

September 2026

Paid Family and Medical Leave

Evidence Review Findings: Effective / Roadmap Policy

A state policy providing at least 12 weeks of paid leave for parents who give birth and at least 6 weeks for all parents with a new child increases the likelihood and length of leave-taking, reduces racial disparities in leave-taking, and has beneficial effects on maternal labor force attachment, postneonatal infant mortality, parent and child health, and nurturing and responsive parenting.

Paid family leave policies allow employees to take time off work and receive a portion of their salary for qualifying reasons which include the birth, adoption, or fostering of a child or caring for a loved one with a serious medical condition. Paid medical leave policies allow employees to take paid time off to recover from one's own serious medical condition, which includes childbirth. By providing parents with the time and financial security to stay home with a new child, paid family and medical leave may improve both economic security and the health and wellbeing of children and parents.

States vary in the number of weeks offered, the portion of wages paid, eligibility requirements, job protection provisions, and funding mechanisms. Studies that examine the causal impact of paid family leave policies find that providing at least 12 weeks of paid leave for parents who give birth and at least 6 weeks for all parents with a new child increases the length and likelihood of leave-taking, increases mothers' labor force participation rates, improves mothers' mental health, and supports better child-parent relationships and child health.

Decades of research in the field of child development have made clear the conditions necessary for young children and their families to thrive.¹ These conditions are represented by our eight policy goals, shown in Table 1. The goals positively impacted by paid family and medical leave are indicated with a filled circle, and the goals theoretically aligned (but without evidence of effectiveness from strong causal studies) are indicated with an unfilled circle.

Table 1: Impacts of Paid Family and Medical Leave on Policy Goals

Goal Alignment	Policy Goal	Summary of Alignment between Policy and Goal
	Access to Needed Services	Positive impacts
	Parents' Ability to Work	Mostly positive impacts
	Sufficient Household Resources	Mixed impacts
	Healthy and Equitable Births	Mostly positive impacts
	Parental Health and Emotional Wellbeing	Positive impacts
	Nurturing and Responsive Child-Parent Relationships	Mixed impacts
	Nurturing and Responsive Child Care in Safe Settings	No strong causal studies identified for this goal
	Optimal Child Health and Development	Positive impacts

What Is Paid Family and Medical Leave?

Paid family leave policies allow employees to take time off work and receive a portion of their salary for qualifying reasons which include the birth, adoption, or fostering of a child or caring for a loved one with a serious medical condition. Paid medical leave policies allow employees to take paid time off to recover from one's own serious medical condition, which includes childbirth. Today, a growing number of states offer these policies as a result of increased women's labor force participation and advocacy throughout the 1900s and early 2000s and limited federal action.

In the early 1900s, approximately 20 percent of women in the United States participated in the labor force. Female labor force participation spiked during World Wars I and II when the male civilian workforce was limited and increased rapidly beginning in the 1960s with the availability of hormonal birth control and 1970s with the introduction of no-fault divorce. For women ages 25 to 54, the rate reached 78.4 percent in 2024.^{54,63,77}

Following World War I, an international movement advocating for fair treatment of women in the labor force gained momentum. The activism of feminists and female trade unionists led to the International Labor Organization's adoption of the Maternity Protection Convention of 1919, which called for 12 weeks of paid maternity leave, free medical care during and after pregnancy, and job protection.⁵ In the following decades, most countries established paid parental leave policies –

policies that require employers to allow eligible parents to take time off work to bond with a new child while receiving a portion of their salary.

As of 2026, the US remains one of only seven countries in the world without a paid maternity leave policy and the only one of 38 Organization for Economic Cooperation and Development (OECD) member nations without a national paid family leave policy.^{55,56}

As more women in the US, especially those age 25 to 54, joined the workforce in the mid-20th century, policies supporting pregnancy and employment gained increased attention. Passed in 1978, the Pregnancy Discrimination Act (PDA) amended the Civil Rights Act to close a key loophole – the law clarified that pregnancy discrimination is a form of sex discrimination, and prohibited employment or workplace discrimination based on current, past, or potential pregnancy or medical conditions related to pregnancy and childbirth.⁶⁴

The PDA required that states and employers providing workers with Temporary Disability Insurance (TDI) also provide benefits to workers who are temporarily unable to work because of pregnancy or childbirth. This meant that, beginning in 1979, the five states with TDI programs (California, Hawaii, New Jersey, New York, and Rhode Island) provide paid leave to pregnant workers to be used in the period immediately before and after birth. As a result, approximately 50 percent of all women and more than 80 percent of working women in these states became eligible for TDI.⁶⁵ Three decades later, California, Rhode Island, New Jersey, and New York would be the first four states to provide paid family leave to all parents, functionally extending paid family and medical leave benefits for parents who give birth and offering benefits to all parents for the first time.

Although the US does not have a national paid family leave policy, there is federal legislation mandating unpaid family leave and prohibiting pregnancy discrimination.⁵⁷ The Family and Medical Leave Act (FMLA), enacted in 1993, is currently the primary federal policy to support parental and family leave in the US. The FMLA mandates that qualifying workers receive 12 weeks of unpaid, job-protected leave with continuous health insurance coverage.⁴⁵ However, firm size and work history requirements preclude some employees from taking time off through the FMLA. Approximately 56 percent of employees are eligible.³ To qualify, employees must have worked at least 1,250 hours in the preceding year, must work in a firm with at least 50 employees, and must have worked for that employer for the past 12 months.²

Momentum for passing paid family and medical leave policies strengthened as a result of the COVID-19 pandemic, which exacerbated difficulties for families trying to balance work and the care of children. In response to the pandemic, the federal government passed the Families First Coronavirus Response Act in March 2020, which included temporary provisions to support emergency paid leave for many employees. Requirements for employers expired December 31, 2020.^{46,47,52} Since October 1, 2020, federal employees have been eligible for 12 weeks of paid leave to care for a new child through the Federal Employee Paid Leave Act (FEPLA), in addition to job protections through the FMLA.⁵

The Pregnant Workers Fairness Act (PWFA), the final regulations for which were effective on June 18, 2024, fills in many gaps in the FMLA for parents who give birth. The PWFA requires employers

with 15 or more employees make reasonable accommodations for employees who have a known limitation from pregnancy, childbirth, or related medical conditions unless the accommodation poses an undue hardship to the employer. Accommodations include providing unpaid, job-protected leave to recover from childbirth. The PWFA is unpaid, however, and does not cover bonding leave, therefore excludes parents who did not give birth.

In the absence of a federal paid leave policy, several states have adopted statewide paid family and medical leave policies. Paid family leave policies include bonding leave, which allows parents time to bond with a new biological, adopted, or foster child, and caregiving leave, which covers leave taken to care for a family member with a serious illness. Medical leave allows individuals to take time off for their own serious illness or health event, including recovery from childbirth. This evidence review is limited to studies that consider the effects of paid family and medical leave policies relevant to families with a new child – bonding leave and medical leave to recover from childbirth.

In 2002, California’s Senate Bill 1661 was signed into law, which made the state the first in the country with a paid family leave program.⁵⁸ Although enacted in 2002, benefits became available to nearly every worker in California in 2004. The policy provided 6 weeks of paid leave for the first time to all parents and built upon an existing state Temporary Disability Insurance (TDI) program to extend paid leave available to parents who give birth from 6 weeks post-birth to 12 weeks. Both TDI and paid family leave replaced wages at a rate of 55 percent (at the time of implementation) of one’s weekly earnings (up to a maximum benefit).

Current state paid family and medical leave policies allow all parents to take at least 6 weeks off from work, depending on the state, with pay varying based on a proportion of the employee’s wages prior to taking leave. By taking a combination of family and medical leave, parents who give birth may be eligible for over 20 weeks of paid leave, depending on the state and type of birth (vaginal or cesarean section). Most state policies also have weekly payment caps and require that individuals have a minimum work history, either by time worked or earnings, in the state during a given “base period” (often 12 months) prior to leave-taking.¹⁴

Who Is Affected by Paid Family and Medical Leave?

The only current national policies for family and medical leave are the Family and Medical Leave Act (FMLA) and the Pregnant Workers Fairness Act (PWFA) for parents who give birth, which is limited to unpaid, job-protected leave. Data show that only approximately 56 percent of workers qualify for the FMLA.³ Research has also found that the policy largely benefits higher-income and White workers.^{4,35} For the 44 percent of workers not eligible for job protections through the FMLA, taking extended leave following the birth of a child may lead to job loss. Because the FMLA provides only unpaid leave, eligible parents with limited resources may choose not to use the time off or shorten the duration of leave taken to minimize lost wages, or may put off paying bills or apply for public assistance because of lost income while taking leave.⁶⁷

Because of historic and contemporary systems of oppression, including discrimination in employment and education and unequal opportunities to build wealth, eligibility for the FMLA and the ability to afford unpaid leave varies by race, ethnicity, and nativity. Black, Hispanic, and Indigenous workers are less likely to be eligible and able to afford unpaid leave than White and

Asian workers, with Hispanic immigrants least likely of all groups to be eligible for job-protections and least able to afford unpaid leave.^{66,i}

Fewer than one in three Americans lives in a state with a fully implemented policy providing paid leave for parents with a new child.ⁱⁱ For many workers, access to paid leave is dependent on the generosity of employer-offered benefits. According to the Bureau of Labor Statistics, as of March 2023, 27 percent of civilian workers had access to paid family leave, whereas 90 percent of workers had access to unpaid family leave.^{iii,6} Employees that are born in the US, are college educated, and are non-Hispanic White have access to paid family leave at higher rates.^{4,35}

Among the minority of workers who receive any paid leave through their employer, the rate at which their wages are replaced varies such that those with high earnings receive the greatest relative benefits. In a 2016 survey conducted by the Pew Research Center, among workers who received some pay while on parental, family, or medical leave, those with a household income of at least \$75,000 were more than twice as likely to report receiving full pay while on leave compared to workers with a household income of less than \$30,000 (58% compared to 22%).⁶⁷

In contrast to the FMLA and employer policies, statewide paid family and medical leave policies have lower eligibility thresholds to be more inclusive and often structure benefits to be more generous for workers with low and middle incomes compared to those with high incomes. However, low uptake among families most in need of support has dampened the positive effects of paid family leave.⁷¹ In states with paid family leave policies, survey data suggest that fewer than half of workers were aware of the policy in the first years following enactment, and that this lack of knowledge was more common among younger workers, non-White workers, and those with less education, lower household income, or no access to employer-provided paid-leave benefits.^{68,69,70}

Encouragingly, in states with longer-established programs, uptake has improved over time, particularly as benefits have become more generous for workers with lower earnings. For example, California's 2025 increase to 90 percent wage replacement for low- and moderate-income workers has already been associated with higher utilization among those previously least likely to take paid family leave.⁷⁹

What Are the Funding Options for Paid Family and Medical Leave?

Most states with a paid family and medical leave policy fund it through employer and employee payroll contributions (where employers are required to withhold contributions from their employees' pay). Other states fund the policy through employee contributions only. In both cases, premiums are typically small (less than 1% of wages total).⁵³

ⁱ Ability to afford unpaid leave was estimated by the percentage of workers for whom total family resources would remain at or above 200% of the Supplemental Poverty Measure after subtracting estimated lost wages from taking 6 weeks of unpaid leave under the FMLA—the average amount of leave taken. (See Joshi et al., 2023).

ⁱⁱ Author calculation based on 2023 state population annual estimates from the U.S. Census Bureau and State-specific research conducted by the Prenatal-to-3 Policy Impact Center.

ⁱⁱⁱ The sum of paid and unpaid leave exceeds 100 percent because some workers had access to unpaid leave through the FMLA, as well as paid family leave.

Why Should Paid Family Leave Be Expected to Impact the Prenatal-to-3 Period?

Paid family and medical leave policies are designed to allow parents time off from work to recover from childbirth and bond with the new child. The guarantee of paid family and medical leave may increase parents' labor force participation and families' economic security after a birth, while also reducing the time parents spend looking for new work.^{6,8}

As discussed in this review, studies show increasing labor force attachment, through paid family and medical leave, has generally made women more likely to return to work following the birth of their first child, which contributes to positive short-term labor market outcomes. However, some long-term studies have shown losses in employment and wages. The losses may result from penalties in the workplace of having children (i.e., mothers may be seen as less competent and committed to their jobs which can negatively impact hiring decisions, salary, and promotions) and the high cost of child care (which can disincentivize participation in the labor force).⁶¹

If parents with access to paid family and medical leave remain attached to the workforce to a greater degree than families without paid leave, access to affordable and high-quality child care is vital to support children's development when parents work.⁴⁴ Robust paid family leave policies may also reduce the need for infant care, and allow families to save for child care later on.

Some scholars emphasize that paid leave policies can incentivize women to invest in their own education and training to a greater degree, because women perceive work as more profitable and compatible with raising children.⁴⁸

Additionally, paid family and medical leave may positively impact parent and child health outcomes.¹⁰ Paid family and medical leave should help new parents have more time to bond with their babies, develop positive caregiving skills, and build the foundation for healthy attachment.¹¹ Children may be more likely to experience positive health outcomes if their families have access to paid family and medical leave.¹² Mothers able to take paid time off after the birth of a child may be more likely to initiate breastfeeding and continue breastfeeding for a longer duration.¹²

Furthermore, both mothers and children may have a lower likelihood of being hospitalized following childbirth, because families may have more time to seek prompt medical care if a need arises.¹ Children may be less likely to experience avoidable poor health outcomes through timely immunizations and infant well-child visits.¹² Through increased breastfeeding, increased time with children, improved maternal health, and improved medical care, paid family and medical leave may also reduce infant mortality rates.

What Impact Does Paid Family and Medical Leave Have, and for Whom?

The evidence for the impact of paid family and medical leave in the US reveals that the policy improves a variety of child and family outcomes, but the research is limited to a few states. Only California, New Jersey, New York, and Rhode Island have family leave laws that were in effect by 2018, and all but one of the causal studies in this review are limited to these four states.

As a note, there are five states (California, Hawaii, New Jersey, New York, and Rhode Island) that also had Temporary Disability Insurance (TDI) programs in place prior to enacting paid family leave. Beginning in 1979, following enactment of the Pregnancy Discrimination Act, state TDI programs provided paid leave to pregnant workers to be used in the period immediately before and after birth. The “treatment” in these studies is therefore the provision of paid bonding leave to all parents, which functionally extended paid leave benefits available to parents who gave birth and the availability of paid leave benefits to all other parents for the first time.

Other states with paid family and medical leave programs have not implemented them for a sufficient period of time to study the impacts in a rigorous way. As a result, the majority of reviewed studies assess the efficacy of a paid family leave policy of 6 weeks in addition to a pre-existing 6 weeks of temporary disability leave for parents who give birth, corresponding to the duration of California’s paid family leave policy between 2004 and 2020.

Many international studies have found positive impacts of paid family and medical leave policies. However, the effects of those laws must be considered within the broader context of universal child care, universal health care, and child allowances offered in many other advanced economies.⁴³ Because of these systemic policy differences, this review is limited to laws within the US to build evidence on the policy’s effectiveness for US families.

The research discussed here meets our standards of evidence for being methodologically strong and allowing for causal inference, unless otherwise noted. Each strong causal study reviewed has been assigned a letter, and a complete list of causal studies can be found at the end of this review, along with more details about our standards of evidence and review method. The findings from each strong causal study reviewed align with one of our eight policy goals from Table 1.

The Evidence of Effectiveness table (Table 2) displays the findings associated with paid family and medical leave for families with a new child (beneficial, null,^{iv} or detrimental) for each of the strong studies (A through KK) in the causal studies reference list. For each indicator, a study is categorized based on findings for the overall study population; subgroup findings are discussed in the narrative. The Evidence of Effectiveness table also includes our conclusions about the overall impact on each studied policy goal. The assessment of the overall impact for each studied policy goal weighs the timing of publication and relative strength of each study, as well as the size and direction of all measured indicators.

Of the 37 causal studies included in this review, 12 examined how outcomes differed by race or ethnicity (beyond simply presenting summary statistics or controlling for race/ethnicity). Where available, this review presents the analyses’ causal findings by race and ethnicity. A rigorous evaluation of a policy’s effectiveness should assess the extent to which a policy reduces or exacerbates pre-existing inequities in economic and social wellbeing.

^{iv} An impact is considered statistically significant if $p \leq 0.05$. Results with p -values above this threshold are considered null or nonsignificant.

Table 2: Evidence of Effectiveness for Paid Family and Medical Leave by Policy Goal

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Access to Needed Services	Leave-Taking	B, N, R, O			Mostly Positive
	Postpartum Care		GG		
	Preventative Care Use		II		
	Doctors Visits		II		
Parents' Ability to Work	Short-Term Labor Force Participation	D, Q			Mostly Positive
	Long-Term Labor Force Participation	F			
	Short-Term Employment	B, D, AA, CC	N, A		
	Long-Term Employment		A, DD	F	
	Weeks Worked	B			
	Average Weekly Work Hours	B, N			
	Attachment to Pre-Birth Employer	B, O	A		
Sufficient Household Resources	Household Income	M	N		Mixed+
	Annual Wage Earnings			A	
	Hourly Wages		B		
	Poverty	M			
	Food Insecurity	Y, FF			
	Reduced Use of Public Assistance	V			
Healthy and Equitable Births	Postneonatal Infant Mortality	S, W			Positive

+ Mixed impacts, with positive impacts for increasing household earnings and reducing child poverty.

Table 2: Evidence of Effectiveness for Paid Family and Medical Leave by Policy Goal (Continued)

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Parent Health and Emotional Wellbeing	Self-Rated Health	P, Z			Mostly Positive
	Number of Days Sick		Z		
	Number of Nights in Hospital	Z			
	Prescription Medication Use	Z			
	Overweight	P			
	Obesity		P		
	Postpartum Depression	GG			
	Mental Health	C	JJ		
	Paternal Mental Health		C		
	Coping With Demands of Parenting	C			
	Psychological Distress	P, T, BB			
	Parental Substance Use	P, JJ			
	Parental Sleep		X		
	Parental Exercise		X		
	Parental Incarceration	JJ			
	Parental Divorce or Separation		JJ		
	Intimate Partner Violence		JJ		
Nurturing and Responsive Child-Parent Relationships	Mothers' Time Spent With Children on Reading, Outings, Meals	A	C		Mixed

Table 2: Evidence of Effectiveness for Paid Family and Medical Leave by Policy Goal (Continued)

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Optimal Child Health and Development	Breastfeeding Duration	H, GG	G, K, U		Mostly Positive
	Exclusive Breastfeeding	G, H, U			
	Infant Hospitalizations	L			
	Acute Care Encounters for Respiratory Infections	KK			
	Delayed Medical Care		II		
	Emergency Department Visits		II		
	Timely Infant Vaccinations	E, EE	U		
	Asthma		C		
	Allergies		C		
	Behavioral Problems		BB		
	Infant Health	C			
	School-Aged Child Health	J			
	Neglect	HH			
	Physical Abuse		HH		
	Abusive Head Trauma	I			
	Adverse Childhood Experiences	JJ			

Access to Needed Services

Studies find paid family and medical leave policies increase leave-taking.^{B,N,R,O} However, these policies may not impact access to other services, such as postpartum^{GG} and preventative care.^{II}

Research from California found that the implementation of paid family leave increased mother and father^v leave-taking durations and both parents taking leave simultaneously.^{B,N,R} One study found that the implementation of the policy increased the likelihood of maternal leave-taking by 3.6 percentage points^N and another study found that leave-taking increased by 5 weeks for mothers, but only up to 3 days for fathers.^B A separate study found that, although the implementation of the policy increased the probability of fathers taking leave by 0.9 percentage points, fathers were still taking only an average of 1.5 weeks out of the 6 weeks that were available at that time in California.^R

^v Studies included in this review did not look at same sex couples.

The study noted that mothers took an average of 9 weeks out of the 12 paid weeks available through both Temporary Disability Insurance and paid family leave at that time.^R

Research on policies in California, New York, New Jersey, and Rhode Island reinforced that implementation of paid family leave increased leave-taking for both mothers and fathers.^O Authors found, for mothers, implementation increased use of leave by 4.3 percentage points during the children's first year, which equates to 2.24 additional weeks. Mothers were also 41 percent more likely to take time off from work compared to before the paid family leave law was implemented. For fathers, implementation increased the use of leave by 1 percentage point, which equates to 3.64 additional days.^O

Research suggests that the effect on leave-taking may be greater for unmarried women and Black women than mothers who are unmarried and of other racial and ethnic backgrounds; one study found that the probability of taking leave increased by 7.2 percentage points for unmarried mothers (from a rate of 2% prior to the policy) and 10.6 percentage points for Black mothers (from a rate of 2% prior to the policy).^N White mothers, meanwhile, saw a statistically insignificant 3 percentage point increase (from a rate of 11% prior to the policy). However, more research on leave-taking effects by subgroup would be valuable to corroborate these findings, which had fairly large standard errors.

Although studies on California's state paid family leave program show increased leave-taking, low uptake among families most in need has dampened positive effects, as discussed earlier in this review. In states with implemented policies, non-causal survey data indicate that fewer than half of eligible workers took advantage of benefits in the several years after enactment. Encouragingly, longer-established programs have seen utilization rise, especially as benefits became more generous for workers with lower earnings.^{6,31}

One study on New Jersey, Rhode Island, New York, Washington, Massachusetts, and the District of Columbia, found that implementation of paid family leave did not impact attendance rates at postpartum check-ups. Using data from 2004 through 2021, authors found that mothers' self-reported attendance did not increase.^{GG}

Lastly, one study examined the implementation of paid family leave in New York and found no impact on health care use. Using survey data from 2016 through 2019, the authors found that the policy did not increase the probability that children ages 0 to 5 had one or more preventative care visits or had visited any doctor within the past year.^{II}

Disparities in Access to Needed Services

Strong, causal evidence suggests that a state paid family leave program can reduce racial disparities in leave-taking. One study examining multiple forms of leave-taking found that non-Hispanic Black and Hispanic women experienced the greatest increases in family leave-taking after the passage of a state paid family leave policy at 14.4 and 6.4 percentage points, respectively, compared to a statistically non-significant increase of 3.2 percentage points for White mothers.^N Another study considered leave-taking behaviors of both mothers and fathers by race and found a slightly larger effect among non-White mothers compared to White mothers and a large difference between

fathers; White fathers extended their leave by almost 2 days under a state paid family leave policy, whereas all other fathers extended their leave by 1.5 weeks.^O

Parents' Ability to Work

Several studies examine the impact of paid family and medical leave policies on mothers' labor force participation and employment, though results are mixed. For labor force participation, research identifies benefits in the short term^{D,Q}. In the long-term, some research finds benefits^F, with other studies finding very minimal impacts^{DD} in the long term. For employment, research finds benefits^{B,D,AA,CC} or minimal impacts^{N,A} in the short term but minimal impacts^{DD,A} in the long term, with one study finding the policy increased the unemployment rate over time.^F

A study of California and New Jersey's policies found a 5 to 8 percentage point increase in mothers' labor force participation rate in the months surrounding birth, as well as a significant increase in the number of weeks employed, compared to the number of weeks spent looking for work.^D A second study that examined both states also found a positive impact of paid family leave policies on labor force detachment. In California, the authors found that paid leave reduced labor market exit by, on average, 20 percent per year across the 5 years after a birth; in New Jersey, paid leave reduced labor market exit by an average of 46 percent each year across the 5 years after a birth.^Q The authors found that the effects were concentrated among women with college degrees or higher levels of education.

Another study found that labor force participation increased by 1.5 percentage points for young women in California following the implementation of paid family leave.^F The study, however, also reported unanticipated effects of paid family leave in the long-term: a significantly higher unemployment rate (1.5 percentage points) and longer durations of unemployment (1.73 weeks longer) among young women.^F The author speculated that paid family leave may result in higher labor costs, and employers may engage in discriminatory hiring practices against younger women, causing higher unemployment rates in this group. However, this theory was not tested in the study, and other research suggests no such effect on employers.⁶

Another study found less conclusive impacts of the policy on long-term employment. In the 12 years following the addition of California's paid family leave policy to the existing Temporary Disability Insurance program (TDI), women's employment decreased slightly (less than 1 percentage point), though the impact was driven by younger women's decreases in employment. The same authors found that the policy led to a decrease in unemployment duration by approximately 1 week for young men with a high school degree or less.^{DD}

One of the largest studies of California's paid leave policy to date also found negative impacts on long-term employment, although decreases were only identified among first-time mothers who took leave immediately after the policy was implemented in 2004. The rationale for focusing on first-time mothers was that "the availability of paid leave may... have a greater impact on new mothers than on women who have already established their child care and work routines [because] women learn how to manage motherhood when they have their first child" (p. 16).^A Authors found no statistically significant impact of the policy on employment among the full sample of mothers.^A The authors found a 7 percentage point reduction in maternal employment and an 8 percent reduction

in wages, 6 to 10 years after giving birth, among women who were eligible for paid leave at the time of their first birth (compared to those who gave birth in the months before policy implementation).^A

Conversely, several studies of California's paid family leave policy found that implementation increased mothers' employment. A study found that the policy increased the probability of mothers working by between 12.9 and 18.3 percentage points, depending on how much work experience the mother had before the birth.^B A second study found that paid family leave increased mothers' employment by up to 0.2 percentage points in the 2 years after giving birth.^D Finally, a study also found that the implementation of the paid leave policy increased the probability of employment for mothers with low income by 11 percent 1 year after birth.^{AA}

Additional research that studied the impact of California's paid family leave policy on employment, found that California employers had an increase of nearly six employees per firm on average after implementation, with even greater increases in large firms (i.e., approximately eight employees).^{vi,CC}

Research also examined the amount new mothers worked following implementation of California's family leave policy (weeks worked and average weekly work hours). Among employed mothers of children ages 1 to 3, access^{vii} to paid leave increased usual weekly work hours by up to 17 percent when compared to mothers in states without access.^N A second study found that the policy increased weeks worked and average weekly hours worked during the child's second year by 7.1 weeks and 2.8 hours, respectively, for those who worked at least 20 weeks during their pregnancy.^B

Findings for job continuity, or attachment to the pre-birth employer, are mixed but lean positive. One study that included men and women of childbearing age, found a paid family leave policy increased the likelihood of working at the same job as prior to giving birth at 1 year after birth by 13 percent.^B A second study reinforced these benefits and found that, for mothers with access to paid family leave in California, New York, New Jersey, and Rhode Island, the probability of changing employers after the child's birth decreased 0.4 percentage points. For fathers, the probability of changing employers decreased by 1.4 percentage points.^O Very small and insignificant effects on job continuity were found in a study of the long-term effects of paid family leave in California.^A

A 2022 study found that California's paid family leave increased fertility by 2.8 percent, driven by higher order births to mothers in their 30s.⁶¹ The increase in fertility resulting from the policy could explain some of the contrasting short-term gains and long-term losses in women's labor market outcomes found in recent research. The authors of the 2022 study posit that, although women may benefit in the short run by remaining attached to their pre-birth employer, women may choose to have more children which can increase penalties in the workplace and the cost of child care.⁶¹

^{vi} Large firms are defined in this study as establishments with greater than 100 employees.^{CC}

^{vii} For the purpose of analyses, most studies included in this review defined "access" as "living in a state with a paid family leave policy" and examined outcomes relative to timeframes prior to implementation of the policy, relative to families in states without a paid leave policy, or relative to families without infants or young children. "Having access" does not mean that every family in the treatment sample was eligible for paid leave or received benefits.

Sufficient Household Resources

The most rigorous evidence to date suggests that paid family and medical leave has mixed effects on household material wellbeing, which includes poverty status and income. More specifically, this research identifies more positive impacts in the short-term and null and negative impacts in the long-term. These conclusions are generally consistent with research on the impact of paid family leave on women's labor market outcomes, specifically employment.

A study from California found that paid family leave improved household economic security in the year following the birth of a child.^M The study found that total income (inclusive of all household members' income) among households with children age 1, was approximately \$3,400 higher (equal to 4.1 percent higher) among families with access to paid family leave relative to those who did not have access.

Effects on total earnings for mothers were greater among married mothers, likely because they tend to take longer leaves than single mothers. The study also showed that families with access to paid leave were 10.2 percent less likely to be in poverty, with the greatest effects for single mothers with low incomes and levels of education.^M

Alternatively, two studies found statistically insignificant increases in mothers' wages (compared with total household wages as in study M) as a result of paid family leave. The first, a study on California's paid family leave program between 1999 and 2010, found that an increase in weekly work hours for mothers who took paid leave led to very small, and statistically insignificant increases in wage income.^N A study of post-birth employment outcomes associated with paid family leave found that the program led to a statistically insignificant increase in hourly wages for mothers of up to 5 percent at 1 year after birth.^B

Other studies demonstrate the potential detrimental or null effects of paid family leave in the long term (i.e., 10 to 12 years following leave). One study found that paid family leave had a detrimental effect on annual wages of first-time mothers in the long run, with a net 10-year loss of \$24,000.^A An additional study also found null effects on earnings 12 years after implementation of California's paid leave policy.^{DD} As discussed above, this may be because paid family leave results in higher labor costs, and employers may engage in discriminatory hiring and promotional practices against younger women.

Two studies have found paid family and medical leave improved food security.^{Y,FF} A study on food security in California between 1999 and 2007 found that the enactment of California's statewide paid family leave policy significantly improved food security for households with infants (under age 1) when compared to states without such a policy.^Y The authors found a 2.3 percentage point decrease in food insecurity as a result of the paid leave law, and measured the strongest effects for households below 185 percent of the federal poverty level and households with multiple children. The resources to purchase nutritious food may be one of the mechanisms driving better health outcomes for families in paid leave states, according to the author.

A study in New York conducted between 2018 and 2021 reinforced beneficial findings and found that the implementation of the statewide paid family leave policy significantly reduced the likelihood of low food security for households with children ages 1 through 3.^{FF} The policy reduced

the probability of low food security for households by 8.6 percentage points, for adults by 9.8 percentage points, and for children by 3.3 percentage points. The policy also significantly reduced the likelihood of very low food security for households by 3.3 percentage points and adults by 3.7 percentage points, but the effect was null for children. Authors posit the null result is because children are unlikely to experience very low food security to begin with and parents typically prioritize their children's wellbeing, including their food needs, over their own.^{FF}

A study published in 2020 found economic benefits for families as measured by their reduced reliance on public assistance.^V The author found that living in a state with paid maternity leave,^{viii} versus not, decreased the use of Temporary Assistance for Needy Families (TANF) by 4.3 percent, and reduced the benefits received per year by \$104 per family. The author suggested that substituting paid family leave benefits for TANF funds can be de-stigmatizing because it allows families with low incomes to participate in a more universal program rather than a public assistance program. However, the results were only significant for the period before the Great Recession (2007), and the author cautions that many mothers who earn low incomes are better off with TANF than with PFL benefits. Therefore, the implications of the study's findings may be different depending on each individual family's overall resources.

Disparities in Sufficient Household Resources

Evidence suggests that a state paid family leave policy may reduce known disparities in income and educational attainment. Households with incomes below 185 percent of the federal poverty level, as well as families with more than one child, saw significantly larger reductions in the incidence of very low food security, which represents a narrowing of known disparities.^{Y,73} Another study found that reductions in poverty and increases in household income attributable to California's paid family leave policy were larger for mothers with no education beyond high school, compared to mothers with more education.^M

Healthy and Equitable Births

Because paid family and medical leave is typically taken in the period after the child's birth, the impact of paid family and medical leave policies on perinatal outcomes is limited. Evidence from two studies show that access to paid family leave reduces postneonatal infant mortality (infant death after the first 28 days of life) – a finding that is especially important given that the US has one of the highest infant mortality rates among advanced economies and postneonatal infant mortality is largely preventable.⁶⁰

Access to paid leave may improve caregiving and reduce the likelihood of accidents and precursors of infant mortality during early infancy. A study of California's paid leave policy found that, following paid family leave's passage in 2004, postneonatal infant mortality decreased by 12 percent with no differences across racial groups, relative to states without the policy.^S A 2022 study reinforced the benefits and found that California's paid family leave policy reduced the postneonatal infant mortality rate by 8 percent.^W

^{viii} The study included California, Hawaii, New Jersey, New York, and Rhode Island as treatment states because they either had a Temporary Disability Insurance policy that covered pregnancy, or a paid family leave policy, or both.

Disparities in Healthy and Equitable Births

Stark racial disparities persist in birth outcomes, with infants who are Black, American Indian or Alaska Native, or Native Hawaiian and Other Pacific Islander experiencing the worst outcomes.⁵¹ Two strong, causal studies to date have examined the impact of paid family leave on postneonatal mortality, but they found no differences across racial groups.^{S,W} The existing evidence does not suggest that state paid family leave policies are effective at addressing this inequality.

Parental Health and Emotional Wellbeing

Studies on several state policies found that parents' physical and mental health benefited when parents had access to paid family leave.^{C,P,Z,BB,GG} The policies were found to have a more mixed impact on parents' health behaviors, such as alcohol consumption, sleep, and exercise.^{P,X}

A study on California's paid family leave policy found that mothers' self-reported health improved during the first 5 months following the child's birth. The share of mothers who reported their health to be in the top category (excellent) was 10 percentage points higher compared to mothers in other states without access to paid family leave.^Z

Most mothers are hospitalized around childbirth, however, the study also found that the number of nights spent hospitalized is significantly lower (0.6 nights) for mothers in California after the implementation of paid family leave, compared to mothers in other states without access.^Z Mothers' likelihood of taking daily prescription medication also decreased by 25.7 percentage points with access to paid leave, which the authors describe as reflecting a decrease in chronic health conditions. The likelihood of reporting any days feeling sick, however, did not decline.^Z

An additional California study found multiple positive impacts on parent health (mothers and fathers), which included a significant, 11 percentage point increase in the likelihood of reporting very good or excellent health and an 8.2 percentage point decline in the risk of being overweight.^P Mothers reported greater impacts on overall health.

A study using data from 2012 through 2021 found paid family and medical leave significantly reduced mothers' postpartum depressive symptoms.^{GG} During the study period, New Jersey, Rhode Island, New York, Washington, Massachusetts, and Washington, D.C. enacted leave policies that were included in the dataset. Implementation of paid family leave decreased the likelihood of postpartum depressive symptoms by 0.93 percentage points, representing an 8.2 percent decrease from the baseline.^{GG} These findings suggest that more recent and more generous state policies also demonstrate beneficial impacts of paid family and medical leave.

Another study on California found that mothers with access to paid family leave were also more likely to report having very good or excellent mental health (an 8.6 percentage point increase) and coping well with the day-to-day demands of parenting (a 5.3 percentage point increase).^C Effects on paternal mental health were not significant in this study. Although measured differently, a study on New York and Rhode Island also found no impact on caregiver mental health. The study found that the implementation of paid family leave in these two states had no impact on the rate of children ages 0 through 2 living with a caregiver who is mentally ill, suicidal, or very depressed.^J

Three studies assessed the implications of paid family leave on parents' postpartum psychological distress. The first study assessed mothers of infants in California and found that access to paid leave led to a 27.6 percent decrease in postpartum psychological distress, as measured by the Kessler Psychological Distress Scale.^T In particular, the authors found the strongest reductions in stress for mothers ages 18 to 29 and for single mothers compared to older and married mothers, respectively. The authors also noted that the policy may have a stronger effect for Black and Hispanic mothers compared to White mothers based on point estimates, but the confidence intervals for these groups overlapped, precluding a definite conclusion. The second study examined the effects of paid leave policies in California and New Jersey and found that, compared to states without paid family leave policies, exposure to a paid family leave policy led to a 0.49 point decrease (on a 24-point scale) in psychological distress among parents of children under age 2.^{BB}

Third, a previously discussed study on California's policy, found a 0.8 point reduction on a 24-point scale of psychological distress for parents (mothers and fathers).^P This study also found a 12-percentage point decline in any alcohol consumption for parents (mothers and fathers).^P Fathers saw greater declines in alcohol consumption. A more recent study on policies in New York and Rhode Island reinforced these findings. The implementation of paid family leave in these two states led to a 1 percent reduction in caregivers' self-reported substance use (including alcohol or drugs).^{JJ}

In contrast, research from New York did not find that implementation of a paid family leave policy improved health behaviors. Parental exercise and hours of sleep among parents with low incomes did not increase during the child's first year of life.^X Despite access to paid leave, time for new parents may still have been limited to engage in various health behaviors.

Finally, a previously discussed study on children ages 0 through 2 in New York and Rhode Island found these policies led to a 2 percent reduction in caregiver incarceration and 4 percent reduction in caregiver divorce or separation. Authors posit that these policies may reduce financial stress and increase mothers' employment, therefore, reducing risk factors for intimate partner violence, serving time in jail, and divorce or separation. However, the authors did not find impacts on physical intimate partner violence, defined in this study as whether the child saw or heard caregivers or adults slap, hit, kick, or punch one another in the home.^{JJ}

Disparities in Parental Health and Emotional Wellbeing

Moderate and severe psychological distress is shown to be higher among White mothers relative to Black, Hispanic, and Asian mothers; higher among single mothers compared to married mothers; and higher for mothers with incomes below the poverty threshold.⁷⁶ The evidence is mixed on the efficacy of state paid family leave to narrow disparities in measures of parental mental health.

One study found that access to paid family leave led to a 1.26 point decrease in psychological distress scores for Black women and a 1.5 score decrease for Hispanic women, but a statistically insignificant decrease for White women.^T The same study found that effects were only significant for single mothers, who saw a 1.0 point decrease in scores.^T

Another study that considered parental psychological distress found that White parents saw greater improvements compared to Black and Hispanic parents (indicating a narrowing of gaps by

race); parents with middle-incomes saw greater improvements compared to parents with low-incomes (suggesting a widening of the documented disparity); and found no significant difference by marital status.^{BB}

A third study showed greater improvements in maternal mental health and coping skills, as well as a greater increase in the likelihood of a family reading to their child more than 4 times per week for families with incomes below 150 percent of the federal poverty line compared to families with higher incomes.^C

Nurturing and Responsive Child-Parent Relationships

Evidence to date suggests that paid family and medical leave may increase the quality of parent-child relationships, although evidence is mixed.^A A study that used data from the Survey of Income and Program Participation found that California's paid family leave policy led to mothers spending more time with their children up to 4 years after the birth; in particular, mothers with access to paid family leave reported reading to their children 2 more times per week, having breakfast with their children 0.7 more times per week, and going on outings with children 1.8 more times per month, when compared with mothers who did not have access to paid leave.^A

A second study also examined reading and found that parents were 8.2 percentage points more likely to read to their infants 4 or more days per week when they had access to paid leave in California, but the result was not significant.^C

Optimal Child Health and Development

Evidence shows that paid family and medical leave policies improve a variety of infant health indicators and later child health in elementary school. In particular, increases in breastfeeding have been cited in multiple studies.^{G,H,K,U,GG} Evidence indicates null impacts of the policy on children's behavioral problems and the development of allergies or asthma, however.^{BB}

Two studies present evidence that access to paid family leave increases breastfeeding duration^{H,GG} and three studies find access increases exclusive breastfeeding (the infant receives only breast milk).^{G,H,U} Breastfeeding duration and exclusive breastfeeding have been linked in some research to a number of beneficial impacts for infants, including stronger immunity, reduced infections, and reduced infant mortality.³²

A previously discussed study on paid family leave policies enacted in New Jersey, Rhode Island, New York, Washington, Massachusetts, and the District of Columbia, found state policies increased breastfeeding duration by approximately 0.53 weeks (a 4.7% increase from the baseline).^{GG} In addition, a study from California, with a higher-income and less generalizable sample, showed that paid family leave led to an increase in any breastfeeding for at least 6 and 9 months that ranged from 10 to 20 percentage points.^H

Three studies found statistically insignificant impacts of paid leave policies on breastfeeding duration.^{G,K,U} One of these studies, on the policy in California, found that paid family leave led to an increase in breastfeeding duration of 18 days, but this finding was not significant.^K

Findings on the impact of paid family leave policies on exclusive breastfeeding are more consistently beneficial. A study with a large sample from California and New Jersey showed that paid family leave policies increased the percentage of exclusively breastfed infants at age 6 months by 1.3 percentage points.^G

Another previously mentioned study found that in California, paid family leave led to a 5 percentage point increase in the likelihood of breastfeeding at age 6 months.^K Finally, California's policy was also found to have increased the likelihood of exclusive breastfeeding for at least 6 months by 15 to 20 percent relative to the pre-law mean (3.7 to 5 percentage points).^U

Beyond breastfeeding, evidence suggests that paid family and medical leave may impact other indicators of child health and development. A study in California found that after the policy went into effect, hospitals saw 6 percent fewer infant admissions overall, and decreased admissions by 33 percent and 15 percent for upper respiratory infections and gastrointestinal diseases, respectively.^L Relatedly, a study in New York found that paid family leave reduced respiratory tract infection-related acute care encounters by 5.6 per 1,000 infants (from 31.4 to 25.8) during the respiratory infection season (October to March).^{KK} Encounters included hospitalizations and emergency department visits not resulting in hospitalization.

In contrast, another study in New York found that paid family leave did not impact whether healthcare for children ages 0 through 5 was delayed or not received. However, when authors included children ages 0 through 17, but limited the sample to children with chronic health conditions, the policy led to a 14.8 percentage point decrease in not having received necessary care or having delayed health care needs.^{II} The study also found no impact on whether children had one or more emergency department visits in the past 12 months. Although findings in this study were mostly null, the authors discuss that reductions in outstanding medical needs among children with chronic conditions is an important finding, as children with chronic conditions are a vulnerable group. Inability to access timely healthcare can lead to long-term health and economic implications.

Another California study found that infants whose families had access to paid family leave were 1.4 to 5 percentage points less likely to receive late vaccinations (measured for vaccines typically given before age 6 months), depending on the specific vaccination. The effect was even stronger for families with low levels of income, with a 5 to 7 percentage point reduction in the likelihood of receiving a late vaccination relative to similar families in states without paid leave.^E

A 2022 study found that the implementation of New York's paid family leave program increased the probability that a first-born child had all vaccinations on-time at age 2 months by approximately 1 percent. The authors limited the sample to first-born children to make the treatment and comparison groups as comparable as possible and to focus on new parents, who are most likely to be affected by the paid family leave law because the family environment and labor force participation has not already been changed by the birth of a child.^{EE}

A third study revealed that California's policy increased the likelihood that a child had very good or excellent health, as reported by their parents, by between 4.8 and 8.6 percentage points (approximately 5 to 10% of the pre-leave mean).^C The study also found a significant reduction in the

likelihood of asthma (5 percentage points) for all children ages 0 to 17. Results for food and respiratory allergies were mixed, with mostly null impacts.

Paid family leave also appears to be linked to better child health in elementary school, suggesting that the policy can have long-lasting beneficial impacts beyond the infant years. One study showed that children whose families had access to paid family leave were less likely than those without access to be overweight (4.1 percentage point difference), have ADHD (0.7 percentage point difference), have hearing problems (2.4 percentage point difference), and have communication problems (1.1 percentage points difference), with greater effects seen among boys and among children with lower socioeconomic status for the likelihood of being overweight and having ADHD.^J

A study from 2004 through 2020 on paid family leave enacted in New Jersey, Rhode Island, and New York found significant reductions in infant (children under age 1) maltreatment report rates of about 8.32 reports per 10,000 children (relative to a mean value of 61.23).^{HH} This represents an approximately 14 percent decline. When split by maltreatment type, authors did not find statistically significant declines in neglect or physical abuse reports.

Substantiated rates of infant maltreatment also declined by approximately 5.5 reports per 10,000 children, a decline of 22 percent. When split by maltreatment type, authors found statistically significant declines in neglect substantiations, but not in physical abuse substantiations. Substantiated rates of infant neglect declined by approximately 8.4 reports per 10,000 children. Authors posit the findings are consistent with paid family leave policies alleviating financial stressors for new parents and allowing time for health promoting behaviors (such as taking infants in for vaccinations). Both reduced parental stress and increased health promoting behaviors can reduce child maltreatment.^{HH}

One study on paid family leave in California showed that the policy was linked to a significant reduction in the rate of pediatric abusive head trauma in children below age 2.^I For children below age 2, paid family leave led to a rate reduction of 2.8 cases per 100,000 children; for children under age 1, the policy led to 5.1 fewer cases per 100,000 children.^I The authors suggested that this finding may be driven by reduced maternal stress and better mental health after the introduction of paid leave, a mechanism supported by other studies reviewed.^{C,P}

Lastly, a study on the implementation of paid leave policies in New York and Rhode Island found reductions in adverse childhood experiences (ACEs), defined by the Centers for Disease Control and Prevention (CDC) as potentially traumatic events that occur in childhood (birth to age 17).⁷⁸ Examples include maltreatment or parental substance use. The study found that paid leave led to a 4 percent reduction in the proportion of young children experiencing any ACE challenge relative to control states without paid leave.^{JJ}

Disparities in Optimal Child Health and Development

No racial/ethnic group currently meets public health objectives for continued or exclusive breastfeeding, but Black mothers have the lowest rate of breastfeeding continuation at 6 and 12 months compared to all other groups in the United States (27.9% and 12.9% compared to 45.1% and

23.6% for White mothers, 46.0% and 24.7% for Hispanic mother).⁴⁹ Existing evidence indicates that paid family leave is unlikely to narrow disparities in breastfeeding duration by race and ethnicity.

One study showed a widening of the racial disparity, such that access to paid family leave led to increases in exclusive breastfeeding at 6 months among Hispanic women, but reductions in exclusive breastfeeding at 6 and 12 months among Black women.^G Another study found larger increases in duration of breastfeeding for women in disadvantaged groups (WIC recipients, those who experience a phone service interruption, mothers with less than a high school education, mothers with incomes below the federal poverty line, and single mothers) but found no clear differences by race.^K

A study that examined differential effects of California's paid family leave policy on total breastfeeding duration, and duration at 3 and 18 months, found larger and statistically significant increases in total breastfeeding duration among White mothers, null effects for mothers of all other races, and no significant differences between Hispanic and non-Hispanic mothers.^U For breastfeeding duration at 18 months, Hispanic mothers saw much larger and statistically significant increases compared to non-Hispanic mothers.^U

Health outcomes among children in low-income families may also improve more as a result of paid family leave laws, though evidence is mixed depending on the outcome. One study found that the probability of late vaccinations decreased by 5 to 7 percentage points, depending on the vaccination type, for children in families with low incomes relative to families with higher incomes.^E

The New York study on respiratory tract infection-related acute care encounters found that reductions in encounters were driven by Hispanic infants. Among this subgroup, encounters decreased by 8.90 per 1,000 infants as compared to a decrease of 2.49 for White infants. The difference was statistically significant. Reductions were also more pronounced (and differences statistically significant) for encounters paid for by Medicaid (6.81 fewer cases per 1,000 infants) compared to private payer (2.59 fewer cases per 1,000).^{KK}

A study considering health outcomes for children in Kindergarten found that reductions in incidence of overweight and ADHD were driven by families with low levels of income and maternal education, but found no such pattern for hearing problems, communication problems, or frequent ear infections.^J Another study found no differences by household income in the effect of paid family leave on asthma, food allergies, respiratory allergies, or general health among infants.^C

Is There Evidence That Paid Family Leave Reduces Disparities?

Of the 37 causal studies included in this review, 12 examined how outcomes differed by race or ethnicity. Studies examined the differential impact of paid family leave policies by a variety of individual or household characteristics, including race, education, marital status, and income. In this section, we briefly summarize the sub-group findings all discussed in detail above.

The results of these analyses suggest that a comprehensive paid family leave policy narrows known disparities in leave-taking and the experience of very low food security and poverty.^{N,O,Y,M} Based on

the evidence to date, it is unlikely that paid family leave is an effective policy tool to narrow known racial disparities in postneonatal mortality or breastfeeding duration.^{S,W,K,U,G}

Has the Return on Investment for Paid Family Leave Been Studied?

Despite initial concern about the impact of the policy on employers and businesses, studies have found that most employers report either “no noticeable effect” or “a positive effect” of paid family leave on employee productivity, profitability, turnover, and morale.^{6,34,35} There is also early evidence of a considerable return on investment for paid family leave but more rigorous research is needed to build the evidence base.

A study of California’s paid family leave policy found that, after the policy went into effect, hospitals saw 6 percent fewer infant admissions overall. Based on the average charge for an infant hospitalization in California at the time, the authors estimated a total reduction in charges of \$218 million annually (in 2015 dollars).^L

A 2023 study included a “back-of-the-envelope” calculation, which estimated that the reduction in infant deaths attributable to a paid family leave program would save approximately \$9.7 billion per year, assuming that a 12-week national paid family leave policy had been in effect in 2020.^W The authors use the adult value per statistical life (VSL) in 2021, equal to approximately \$10 million to generate this estimate. The VSL for a child in the same year was \$23 million (\$26 million in 2023 dollars), suggesting that their projected savings may be an underestimate.⁷⁴

Finally, the Prenatal-to-3 Policy Impact Center conducted a benefit-cost analysis modeled on Pennsylvania H.B. 181. The analysis considered access to 20 weeks of leave for a child’s birth. Estimates found a paid bonding leave benefit would generate \$379 million in annual net benefits to Pennsylvania families, businesses, and the Commonwealth, and generate \$1.7 billion in lifetime net benefits for each year of births covered by the paid leave policy.⁷⁵

What Do We Know, and What Do We Not Know?

The research to date shows that the implementation of paid family leave policies in the US is effective at supporting labor force attachment and improving maternal and child health and parenting outcomes. The evidence from the most methodologically rigorous studies shows that parents take longer periods of family leave and that families are less likely to experience economic precarity when they have access to paid family and medical leave. Additional research also shows positive effects for maternal health and for a variety of child health outcomes.^{A,36}

Although the current evidence generally supports the notion that paid family leave has positive impacts on family outcomes, most of the research to date comes from California because of the recent enactment and implementation of other statewide leave laws. Most strong, causal research to date has examined the effects of California’s implementation of a paid family leave program in 2004, which provided 6 weeks of paid leave for the first time to all parents and built upon an existing state Temporary Disability Insurance (TDI) program to extend paid leave available to parents who give birth from 6 weeks to 12 weeks. A growing number of studies also consider the effects of New Jersey, New York, and Rhode Island’s paid family leave laws that were all in effect by 2018.

A more nuanced understanding of the optimal length of leave, the percent of pay that is reimbursed, and program administration and funding is necessary to highlight the specific components of paid family and medical leave policies that lead to the greatest impacts on health and wellbeing. Findings from various studies suggest that the benefits of paid leave, such as maternal mental health and breastfeeding, may increase as length of leave increases, with better outcomes when mothers return to work after 6 weeks of TDI and 12 weeks of paid family leave.^{38,39,40}

There are also some inconsistencies in research on women's labor market outcomes. Studies largely suggest positive short-term impacts of paid family leave on employment and earnings, but some research finds negative long-term impacts, potentially because of workplace penalties mothers may face and child care costs.⁶¹ More research to reconcile short- and long-term findings is needed.

Additionally, the current research is not able to assess the complete impact of paid family leave for families with low incomes and fathers, whose take-up rates are lower than families with higher incomes and mothers, respectively.^{31,R} Few studies focus on how fathers are affected by paid family leave, despite the fact that research from other countries has shown positive outcomes for the entire family if fathers take paternity leave.³⁷ Noncustodial fathers are absent from this research.

Reliable data on access to paid leave and leave-taking across the US are also limited; the Bureau of Labor Statistics' American Time Use Survey does not provide sufficient sample sizes in every state to gain a complete picture of access to and take-up of paid family leave.

Finally, more research is needed on the intersection of paid family leave policies with other policies, particularly those related to infant child care. Infant care is expensive, and demand for care in the immediate period after birth is high. Paid leave offers a variety of benefits on its own, but it can also serve as a solution to infant care challenges, and further research to understand the intersection with this challenge is needed.

Is Paid Family Leave an Effective Policy for Improving Prenatal-to-3 Outcomes?

The evidence demonstrates that a paid family leave policy of at least 12 weeks for parents who give birth and at least 6 weeks for all parents with a new child is an effective policy to improve a variety of child and family outcomes. Extending paid leave to at least 12 weeks for parents who give birth and at least 6 weeks for all parents increases the length and likelihood of leave-taking among mothers and fathers, narrows racial disparities in leave-taking, increases mothers' labor force participation, improves postneonatal infant outcomes, improves mothers' mental health, supports more nurturing child-parent relationships, and fosters better child and parent health.

How Did We Reach Our Conclusions?

Method of Review

This evidence review began with a broad search of all literature related to the policy and its impacts on child and family wellbeing during the prenatal-to-3 period. First, we identified and collected relevant peer-reviewed academic studies as well as research briefs, government reports, and working papers, using predefined search parameters, keywords, and trusted search engines. From this large body of work, we then singled out for more careful review those studies that endeavored

to identify causal links between the policy and our outcomes of interest, taking into consideration characteristics such as the research designs put in place, the analytic methods used, and the relevance of the populations and outcomes studied. We then subjected this literature to an in-depth critique and chose only the most methodologically rigorous research to inform our conclusions about policy effectiveness. All studies considered to date for this review were released on or before February 28, 2026. This evidence review was first published in 2020 and is updated on a recurring basis.

Standards of Strong Causal Evidence

When conducting a policy review, we consider only the strongest studies to be part of the evidence base for accurately assessing policy effectiveness. A strong study has a sufficiently large, representative sample, has been subjected to methodologically rigorous analyses, and has a well-executed research design allowing for causal inference—in other words, it demonstrates that changes in the outcome of interest were likely caused by the policy being studied.

The study design considered most reliable for establishing causality is a randomized controlled trial (RCT), an approach in which an intervention is applied to a randomly assigned subset of people. This approach is rare in policy evaluation because policies typically affect entire populations; application of a policy only to a subset of people is ethically and logistically prohibitive under most circumstances. However, when available, RCTs are an integral part of a policy's evidence base and an invaluable resource for understanding policy effectiveness.

The strongest designs typically used for studying policy impacts are quasi-experimental designs (QEDs) and longitudinal studies with adequate controls for internal validity (for example, using statistical methods to ensure that the policy, rather than some other variable, is the most likely cause of any changes in the outcomes of interest). Our conclusions are informed largely by these types of studies, which employ sophisticated techniques to identify causal relationships between policies and outcomes. Rigorous meta-analyses with sufficient numbers of studies, when available, also inform our conclusions.

Studies That Meet Standards of Strong Causal Evidence

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Evidence Review Citation:

Prenatal-to-3 Policy Impact Center. (2026). *Prenatal-to-3 policy clearinghouse evidence review: Paid Family and Medical Leave*. Peabody College of Education and Human Development, Vanderbilt University. <https://pn3policy.org/policy-clearinghouse/paid-family-leave/>