication, and services between the employee, the employer, the health care provider, and the worker's personal environment. Further, effective strategies maintain an overarching focus on the person's functional capacity and ability to stay at or return to work (Christian, Wickizer and Burton 2016). Interventions that follow this model have been shown to have a positive impact on workers, employers, and government spending.

The impact of return-to-work interventions that include these characteristics has been researched extensively, though focus has primarily been on countries outside the US. In an earlier paper, we synthesize findings from several systematic reviews of research on early intervention return-to-work programs as well as evaluations of two health care-based models (Smalligan and Boyens 2019). Our review finds that evidence-based interventions are effective in increasing employment rates and earnings, reducing time spent out of the workforce, increasing worker retention, combating depression, and reducing the likelihood of long-term disability. These models are effective at helping

workers with a range of medical impairments, from musculoskeletal conditions to common mental disorders.

Most research on evidence-based return-to-work interventions focus on workplace-based programs. But a large and innovative program in Washington State provides important evidence of the impact of a public health care-based model. Known as the Center for Occupational Health and Education, this state-based early intervention program was established within the worker's compensation system and is funded by premiums paid by employers. As such, it focuses on workers with occupational illnesses and injuries. The program was subject to an eight-year follow-up evaluation that found, relative to a comparable group of injured workers, workers receiving the Center for Occupational Health and Education intervention had a 30 percent reduction in workplace-based disability and 30 percent lower rate of injured workers transitioning to SSDI (Wickizer, Franklin, and Fulton-Kehoe 2018). This study reinforces the potential savings to other government programs from investment in return-to-work programs as well as the viability of non-workplace-based models for delivering services to workers.

Implications for Paid-Leave Policy

This evidence base suggests that additional investment to expand worker access to evidence-based return-to-work services is warranted. So how does this get accomplished? Many countries with meaningful return-to-work programs have expanded worker access through employer mandates, but these are less commonly used in the United States. Further, as discussed, existing programs are not well suited to assisting this population of workers with temporary work disabilities.

Instead, we propose a system built in tandem with paid family- and medical-leave benefits. As the number of states with paid family and medical leave programs grows (as does support for federal legislation), an opportunity could exist to enact a new federal paid family and medical leave program that includes a robust return-to-work component.¹ Under this comprehensive approach, a new national paid medical-leave benefit would be combined with grants to states to provide return-to-work services targeted to workers who struggle after taking leave. The paid medical-leave benefit would provide the administrative mechanism to identify and engage with workers with serious new illnesses and injuries. Moreover, combining return-to-work services with wage replacement benefits could boost expected positive labor force participation and health outcomes associated with paid-leave benefits. Absent federal legislation to enact national paid leave, a similar approach could be used by partnering with states that already have paid leave programs in place.

Although most recently enacted programs and proposals to expand paid family- and medical-leave benefits focus on providing 12 weeks of leave, some states provide a longer duration benefit for paid medical leave. Twelve weeks of leave is consistent with the federal Family and Medical Leave Act (FMLA), but older state programs provide for as much as 6 to 12 months of paid medical leave (also commonly referred to as temporary disability insurance). However, less is known about the expected costs and benefits of providing a longer benefit. Therefore, we also propose testing a longer-duration

paid medical leave-benefit for some workers who need leaves lasting more than 12 weeks. We describe both of these proposals in more detail here.

Proposal 1: Pair Paid Medical-Leave Benefits with Return-to-Work Supports

Access to return-to-work services could be expanded by providing grants to states to establish evidence-based return-to-work programs targeted to workers at risk of negative employment outcomes (such as exiting the labor market). The grants could be used to test promising new evidence-based approaches and to redesign existing programs to fit state needs and capacities. State performance would be measured in terms of improved employment outcomes over an extended period, including both increased rates of employment and earnings. The funding and authorization for state grants could be included in legislation establishing a new federal paid family and medical leave program. Absent federal paid leave legislation, grants could still be made available to states with existing paid leave programs, establishing a federal-state partnership in this area.

Funding would be provided through grants to states modeled after the tiered-evidence approach used in the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, described in more detail later in this section. Initial grants to states would be modest, perhaps starting at \$100 million a year and gradually increasing to \$400 million a year by the fifth year. At the start of the program, the grants would allow states to build capacity and then scale up promising programs based on rigorous evaluation methods, including the use of randomized controlled trials. To incentivize state oversight of the programs, beginning in the fourth year, states could be required to provide a 25 percent match on the federal funds.

The primary objective of these return-to-work grants would be to improve at-risk workers' employment outcomes. However, if states succeed in achieving this objective, they will likely also reap fiscal benefits in two ways. First, increased labor force participation could lead to higher tax revenues. Second, it would help many workers avoid or delay long-term disability and therefore reduce claims to the SSDI and Supplemental Security Insurance programs. Reduced or delayed participation in these programs reduces expenditures at the federal level. These savings could be shared with states by reinvesting a portion back into the program, thereby increasing the size of future grants and encouraging states to further scale successful programs.

USING A TIERED-EVIDENCE APPROACH TO FUND PROMISING MODELS

The MIECHV program, created as part of the Affordable Care Act, is a useful example of how to design a national return-to-work program (Adirim and Supplee 2013). MIECHV provides grants to states to provide maternal and early childhood services and supports through home visits (Sandstrom and White 2018). Before MIECHV, federal support for home visiting programs was limited. At the state level, support for home visiting varied widely, with some states having well-developed programs and other states having virtually nothing in place. The evidence base was very mixed as well. One program, Nurse Family Partnership, had a substantial number of randomized controlled trials, but many other models had little rigorous evidence.

Some of MIECHV's features could be used as a model for early intervention state grants:

- **A tiered evidence funding structure and evidence clearinghouse.** In a tiered evidence funding structure, funding preference is given to models with the strongest evidence base.² HHS created an evidence clearinghouse and used it to allocate funding to states that prioritized models with the strongest evidence base and to fund new promising approaches. Home-visiting experts said this funding structure helped lead many home-visiting models to undertake rigorous evaluations so they would be included in the highest tier.
- **Grants tailored to states' capacities and needs.** For states with a limited infrastructure, funding was included for capacity building grants, followed by grants to scale up existing programs. HHS was therefore able to provide a range of grants tailored to states' widely differing capacities.

Although the MIECHV approach has had much success, it also yielded important lessons and caveats. First, it can be difficult to strike the right balance on evidence building. Initially, states funded many small evaluations, which were of limited quality. Second, building capacity also required developing a skilled workforce to conduct high-quality home visits.³ This can take time, so funding to states needs to include realistic assumptions regarding a schedule to hire and train staff. Finally, a tiered evidence structure that leaves the choice of approaches to the local level may also find that states and localities mainly choose safe, proven interventions and, as a consequence, programs may struggle to expand the evidence base by testing promising but unproven approaches. Addressing these concerns would be important to developing a more detailed version of this proposal that uses funding based on a tiered-evidence framework.

Although evidence-based return-to-work services could be effectively employed for at-risk workers with access to a 12-week paid medical-leave benefit, some workers would likely benefit from a longer paid medical-leave benefit before returning to work. In the next section, we discuss how return-to-work grants to states could also be combined with an evaluation of a longer temporary-disability benefit.

Proposal 2: Rigorously Test a Short-Term Disability Benefit

In our first proposal we consider policies to help workers who have experienced a short-term medical condition return to work in the context of a 12-week medical-leave benefit. However, some workers will experience medical conditions that prevent them from returning to work quickly and for whom a longer period of income assistance may be necessary. To better understand how workers could benefit from a temporary disability benefit lasting longer than 12 weeks, we propose funding for state demonstration projects to expand the evidence base. Importantly, we recommend these projects be tested as expansions to a paid medical-leave benefit and not in connection with the SSDI program.

DURATION OF PAID MEDICAL-LEAVE BENEFITS

Policymakers do not agree on the optimal duration for a publicly financed paid medical-leave benefit. Currently, support seems highest for a federal benefit lasting 12 weeks. This is reflected in the most recently enacted state paid family and medical leave programs, most of which provide 12 weeks of benefits for parental, caregiving and medical leave.⁴ Further, the most widely sponsored paid leave bill, the FAMILY Act, also proposes 12 weeks of federal benefits. These programs are modeled after the FMLA of 1993, which provides for 12 weeks a year of job-protected, unpaid leave for medical, parental, and caregiving reasons. However, the four oldest state paid-leave programs, which include those in California, New Jersey, New York, and Rhode Island, operate as temporary disability insurance programs and offer as much as 26 to 52 weeks of benefits. In addition, the earliest version of the FMLA, the Family Employment Security Act of 1984, proposed up to 26 weeks of leave a year.⁵

Some experts argue for a longer duration of leave, such as six months. The World Policy Center, for example, convened medical experts to consider the amount of leave needed to recover from a serious illness, looking specifically at cancer, heart disease, and diabetes. They concluded that “medical evidence on treatment and recovery times suggests that six months of paid leave is important to cover severe illnesses” (Raub et al. 2018). They also found that 28 of 34 OECD countries provide at least six months of paid leave for serious illness. Moreover, the median short-term disability benefit offered to workers in the United States provides six months of benefits.⁶

A new federal paid medical-leave policy would likely need to consider many factors in determining the optimal duration of leave and would entail compromises between competing priorities, such as ensuring robust wage insurance for workers, keeping program costs manageable, avoiding undue employer burden, and maintaining strong labor force attachment. Some data suggests that a 12-week benefit would be sufficient to address most needs. For instance, data from Rhode Island’s short-term disability program, which has a maximum of 30 weeks of benefits, indicate that 12 weeks of leave is sufficient to cover almost three-quarters of all medical leave claims (National Partnership for Women & Families 2019). And recent estimates from the Social Security Office of the Chief Actuary and the Congressional Budget Office indicate that the average duration of medical leave that would be taken under the FAMILY Act would be about two months.⁷

PROPOSALS FOR TEMPORARY DISABILITY BENEFITS

In the context of disability policy, many proposals have called for the creation of a temporary (or sometimes referred to as a short-term) disability benefit that could last anywhere from six months to two years. These proposals are not usually conceptualized as an extension of paid medical-leave benefits but rather as a version of SSDI or a new type of benefit. Proposals for temporary disability benefits have usually recommended testing and evaluating the policies first because their potential impact on health, employment and government costs is not well established. For example, Autor and Duggan (2010) propose a short-term disability benefit lasting up to two years, funded by employers, that would give an employer the opportunity to provide supports and accommodations that could help workers retain their job and support overall attachment to the labor force. Hildred and colleagues (2016) proposed short-term disability benefits for SSDI beneficiaries with conditions most likely to

improve. Stapleton, Ben-Shalom, and Mann (2019) propose what they call an Employment/Eligibility Services system that would combine return-to-work services with short-term cash benefits. Fichtner and Seligman (2019) propose a package of SSDI demonstration projects, including a test of temporary disability benefits.

Several arguments exist for testing a new national temporary disability benefit. Some proponents say that it can provide a benefit superior to SSDI for workers with conditions that may be temporary or that can be eventually managed with appropriate accommodations or therapy. These experts also emphasize the importance of linking the temporary income support with provision of return-to-work services, similar to our first proposal. Some also argue that a short-term disability benefit will ultimately reduce participation in SSDI and eventually reduce federal expenditures. However, interest in testing a short-term disability benefit does not need to be predicated on potential reductions in participation in SSDI. Although some savings might be realized in cases where an individual is helped to return to work and thereby either avoids or delays receipt of long-term disability benefits, many of the important benefits from an expanded temporary disability benefit would be realized by individuals who never receive SSDI benefits. For example, a review of data from the Panel Study of Income Dynamics found that after six years, one-third of workers with new disabilities who have left the labor force are receiving no public assistance. The number of full-time workers who develop a new work-limiting health condition and are living in poverty almost doubles within two years following the onset of their health issue (Mudrazija and Smalligan 2019).

TESTING A TIME-LIMITED DISABILITY BENEFIT OUTSIDE OF SSDI

Proposals to test a time-limited disability benefit have usually been made in the context of SSDI. SSDI is a long-term disability program with very strict eligibility standards focused on a person's inability to work. Testing a time-limited benefit in that context raises important concerns and limitations. First, note that SSDI benefits are already time limited for those who are fortunate enough to have their medical condition improve or who, despite a serious medical condition, are able to achieve sustained employment above the established threshold. This threshold, known as the substantial gainful activity level, is the amount a beneficiary may earn from work before they become subject to the SSDI work rules that can eventually terminate their benefits. In 2020, that amount was equal to \$1,260 a month.⁸ This means that by definition, those who are eligible for SSDI cannot substantially work and have already been out of the workforce for months or years when they are approved for long-term disability benefits. Effective interventions, as discussed, require a worker to still have some attachment to the workforce, which is rarely the case with SSDI.

Second, short-term benefit proposals could be used or perceived as an effort to reduce participation in the SSDI program by undermining the SSDI medical improvement standard. The standard protects beneficiaries from being removed from the program unless the Social Security Administration demonstrates that the beneficiary's medical condition has improved. Third, it may be difficult or impossible to rigorously evaluate a short-term SSDI benefit using randomized controlled trials. SSDI benefits are "earned" through payroll tax contributions and based on work history. Individuals who meet the eligibility criteria are entitled to benefits under the law. Finally, SSDI is not

designed to assist workers who have a new serious illness or injury, and the evidence shows early intervention is most effective. Consequently, Congress has required that participation in SSDI demonstration projects be voluntary, because denying benefits to eligible individuals would impinge on their legal entitlement. Evaluating a voluntary program would raise serious selection bias issues because individuals who know they are eligible for SSDI could reasonably be expected to decline a shorter-term SSDI benefit.

Testing a short-term disability benefit as an expansion of a 12-week paid medical-leave benefit does not present the same challenges. The new benefit being evaluated would be an enhancement to the base benefit and would not need to have any relationship to SSDI eligibility. A rigorous evaluation of a short-term disability-leave benefit would help inform future disability policy. The few states with existing short-term disability programs cannot be easily evaluated (Ben-Shalom 2020). One analysis of those programs concluded they could not estimate the program's impact because of the longstanding nature of the program and data limitations (Autor et al. 2013).

Conclusion

Support for paid family and medical leave policies is growing. The COVID-19 pandemic has only served to call more attention to the vulnerability of workers who lack these benefits, including paid medical leave to address serious health conditions requiring longer leaves from work. Although most workers who take medical leave return to their jobs quickly, research shows that some are at an increased risk of leaving the labor force and experiencing serious hardship. Although the ability to take time off with pay is critical for these workers, return-to-work services could provide an opportunity to improve their health and employment outcomes.

Evidence-based return-to-work services that emphasize early intervention after the onset of a new condition have been shown to improve employment rates and earnings levels, reduce time spent out of the workforce, increase worker retention, combat depression, and reduce the likelihood of long-term disability. However, access to these services largely depends on the benefits offered by employers, leaving many workers out and leading to disparities in access.

We propose investing in evidence-based return-to-work services through grants to states. The grants could be combined with proposals to enact a new national paid family and medical leave program. Absent new legislation, grants could be targeted to states with existing paid family and medical leave programs. Although strong evidence exists on the types of interventions that work, less is known about how to deliver these services outside of the employer-based model used in the United States. For this reason, we recommend using a tiered evidence approach to funding that would allow states to test new approaches and scale promising models over time.

At the same time, the federal government could also fund state demonstration programs that combine employment supports with a temporary disability benefit lasting longer than 12 weeks. These demonstrations should be conducted in coordination with (but outside of) SSDI. State demonstrations would allow for rigorous evaluation of the impacts of providing a temporary disability benefit that is

longer than the unpaid leave provided for in the FMLA, the paid-leave benefit envisioned in the FAMILY Act, and many new state paid leave programs. With this two-pronged strategy, national paid leave legislation could substantially expand our support to newly ill and injured workers and reduce the number of workers who permanently leave the labor force because of health conditions.

Notes

- ¹ “COVID-19 Sparks Huge Shifts in American Financial Well-Being; Poll Finds Openness to Change,” Bipartisan Policy Center blog, June 8, 2020, <https://bipartisanpolicy.org/blog/economic-opportunity-poll/>; Smith and Kim (2010).
- ² “Home Visiting Evidence of Effectiveness,” Administration for Children and Families, accessed December 14, 2020, <https://homvee.acf.hhs.gov/home>.
- ³ “Home Visiting Career Trajectories,” Urban Institute, accessed December 14, 2020, <https://www.urban.org/policy-centers/center-labor-human-services-and-population/projects/home-visiting-career-trajectories>.
- ⁴ “Overview of Paid Family & Medical Leave Laws in the United States,” A Better Balance, last updated November 12, 2020, <https://www.abetterbalance.org/wp-content/uploads/2020/11/CombinedPFMLChart-Nov.-2020.pdf>.
- ⁵ Megan A. Sholar, “The History of Family Leave Policies in the United States,” *American Historian*, November 2016, <https://www.oah.org/tah/issues/2016/november/the-history-of-family-leave-policies-in-the-united-states/>.
- ⁶ Kristen Monaco, “Disability Insurance Plans: Trends in Employee Access and Employer Costs,” *Beyond the Numbers: Pay and Benefits*, February 2015, <https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.
- ⁷ C. Goss, letter to Rosa DeLauro, Social Security Office of the Chief Actuary, January 28, 2020, https://www.ssa.gov/oact/solvency/RDeLauro_20200128.pdf; and Congressional Budget Office, “H.R. 1185, FAMILY Act,” February 13, 2020, <https://www.cbo.gov/publication/56129>.
- ⁸ “The Red Book – What’s New in 2020?” Social Security Administration, accessed December 14, 2020, <https://www.ssa.gov/redbook/newfor2020.htm>.

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