MARYLAND FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI) PROGRAM-- PHASE II: ANALYSIS OF EXPECTED PROGRAM CLAIMS AND ADMINISTRATION EXPERIENCE

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This report includes an actuarial report in Appendix III from Milliman, Inc.

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Executive Summary

This report provides a comprehensive analysis of expected program claims and administration experience for the Maryland Family and Medical Leave Insurance (FAMLI) program. It studies and projects the expected volumes, costs, and durations of claims by leave types for 2026-2030, and expected employer opt-out and the opt-in of self-employed individuals. The findings underscore the significance of ongoing monitoring, targeted initiatives, and stakeholder engagement through surveys to shape evidence-based policies that optimize program effectiveness and inclusivity.

First, we conducted three independent studies to make predictions on the number, cost, and duration of claims, based on econometric modeling (Chapter 1), the USDOL Worker PLUS model (Chapter 2), and an actuarial study by Milliman Inc. (Chapter 6). The three studies:

1. Projected the expected volumes of claims by month or quarter for 2026 and by year for 2027-2030 and their breakdowns by leave types (medical, family care, birth of a child, military exigency).
2. Projected the expected costs by leave types (medical, family care, birth of a child, military exigency).
3. Projected the duration of claims with details by claim type (medical, family care, birth of a child, military exigency in two of the three studies).

The data from all the states where the monthly claims data are available (California, Rhode Island, and Washington) exhibit no significant seasonality on the number of claims. Our estimation of the volume of first-year monthly claims in Maryland in Chapters 1 & 2 is predicted based on the first-year data of California, Rhode Island, and Washington. Annual claims and costs over 2027-2030 are projected based on updated policy parameters, wage inflation adjustment, employment growth, and the growth of take-up rates over the years. A slight increase in the number of claims from 2026 to 2030 is forecasted. The duration of different types of leaves varies based on factors like gender, age, marital status, and education. For example, women typically take longer leaves for medical reasons and for new childcare, while factors like being married influence the duration of family leaves. The expected leave durations are simulated from FMLA-based distribution with no wage replacement, and the actual durations with paid leave in the FAMLI program should be longer than the simulation results. The table below summarizes the expected benefit expenses estimated with three different models presented in Chapters 1, 2, and 6.

Table 1. Summary of Projected Benefit Costs of FAMLI Claims ($ Millions)

Year	Econometric Model	USDOL Worker PLUS Model	Actuarial Model
2026	$1,675	$1,677	$1,630
2027	$1,754	$1,752	$1,608
2028	$1,893	$1,895	$1,748
2029	$2,029	$2,032	$1,881
2030	$2,166	$2,169	$2,004

Second, an empirical analysis of the growth of leave lengths is performed in Chapter 3. A wide variation of leave durations is found across both the leave types and states, regardless of whether the leave durations are measured by raw length or a ratio of the raw length to the maximum state-allowed duration. Despite the wide variations of leave durations, medical leaves tend to be longer than family leaves presumably reflecting their generally much longer state-allowed maximum durations. In terms of the ratio of the leave length to the maximum state-stipulated leave length, however, the pattern is reversed. In fact, we also observe a general negative relationship between the maximum state-stipulated leave duration and the ratio of the leave length to this maximum duration, presumably reflecting a less than proportional increase in the leave duration with an increase in the maximum leave length. Our most important result in this chapter, however, is that the leave durations do not exhibit a consistent temporal trend over the years after the implementation of the state paid FAMLI programs, either based on the graphic or regression analysis. As a result, we do not consider the growth of the leave durations in our cost analyses.

Lastly, the expected behaviors of the opt-out of employers and the opt-in of self-employed individuals are discussed in Chapter 4 and 5, respectively. Chapter 4 explores the landscape of businesses opting out of state-paid family leave programs across the U.S., analyzing factors influencing their decisions. The study delves into opt-out rates and examines each state's policies. Overall, opt-out rates range from 3% in California to 33% in Massachusetts, presumably driven by policy differences across states, including whether government agencies can opt out and the division of the FAMLI contribution rate between employers and employees. The impact of employer size, industry dynamics, salary structures, and public perception on participation rates is also investigated. Strategies to reduce business opt-out rates are proposed, including financial incentives, administrative simplification, and collaborative efforts between government agencies and business associations. The importance of educating businesses about state-paid family leave is underscored, with recommendations for government initiatives to support businesses, including online tools, training programs, and helplines. An overview of various state approaches to paid leave programs, along with their impacts and reasons for opting in or out is provided.

Chapter 5 examines self-employed workers' opt-in behavior and access to FAMLI programs in the United States. As of January 2024, 13 states and Washington D.C. have implemented FAMLI

initiatives allowing self-employed individuals to voluntarily participate. However, opt-in rates remain very low with low awareness and high costs deterring participation: only around 1.8% averagely across existing state programs and based on available data. Several factors contribute to this trend, including that the costs of opt-in are disproportionately higher for self-employed individuals versus salaried workers in some states, eligibility barriers like waiting periods, and limited awareness of FAMLI programs. An analysis of survey data indicates that only 11% of self-employed workers taking leave for family/medical reasons had paid leave coverage, compared to 47% of employees. Addressing the low opt-in rate is crucial to expand access and ensure self-employed individuals can balance work with personal and family needs. Recommended strategies include enhancing affordability, raising awareness through outreach and education, and implementing regulatory measures to promote equity.

In addition to the analysis of expected claim costs for the FAMLI program, the actuarial study by Milliman Inc., Chapter 6 also provides a summary of the expected opt-out and opt-in behaviors by employers and self-employed individuals, respectively, based on publicly available information from states that have mandated FAMLI benefits.

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Chapter 1
Estimating Growth of The Program Utilization Rates

In the second stage of Phase II, we are tasked to conduct an analysis of expected program claims and administration experience by studying and providing projections on

- Expected volume of claims made on the state trust fund by employees employed in the state with predictions on the first year by month or quarter (2026), projections on at least an annual basis for later years (e.g., 2027 – 2030), and projections with break-downs of projected claims by leave type (medical, family care, birth of a child, military exigency)
- Expected cost and duration of claims with details by claim type (medical, family care, birth of a child, military exigency)
- Expected employer opt-out behavior, based on available information and data
- Expected self-employed individual opt-in behavior based on publicly available information from states that have mandated FAMLI benefits, based on available information and data.

1.1 Estimating the Volume of Claims in the First Year (2026)

To predict the volume of claims on the state trust fund by employees employed in the state by month or quarter in the first year (2026), we consider two potential trends, the seasonal trend (e.g., more claims in some months than others) and the trend in the first year after the payment starts (e.g. higher or lower claims since the program starts). We use data in other states to estimate the influence of these two trends. Table 1.1.shows the number of quarters that we used for our estimates in this chapter.

Table 1.1. Number of Quarterly Observations from Other States.

	Bonding			Family Care			Medical			
Quarter	CA	RI	Total	CA	RI	Total	CA	RI	WA	Total
1	18	10	28	18	10	28	49	10	3	62
2	18	10	28	18	10	28	49	10	3	62
3	18	9	27	18	9	27	48	9	3	60
4	18	9	27	18	9	27	48	9	3	60
Total	72	38	110	72	38	110	194	38	12	244

Note: For California, the dataset pertaining to bonding and family care spans from Quarter 3 in 2004 to Quarter 2 in 2022. Meanwhile, the dataset concerning medical claims encompasses the period from Quarter 1 in 1974 to Quarter 2 in 2022. Our seasonality analysis incorporates all the data available within these specified time frames. For the first-year trend analysis, we focus on the data from the inaugural year of the family care program, 2004, when payments for family care and bonding claims were initiated.

In our analysis, we first examine the seasonal effect. In doing so, we conducted two types of analysis to examine the seasonal effect. First, utilizing the data from four states (California, Rhode Island, and Washington), we examined whether there exists a seasonal effect for the three types of leaves for which data is available, including medical, birth of child/bonding and family care. Seasonal data for different types of leaves may vary across states. Quarterly data from DC is only available for submitted claims and therefore not included in the analysis.

We present the regression results examining the seasonal effects in Table 1.2. The results show that the dummy variables representing seasonality are not statistically significant. This suggests that the number of approved claims does not exhibit seasonality. To further validate this finding, we conducted additional analysis using data from California, where the dataset encompasses the largest number of seasons and takes advantage of the dataset's longitudinal nature. A seasonality test was employed to assess whether seasonality significantly affects the number of approved claims each season. The test results confirm that seasonality does not exert a statistically significant impact on the number of approved claims. We further examined the seasonality on the monthly basis. Appendix – Figures 1.1-1.3 show that the number of approved claims does not show monthly seasonality either.

Table 1.2. Estimation of Claim Seasonality

	Model 1 New Child	Model 2 Medical	Model 3 Family Care
Season1	-0.113	-0.082	-0.038
	(-0.231)	(-0.378)	(-0.100)
Season2	-0.148	-0.038	-0.01
	(-0.303)	(-0.174)	(-0.027)
Season3	0.029	0.011	0.01
	-0.059	-0.052	-0.027
Constant	9.535***	11.434***	7.734***
	-27.425	-73.925	-28.532
r2	0.002	0.001	0
N	110	244	110

*Notes: (1) Estimations are based on data on the number of approved claims from three states (CA, RI, and WA). The reference group is Season 4. (2) *p<0.10, **p<0.05, ***p<0.01.*

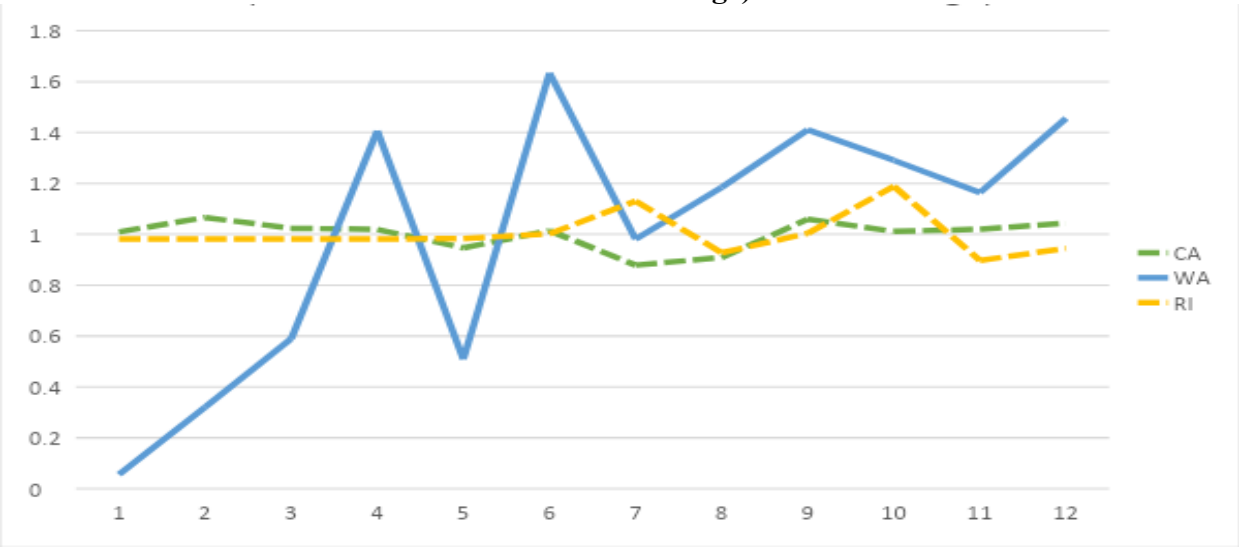
Following this, our attention turns towards analyzing the number of approved claims after the initiation of program payments in other states where claim data is available. This analysis is conducted separately for medical, bonding, and family care claims for the first 12 months.

For medical claims, our analysis was conducted using data from California, Washington, and Rhode Island. As depicted in Figure 1, in Washington (WA) the number of medical claims, normalized based on the first 12-month average, increased significantly over the

course of four months, followed by some fluctuations in months 4-7. Then it stabilized in the subsequent months. In contrast, data from California (CA) and Rhode Island (RI) exhibited a relatively flat monthly pattern.

This divergence in trends can be attributed to the fact that the paid medical leave program has been in existence for more than one decades in CA and RI, different from that in Washington: the claim data available for analysis starts from July 2004 for California and January 2014 for Rhode Island. With years' experience in managing and finetuning medical leaves, as well as increased awareness of the availability of the paid medical leave program, the monthly variations reached stability overtime.

Figure 1.1 Trend in Approved Medical Claims in the First year (normalized based on the 12-month average)



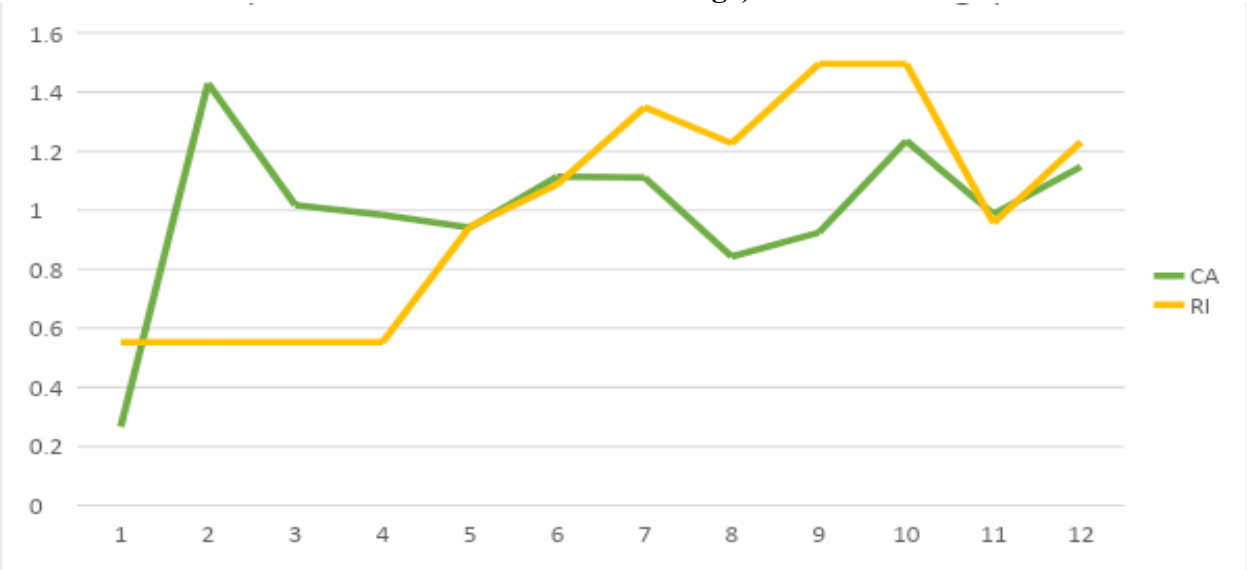
Note: The index is calculated based on the average number of approved claims in the first 12 months, which is obtained by dividing the number of approved claims each month by the average in the first 12 months.

For bonding leaves and family leaves, we have data available for trend analysis again from CA and RI. It's important to highlight that in the case of RI, the number of claims for the first four months was documented as a sum of the four months. Consequently, our RI data for Month 1 – 4 is represented as ¼ of the total number each month, i.e., evenly distributed, as we do not have a better way to assume differently. For Month 5-12, the data was recorded on a monthly basis. The summary of the data is presented in Table 1.3.

Figure 1.2 illustrates the trend of monthly approved claims for bonding leaves in CA and RI. Similar to the trend observed in medical claims, the number of bonding claims exhibits an upward trend in the first few months, followed by a more stable pattern in the subsequent months. An interesting observation in this trend is that both CA and RI show dips in Month 8 and Month 11, and a peak in month 10 during the later months. Figure 1.3 illustrates the trend of monthly approved claims for family care leaves. In contrast to the

medical and bonding leaves, the family care leaves are relatively stable from month to month in the first year of program implementation.

Figure 1.2 Trend in Approved Bonding Claims in the First Year (normalized based on the 12-month average)



Note: Claims data began in July 2004 in California and January 2014 in Rhode Island. Note that the horizontal axis represents the months since the payment commencement, not the calendar months.

Figure 1.3 Trend in Approved Family Care Claims in the First Year (normalized based on the 12-month average)

Note: Claims data began in July 2004 in California and January 2014 in Rhode Island. Please note that the horizontal axis represents the months since the payment commenced, not the calendar months.

The estimates of the month-to-month variation are shown in Table 1.2 for the three types of leaves. For military leaves, there isn't sufficient data to estimate the trend.

Table 1.3. Monthly Trend of Approved Claims in Other States (WA, CA, and RI)

Month	Medical				Bonding			Family Care		
	CA	WA	RI	Average	CA	RI	Trending	CA	RI	Average
1	0.0841	0.0046	0.0557	0.0482	0.0223	0.0461	0.0342	0.0536	0.0628	0.0582
2	0.0888	0.0267	0.0557	0.0571	0.1192	0.0461	0.0826	0.0901	0.0628	0.0765
3	0.0853	0.0491	0.0557	0.0634	0.0848	0.0461	0.0654	0.0878	0.0628	0.0753
4	0.0849	0.1172	0.0557	0.0859	0.0819	0.0461	0.0640	0.0930	0.0628	0.0779
5	0.0789	0.0424	0.0559	0.0591	0.0784	0.0787	0.0786	0.0790	0.1232	0.1011
6	0.0845	0.1362	0.0569	0.0925	0.0928	0.0906	0.0917	0.0959	0.1026	0.0993
7	0.0732	0.0817	0.0642	0.0730	0.0926	0.1124	0.1025	0.0778	0.0890	0.0834
8	0.0757	0.0987	0.0527	0.0757	0.0702	0.1022	0.0862	0.0639	0.0626	0.0632
9	0.0883	0.1175	0.0570	0.0876	0.0770	0.1247	0.1009	0.0836	0.1007	0.0922
10	0.0843	0.1076	0.0675	0.0864	0.1029	0.1247	0.1138	0.1001	0.1085	0.1043
11	0.0850	0.0970	0.0510	0.0777	0.0822	0.0797	0.0810	0.0845	0.0704	0.0774
12	0.0870	0.1214	0.0537	0.0873	0.0956	0.1026	0.0991	0.0906	0.0919	0.0913

Note: In this table, "Month" refers to the number of months since the claim initiation, not the calendar month.

Based on the monthly trends in other states in the initial 12 months of the program implementation, and the predicted number of medical, bonding and family claims in the first year in Maryland, we estimate the number of claims by month. The predicted numbers of approved claims are shown in Table 1.4.

Table 1.4. Predicted Number of Claims Based on Trends in Other States

Month	Medical				Bonding			Family Care		
	CA	WA	RI	Average	CA	RI	Average	CA	RI	Average
1	14537	799	9630	8322	899	1860	1380	2867	3360	3113
2	15355	4616	9630	9867	4808	1860	3334	4822	3360	4091
3	14739	8481	9630	10950	3420	1860	2640	4695	3360	4027
4	14677	20249	9630	14852	3306	1860	2583	4976	3360	4168
5	13630	7330	9656	10205	3165	3175	3170	4227	6589	5408
6	14607	23533	9834	15991	3746	3656	3701	5129	5491	5310
7	12655	14114	11100	12623	3735	4535	4135	4164	4759	4461
8	13086	17062	9103	13084	2834	4124	3479	3418	3347	3383
9	15254	20312	9853	15140	3108	5031	4070	4474	5386	4930
10	14561	18588	11666	14938	4153	5031	4592	5357	5804	5580
11	14691	16765	8807	13421	3318	3217	3268	4518	3765	4141
12	15030	20973	9274	15093	3858	4138	3998	4849	4915	4882

Considering the data sources (e.g. states) in forecasting monthly claims for the first year, our approach is as follows:

- Utilizing data from WA for medical claims since it is the only state with available data for the first year of approved medical claims.
- Combining data from CA and RI to calculate the average for bonding and family care claims.
- For monthly estimates of military claims, employing the monthly average of the predicted total number of claims.

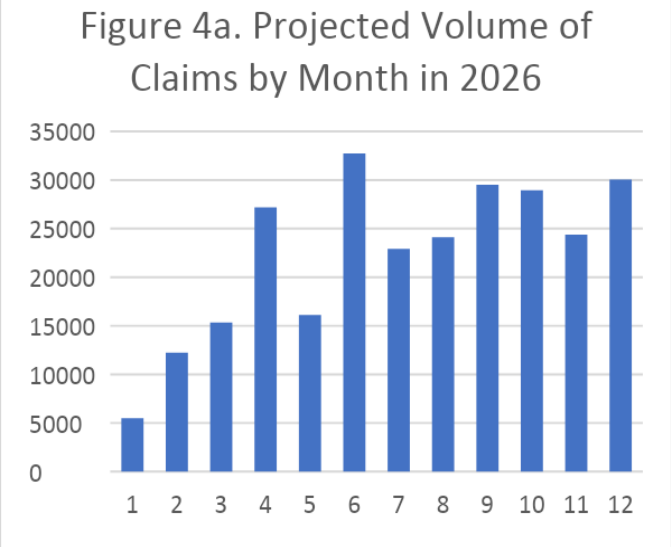
Based on this approach, we present our predicted number of claims by month in Table 1.5.

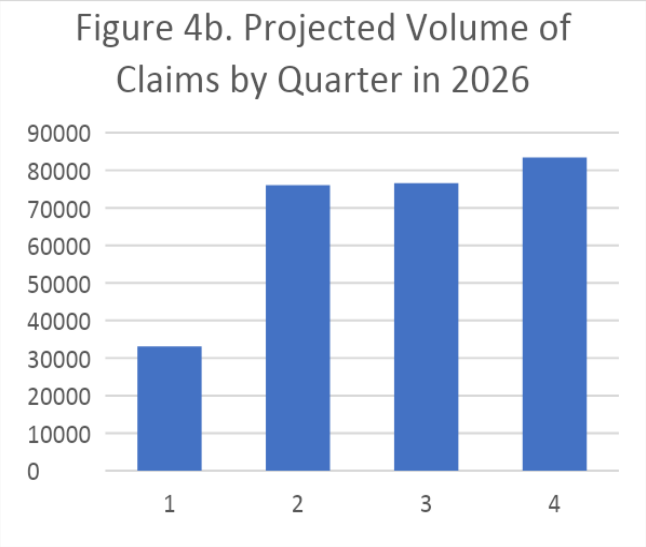
Table 1.5. Estimated Volume of Approved Claims in January – December 2026

Month	Medical	Bonding	Family Care	Military	Total
1	799	1380	3113	203	5495
2	4616	3334	4091	203	12243
3	8481	2640	4027	203	15351
4	20249	2583	4168	203	27203
5	7330	3170	5408	203	16110
6	23533	3701	5310	203	32747
7	14114	4135	4461	203	22912
8	17062	3479	3383	203	24126
9	20312	4070	4930	203	29515
10	18588	4592	5580	203	28963
11	16765	3268	4141	203	24377
12	20973	3998	4882	203	30056
Total	172823	40349	53495	2432	269099

As shown in Table 1.5, the projected volumes of claims vary by month in the first year. Figure 1.4 illustrates the trend. The volume is expected to rise in the first four months and tend to be stable in the later part of the year.

Figure 1.4 Projected Volume of Total Claims by Month and by Quarter in 2026





1.2 Projections of Claim Volumes for Later Years (e.g., 2027 – 2030)

In this section, we estimate the claim volumes in 2027-2030. We utilize two datasets for our analysis: the Family and Medical Leave Act (FMLA) (2018) survey data and the American Community Survey (2017-2021) data. The FMLA survey collected information on workers' leave-taking behaviors in the 12 months prior to the survey. As explained in our 2023 report (see The Jacob France Institute, 2023), we developed a leave-taking behavior model that takes into account various individual and employer attributes, including demographic factors such as gender, age, race, and marital status, educational achievements, employment sectors (government, private, and non-profit), as well as specific occupations and industries. By considering these attributes and leave-taking behaviors, we create a model that allows us to analyze the factors influencing leave-taking behavior. This model, in turn, informs our estimation of expected claims and benefit payments under the FAMLI program[1].

The projection considers the take-up rate adjustments over years. The projection shows after a spike of claims in 2026 due to the pent-up effect, the number of claims in the second year experiences a slight decrease. There is a gradual increase in the number of claims from 2027 to 2030 as the projected take-up rate is expected to rise with greater awareness of the program. However, the projection needs to be interpreted with the caution that the number of claims is also influenced by other factors, such as unforeseeable shocks, the opt-in of the self-employed individuals as well as the opt-out of those employers that offer similar or better coverage for their employer-provided family and medical leave plans. We will discuss these two factors in Chapters 4 & 5.

[1]The specifics of the model are provided in the Phase II- Part 1 of the project, Chapter 2.

Table 1.6. Volume of Claims 2027 -2030

Year	Medical	Bonding	Family Care	Military	Total
2026	172823	40349	53495	2432	269099
2027	168547	48882	56708	2578	276715
2028	174756	54286	58797	2673	290512
2029	181194	57546	60963	2771	302474
2030	187869	59666	63209	2873	313617

Note: Military leaves use the adjustments of take-up rate of family care leaves as in Phase II – Part 1.

In the projection analysis for number of claims, employment size[2] is adjusted based on the short-term (2021-2023) and long-term (2021-2031) occupational projections in Maryland (Maryland Department of Labor, 2022). Next, we provide the estimates of the expected cost of claims. The estimation is based on the following policy parameters:

- The individual weekly average wages, state average weekly wage, and inflation-adjusted maximum weekly benefit[3].
- Take-up rates each year are adjusted based on the analysis of other states' experience, as summarized in Table 1 in the Executive Summary of Phase II- Part 1.

Table 1.7. Expected Cost of Claims (in thousands)

Year	Medical	Bonding	Family Care	Military	Total
2026	$1,250,579	$217,039	$195,171	$11,971	$1,674,760
2027	$1,256,663	$271,011	$212,796	$13,073	$1,753,543
2028	$1,342,308	$310,149	$226,930	$13,967	$1,893,354
2029	$1,433,191	$338,650	$241,883	$14,912	$2,028,635
2030	$1,530,275	$361,671	$257,856	$15,923	$2,165,725

1.3 Duration of Leaves

To analyze the duration of leaves, we rely on two datasets: the FMLA (2018) survey data and the American Community Survey five-year data spanning from 2017 to 2021. We utilize the FMLA survey data to investigate the factors influencing the length of leaves. In this section, we present the analysis of factors that tend to affect the duration of medical, family and bonding leaves. The predicted leave lengths, generated through the simulation using the modified USDOL Worker PLUS Model, are presented in Chapter 2.

Our analysis develops a model of leave length conditional on known and/or estimated attributes of an individual and the employer for which he/she works. These attributes include workers'

[2] The employment data by business employment size classes are from the calculated administrative records.
[3] Wage inflation adjustment uses the current year's inflation rate (CPI); Benefit inflation adjustment uses the previous year's inflation rate.

demographics (sex, age, race, marital status), education attainments, the employment sectors (government, private and non-for profit), as well as occupations and industries. The analysis reveals that different types of leaves are influenced by distinct factors when it comes to their duration. Specifically:

- For medical leaves, the regression analysis indicates that being a woman aged 40 or older is associated with longer medical leaves.
- In the case of family leaves, women tend to take longer leaves compared to men. Additionally, individuals aged 35 to 44 are more likely to take longer family leaves, and being married is also associated with extended family leaves.
- Regarding bonding leaves, it's not surprising to find that the duration for women is significantly longer than that for men.
- Education, in general, does not have a substantial impact on leave duration, except for leaves taken to care for a sick child. Individuals with college degrees and higher qualifications tend to take shorter leaves for this purpose.

Chapter 2
Simulation of Claims and Costs using the USDOL Modified Worker PLUS Model

2.1 Simulation Methodology

The expected program claims, costs, and durations are simulated based on the modified Worker Paid Leave Usage Simulation model developed by the U.S. Department of Labor (USDOL Worker PLUS). We modified the USDOL Worker PLUS model to comply with the provisions of the Maryland Family and Medical Leave Insurance Program (FAMLI). We used the DOL Family and Medical Leave Act (FMLA) Employee Survey public microdata to train models for individual workers' leave needs and then draw individual Maryland workers' characteristics from 2017-2021 five-year American Community Survey (ACS) Public Use Microdata Sample (PUMS) to simulate individual Maryland workers' leave-taking behavior. The modified USDOL Worker PLUS simulation model thus "runs" each sample person from Maryland ACS data to predict his/her probability of taking a leave and the leave length based on the Maryland FAMLI program parameters including eligibility rules and maximum leave length, as well as FMLA-based distributions. The benefit costs are further simulated based on the wage replacement structure, predicted leave length, and individual characteristics from the ACS microdata.

2.2 Expected volume of claims

a. Projected monthly claims for 2026.

Appendix II Figures II.1-3 presents the data of approved monthly claims of all states with available data including California from 2004 to 2022, Rhode Island from 2014 to 2023, and Washington from 2020 to 2022. No seasonality is observed from the monthly data in those figures. We use the number of approved claims during the first year of the respective paid family and medical leave programs of California, Rhode Island, and Washington to estimate monthly claims for Maryland in 2026.

The potential monthly medical and family claims of Maryland's first program year are projected based on the first-year monthly data of medical and family claims, in the state of Washington and California, respectively. Washington is the only state with available data for the approved medical claims and the first-year data of Washington is most recent to better reflect the monthly trend of first-year approved claims among all the states with state paid family and medical leave programs. The monthly bonding claims are predicted based on California data due to the unavailability of data from Washington and unavailability of monthly data from Rhode Island for the first quarter. The monthly military leaves are assumed to be evenly spread out over the 12 months because no data is available to study monthly trends in military leaves.

The estimated monthly approved claims for Maryland in 2026 by claim type is summarized in Table 2.1 based on the following assumptions:

- The monthly medical claims and family claims are predicted based on the first-year monthly trend of medical claims and family claims respectively from Washington state.
- The monthly bonding claims are predicted based on California data.
- The monthly military leaves are evenly spread out over the 12 months.

Table 2.1. Projected monthly approved claims for Maryland in 2026.

	Medical	Family	Bonding	Military
January	1,261	3,359	2,440	326
February	7,279	4,232	13,045	326
March	13,376	6,453	9,279	326
April	31,935	11,951	8,970	326
May	11,560	5,154	8,586	326
June	37,113	15,609	10,163	326
July	22,258	8,643	10,133	326
August	26,907	9,904	7,690	326
September	32,033	11,719	8,433	326
October	29,315	9,906	11,267	326
November	26,440	8,450	9,002	326
December	33,076	10,833	10,466	326
Total	272,553	106,213	109,475	3,916

b. Projected annual claims for 2026 – 2030

The annual claims from 2026 to 2030 are simulated from USDOL Worker PLUS model adjusted to align with Maryland's most updated FAMLI program parameters by the time this study is conducted, wage inflation assumptions, projected employment growth, and the growth of take-up rates as summarized in Phase II Cost Analysis Report (Jacob France Institute, 2023). The expected backlog bonding leaves from 2025 are added to the projected bonding claims in 2026 with a 50% increase, due to the fact that workers may take bonding leave to care for a child within one year after the child's birth in 2025 according to the eligibility rule of the Maryland FAMLI program. The predicted number of claims by leave type from 2026 to 2030 is summarized in Table 2.2.

Table 2.2. Projected Approved Claims for FAMLI Benefits by Leave Type for 2026-2030.

Year	Medical	Bonding	Family Care	Military
2026	272,553	109,475	106,213	3,916
2027	327,064	76,632	111,524	4,112
2028	359,770	78,701	114,535	6,334
2029	377,758	80,826	117,627	6,505
2030	387,958	83,008	120,803	5,345

2.3 Expected annual cost for 2026-2030

a. Expected benefit expenses

Similar to the number of approved claims, the annual benefit payments from 2026 to 2030 are also simulated from the USDOL Worker PLUS model incorporating the updated Maryland FAMLI program parameters and aforementioned wage inflation assumptions, employment growth projection, and the growth of the take-up rates. Table 2.3 presents the expected benefit expenses for FAMLI program from 2026 through 2030 by leave type.

Table 2.3. Expected Benefit Payments by Claim Type for 2026-2030 ($million)

Year	Medical	Bonding	Family Care	Military
2026	$1,079.57	$368.58	$207.45	$21.29
2027	$1,181.98	$320.14	$226.18	$23.25
2028	$1,262.54	$366.38	$241.20	$24.84
2029	$1,348.02	$400.05	$257.10	$26.52
2030	$1,439.34	$427.24	$274.07	$28.32

b. Expected administrative expenses

The administrative costs are assumed to be 8% of the benefit payments, based on other states' data we reviewed (Jacob France Institute, 2023). Table 2.4 presents the administrative cost estimates by year.

Table 2.4. Expected Administrative Expenses by Leave Type for 2026-2030 ($million)

Year	Medical	Bonding	Family Care	Military
2026	$86.37	$29.49	$16.60	$1.70
2027	$94.56	$25.61	$18.09	$1.86
2028	$101.00	$29.31	$19.30	$1.99
2029	$107.84	$32.00	$20.57	$2.12
2030	$115.15	$34.18	$21.93	$2.27

2.4 Expected duration of claims

The expected durations of claims are simulated also using the USDOL Worker PLUS simulation model adapted to comply with Maryland's FAMLI program parameters. The FAMLI program specifies a maximum leave length of 12 weeks in an application year except that the employee may receive an additional 12 weeks for bonding with a newborn child or a child newly placed for adoption and foster care, etc., or if a serious health condition arises. The simulated durations of different leave types for one year are shown in Table 2.5 below.

Table 2.5. Expected Duration of Claims by Leave Type (days)

Bonding	Ill Child	Ill Parent	Ill Spouse	Maternity	Own Health
31.27	17.18	19.29	16.97	43.42	37.73

Since the projected durations displayed above are simulated from FMLA-based distribution without benefit payment, the actual durations with benefit payment in the FAMLI program could be longer than the values shown in Table 2.5.

Chapter 3
Empirical Analysis of the Growth of Leave Lengths

3.1 Data Collection and Summary Statistics

To analyze the growth of leave durations over time, we collected data on the average leave lengths by different leave types from states that have implemented their paid FAMLI programs, including CA, NJ, RI, NY, WA, DC, and MA. The sources of these data collections are similar to our 2023 report (The Jacob France Institute, 2023), which involved collecting data on the volumes of claims by leave types, conditional on states. A summary of the data collection is provided in Table 3.1, where we list the number of annual observations conditional on leave type for each state. 'Family' and 'Medical' categories represent the overall family and medical leaves, respectively, with the former primarily being a combination of bonding and family care leaves, and the latter comprising general own health-related and pregnancy-related medical leaves. We also list the starting dates/years of the family and medical leave programs for each state.

Table 3.1. Summary of Data Collection

			Number of Data Points						
	Start Date/Year		Family				Medical		
State	Family	Medical	Bonding	Family Care	Military	Family	Medical Self	Pregnancy	Medical
CA	7/1/2004	1946				18			18
NJ	7/1/2009	1948	11	11		11	13	13	13
RI	1/1/2014	1942	1	1		5		2	5
NY	1/1/2018	1949	5	5	5	5			
WA	1/1/2020	1/1/2020	2	2	2		2	2	
DC	7/1/2020	7/1/2020	1			1			1
MA*	1/1/2021	1/1/2021				2			2
		Total	20	19	7	42	15	17	39

**Reported leave lengths are median values. Other states report average/mean values.*

As can be seen, the number of data points on leave durations is generally small, which limits the scope and types of our empirical analysis. For instance, it may not be suitable to conduct regression analyses on leave durations, except possibly for family leaves where we have the largest number of observations at 42. Although medical leaves have a comparable sample size to family leaves, most observations come from the states that implemented their medical leave programs a long time ago. This makes it challenging to analyze the growth of leave durations over the years since the programs' inception since all data collections are based on the start years of the family leave programs. For example, California initiated its medical leave program in 1946, but the duration data only commenced in 2004, aligning with the start year of the family leave program.

As it turned out, the state of MA reported their leave duration data as the median, rather than the mean values as in other states. This makes it challenging to compare the statistics across the states. As a result, we drop the two observations of MA from all of the subsequent analyses.

In Table 3.2, we report the summary statistics of leave lengths conditional on leave types and states. For each leave type and state, we report two statistics, the average leave duration in weeks and the average ratio of the leave duration to the maximum law-stipulated leave duration (in the parentheses). It is apparent that the latter statistic has a maximum value of 1. We also report the average leave duration and the ratio of leave lengths conditional on leave types across the states at the bottom of the table.

Table 3.2. Summary Statistics of Leave Lengths by State and Leave Type*

	Family				Medical		
State	**Bonding**	**Family Care**	**Military**	**Family**	**Medical Self**	**Pregnancy**	**Medical**
CA				5.49 (0.89)			15.61 (0.3)
NJ	5.29 (0.88)	4.02 (0.67)		5.08 (0.85)	10.3 (0.4)	9.15 (0.35)	9.98 (0.38)
RI	3.2 (0.8)	2.8 (0.7)		3.34 (0.79)		7.4 (0.25)	10.24 (0.34)
NY	7.74 (0.75)	4.48 (0.43)	3.68 (0.35)	6.86 (0.66)			
WA	7.8 (0.81)	6.05 (0.63)	3 (0.31)		6.95 (0.58)	8 (0.57)	
DC	6.7 (0.84)			3.6 (0.45)			2.95 (0.49)
MA**				11.15 (0.93)			11.72 (0.59)
Average	6.12 (0.83)	4.29 (0.6)	3.49 (0.34)	5.24 (0.82)	9.85 (0.42)	8.81 (0.37)	12.57 (0.34)

**Within each cell two statistics are reported, the average leave duration in weeks (the number outside the parentheses) and the average ratio of the leave duration to the maximum law-stipulated leave duration (the number in the parentheses)*

***Reported leave lengths are median values. Other states report average/mean values.*

Several observations can be made from Table 3.2:

1. The average leave durations vary widely across different leave types and states. For example, while the average duration of bonding leaves in RI is only 3.2 weeks, it is 7.8 in WA. This is likely due to the much longer law-stipulated maximum leave duration in WA (8 weeks before 2022 and 12 weeks starting from 2022) than RI (4 weeks before 2022, 5 weeks at 2022, and 6 weeks starting from 2023), as we observe a general relationship between the maximum law-stipulated leave durations and actual leave lengths in the next section. Similarly, in the state of NY, while bonding leaves last on average for 7.74 weeks, the durations of the other two types of family leaves, family

care and military-related leaves, last much shorter, for 4.48 and 3.68 weeks, respectively, though all three types of family leaves have the same maximum law-stipulated durations.

The above observations suggest that it is important to control for the influence of state-specific factors on leave durations such as state-allowed maximum leave lengths as well as analyzing the durations of different leave types separately, which we do subsequently. Specifically, in the following analyses we focus on examining the ratio of leave length to the maximum law-stipulated duration, which is short for *leave length ratio*, rather than the raw duration in weeks. In the graphic analysis of the growth of the leave length ratios we focus on the within-state variation of the leave length ratios over time. In the regression analyses, our primary model specifications control for state fixed effects, which considers the impact of state-specific time-invariant factors that may affect leave durations but nonetheless are hard to control in the models.

2. Although the *leave length ratio* (i.e., ratios of leave lengths to the maximum law-stipulated durations) vary much less significantly than the raw duration of leaves as shown by statistics in the parentheses of Table 3.2, they can still vary significantly across the leave types and states. For example, while bonding leave length ratios vary only from 0.75 to 0.88, a much smaller variation as compared to the raw length of more than twice of the longest average leave length as compared to the shortest average leave length, the largest ratio (0.88) still increases by more than 17% relative to the smallest ratio (0.75).

Even within the same state, the ratios can significantly vary between leave types, even when these types fall broadly within the same category. For instance, in the state of NY, the average ratio for military-related leaves is only 0.35, while it more than doubles to 0.75 for bonding leaves.

3. In terms of raw lengths, medical leaves generally have longer durations than family leaves, but the ratios switch order between these two categories. For example, while the average duration of family leaves across all states with available data is only 5.24 weeks, medical leaves average 12.57 weeks. This discrepancy arises because states typically allow for longer durations of paid medical leaves compared to family leaves, resulting in an average ratio of medical leave duration to the maximum state-allowed duration of only 0.34, as opposed to 0.82 for family leaves.

Table 3.2 further reveals that within the family leave category, bonding leaves typically last longer than leaves for caring for sick family members, which in turn last longer than military-associated leaves. Within the medical leave category, leaves for one's own medical conditions generally last longer than pregnancy-related medical leaves.

These cross-sectional results offer intriguing insights for our subsequent analyses and policymakers. However, given our emphasis on the temporal growth of leave durations, our focus will be on the variation of these durations between states and over time, a topic we explore in the next two sections.

3.2 Graphic Analysis of Growth of Leave Durations

We first analyze the time trend of leave durations for family leaves, followed by a similar analysis for medical leaves.

To underscore the significance of the maximum state-stipulated leave durations in influencing actual leave lengths, we begin by scatter-plotting the maximum law-stipulated durations of family leaves against their average durations in Figure 3.1. This figure also includes a regression line fit from the plot.

The horizontal axis of Figure 3.1 represents the maximum allowable length of bonding leaves, as opposed to that of general family leaves, due to occasional slight differences in the maximum allowable lengths between bonding and other types of family leaves, with the majority of leaves within the family leave category being bonding related.

Figure 3.1 Relationship between Maximum Law-Stipulated Length of Family Leaves and Average Family Leave Length

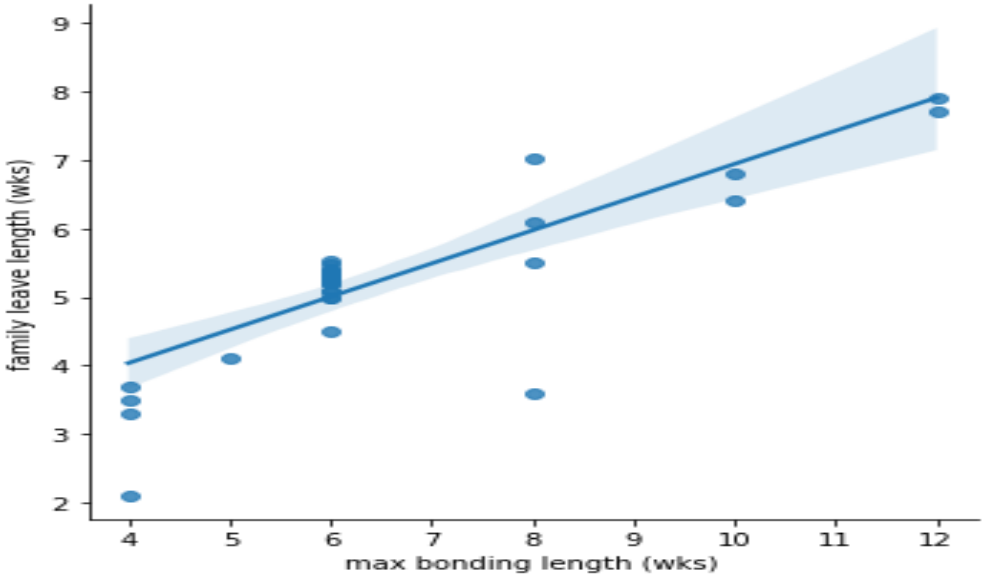
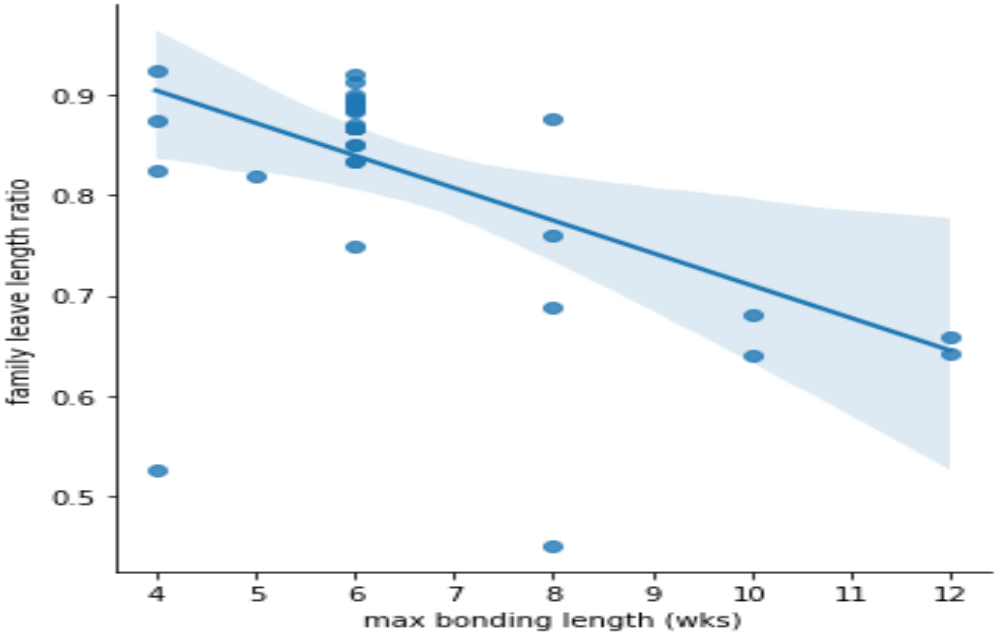


Figure 3.1 displays a clear positive relation between the maximum law-stipulated leave length and the actual leave duration of family leaves. This indicates the importance of accounting for state-specific factors, such as the maximum law-stipulated leave length, when studying the growth of leave durations. Consequently, our focus in subsequent analyses shifts to the ratio of the actual leave length to the maximum leave length, rather than the raw leave length itself.

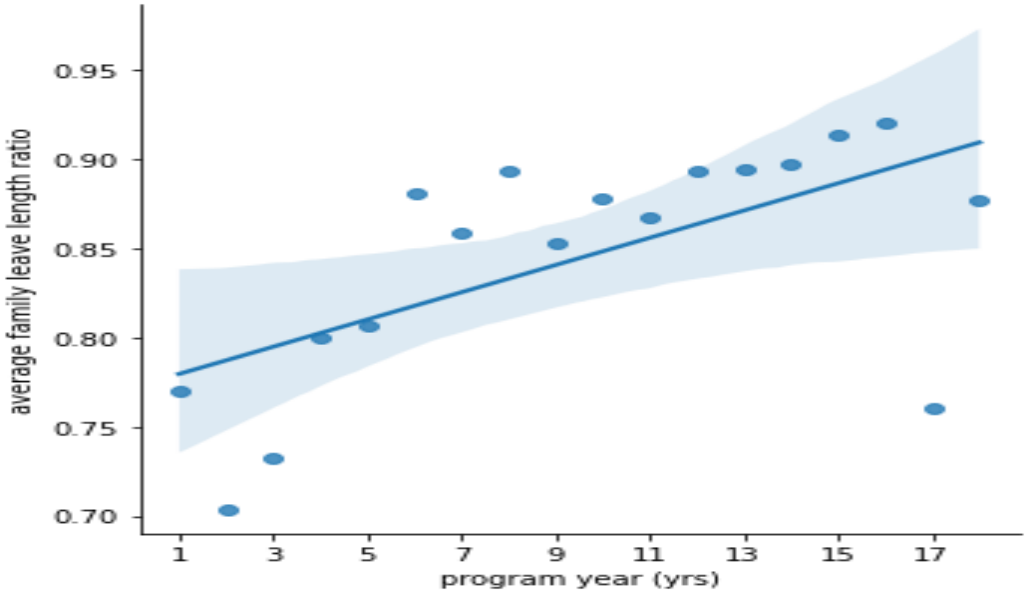
Interestingly, Figure 3.2 reveals that when we shift our focus from the raw leave length to the *leave length ratio*, the nature of the relationship with the maximum law-stipulated leave duration reverses. The downward-sloping fit line in the scatter plot implies that the longer the maximum state-allowed leave duration, the smaller the ratio of the actual leave duration to this maximum. This inverse relationship is corroborated in most of the regression models that we demonstrate in Section 3.3.

Figure 3.2 Relationship between Maximum Law-Stipulated Length of Family Leaves and Family Leave Length Ratio



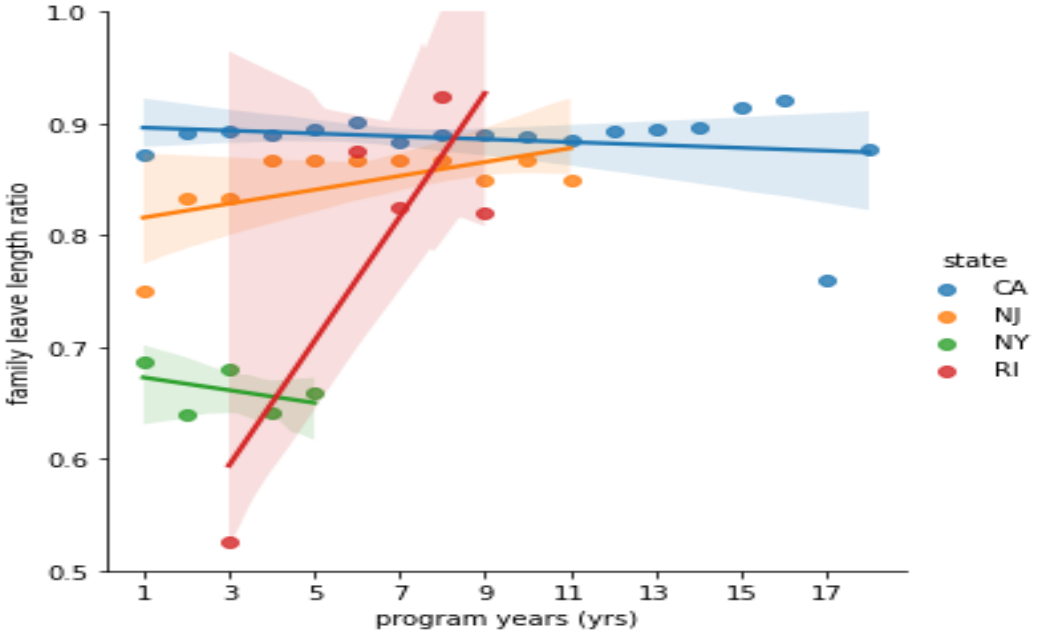
Having established the significance of focusing on ratios rather than the raw leave lengths, we proceed to the central part of our analysis – the growth of leave durations over time. We initially plot the average of family leave length ratios across states for a given program year – defined as the number of years since the initiation of the paid family leave program in a particular state – against the program year, as depicted in Figure 3.3.

Figure 3.3 Relationship between Family Leave Length Ratio and Program Year



The figure indicates a positive correlation between the program year and the leave length ratios, suggesting an upward trend in leave length ratios over time. Nonetheless, considering the earlier noted wide variation in leave length ratios across states, the cross-sectional average may not imply a uniform pattern across all states. This variation is exemplified in Figure 3.4, where we present similar but state-specific relationships. Of the four states (CA, NJ, NY, and RI) with at least two observations on family leave length ratios, NJ and RI exhibit a positive trend, whereas CA and NY display a negative trend. These differing trends, particularly the steep positive trend in RI, hint that the overall positive time trend as seen in Figure 3.3 might be largely influenced by RI's data. However, with only five observations for RI, it is difficult to assert that the trends observed in this state are broadly representative.

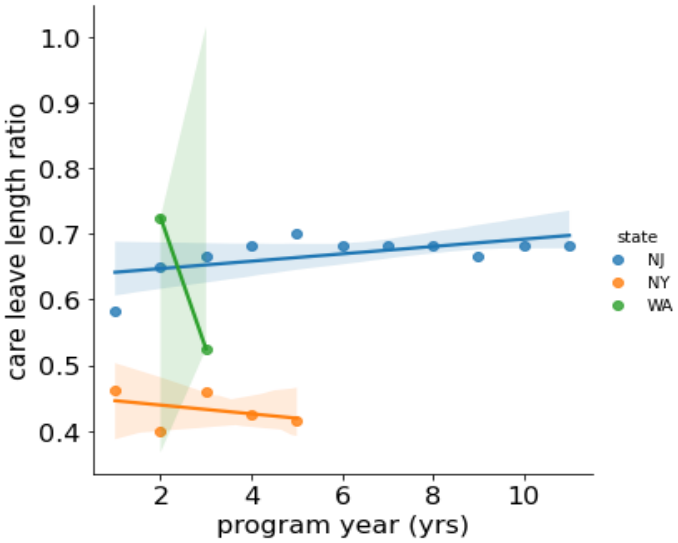
Figure 3.4 Relationship between Family Leave Length Ratio and Program Year Conditional on State



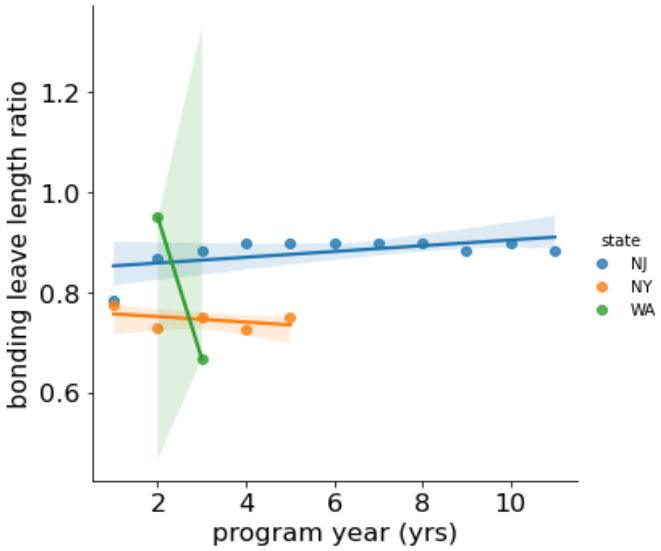
In Figure 3.5, we plot the relationships between the leave length ratios of various types of family leaves (bonding, family care, and military-related family leaves) and the program year. It is evident from the figure that none of the leave types exhibit a consistent relationship between leave length ratio and program year across all states.

Figure 3.5 Relationship between Leave Length Ratios of Different Types of Family Leaves and Program Year Conditional on State

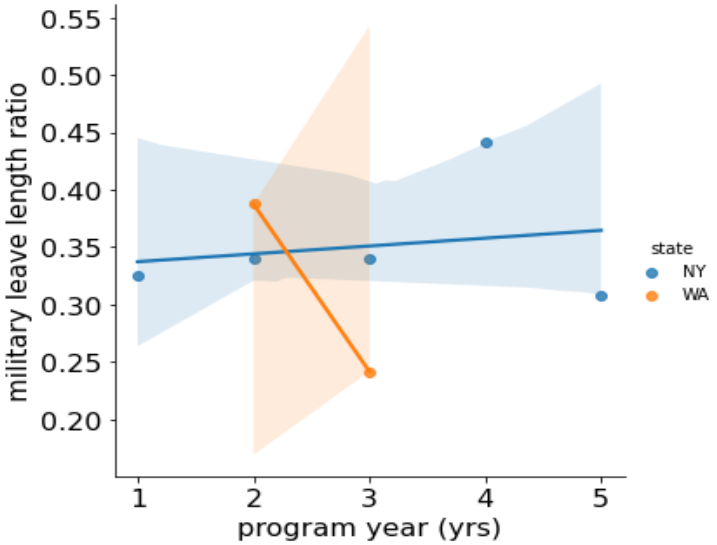
Panel A. Bonding



Panel B. Caring Sick Family Members



Panel C. Military-Related

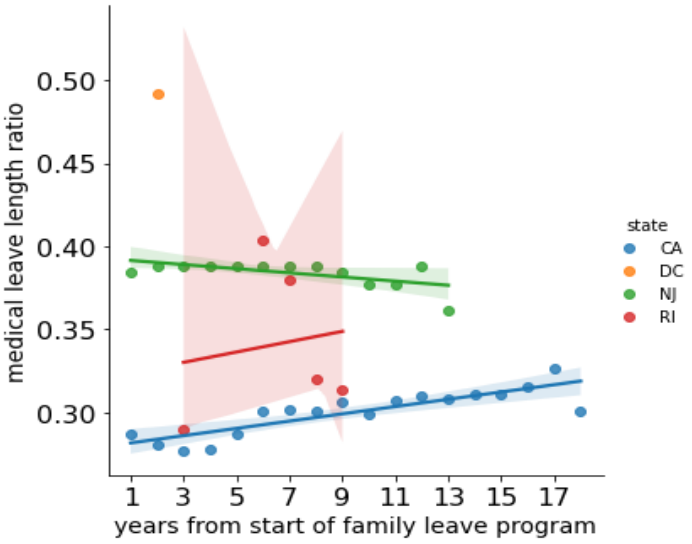


So far, the evidence does not indicate a clear time trend in the leave duration ratios for family leaves. As indicated by Table 3.1, family leaves provide a larger number of observations for analysis regarding their relationship with program years, mainly because most state-paid family leave programs began only recently. In contrast, the states with available data typically initiated their paid medical leave programs much earlier. Consequently, an analysis of the time trend in medical leave length ratios is only suggestive. Figure 3.6 illustrates the relationships between various types of medical leave length ratios and the number of years since the initiation of *family* leave programs. As previously mentioned, we use the initiation of *family*, rather than *medical* leave programs, as a reference point here due to the lack of early data on the durations of medical

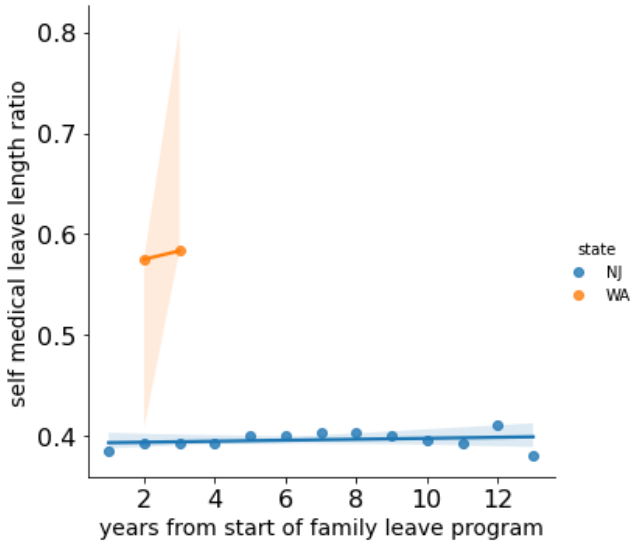
leaves, which, in many cases, started in the 1940s. This approach implies that, except for a few states like WA and DC that launched their paid family and medical leave programs simultaneously, the plot primarily depicts the relationship between leave length ratio and program year during the period significantly after the commencement of the medical leave programs.

Figure 3.6 Relationship between Leave Length Ratios of Different Types of Medical Leaves and Years Since the Initiation of Family Leave Programs Conditional on State

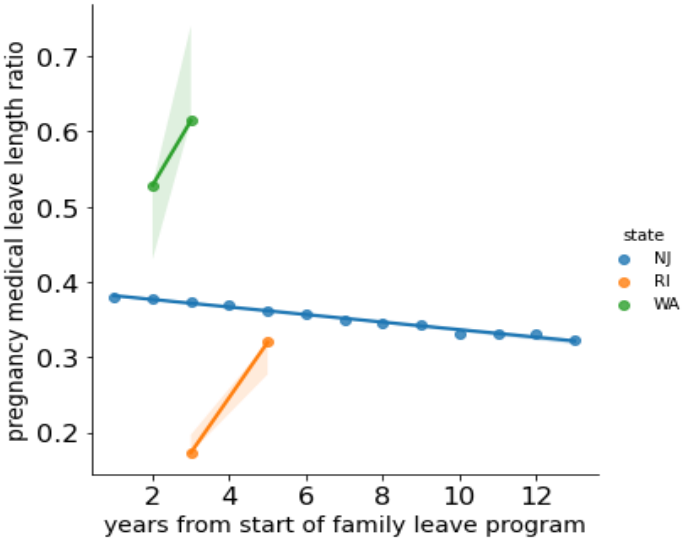
Panel A. Medical



Panel B. Medical - Self



Panel C. Medical – Pregnancy-Related



Due to the limited number of observations from states that initiated their medical leave programs concurrently with family leave programs, the findings illustrated in Figure 3.6 are not definitive. Moreover, the current plots, including those for states that started their medical leave programs

long ago, fail to reveal a clear trend in the medical leave length ratios, irrespective of the type of leave.

Consequently, the graphic analysis presented in this section does not establish strong evidence of a consistent time trend in leave lengths over time for any leave type. In the following section, we will employ regression analysis to further investigate this issue. One advantage of this approach is its ability to supplement the graphic analysis by controlling for additional variables that might affect leave length ratios, beyond just program years. As indicated in Table 3.1, the majority of the observations are concentrated in overall family and medical leaves. Given that most medical leave data are at a period long after the programs' initiation, our regression analysis will primarily focus on overall family leaves.

3.3 Regression Analysis of Growth of Family Leave Lengths

We employ the following model specification to analyze the time trend of the family leave length ratios:

$$Family\ leave\ length\ ratio_{it} = \beta_1 \times Program\ year_{it} + \left(\overline{\beta_2} \times \overline{Control\ variable}_{it}\right) + (\mu_i) + \theta_t + \varepsilon_{it} \quad (3.1)$$

where i and t are state and program year indicator, and i and t are state and time fixed effects (FEs), respectively. Echoing our approach in our 2023 report (The Jacob France Institute, 2023), and to enhance the test's power due to the small sample size for regression analyses (approximately 40 observations), rather than controlling for year FEs, we include a time dummy variable. This variable is assigned a value of one for the years post-2019, representing the pandemic period, and zero otherwise.

In the equation, control variables include the maximum state law-stipulated leave duration (*bonding max leave length*), the wage replacement rate, and the inflation-adjusted maximum weekly benefit at a given state. Additionally, state demographics potentially influencing the propensity to take bonding and family care leaves are considered, such as the proportion of female workers in a state who gave birth in the previous year (*female worker birth rate*) and the state's mortality rate. These variables were also considered in the regression analysis for the utilization rate of family leaves, as conducted in our 2023 report (The Jacob France Institute, 2023).

In all regressions, the standard errors are adjusted for heteroscedasticity and clustered at the state level to address autocorrelations. Table 3.3 presents the regression results.

Model 1 includes no controls except for the Covid time dummy. Consistent with the positive time trend observed in the cross-sectional average of family leave length ratios across states as seen in Figure 3.3, the coefficient on program year is positive and weakly significant at the 10% level. This suggests an overall growth in the average family leave length ratio across states over time since the program's initiation.

However, the previous section's observations indicate that the time trend of the average cross-sectional leave length ratio might obscure the variations in this relationship across states. Indeed,

when we incorporate state FEs in Model 2, the significance of the coefficient on the 'Program year' variable disappears, and its magnitude substantially decreases.

In Model 3 of Table 3.3, we introduce the control variable 'bonding max leave length', which represents the maximum law-stipulated leave length in a state for a given year. The analysis shows that the program year continues to be insignificant, and the newly added control variable is negative but not significant.

In Model 4 we continue to add another two state-leave related variables, the wage replacement rate and the inflation-adjusted maximum weekly benefit protection to consider the impact of the benefit features on the incentive to take leaves. Ideally we would like to adjust the maximum weekly benefit by *state-*

Table 3.3. Regression Analysis on the Growth of Family Leave Length Ratio Over Program Years*

Model	(1)	(2)	(3)	(4)	(5)
Dependent variable	**Family leave ratio**	**Family leave ratio**	**Family leave ratio**	**Family leave ratio**	**Family leave ratio**
Program year	0.013*	0.001	0.002	0.011	0.011
	(2.373)	(0.676)	(0.811)	(1.864)	(2.242)
Bonding max leave length			-0.044	-0.074**	-0.084**
			(-1.857)	(-3.235)	(-3.361)
Wage replacement rate				1.692**	1.501***
				(3.031)	(6.195)
Inflation-adjusted max weekly benefit				-0.001	-0.000
				(-1.784)	(-2.135)
Female worker birth rate					-9.357
					(-0.977)
Mortality rate					0.000
					(0.983)
Covid	-0.121*	0.008	0.065	0.079	0.010
	(-2.172)	(0.166)	(1.179)	(1.554)	(0.205)
State dummies	No	Yes	Yes	Yes	Yes
Observations	40	40	40	40	37
Adjusted R^2	0.38	0.69	0.73	0.77	0.71

*t-statistics are in parentheses. ***Significant at the 1% level. **Significant at the 5% level. *Significant at the 10% level.

specific inflation factors rather than a national inflation factor because there are variations in inflation rates across the states. However, for some states and years the data on the state inflation variables are not available. Consequently, we use the overall inflation rates in the U.S. to adjust

for the maximum weekly benefit in our primary regression analyses, and examine the robustness of the results using the state inflation-adjusted maximum weekly benefit variable.

Model 4 reveals that the program year remains insignificant with the inclusion of these two state-leave related control variables. Intriguingly, upon controlling for these variables, *bonding max leave length* becomes significant at the 5% level. This finding aligns with the negative correlation between the family leave length ratio and *bonding max leave length* observed in Figure 3.2. Additionally, Model 4 highlights that the wage replacement rate has a positive and significant association with the leave length ratio. This is consistent with the notion that a higher wage replacement rate lowers the opportunity cost of taking leaves, potentially leading to longer leave durations. Conversely, the inflation-adjusted maximum benefit, while negative, is not significant. In an analysis not reported here, we adjust the maximum weekly benefit for state-specific inflation factors, and find results similar to those documented in Model 4.

In Model 5, we control state demographic variables, including the *female worker birth rate* and *mortality rate*. The addition of these variables reduces the sample size from 40 to 37 observations, but the results are similar to those in Model 4, particularly the insignificance of the program year. It is also notable that the two added state demographic variables are also not significant.

Overall, our analysis in this section fails to demonstrate a consistent time trend in leave durations. Consequently, unlike our approach for projecting the growth of claim volumes in our 2023 report (The Jacob France Institute, 2023), we do not consider a growth rate of leave durations in our cost analyses in other sections of this report.

Chapter 4
Analysis of Potential Opt-Out Behaviors of Employers From the State FAMLI Programs

4.1 Considerations for Opting Out of the State Paid FAMLI Programs

The question of whether and how many employers opt out of the state FAMLI programs has become increasingly relevant as more states across the country implement these programs. State FAMLI programs are designed to provide paid time off to employees who need to care for a new child, a seriously ill family member, or their own health conditions. In some states, employers have the option to opt out of the state paid family leave programs by providing their own private plans to employees. This opt-out option was introduced to offer flexibility for employers, who may have existing paid leave policies in place. However, critics argue that the opt-out provision undermines the effectiveness of paid leave programs (Quinby and Siliciano, 2021).

Employer opt-out rates refer to the percentage of employers that choose to opt out of the state paid FAMLI programs. These rates vary across states, with some states experiencing higher opt-out rates than others. Understanding the factors that contribute to these opt-out behavior is crucial for addressing their ramifications on program solvency, identifying potential participation barriers, and assessing the broader social and economic implications associated with opting out. In this chapter, we delve into the opting-out patterns within states implementing Family and Medical Leave Insurance (FAMLI) programs. We explore the eligibility criteria and specific provisions of these state programs. Additionally, we conduct a thorough analysis of factors influencing employers' decisions to opt out, considering aspects such as industry types, job roles, workforce composition, and policy parameters within FAMLI. This comprehensive examination aims to unravel the complex dynamics that shape employers' opting-out behaviors, contributing to a nuanced understanding of the broader impact on the effectiveness of FAMLI programs.

4.2 Opt-Out Rates Across States

Opt-out rates for state paid family leave programs vary significantly across states. Some states have reported high opt-out rates, while others have managed to keep opt-out rates relatively low. Understanding these variations can provide valuable insights into the effectiveness of different program structures and policies. This section provides a state-by-state breakdown of opt-out rates, as well as the conditions under which private employers can opt out. It explores the reasons employers may opt out of state programs, such as cost considerations, pre-funding requirements, and the availability of private plans that meet or exceed state requirements. Table 4.1 details the opt-out provisions in different states, along with other relevant information and information sources. The opt-out rate ranges from 3% in California to 33% in Massachusetts. For example, New Jersey allows private employers subject to the NJ Unemployment Compensation Law to partially opt-out of the family leave program, with the requirement that their coverage is equal to or better than the state plan. In New York, businesses with no more than two corporate officers or sole proprietors and co-owners of partnerships can opt in. In Rhode Island[4], all private employers are automatically enrolled in the program and cannot opt-out.

[4] Employees fund the benefit through payroll deductions.

Table 4.1. Opt-Out Rates across States

State	Opt-out Rate	Opt-Out Provisions for Private Employers
CA	3%	Allowed if a majority of employees in the company apply for a voluntary plan in place of SDI coverage[5].
CO	N/A	Allowed if the employer's private plan can provide equal or greater benefits and protections than the state plan[6].
CT	N/A	Allowed if the private plan is comparable to the state plan AND a majority of the employees agree to the private plan[7].
DC	N/A	Not Allowed to opt out but employer can have a private plan that supplements the state plan[8].
MA	33%	Allowed if the employer's private plan can provide equal or greater benefits and protections than the state plan[9].
NJ	23%	Allowed if the private plan (1) offers benefits at least equal to the state plan, (2) has eligibility requirement no more restrictive than they would be fore a state plan claim, (3) has coverage at least equal to that offered by the state plan, and (4) is supported by the majority of the employees[10].
NY	N/A	Allowed if your business is a corporation with no more than 2 corporate officers, or if you are a sole proprietor or co-owner of a partnership, you may choose to exclude your spouse by submitting a spousal exclusion[11].
RI	N/A	Not allowed[12].
WA	10%	Allowed if the employer's private plan can provide equal or greater benefits and protections than the state plan, and the cost to the employees is less[13].

[5] California Employment Development Department (2023), Boyens, Smalligan, & Bailey (2021).
[6] https://famli.colorado.gov/ , Colorado Department of Labor and Employment. (2023).
[7] Connecticut Paid Leave Authority. (2023), https://www.ctpaidleave.org/How-CT-Paid-Leave-Works/Coverage-and-eligibility?language=en_US.
[8] https://www.standard.com/businesses-organizations/workplace-solutions/paid-family-medical-leave/states-paid-family-medical/washington-dc, DC Paid Family Leave (2023)
[9] Boyens, Smalligan, & Bailey (2021).
[10] Boyens, Smalligan, & Bailey (2021), https://www.nj.gov/labor/myleavebenefits/employer/index.shtml?open=PrivatePlan.
[11] New York State. (2023), https://paidfamilyleave.ny.gov/paid-family-leave-and-other-benefits.
[12] Rhode Island paid leave (2023), http://ripaidleave.net/.
[13] Boyens, Smalligan, & Bailey (2021), Washington paid family and medical leave, (2023), https://paidleave.wa.gov/elective-coverage/.

4.3 Factors Affecting Opt-out Rates in FAMLI Programs

Various interconnected factors play a pivotal role in shaping employers' decisions to opt out of paid FAMLI Family and Medical Leave programs. We explore each of these factors, categorizing them into four distinct groups: firm and industry characteristics, employee attributes, market and financial considerations, and FAMLI policy factors. This section addresses the first three categories, while the subsequent section delves into FAMLI policy factors, offering recommendations for policymakers.

Firm and Industry Characteristics

Opting out is prohibited in some states, and where allowed, provisions differ across states. Employers' responses to these provisions hinge on the comparative costs of staying in the state program versus opting out. With federal paid family and medical leave absent, providing such leaves becomes an optional benefit at the discretion of employers. Certain characteristics, such as industry type and larger size, make certain employers more inclined to offer these benefits voluntarily (BLS, 2023). Similar to other discretionary benefits like retirement plans, employers may offer paid family and medical leaves to attract and retain talent. Those with pre-existing private leave benefits before FAMLI enactment may consider opting out if their programs meet opt-out provisions or choose to supplement the state program with additional leave benefits. Therefore, examining the characteristics of employers likely to have existing private leave plans is crucial.

First, the likelihood of employers offering paid family and medical leaves varies with employer size. According to the latest BLS report, in the private sector, employers with 500 or more workers provide paid sick leave to 89% of their employees, while those with 100 to 499 workers offer it to 83%. Conversely, employers with fewer than 99 workers provide paid sick leave to only 72% of their employees in 2023 (BLS, 2023). The contrast is more pronounced for personal leaves, including family leaves, with access percentages being 62%, 57%, and 35% for employers with 500 or more workers, 100 to 499 workers, and fewer than 99 workers, respectively[14]

Second, the prevalence of private plans may be influenced by the characteristics of industries and employees' occupations. According to a recent Bureau of Labor Statistics (BLS) report in March 2023, 27 percent of civilian workers had access to paid family leave, while 90 percent had access to unpaid family leave. In the private sector, 27 percent of workers had access to paid family leave, with 89 percent having access to unpaid family leave. In comparison, state and local government employees showed slightly higher figures, with 28 percent having access to paid family leave and 94 percent to unpaid family leave. Examining specific occupational categories, the report revealed that 93 percent of those in management, professional, and related occupations had access to unpaid family leave, while 39 percent had access to paid leave. Conversely, in service occupations, 83 percent of workers had access to unpaid family leave, but only 16 percent had access to paid leave[15].

[14] https://www.bls.gov/charts/employee-benefits/percent-access-paid-leave-by-establishment-size.htm。

[15] https://www.bls.gov/ebs/factsheets/family-leave-benefits-fact-sheet.htm。

Third, companies with a higher proportion of part-time employees are less inclined to provide private paid family and medical leave benefits. Offering paid sick leave to part-time workers is less prevalent, with 56% of large firms and only 26% of small firms providing this benefit (KFF, 2021). Recent data from the Bureau of Labor Statistics (BLS) underscores this trend, indicating that 87% of full-time employees in the private sector have access to sick leave benefits, while only 51% of part-time employees enjoy the same benefit[16].

Employee Characteristics

The eligibility of employers to opt out may be influenced by the characteristics of their workforce. In states like California, Connecticut, and New Jersey, employer opt-out from the state plan requires majority employee support, in addition to meeting other provision criteria. Consequently, employee opinions play a significant role in the opt-out process. Although Maryland does not mandate majority employee support, employees' preferences still hold significance as leave benefits are designed to support them during medical and family-related absences.

The availability of paid leaves for employees is correlated with various individual characteristics. Higher-income individuals are more likely to have access to paid leaves, as highlighted in a recent report from the Bureau of Labor Statistics (BLS). Among those in the top 25% of employment income, 41% have access to paid family leave, 85% to paid holidays, 67% to paid personal leaves, 88% to sick leaves, and 90% to paid vacations. In contrast, employees in the lowest 25% of employment income experience substantially lower access rates, with figures standing at 14%, 60%, 26%, 58%, and 55%, respectively[17]. In workplaces where employee compensation is significantly lower, the likelihood of employees having access to private paid leaves diminishes. Such employers are less prone to opting out of the state plan and establishing their private plan, which is mandated to provide leave benefits at least equal to or better than those of the state plan.

Regarding the duration of paid time off in private plans, there is typically an association with employees' length of service. Those with longer tenure are likely to have access to more days of paid time off in private plans. This contrasts with state plans, where the maximum leave duration is uniform for all employees. Consequently, employees with less service time are more likely to benefit from state plans, while those with longer service time may not. This distinction between state and private plans may result in varying levels of employee support for opting out. Moreover, employees' experiences with private plans versus state plans can be influential. Positive encounters with the benefit claim process may lead employees to recommend retaining the state plan. Conversely, if employees face prolonged claim processing times and encounter challenges in securing their benefits, they may advocate for their employers to opt out of the state plan.

[16] https://www.bls.gov/news.release/archives/ebs2_09212023.htm。

[17] https://www.bls.gov/charts/employee-benefits/percent-access-paid-leave-by-wage.htm。

Market and Financial Considerations

Employers' decisions to opt out are significantly influenced by market and financial considerations, with two key factors playing pivotal roles: the status of "at-risk" employees and the availability of competitive private plans.

If private plans prove more cost-effective for employers, they are more likely to opt out of the state program. Employers with workers less likely to require family and medical leaves may find it advantageous to opt out and offer a private plan. Conversely, employers with a workforce at a higher risk of taking leaves may be inclined to refrain from opting out. This inclination arises from the fact that private plans operate on an experiential rating basis, where premium assessments depend on the actual utilization of leave benefits. In contrast, the state plan follows a fixed-rate structure, irrespective of an employer's experiential rating.

Moreover, the challenge of finding a suitable private plan, especially for employers inexperienced in offering such plans, is a significant factor impacting opting-out behaviors. The availability of low-cost private plans becomes crucial in influencing employers' decisions. If the private insurance market provides accessible options with feasible program establishment, employers may be more inclined to opt out. Additionally, given the equal split of contributions to the Family and Medical Leave Insurance (FAMLI) program between employers and employees in Maryland, individuals enrolled in private plans without out-of-pocket expenses may perceive the state plan as an additional financial burden. Consequently, such employees may express a preference for their employers to opt out of the state plan.

4.4 Strategies to Address Business Opt-Out Rates

To understand business opt-out rates for state paid family leave programs, it is essential to address the concerns and challenges faced by businesses. Simplifying administrative processes can boost business participation in state paid family leave programs. Clear guidelines, streamlined paperwork, and supportive resources, like online portals and training programs, facilitate compliance. Collaboration among government agencies, business associations, and advocacy groups is vital for raising awareness and dispelling misconceptions. Examining case studies from states like California, New Jersey, and Rhode Island, which have low opt-out rates, offers insights into successful implementation. Education is crucial; initiatives such as seminars and webinars help businesses understand program benefits and requirements. Government support, including online tools and training programs, can alleviate financial and administrative burdens, fostering successful program implementation. Furthermore, employers' opting-out decisions are impacted by the administrative costs associated with opting out and the likelihood of their employees taking leave. If the provisions for opting out are challenging to navigate and the opt-out process incurs high costs, extensive reporting requirements, or prolonged approval procedures, the opt-out rates are expected to be lower.

4.5 Conclusion and Recommendations for Improving Business Opt-Out Rates

State-paid family leave programs provide businesses with multiple advantages, including enhanced work environment, increased employee loyalty, and improved performance. By

offering paid time off for family or personal health needs, businesses demonstrate support during challenging times, leading to greater retention of valuable employees and a competitive edge in attracting top talent.

Business opt-out rates for state paid family leave programs vary across states and can have significant implications for employees and businesses alike. To ensure that all employees have access to the benefits they deserve, it is crucial to address the factors that contribute to high opt-out rates and implement strategies to reduce them.

Government initiatives, such as providing financial incentives, simplifying administrative processes, and educating businesses about the benefits of state paid family leave, can play a significant role in encouraging participation. Furthermore, collaboration between government agencies, business associations, and advocacy groups is essential in raising awareness and providing support to businesses. By working together to address the concerns and challenges faced by businesses, we can create a more inclusive and supportive work environment for all employees, ultimately benefiting both businesses and their workforce. It is time to prioritize the well-being of working families and ensure that no employee is left behind when it comes to paid family leave.

Chapter 5
Self-Employed Workers' Opt-in Behavior

In contemporary labor markets, the imperative for paid family and medical leaves is increasingly salient. Family and Medical Leave Insurance (FAMLI) initiatives have witnessed considerable momentum, with 13 states along with the District of Columbia legislating for these worker benefits. As of January 1, 2024, the most recent of these FAMLI programs, the Colorado program came into effect. Conversely, the opt-out clause permits specific employers to abstain from these programs, consequently, restricting their employees' access to coverage. While these benefits are typically available to traditional employees, self-employed workers often struggle to access them. Notably, a number of self-employed workers choose self-employment to meet certain family and medical needs as it allows for greater flexibility (Zhang & Acs, 2018). This raises the question of whether self-employed workers choose to opt in. This chapter aims to explore the opt-in rate of self-employed workers for state-paid family and medical leaves and the potential reasons behind these numbers.

As the gig economy continues to thrive, a growing number of individuals are choosing self-employment as their primary source of income. Abraham et al (2023) reported approximately 15% of the US workforce are independent contractors or self-employed based on a recent large-scale telephone survey conducted by Gallup. This figure is about 5% higher than the statistics based on surveys conducted among conventional households surveys conducted by the Bureau of Labor Statistics and the US Census Bureau (such as the Current Population Survey and American Community Survey) because it considered independent contractors, including those who may be coded incorrectly as employees in conventional household survey data and those who are independent contractors as the secondary work activity.. These individuals, however, often face unique challenges when it comes to accessing benefits such as paid family and medical leaves. Understanding the opt-in behavior for self-employed workers is crucial in evaluating the effectiveness and accessibility of these programs for those who work for themselves.

5.1 State Programs Permitting Self-employed Workers to Opt-in

Most (12 our of 14) of these states or district' FAMLI laws encompass the provision for self-employed workers—including freelancers, independent contractors, and sole proprietors—to access coverage. It is worth noting that under the law, individuals frequently referred to as independent contractors by businesses are often considered employees (A Better Balance, 2024). While certain states have extended the opportunity for self-employed individuals to voluntarily opt into coverage, not all state paid leave programs incorporate this provision. Twelve out of the 14 current state paid leave programs permit, or will permit once operational, self-employed workers to voluntarily opt into coverage. These include Maryland and 11 other states[18]: California, New York, Washington state, Massachusetts, Connecticut, Oregon, Colorado, Delaware, Minnesota, Maine, and Washington, D.C. (Williamson, 2023).

[18] New Jersey and Rhode Island are not included in the list.

5.2 Low Opt-in Rates

While the majority of state programs have incorporated this voluntary opt-in clause for self-employed workers, the actual rate of adoption remains surprisingly low. An examination of the fully-implemented FAMLI programs reveals an intriguing pattern. Out of the six programs that allow self-employed workers to opt in, as reported by the Center for American Progress (2023), the participation has been minimal. Specifically, out of the 6.7 million sole proprietors or self-employed individuals operating businesses without employees (nonemployer small businesses), a mere fraction, 120,828 or 1.8%, have chosen to participate in the state programs.

This figure is further skewed by the disproportionately high opt-in rate in Massachusetts, which stands at 7.39%. This rate significantly surpasses those in other states, leading to an overall average that does not accurately reflect the individual state trends. When Massachusetts' figure is excluded, the average opt-in rate across the rest of the states is substantially lower than the overall 1.8%. The following table shows these details more comprehensively.

Table 5.1. The Number and Rate of Opt-in for Nonemployer Small Businesses Across States

	Number of opt-ins	Number of nonemployer small businesses	Approximate takeup rates
California	1,945	3,458,667	0.06%
New York	70,000	1,806,664	3.87%
Massachusetts	42,631	576,528	7.39%
Washington	2,907	500,954	0.58%
Washington, D.C.	73	61,721	0.12%
Connecticut	3,364	292,009	1.15%
Total	**120,920**	**6,696,543**	**1.81%**

Notes: (1) The situation in Oregon is of particular interest. The option to opt into the FAMLI program has been made available, yet benefits did not commence until September 2023 after the above table was generated. As a result, it is plausible that a number of self-employed individuals intending to opt in may be deferring their decision until closer to the benefits commencement date. Thus far, approximately 300 applications for opt-in have been submitted, with approval granted to about half of them. (2) The methodology employed in this analysis utilizes the reported number of nonemployer small businesses - businesses devoid of employees - as provided by the U.S. Small Business Administration (SBA) as a representative figure for the number of self-employed individuals within each jurisdiction. While this approach provides a useful estimate, it is important to bear in mind that it is likely an underestimation. This is due to the fact that the category of relevant self-employed individuals could encompass owners of businesses with employees, as well as others who are not included in the SBA data. (Center for American Progress 2023).
Data Source: The data used in this analysis was obtained from the Center for American Progress (2023).

5.3 Self-employed Workers' Low Paid Family/Medical/Sick Leave Coverage

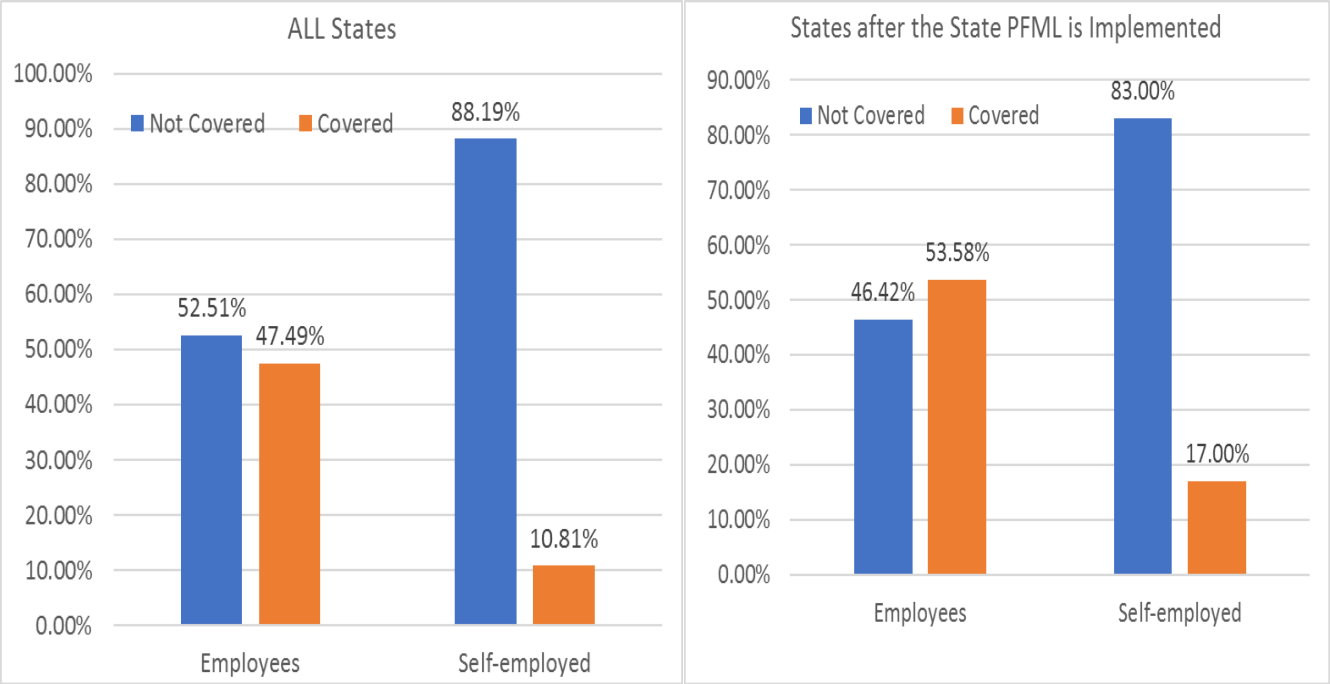
Our analysis conducted on the weighted Current Population Survey Annual Social and Economic Supplement (ASEC) dataset[19] spanning the years 2014-2023, reveals that approximately 11% of self-employed workers, in contrast to 47% of wage-and-salaried employees across all sampled states[20], who were absent from work for family and medical reasons in the previous week were beneficiaries of paid leave (inclusive of sick leave). Those leaves include public and private leave plans. In the case of Maryland, this proportion increased to 13.48%, thereby exceeding the national average. Overall, in the subset of states where a paid family and medical program has been implemented, this coverage rate rose to 17% (compared to 54% for wage-and-salaried employees)[21]. Evidently, state-sponsored paid family and medical plans contribute to enhanced coverage. The specifics are delineated in Figure 5.1.

It is of paramount importance to note that these rates are not restricted solely to paid family and medical leave, and they are not limited exclusively to state plans. Therefore, these figures do not directly indicate the opt-in rates of self-employed workers. However, they do demonstrate that only a small proportion of self-employed workers are covered by the paid family and medical leave, sick leave, and other forms of leave, regardless of whether these are part of a state plan or a private plan. This underscores the necessity for coverage of self-employed workers in instances where such needs arise.

State-paid family and medical leaves offer numerous advantages for self-employed individuals. By providing financial support and job protection during times of need, these leaves can help maintain their financial security, work-life balance, and overall well-being. However, the opt-in rate among self-employed workers tends to be significantly lower compared to the participation rate among traditional employees, as our aforementioned data shows above. To improve access to these benefits, it is vital to identify and address the factors that influence the opt-in rate for self-employed individuals.

[19] The data is compiled by Flood, et al.(2023) in the IPUMS data series.
[20] Based on this survey, none of the unincorporated self-empoyment workers report receiving earnings when they took family leaves.
[21] For those two states (New Jersey and Rhode Island, this coverage rate rose to 35% and 47% respectively for self-employed workers and wage-and-salaried employees.

Figure 5.1 Percentage received Earnings during Medical and Family Leaves (Private & Public), All States vs. States with implemented Public FAMLI Programs



Note: In the dataset, the provision for paid family/medical/sick leave is established if the following conditions are met: (A) The reasons for the absence of jobholders who were not engaged in work during the preceding week encompass at least one of the following: (1) Personal illness/injury/medical complications (2) Issues related to child care (3) Other family or personal obligations (4) Maternity/Paternity leave; and (B) The respondents were recipients of wages or salary for the duration of their absence from work in the preceding week.
Data Source: The data employed for this analysis was derived from the weighted Current Population Survey Annual Social and Economic Supplement (ASEC) dataset for the years 2014-2023 (Flood, et al., 2023).

5.4 Reasons for the Low Opt-in Rates

The question arises: why is the opt-in rate for self-employed workers so low? Several factors may contribute to the low opt-in rate among self-employed workers for state-paid FAMLI programs. The costs and barriers associated with opting in are certainly significant factors, along with potential issues related to awareness. Given the importance of a sizeable insurance pool in mitigating shared costs, the low opt-in rate warrants further investigation.

Opt-in Costs

Financial considerations may also play a significant role in the opt-in rate for self-employed workers. Unlike traditional employees, self-employed individuals do not have access to employer-provided benefits. This means that they must bear the full financial burden of their leaves, including lost income and potential hiring of temporary help. The financial strain can discourage self-employed individuals from opting in for state-paid family and medical leaves, as they may prioritize maintaining their businesses and income stability over taking time off.

State paid leave laws typically offer automatic coverage for employees, necessitating contributions from both the employees and their employers towards the program. However, the same principle does not apply to self-employed workers. As reported by the Center for American Progress (2023), the table below presents the percentages of their incomes that self-employed workers are required to contribute if they choose to opt into state paid leave programs, in comparison with employers and employees. Additionally, it highlights exceptions based on employer size.

Only five states (Colorado, Oregon, Washington, Maine, and Connecticut) maintain an identical contribution rate for employees and self-employed workers. In these cases, self-employed individuals are only required to pay the employee share. However, in several other states' programs, self-employed workers are obliged to contribute a larger share of their income than employees. For instance, in California, self-employed workers need to contribute significantly more (at 6.93% of their net profit on their first $154,164 in income, nearly eight times that of employees' contributions) towards the program. Notably, self-employed workers are also eligible for fewer weeks of benefit, with a maximum of 39 weeks allowed, compared to 50 weeks for employees (Williamson 2023). In Washington, D.C., where employees do not contribute to the cost of the program, self-employed individuals who opt in bear the full employer contribution (National Partnership for Women & Families, 2023). States like Massachusetts, Minnesota, and Maryland require self-employed workers to contribute both the employer and employee shares, which is twice as much as regular employees' contributions.

Table 5.2. Contribution Rate for Self-Employed Workers Compared to Employees

	Self-Employed rate	Employee rate	Employer rate	Size Exception for Employer Contributions
California	6.93%	0.90%	N/A	N/A
Colorado	0.45%	0.45%	0.45%	Fewer than 10 employees
Connecticut	0.50%	0.50%	N/A	N/A
Washington, D.C.	0.26%	N/A	0.26%	N/A
Maine	To be decided (50% of total rate)	To be decided (50% of total rate)	To be decided (50% of total rate)	Fewer than 15 employees
Maryland	0.90%*	0.45%*	0.45%*	Fewer than 15 employees*
Massachusetts	0.63%	0.32%	0.31%	Fewer than 25 employees
Minnesota	0.70%	0.35%	0.35%	Employers with fewer than 30 employees pay reduced contribution
Oregon	0.60%	0.60%	0.40%	Fewer than 25 employees
Washington	0.58%	0.58%	0.22%	Fewer than 50 employees

Notes: In New York, employees bear the entire cost of paid family leave coverage, currently set at a rate of 0.455 percent of wages, up to a specified cap. Similarly, self-employed individuals are subject to the same rate. However, for temporary disability coverage, costs are shared between employers and employees, with varying amounts. In contrast, self-employed individuals bear the full and variable cost. Refer to NY Workers Comp. Law § 209-210 for details. In Delaware, there is a need for regulatory clarification concerning opt-ins for self-employed workers, as outlined in 19 Del. Code § 3717.
*Data Sources: Center for American Progress (2023), and * from Maryland Department of Labor (2024)*

Eligibility and Waiting Periods

Aside from the cost issue, various barriers exist when opting into a state-paid leave program. Participation typically entails submitting an application or notice to a state agency, providing documentation, and adhering to the state's regulations. Self-employed individuals opting in are obliged to contribute to the program's insurance system, gaining eligibility for cash benefits during periods of inability to work due to covered health or caregiving needs. The benefit amount is determined by a percentage of their self-employment income.

Eligibility for self-employed workers in state-paid leave programs is generally linked to specific post-enrollment requirements. These may encompass a waiting period, a minimum contribution period or amount, or both. Failure to opt in within a set timeframe after becoming self-employed in some states can extend the waiting period before benefit eligibility.

Most state programs necessitate self-employed individuals to commit to remaining in the program for a specified period, typically three years. These requirements are in place to ensure the program's sustainability and offer long-term benefits to participants. In New York, self-employed workers encounter a distinctive challenge. Those opting into the state's paid family leave program must do so within 26 weeks of becoming self-employed. Washington, D.C., and New York impose extended waiting periods for those failing to opt in promptly—one year in Washington, D.C., and two years in New York. Additionally, most programs mandate self-employed individuals to commit to a three-year participation period (Williamson 2023). For example, in Colorado, self-employed workers can access paid family leave insurance through the FAMLI program, which requires a commitment to pay premiums for three years (Colorado Department of labor and Employment, 2024). Connecticut requires a minimum three-year enrollment for sole proprietors and self-employed individuals who opt-in, with automatic re-enrollment unless they choose to withdraw (Colorado Department of labor and Employment 2024). As noted earlier, self-employed workers in California are entitled to fewer weeks of benefits, with a maximum of 39 weeks compared to 50 weeks for employees (Williamson 2023).

Low Awareness

Another probable explanation for the extremely low opt-in rate could be attributed to the limited awareness of the program. Many self-employed individuals may not be aware that these benefits are available to them, as the focus is often on employees of traditional companies. The lack of education and outreach specifically targeting the self-employed population can result in missed opportunities for these individuals to access the support they need. Given that many state policies are relatively new and not mandatory for self-employed workers, many self-employed workers may not naturally prioritize the leave issues. As highlighted by Willliamson (2023), numerous self-employed individuals may not actively seek information on paid family and medical leave until they face an urgent need, often when it is already too late. Workers typically only inquire about paid leave when an immediate requirement arises, resulting in missed opportunities for enrollment. This lack of awareness significantly contributes to the low participation rates. Coupled with the substantial costs associated with opting into coverage, especially in states like California, and the barriers related to eligibility and waiting periods, many self-employed workers might be dissuaded from engaging in these programs.

Other Challenges Faced by Self-Employed Workers in Opting In for State Paid Leaves

Self-employed workers encounter unique challenges when it comes to opting in for state-paid family and medical leaves. One significant challenge is the absence of a traditional employer who can facilitate and guide them through the opt-in process. Unlike employees who have HR departments to assist them, self-employed individuals must navigate the system on their own. This can be daunting, especially if they are unfamiliar with the procedures and paperwork involved.

Additionally, self-employed individuals often have irregular income streams, making it difficult to plan for the financial implications of taking a leave. Unlike traditional employees who receive a regular paycheck, self-employed workers' income can fluctuate significantly. This uncertainty can make it challenging to estimate the financial impact of taking time off, further discouraging them from opting in for state-paid family and medical leaves.

Another challenge is the potential negative impact on their businesses. Self-employed individuals rely on their businesses to generate income and support their livelihoods. Taking a leave can disrupt their operations, potentially leading to financial instability or loss of clients. The fear of losing business opportunities and damaging their professional reputation can deter self-employed workers from opting in for state-sponsored leaves.

5.5 Benefits of Opting In State FAMLI Programs as a Self-Employed Worker

While self-employed workers face challenges in opting in for state-paid family and medical leaves, there are significant benefits to consider. First and foremost, these leaves provide financial support during times of need. By receiving partial or full wage replacement, self-employed individuals can alleviate the financial burden associated with taking time off work. This financial support enables them to prioritize their health and the well-being of their loved ones without sacrificing their financial stability.

Many state-paid leaves also offer job protection for self-employed workers. With the assurance that their businesses will be waiting for them when they return, self-employed individuals can take the necessary time off without worrying about losing clients, projects, or income opportunities. This job protection allows self-employed workers to prioritize their personal and family needs without compromising their professional commitments.

Furthermore, opting in state-paid family and medical leave programs can contribute to improved work-life balance for self-employed individuals. By taking the time to care for themselves or their loved ones, they can maintain their physical and mental well-being. This, in turn, can lead to increased productivity, creativity, and overall job satisfaction when they return to work.

5.6 Strategies to Increase the Opt-In Rate for Self-Employed Workers

To improve the opt-in rate for self-employed workers, it is crucial to implement targeted strategies to address the challenges. First, increasing awareness among self-employed individuals is key. Outreach campaigns can target educating self-employed workers about the availability and benefits of state-paid family and medical leaves. Utilizing various channels such as social media, industry-specific publications, and professional networks can effectively reach self-employed workers and ensure they are informed about their options. State labor departments and government websites are the entry steps to provide detailed information about the benefits, eligibility requirements, and application procedures. These resources can help self-employed individuals understand their options and make informed decisions regarding their leaves. Additionally, professional associations and industry-specific organizations often offer guidance and support for self-employed individuals seeking to access state-paid leaves. These organizations can provide valuable insights, resources, and networking opportunities for self-employed workers navigating the opt-in process.

Financial considerations can be addressed by exploring potential solutions such as tax incentives or subsidies for self-employed individuals who opt in state-paid leaves. These financial incentives can help offset the costs associated with taking time off work, making it more financially feasible for self-employed workers to access these benefits.

Simplifying the opt-in process and providing comprehensive guidance can also encourage self-employed workers to utilize state-paid family and medical leaves. The creation of user-friendly online platforms, clear eligibility criteria, and streamlined application procedures can remove barriers and make it easier for self-employed individuals to navigate the system.

5.7 Potential Impact on the Program Fund

In our initial report (Jacob France Institute 2022), the calculated contribution rates remain remarkably consistent, whether we assume full or no participation by self-employed workers in the program. The minimal marginal difference suggests that the potentially more or less inclusion of self-employed individuals is unlikely to jeopardize the program's financial stability. Nonetheless, the majority of self-employed workers choosing not to participate will still impact the insurance pool base and costs to some degree. More significantly, ensuring coverage for self-employed workers and providing them with paid family and medical leave benefits is crucial for fostering social equity and cultivating a healthier and more productive labor force.

Increasing the opt-in rate for self-employed workers has significant implications for both individuals and society. For self-employed workers, accessing state-paid family and medical leaves can improve their financial security, work-life balance, and overall well-being. These benefits contribute to their overall job satisfaction, productivity, and ability to maintain and grow their businesses.

From a societal perspective, a higher opt-in rate among self-employed workers can lead to increased economic stability and reduced reliance on public assistance programs. By providing

self-employed individuals with the support that they need during times of personal or family health emergencies, society as a whole benefits from a more resilient and productive workforce.

5.8 Conclusion

State-sponsored family and medical leave programs extend crucial benefits to workers, including self-employed workers. Although not all states explicitly include provisions for self-employed individuals, many allow voluntary participation. These initiatives furnish cash benefits, calculated as a percentage of self-employment income, with contribution rates and eligibility criteria varying across programs.

The prevalent trend of staying out from state paid family and medical leave programs poses challenges in ensuring equitable access to leave benefits. This is especially true for self-employed individuals, resulting in low utilization rates. The opt-in rate of self-employed workers for state paid family and medical leaves is a crucial metric in evaluating the accessibility and effectiveness of these programs. Self-employed individuals face unique challenges in accessing these benefits, such as lack of awareness, financial considerations, and the perception of eligibility requirements. However, by addressing these barriers and implementing targeted strategies, policymakers and advocates can improve access to state-paid leaves for self-employed workers.

Despite the existence of these programs, the uptake rate among self-employed workers remains relatively low. Factors such as limited awareness, elevated costs, barriers related to eligibility and waiting periods collectively contribute to the restrained engagement of self-employed individuals in state-sponsored leave programs. Addressing these challenges demands a holistic approach involving heightened awareness, policy adjustments, and concerted efforts to diminish pricing inequalities. Increasing awareness, implementing effective educational strategies, providing financial incentives, enhancing affordability, and simplifying the opt-in process can encourage self-employed individuals to utilize state-paid family and medical leaves. This can be achieved through targeted outreach campaigns and educational initiatives. Policymakers could explore measures to alleviate the cost burden on self-employed workers, such as adjusting contribution rates or offering subsidies.

With the right support and resources, self-employed workers can benefit from the financial support, job protection, and improved work-life balance provided by these leaves. By improving the opt-in rate for self-employed workers, we can ensure that these individuals have the necessary support to prioritize their health and the well-being of their loved ones without compromising their financial security or professional commitments. This not only benefits self-employed workers themselves but also contributes to a more resilient and productive society as a whole.

Chapter 6
Actuarial Analysis for the Maryland Family and Medical Leave Instance Program

(see Appendix III)

Chapter 7
Conclusion & Discussions

In this project, we conducted an analysis of expected program claims and administration experience by studying and providing projections on

- Expected volume of claims made on the state trust fund by employees employed in the state with predictions on the first year by month or quarter (2026), projections on at least an annual basis for later years (e.g., 2027 – 2030), and projections with break-downs of projected claims by leave type (medical, family care, birth of a child, military exigency)
- Expected cost and duration of claims with details by claim type (medical, family care, birth of a child, military exigency)
- Expected employer opt-out behavior, based on available information and data
- Expected self-employed individual opt-in behavior based on publicly available information from states that have mandated FAMLI benefits, based on available information and data.

In Chapters 1 and 2, we utilized two simulation models, namely the micro econometric simulation model and the USDOL Modified Worker Plus Model, to estimate the expected volume, costs, and duration of claims by different types. Our analysis drew upon data from the FMLA (2018) survey and the American Community Survey (2017-2021). Moving on to Chapter 3, we conducted an empirical examination of the temporal pattern of leave durations, leveraging data on average leave lengths across different leave types from the states with established paid family and medical leave programs, including California, New Jersey, Rhode Island, New York, Washington, D.C., and Massachusetts. Chapters 4 and 5 delve into the analysis of anticipated employer opt-out behavior and the expected opt-in behavior of self-employed individuals. This examination is based on publicly accessible information from the Current Population Survey Annual Social and Economic Supplement (ASEC) dataset spanning the years 2014-2023. Chapter 6 is an actuarial study conducted by Milliman. Below, we summarize our key findings and policy implications from these analyses.

Projected Claims in the First Year

Our analysis provides predictions of the volumes of claims in the first year by month and quarter. In doing so, we compiled the FAMLI data from California, Rhode Island, and Washington, and finds that in spite of a lack of seasonality in the number of claims, significant variations exist in the monthly claims for medical, bonding, and family care leaves in the first year of program implementation. The total projected claims for 2026 are estimated to be the highest in June and December. The monthly variations of the predicted volumes of claims have several implications.

Resource Allocation: State agencies and policymakers need to allocate resources effectively to manage higher claims volumes during peak months (June and December). This might include additional staffing or adjusting budgets to accommodate increased demand during these times of the year.

Communication and Education: Communication and education are needed to inform employees about the availability and details of FAMLI benefits, especially before the start of the payment and during the first year of the program. This can help individuals make informed decisions about when to take a leave.

Employer Planning: Employers should be aware of the expected surge in leave requests during peak months and plan their staffing and work arrangements accordingly to minimize disruptions to their operations.

Budgeting and Fiscal Planning: FAMLI program administration needs to consider the projected high claims months (June and December) when budgeting and fiscal planning. Adequate reserves and financial preparations are essential to cover these peak periods.

Policy Evaluation: Policymakers should continually monitor and evaluate the FAMLI program's performance, especially during the first year of implementation, to assess whether it is meeting its goals and whether adjustments are needed to better align with actual demand patterns.

Projected Claims in 2026-2030 & Leave Length

Three different approaches were utilized to estimate projected claims for the years 2026 to 2030. These projections align closely with one another. The forecast indicates a slight uptick in claims from 2027 to 2030, driven by increased awareness of the program and higher adoption rates. However, it's essential to interpret these projections cautiously, as the number of claims is also affected by the participation of self-employed individuals and the decisions of employers who may offer comparable or superior coverage through their in-house family and medical leave plans, potentially leading to opt-outs.

In terms of leave lengths, when examining data from other states, we find that medical leaves are generally longer in duration than family leaves. This occurs because states often allow more extended paid medical leaves compared to family leaves, resulting in a lower ratio of medical leave duration to the maximum state-allowed duration , compared to family leaves. There is a clear positive relation between the maximum law-stipulated leave length and the actual leave duration. Our analysis also shows that the wage replacement rate has a positive and significant association with the leave length ratio, that is, higher wage replacement rate lowers the opportunity cost of taking leaves, potentially leading to longer leave durations. Further analysis reveals that the duration of different types of leaves is influenced by demographic factors. Specifically, the length of medical leaves is correlated with age and gender, whereas family leaves exhibit associations with age, gender, marital status, and education. These findings have the following implications:

Legal Framework Consideration: Policymakers should consider how the maximum law-stipulated leave length impacts the actual leave duration and explore potential adjustments to strike a balance between legal requirements and the practical needs of individuals and employers.

Data, Monitoring and Evaluation: Continuous monitoring and evaluation of the program's performance, including demographic influences on leave duration, can help policymakers make informed decisions and refine program policies over time. As unforeseeable factors could affect the actual caseload and leave length, collecting needed data for monitoring and evaluation will help develop an effective and sustainable program.

Equity and Accessibility: Efforts should be made to ensure that family and medical leave programs remain accessible and equitable for all individuals, considering demographic factors like age, gender, marital status, and education. Outreach and communication efforts should be tailored to specific demographic groups, acknowledging that different factors influence the leave-taking decisions of individuals.

Research and Analysis: Continuous and thorough studies are essential to track the dynamic changes in family and medical leave programs. Researchers should continually assess the impact of demographic factors, program awareness, and employees' decisions on leave uptake and duration. Longitudinal studies can provide valuable insights into how these factors change over time and inform policy adjustments to optimize program effectiveness and inclusivity.

Opting-Out by Employers and Opting-In by Self-Employed Individuals

Our analysis reveals significant variability in employer opt-out rates across states, ranging from 3% in California to 33% in Massachusetts. This variability is influenced by policy differences, including whether government agencies can opt out and the division of the FAMLI contribution rate between employers and employees. For instance, in Rhode Island, where employees bear the entire burden of contributions, all private sector employers are automatically included and cannot opt out.

Self-employed individuals' opting-in rate is very low, averaged only around 1.8% across states with available data from existing programs, and the rates vary widely by state, with Massachusetts having the highest opt-in rate of 7.39% and California having the lowest rate of 0.06%. Despite this variability, our analysis of data from 2014-2023 shows that only 11% of self-employed workers, compared to 47% of salaried employees in sampled states, had access to paid family and medical leave. In Maryland, this rate was at 13.48%. In states with paid leave programs, self-employed worker coverage increased to 17%, while it was 54% for salaried employees. These low opting-in rates for paid FAMLI programs, albeit varying by states, underscore the need for further analysis and policy considerations to enhance accessibility of these programs for self-employed individuals. These findings have important policy implications:

Enhance Program Opt-in: As an insurance program, the size of the insured pool is critical to its sustainability. Offering financial incentives, simplifying administrative processes, reducing eligibility barriers, enhancing awareness of the program benefits, enhancing affordability, and promoting private-public partnership could help boost businesses' participation.

Initiatives Targeted at Self-employed Individuals: There is a need for educational campaigns targeting self-employed individuals to raise awareness about the benefits and availability of FAMLI programs. Enhanced awareness can potentially lead to higher opt-in rates and better participation and utilization of these programs. Further analysis is important to understand the barriers that deter self-employed individuals from opting in. Identifying and addressing these barriers can make the FAMLI program more accessible to this group.

Economic Impact Assessment: Assessing the economic impact of increasing opt-in rates for self-employed individuals can inform decision-making. Evaluating the potential benefits and costs can guide policy adjustments.

Employer Survey - Factors Influencing FAMLI Opt-Out or Opt-In: A survey directed at employers and self-employed individuals to gather insights on their decisions to opt in or opt out of the FAMLI program would help inform policy decisions. This approach enables policymakers to understand employer perspectives, tailor policies to meet their needs and concerns, conduct cost-benefit analyses to assess program viability, evaluate program effectiveness, leverage competitive advantages for attracting talent, simplify administrative processes, ensure legal compliance, implement targeted educational initiatives, make evidence-based decisions, and continuously improve FAMLI policies. In essence, such surveys provide a direct line of communication with employers, allowing policymakers to create more effective, inclusive, and sustainable FAMLI programs that benefit businesses and employees alike.

Conclusion

In summary, our research offers a thorough exploration of projected claims in both the short and long terms, leave duration projections, and the influence of employer opt-outs and opt-ins by self-employed individuals. The outcomes of this study hold critical policy implications, highlighting the need for ongoing monitoring, effective communication and education initiatives, customized programs and targeted strategies to address stakeholder engagement through tools like surveys to shape the evolution of the FAMLI program. This underscores the important role of evidence-based policymaking in crafting programs that effectively address the diverse requirements of individuals and employers while safeguarding program sustainability and financial stability.

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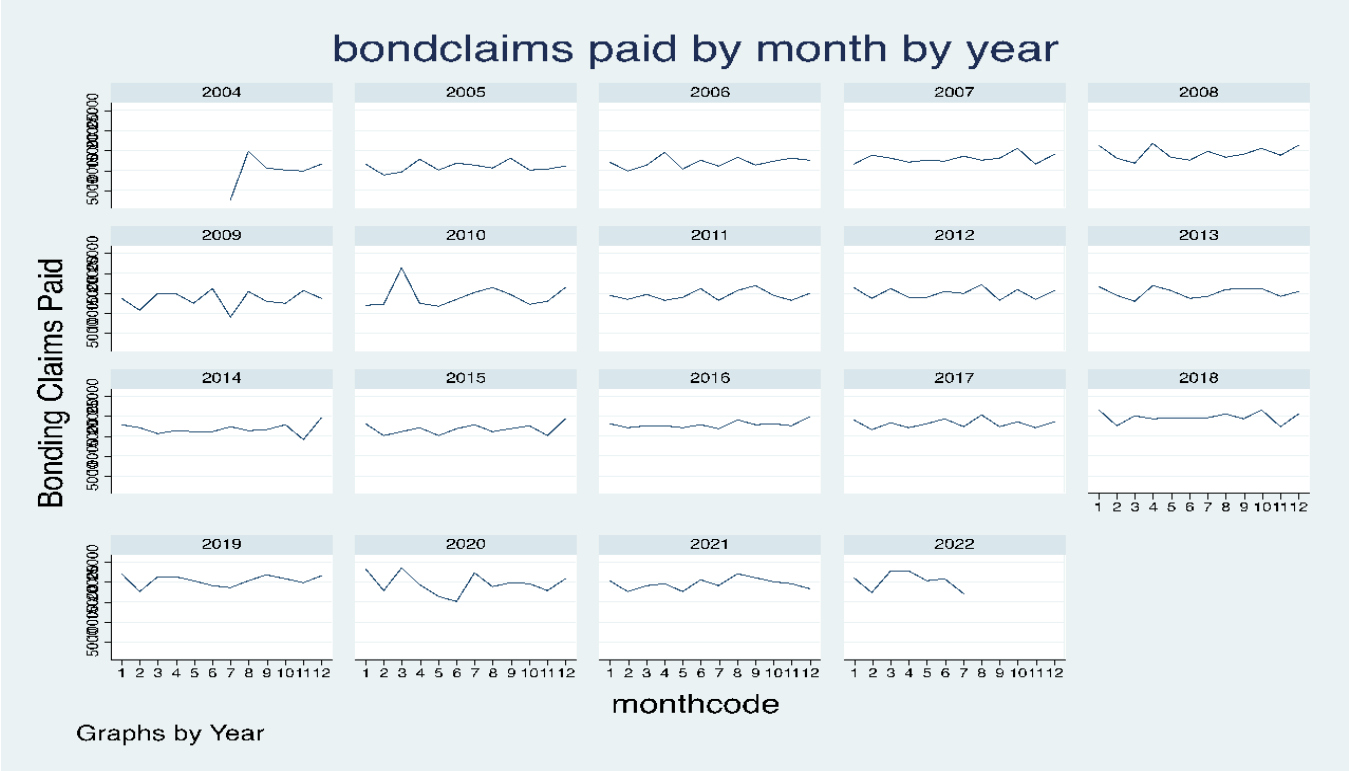
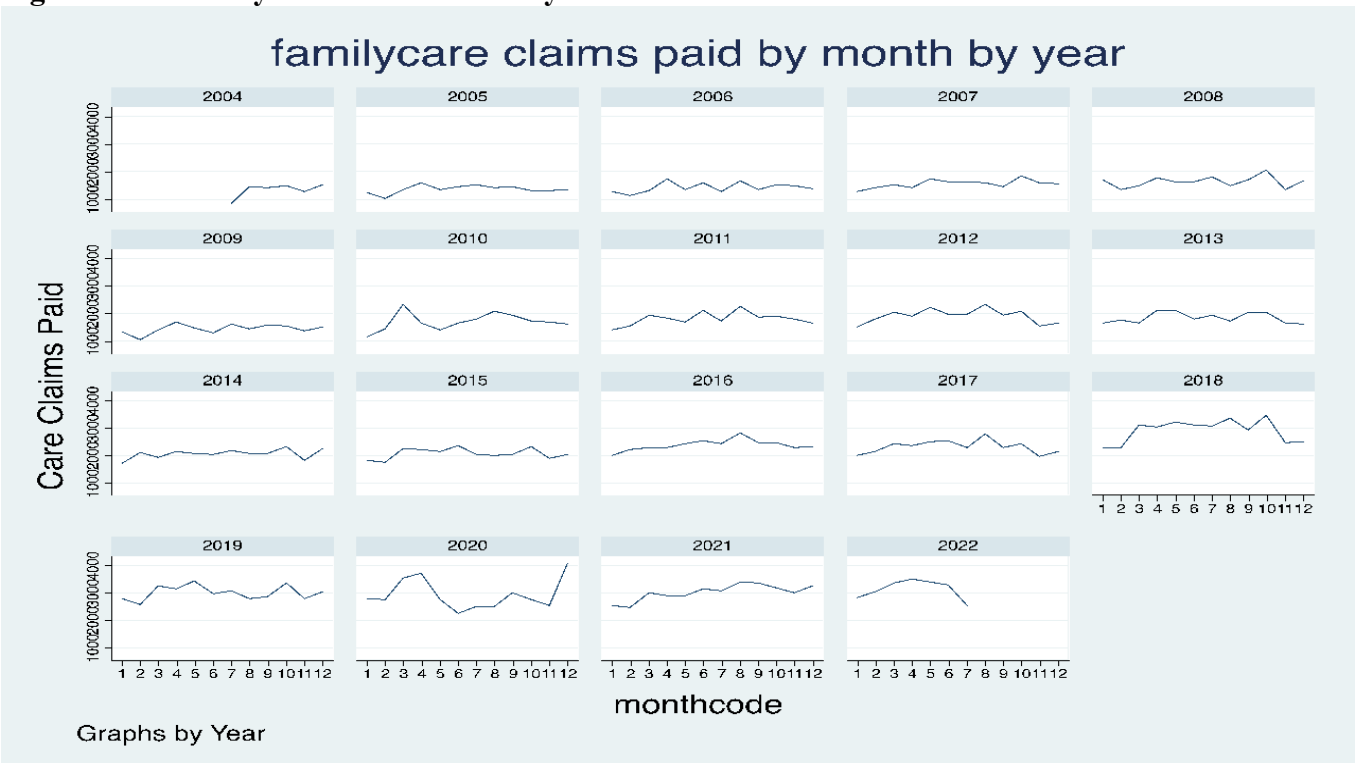
Appendix I

Figure I.1. Monthly Variations of Bonding Claims Approved in California



Note: It appears that monthly variation does not play a big role. Exceptions are the first month (July 2004), 2009 and 2010 (economic recession), 2020 (start of the covid).

Figure I.2. Monthly Variations of Family Care Claims Paid in California



Appendix II

Historical monthly claims by leave type in California, Rhode Island, and Washington state.

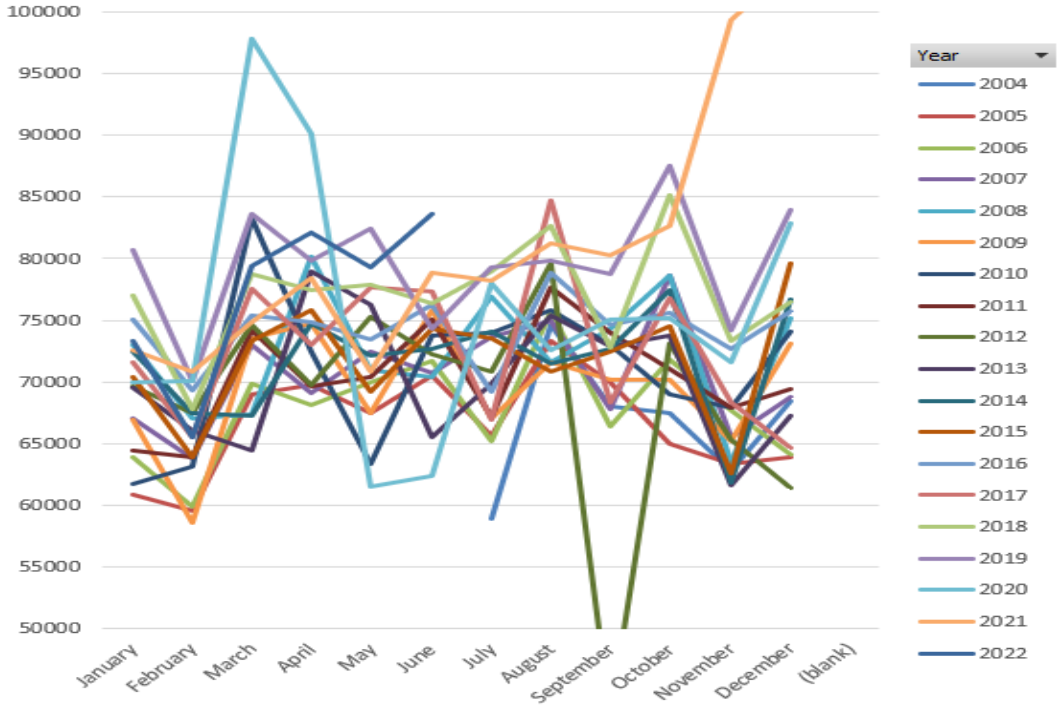
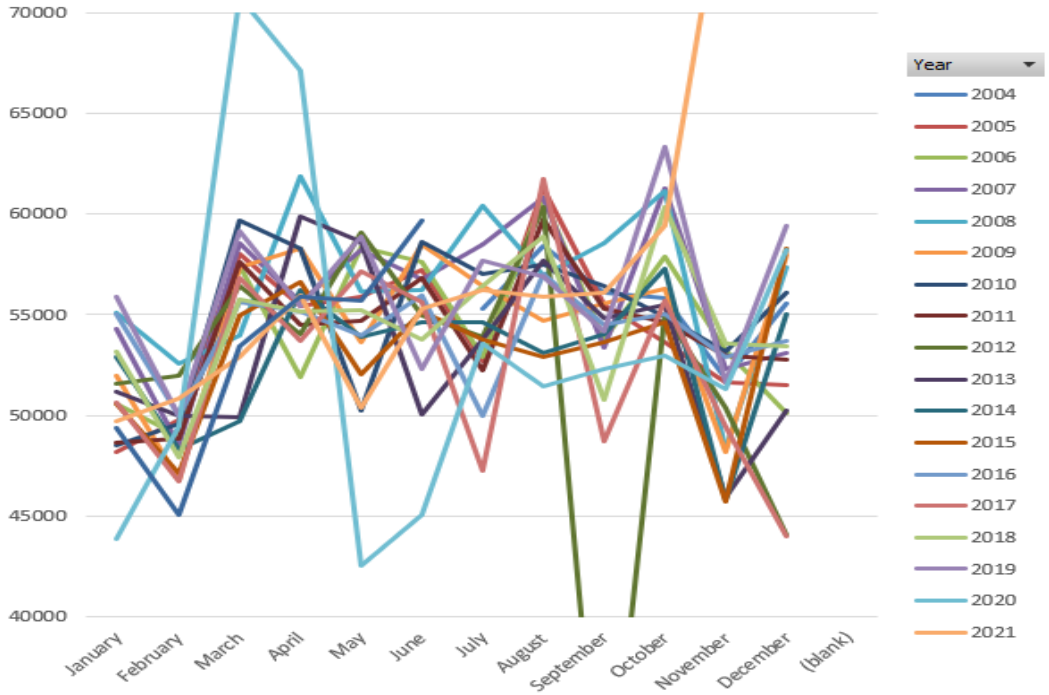


Figure II.1(a). Monthly Approved Total Claims in California



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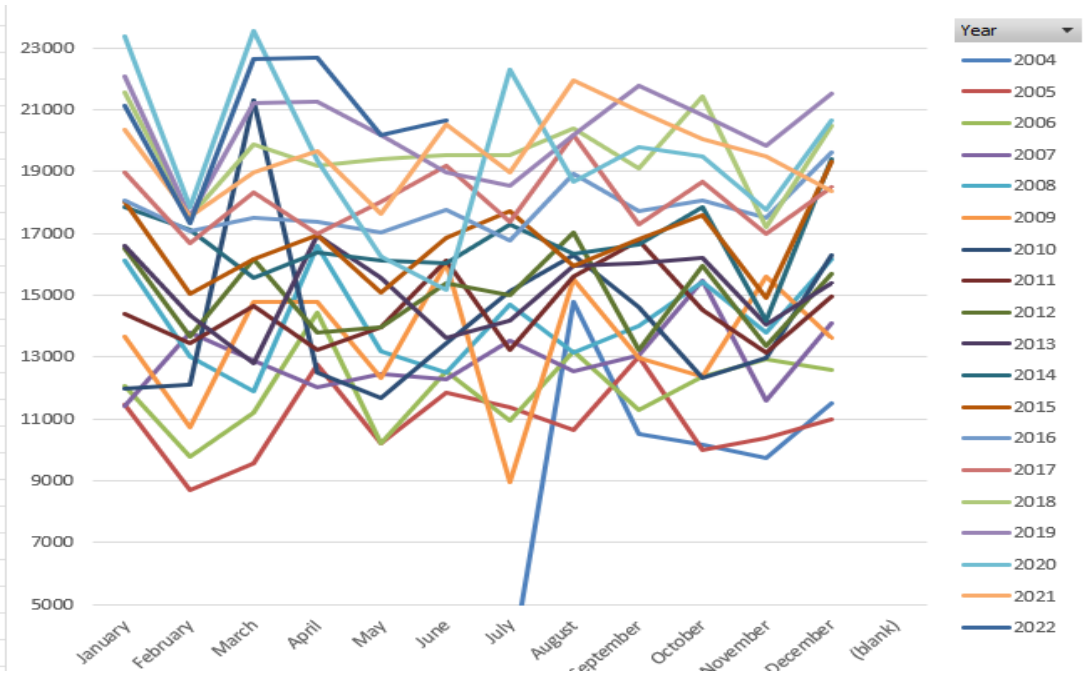


Figure II.1(c). Monthly Approved Family Bonding Leaves in California

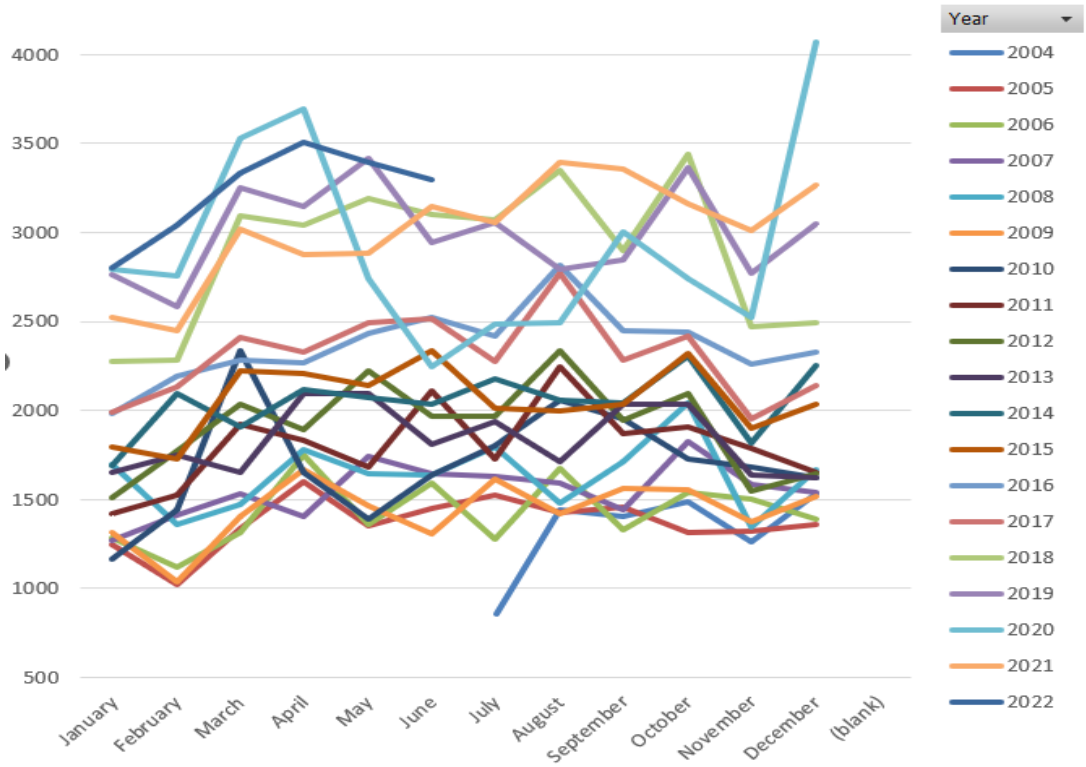


Figure II.1(d). Monthly Approved Family Care Leaves in California

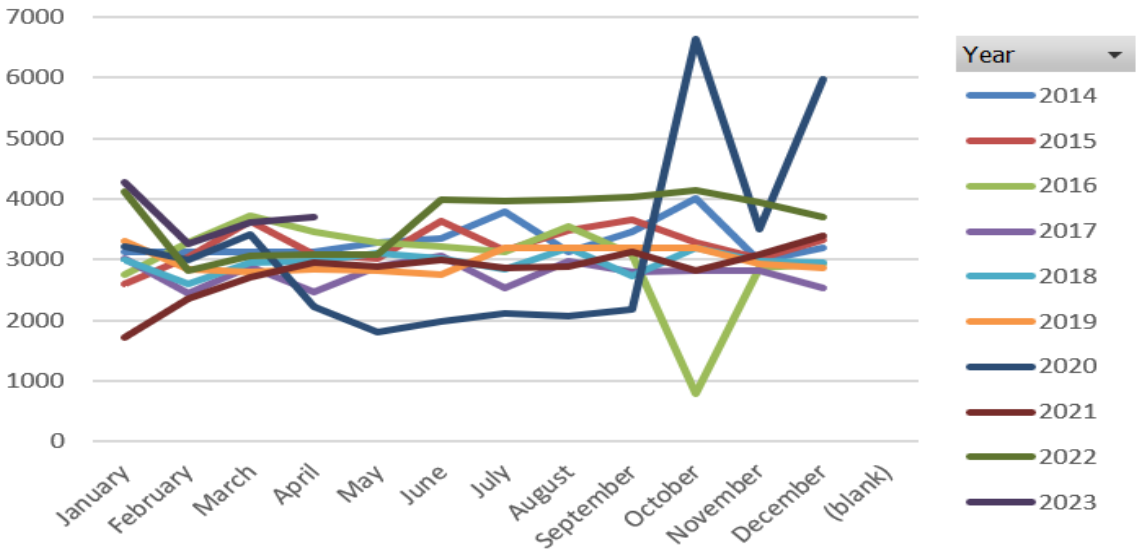


Figure II.2(a). Monthly Approved Total Claims in Rhode Island

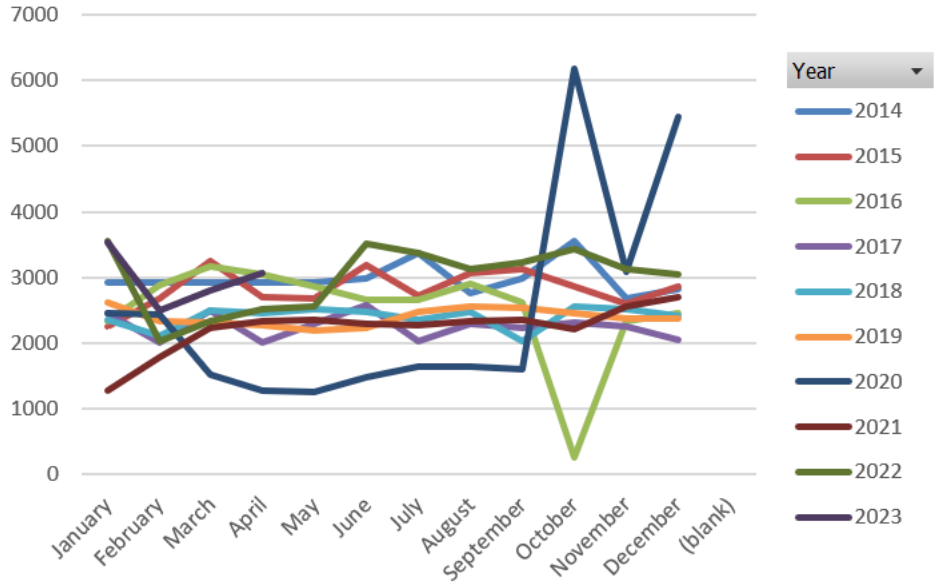


Figure II.2(b). Monthly Approved Total Medical Claims in Rhode Island

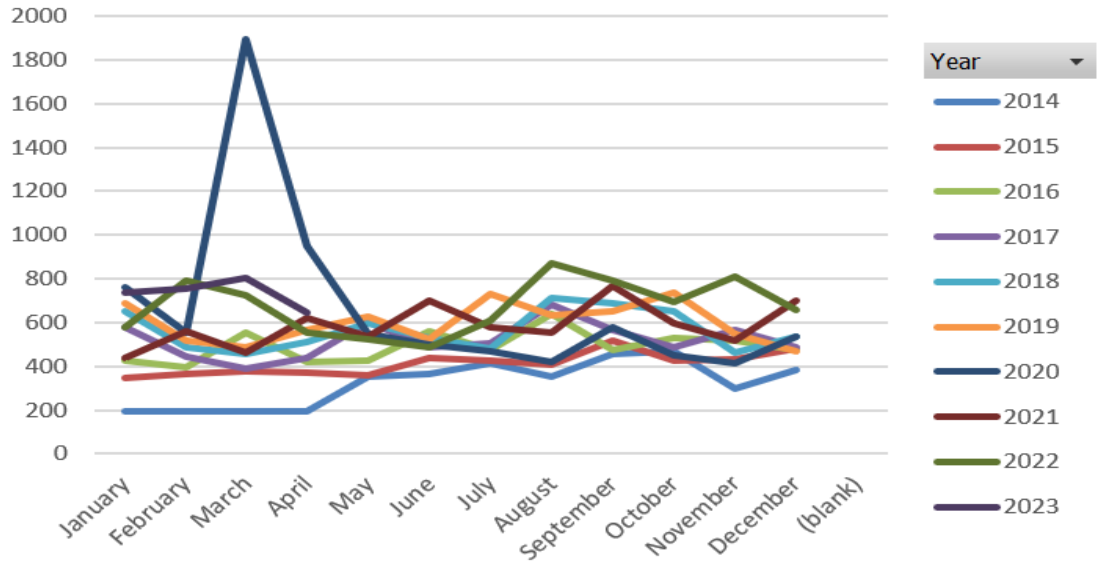


Figure II.2(c). Monthly Approved Total Family Claims in Rhode Island

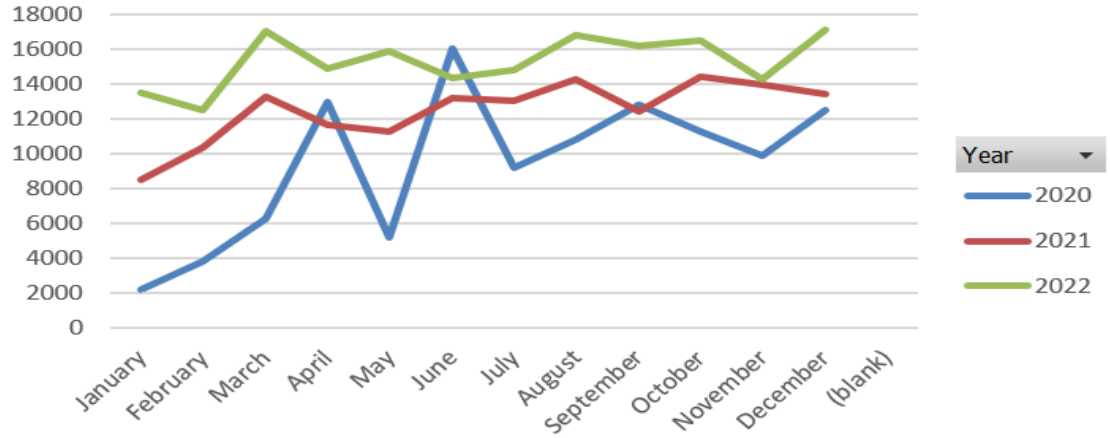


Figure II.3(a). Monthly Approved Total Claims in Washington

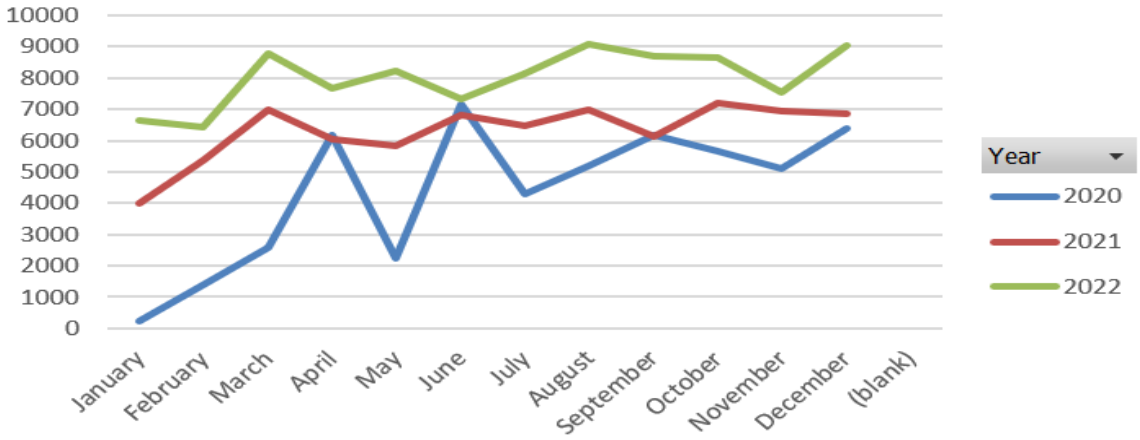


Figure II.3(b). Monthly Approved Total Medical Claims in Washington

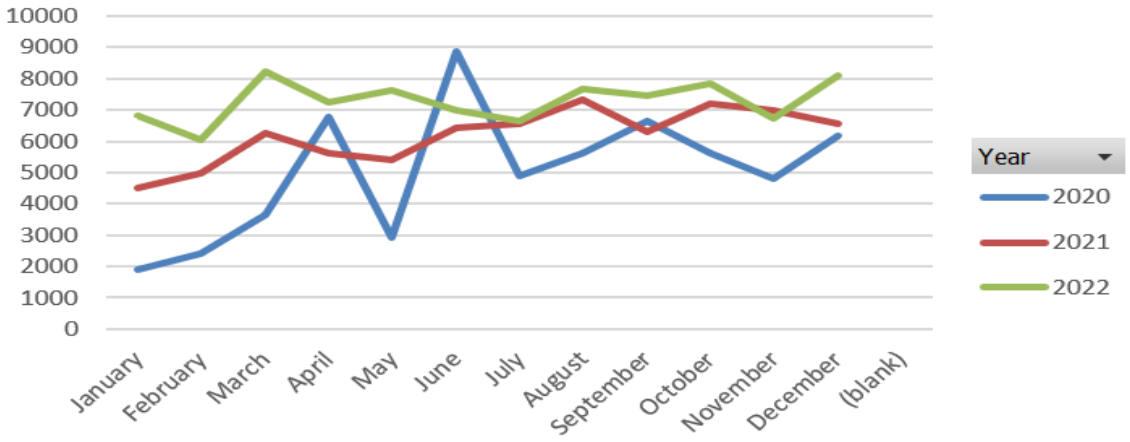


Figure II.3(c). Monthly Approved Total Family Claims in Washington

Appendix III

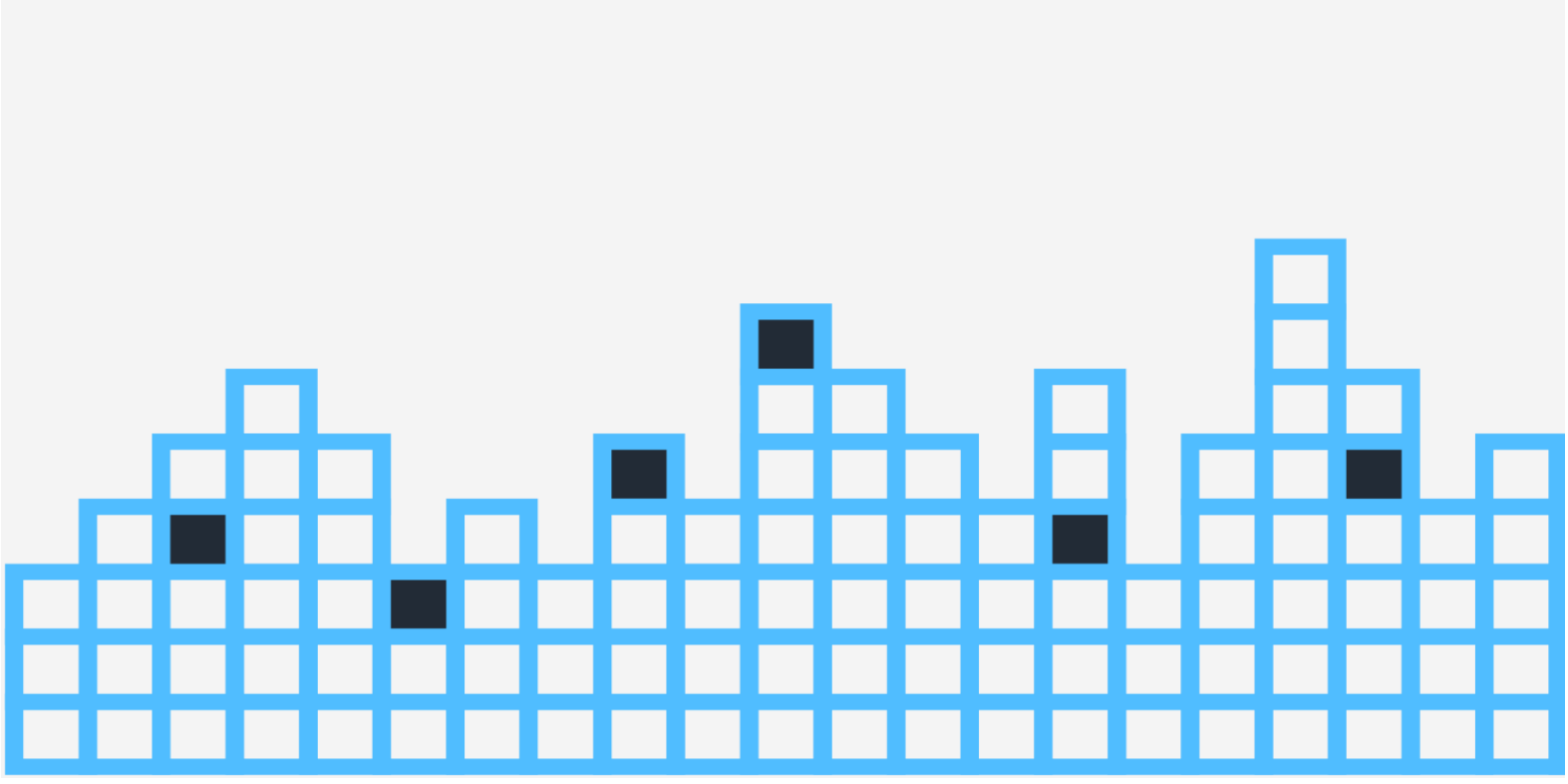
MILLIMAN REPORT

Actuarial Analysis for the Maryland Family and Medical Leave Insurance Program

Commissioned by University of Baltimore

Revised on November 27, 2023

Paul Correia, FSA, MAAA



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Section 1 – Introduction

Earlier this year, Milliman performed an actuarial analysis for the Maryland Family and Medical Leave Insurance (FAMLI) program. The results included estimated contribution rates and financial projections for the FAMLI program, which were provided to University of Baltimore in a report dated July 19, 2023. Since then, we have performed an additional analysis of expected claim costs (i.e., benefits and administrative expenses) for the FAMLI program by studying and providing projections for the following items specified by University of Baltimore:

- Expected volume of claims approved for FAMLI benefits provided through the state trust fund, expressed on a monthly or quarterly basis for 2026 and on an annual basis for 2027 and beyond, and split by leave type (i.e., family bonding, family care, medical maternity, medical non-maternity, and military exigency).

- Expected cost and duration of FAMLI claims with details by leave type.

We were also asked to research experience in other states with paid family and medical leave (PFML) programs, and to summarize the following aspects of these programs:

- Expected employer opt-out behavior for employers who choose to provide benefits through private plans in lieu of the state program, including the following:

    a) Analysis of employer participation in private options in different states based on publicly available data from states that have mandated PFML benefits;

    b) Discussion of the reasons why employers opt out of the state program;

    c) High-level comparison of the characteristics of employers expected to opt out versus those expected to remain in the state program; and

    d) Discussion of the likely leave-taking behavior of workers employed by opt-out employers versus those who participate in the state program.

- Expected self-employed individual opt-in behavior based on publicly available information from states that have mandated PFML benefits.

This report contains the results of our analysis and research, along with documentation of the methods we used for performing the analysis. Section 2 contains projections of FAMLI claims and claim costs by leave type from 2026 though 2034. Note that these projections are consistent with the projections included in our report to University of Baltimore dated July 19, 2023, which were provided in aggregate (rather than split by leave type) in the prior report. Section 3 provides an overview of employer opt-out behavior for those who choose to provide benefits through private plans in lieu of the state program. Section 4 contains observations on self-employed workers who elect to participate in PFML programs in different states. Section 5 contains documentation of the data, assumptions, and methods used in our analysis.

Data Reliance

In performing the research and analysis, Milliman relied on publicly available data from PFML programs in states with mandated benefits, as well as Maryland employment statistics from a variety of sources. Milliman did not audit or independently verify any of the data and other information, except that we did review the data for reasonableness and consistency. To the extent that any of the data or other information is incorrect or inaccurate, the results of our analysis could be affected and may need to be revised.

Distribution

Milliman's work is prepared solely for the use and benefit of the University of Baltimore. Milliman recognizes that this report may be public records subject to disclosure to third parties. Milliman does not intend to benefit and assumes no duty or liability to any third-party recipients of the report. To the extent that this report is not subject to disclosure under applicable public records laws, the University of Baltimore shall not disclose Milliman's work to any third parties without our prior written consent.

Variability of Results

The projections contained herein are estimates based on carefully constructed assumptions. Actual experience, however, will almost certainly differ from those assumptions. As such, actual costs may be either higher or lower than the amounts illustrated in this report.

Certification

I certify that all costs, liabilities, and other factors used or provided in this report have been determined on the basis of actuarial assumptions and methods that are individually reasonable and which, in combination, offer our best estimate of anticipated experience of the Maryland FAMLI program. I further certify that, to the best of my knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices which are consistent with the Actuarial Standards of Practice promulgated by the Actuarial Standards Board and the applicable Guides to Professional Conduct, amplifying Opinions, and supporting Recommendations of the American Academy of Actuaries.

Qualifications

I, Paul Correia, am a consulting actuary for Milliman, Inc. and a member of the American Academy of Actuaries. I meet the qualification standards of these organizations for rendering the actuarial opinions contained herein.

Section 2 – Expected Claim Volumes, Costs, and Durations

Tables 1A and 1B contain estimated claims approved for FAMLI benefits provided through the state trust fund from 2026 through 2034 by leave type – i.e., family bonding, family care, medical maternity, medical non-maternity, and military exigency, as defined below:

- Family Bonding – Family leave taken by covered workers to care for newborn and/or newly adopted or fostered children during the first year after the child's birth or after the placement of the child through foster care, kinship, or adoption.

- Family Care – Family leave taken by covered workers to care for family members with serious health conditions.

- Medical Maternity – Medical leave taken by covered workers for pregnancy and childbirth recovery that results in the covered worker's inability to perform their normal work duties.

- Medical Non-maternity – Medical leave taken by covered workers to care for one's own serious health condition that results in the covered worker's inability to perform their normal work duties, excluding maternity.

- Military Exigency – Leave taken by eligible workers who have a qualifying exigency arising from the deployment of a service member who is a family member of the covered worker.

The expected claims in Tables 1A and 1B are expressed on a quarterly basis for 2026 and on an annual basis for 2027 and beyond. The projections shown below are consistent with the projections included in our report to University of Baltimore dated July 19, 2023, which were provided in aggregate (rather than split by leave type) in the prior report. As in our prior analysis, we did not make an assumption about employers opting out of the program and using private plans for providing benefits, in part because we do not have data or any information on Maryland employers opting out of the FAMLI program, and because opt-out rates vary widely in other states. These dynamics are discussed in detail in Section 3 of this report.

Table 1A
Estimated Claims Approved for FAMLI Benefits
By Leave Type
Q1 2026 through 2028

	Q1 2026	Q2 2026	Q3 2026	Q4 2026	2027	2028
Family						
Bonding	24,753	8,533	8,638	8,744	36,405	38,222
Care	2,233	2,261	2,288	2,317	9,645	10,127
Military	21	22	22	22	92	97
Subtotal Family	*27,008*	*10,815*	*10,948*	*11,082*	*46,142*	*48,446*
Medical						
Maternity	5,309	5,374	5,440	5,506	22,927	24,071
Non-Maternity	20,679	20,933	21,190	21,450	89,308	93,766
Subtotal Medical	*25,988*	*26,307*	*26,629*	*26,956*	*112,234*	*117,837*
Total FAMLI	**52,995**	**37,122**	**37,577**	**38,039**	**158,377**	**166,283**

Table 1B Estimated Claims Approved for FAMLI Benefits By Leave Type 2029 through 2034						
	2029	**2030**	**2031**	**2032**	**2033**	**2034**
Family						
Bonding	39,745	40,926	41,317	41,711	42,109	42,510
Care	10,530	10,843	10,946	11,051	11,156	11,263
Military	101	104	105	106	107	108
Subtotal Family	*50,375*	*51,873*	*52,368*	*52,867*	*53,372*	*53,881*
Medical						
Maternity	25,030	25,774	26,020	26,268	26,519	26,772
Non-Maternity	97,500	100,399	101,357	102,324	103,300	104,285
Subtotal Medical	*122,530*	*126,173*	*127,376*	*128,592*	*129,818*	*131,057*
Total FAMLI	**172,905**	**178,046**	**179,744**	**181,459**	**183,190**	**184,937**

The estimated claims in 2026 are higher in Q1 than the other quarters because we included an estimate of backlog bonding claims for children born, fostered, or adopted in 2025. Under FAMLI legislation, workers can take bonding leave to care for a child during the first year after the child's birth or after the placement of the child through foster care, kinship care, or adoption.

The estimated claims in Tables 1A and 1B increase each period beyond Q1 2026. This is partly because we assumed the population of covered workers would grow at an annual rate of 0.95%, based on employment growth forecasts from the Maryland Department of Labor. In addition, we assumed claim incidence rates will increase gradually in the initial years as the program phases in, a trend we have observed in other states with new PFML programs.

Tables 2A and 2B contain estimated benefit payments for FAMLI benefits provided through the state trust fund from 2026 through 2034 by leave type. The benefit payments in Q1 of 2026 are higher than the other quarters because of the estimated backlog bonding claims for children born, fostered, or adopted in 2025.

Table 2A Estimated FAMLI Benefit Payments ($ Millions) By Leave Type Q1 2026 though 2028						
	Q1 2026	**Q2 2026**	**Q3 2026**	**Q4 2026**	**2027**	**2028**
Family						
Bonding	$250.5	$87.5	$88.6	$89.7	$386.5	$420.0
Care	$20.7	$20.9	$21.2	$21.4	$92.4	$100.4
Military	$0.2	$0.2	$0.2	$0.2	$0.9	$1.0
Subtotal Family	$271.3	$108.7	$110.0	$111.3	$479.8	$521.4
Medical						
Maternity	$47.7	$48.3	$48.8	$49.4	$213.1	$231.6
Non-Maternity	$204.7	$207.3	$209.8	$212.4	$915.2	$994.5
Subtotal Medical	*$252.4*	*$255.5*	*$258.7*	*$261.8*	*$1,128.3*	*$1,226.1*
Total FAMLI	**$523.8**	**$364.2**	**$368.6**	**$373.2**	**$1,608.1**	**$1,747.5**

Table 2B Estimated FAMLI Benefit Payments ($ Millions) By Leave Type 2029 through 2034						
	2029	**2030**	**2031**	**2032**	**2033**	**2034**
Family						
Bonding	$452.0	$481.8	$503.4	$526.0	$549.6	$574.2
Care	$108.0	$115.1	$120.3	$125.7	$131.4	$137.2
Military	$1.0	$1.1	$1.2	$1.2	$1.3	$1.3
Subtotal Family	$561.1	$598.0	$624.8	$652.9	$682.2	$712.8
Medical						
Maternity	$249.2	$265.6	$277.5	$290.0	$303.0	$316.6
Non-Maternity	$1,070.3	$1,140.7	$1,191.9	$1,245.4	$1,301.3	$1,359.7
Subtotal Medical	*$1,319.5*	*$1,406.3*	*$1,469.4*	*$1,535.4*	*$1,604.3*	*$1,676.3*
Total FAMLI	**$1,880.6**	**$2,004.3**	**$2,094.3**	**$2,188.3**	**$2,286.5**	**$2,389.1**

Tables 3A and 3B contain estimated expenses for administering FAMLI benefits provided through the state trust fund from 2026 through 2034 by leave type. Again, the expenses in Q1 of 2026 are higher than the other quarters because of the estimated backlog bonding claims for children born, fostered, or adopted in 2025.

Table 3A Estimated FAMLI Administrative Expenses ($ Millions) By Leave Type Q1 2026 though 2028						
	Q1 2026	**Q2 2026**	**Q3 2026**	**Q4 2026**	**2027**	**2028**
Family						
Bonding	$13.2	$4.6	$4.7	$4.7	$20.3	$22.1
Care	$1.1	$1.1	$1.1	$1.1	$4.9	$5.3
Military	$0.0	$0.0	$0.0	$0.0	$0.0	$0.1
Subtotal Family	*$14.3*	*$5.7*	*$5.8*	*$5.9*	*$25.3*	*$27.4*
Medical						
Maternity	$3.6	$3.6	$3.7	$3.7	$16.0	$17.4
Non-Maternity	$15.4	$15.6	$15.8	$16.0	$68.9	$74.9
Subtotal Medical	*$19.0*	*$19.2*	*$19.5*	*$19.7*	*$84.9*	*$92.3*
Total FAMLI	**$33.3**	**$25.0**	**$25.3**	**$25.6**	**$110.2**	**$119.7**

Table 3B Estimated FAMLI Administrative Expenses ($ Millions) By Leave Type 2029 through 2034						
	2029	**2030**	**2031**	**2032**	**2033**	**2034**
Family						
Bonding	$23.8	$25.4	$26.5	$27.7	$28.9	$30.2
Care	$5.7	$6.1	$6.3	$6.6	$6.9	$7.2
Military	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1
Subtotal Family	*$29.5*	*$31.5*	*$32.9*	*$34.4*	*$35.9*	*$37.5*
Medical						
Maternity	$18.8	$20.0	$20.9	$21.8	$22.8	$23.8
Non-Maternity	$80.6	$85.9	$89.7	$93.7	$97.9	$102.3
Subtotal Medical	*$99.3*	*$105.9*	*$110.6*	*$115.6*	*$120.8*	*$126.2*
Total FAMLI	**$128.9**	**$137.3**	**$143.5**	**$149.9**	**$156.7**	**$163.7**

We calculated the expected benefit payments and expenses shown above based on a formula that takes into consideration the expected claim duration, as well as other factors such as incidence rates and benefit amounts. The assumed claim durations vary by age, gender, and leave type (family and medical), and are provided in Table 4 below. The assumed durations for family leave are higher for younger employees because bonding durations tend to be longer than other family leave durations, and bonding leaves are usually taken by younger workers. The assumed durations for medical leave are lower for younger female employees because maternity durations tend to be shorter than other medical leave durations, and maternity leave is mostly taken by younger female workers.

Table 4 Assumed FAMLI Leave Durations (in Weeks) By Attained Age, Gender, and Leave Type				
Attained Age	**Family Leave**		**Medical Leave**	
	Female	**Male**	**Female**	**Male**
< 25	9.6	9.6	7.8	9.3
25-34	9.6	9.6	7.8	9.3
35-44	8.7	8.7	8.6	9.3
45-54	7.8	7.8	9.3	9.3
55-64	7.8	7.8	9.3	9.3
65 +	7.8	7.8	9.3	9.3

Section 3 – Private Plans

In most states, employers can provide PFML benefits through insured or self-insured plans in lieu of the state plan, as long as benefits are at least equivalent to the statutory plan and other requirements are met. For example, in some states (e.g., Massachusetts) the employee contribution for private plans cannot be greater than the contribution would be under the state plan.

There are several reasons why an employer may choose to opt-out of the state program and provide benefits through a private plan:

- Employers with existing disability and leave policies that comply with PFML laws may be eligible to opt out, and may not wish to make changes to these policies. According to Milliman's Group Disability Market Survey, approximately 500,000 private short-term disability insurance plans were inforce in the US in 2022, covering approximately 35 million workers.

- Private plans can provide employers with flexibility in designing PFML benefits that meet their employees' needs. For example, employers with high wage workers may consider wage replacement ratios to be too low under the state plan for these high wage workers, because these workers would qualify for the statutory maximum benefit amount. A maximum weekly benefit amount of $1,000 (which is the maximum weekly benefit amount for Maryland FAMLI benefits in 2026) only replaces 35% of weekly wages for workers with an annual income of $150,000, and the replacement ratio decreases with increasing wages. Employers with high wage workers may wish to enhance benefits using a private plan that provides higher replacement ratios and/or includes a higher maximum benefit amount than the state plan. Similarly, private plans can be used to increase the benefit period, eliminate the waiting period, etc., as long as benefits are at least equivalent to the state plan.

  Examples of employers with high wage workers are provided below:

  - Accounting firms
  - Architecture and engineering firms
  - Banks, investment firms, and financial institutions
  - Dentist offices
  - Hospitals and physician offices
  - Law firms
  - Universities
  - Veterinary clinics

- Large employers may have incentives to outsource the administration and compliance of their employee benefits program, which can be complicated to administer internally and often includes sick leave, medical leave, paternal leave, FMLA, ADAAA, etc., in addition to mandated PFML benefits in multiple states. Insurance companies and third-party administrators provide absence management services that appeal to large employers because all leave and disability benefits can be integrated and administered in a coordinated manner by a single administrator or insurer. The services often include other features that appeal to large employers, such as technology platforms and streamline methods for initiating leaves of absence. For these reasons, large employers may see advantages in providing PFML benefits through a private plan administered by the same

insurer that already administers other leave benefits. This is especially true for employers with workers in multiple states with different leave laws.

- Some employers may find an insured or self-insured plan to be less expensive than providing benefits through the state plan. For example, employers with a large percentage of male workers might obtain coverage through a private plan for a lower cost than the state plan, because maternity and bonding claims for this group would be lower than other groups with a higher proportion of female employees, and insurers would take this into consideration for developing premium rates. In other words, an insurer would use the group's demographics and historical experience to determine the premium rate, which would likely yield fewer maternity and bonding claims than would be assumed in the state rate, because the state rate is a single rate for all employers and reflects a relatively uniform distribution of employees by gender.

- Employers may have financial incentives to use private plans because they would be exempt from paying the initial contributions collected by the state before benefits begin.

The requirements for demonstrating equivalence and other features of private plans vary by state, which most likely impacts employer opt-out behavior. Employers must complete an application process in every state. Other requirements may include limits on employee contributions, and requirements for the employer to remit a surety bond and/or other process fees. An overview of the private plan structure and employer participation in states with PFML mandates is provided below. Private plans are not allowed in Rhode Island and the District of Columbia; therefore, these programs are excluded from the discussion below.

California State Disability Insurance and Paid Family Leave

Employers in California may provide benefits through voluntary plans in lieu of the state program. Employers who wish to use voluntary plans must obtain written consent from a majority of employees, and voluntary plans must offer benefits that are equivalent and have at least one benefit that is more generous than the state plan. Also, the employee cost cannot exceed the cost to participate in the state plan. Based on reports from California Employment Development Department, less than 5% of employers choose to use private plans for providing benefits, as shown below in Table 5. The fact that these employers represent approximately 14% of covered wages suggests that private plans appeal to employers with high wage workers, who may consider statutory wage replacement levels to be too low.

Table 5 California SDI Covered Employees and Wages[1,2] 2020 through 2022				
	State Plan	**Private Plans**	**Total**	**% Private**
Covered Employees				
2020	15,111,828	550,052	15,661,880	3.5%
2021	17,671,648	637,043	18,308,691	3.5%
2022	18,605,846	664,334	19,270,180	3.4%
Covered Wages ($ billion)				
2020	$1,005	$156	$1,161	13.4%
2021	$1,112	$195	$1,307	14.9%
2022	$1,174	$177	$1,351	13.1%

Connecticut Paid Leave

Employers in Connecticut may provide benefits through an insured or self-insured private plan, as long as benefits are at least equivalent to Connecticut Paid Leave benefits defined in statute. In addition, employee contributions cannot be greater than the contributions would be under the state plan, and employers must obtain consent from a majority of employees to use private plans. According to the 2023 Connecticut Paid Leave Annual Report, approximately 0.5% of participating employers were approved for private plans as of May 31, 2023[3].

Washington Paid Family and Medical Leave

Employers in Washington can provide PFML benefits through self-insured voluntary plans, which can be administered either internally or by a third-party administrator. Insured PFML options are not allowed under the state's PFML laws. According to reports from the Washington State Employment Security Department, approximately 3% of eligible employees are covered through voluntary plans, representing approximately 10% of wages, as shown below in Table 6. The vast majority of employers with voluntary plans employ 50 or more workers, suggesting that private options appeal more to larger employers.

Table 6[4] Washington PFML Voluntary Plans 7/1/2021 through 6/30/2022				
Employer Size	Employees Covered by Private Plans	Share of Statewide Employment	Gross Wages of Employees Covered by Private Plans ($ Billions)	Share of Statewide Gross Wages
< 50 Employees	1,487	0.1%	$0.18	0.3%
50+ Employees	126,284	5%	$26.65	13%
Total	127,771	3%	$26.83	10%

[1] May 2022 Disability Insurance (DI) Fund Forecast, State of California Employment Development Department, Table 2

[2] May 2023 Disability Insurance (DI) Fund Forecast, State of California Employment Development Department, Table 2

[3] Supporting Connecticut Workers, Families, and Businesses. Connecticut Paid Leave Annual Report, 2023.

[4] Washington Paid Family & Medical Leave Annual Report, Washington State Employment Security Department, 2022.

New York Disability Benefits Law and Paid Family Leave

Paid leave benefits in New York are provided through coverage issued by either the New York State Insurance Fund (NYSIF) – a self-supporting insurer established by the state for providing Disability Benefits Law (DBL) and Paid Family Leave (PFL) benefits – or by insurance companies that participate in the program. NYSIF competes with other insurance companies for providing PFL and DBL benefits in New York. According to annual surveys performed by Milliman of DBL and PFL markets, most of the leading disability insurers in the US participate in the New York program, and less than 10% of eligible workers are covered through NYSIF.

Insurers (including NYSIF) can vary their DBL premium rates for different employers based on underwriting discretion, subject to minimum loss ratio requirements established by New York Department of Financial Services (DFS). On the other hand, the PFL contribution rate is a single community rate for all plans, determined annually by DFS which uses experience rating methods and risk adjustments to set the rates and pool the experience among participating insurers.

Massachusetts

Employers in Massachusetts can provide PFML benefits through an insured or self-insured private plan as long as benefits are equal to or more generous than the state plan, and employee contributions are no greater than they would be under the state plan. Consent from a majority of employees is not a requirement in Massachusetts. Insurers who participate in the Massachusetts PFML program can vary their premium rates for different employers based on underwriting discretion.

The insurance industry plays a significant role in providing PFML benefits in Massachusetts, and most of the leading disability insurers participate in the program. According to a report from The Center for Law and Social Policy, approximately one-third of eligible workers in Massachusetts were covered under private plans when benefits began in 2021[5]. Employers who elected private plans in Massachusetts were exempt from paying the initial premium collected by the state before benefits began, which could have impacted an employer's decision to use private options.

New Jersey

Employers in New Jersey can provide Family Leave Insurance (FLI) and/or Temporary Disability Insurance (TDI) benefits through an insured or self-insured private plan as long as benefits are at least equivalent to the state plan, and employee contributions are no greater than they would be under the state plan. Consent from employees is not required except for private plans covering members of a collective bargaining agreement. Insurers who participate in New Jersey FLI and/or TDI can vary their premium rates for different employers based on underwriting discretion.

According to statistics reported by New Jersey Department of Labor and Workforce Development, less than 1% of eligible workers are covered through private plans for FLI benefits, and roughly 34% of eligible workers are covered through private plans for TDI benefits, as shown below:

[5] Paid Family and Medical Leave and Employer Private Plans, The Center for Law and Social Policy, July 2021

Table 7 New Jersey Covered Employees by Coverage Type 2021		
Coverage Type	**Family Leave Insurance**	**Temporary Disability Insurance**
Private Plans	14,595	843,747
State Plan	3,727,600	2,471,696
% Private Plans	0.4%	25.4%

There is a large discrepancy between FLI and TDI participation rates, which may suggest that there were more TDI private plan options for employers to choose from in 2021 than there were FLI plan options. It is possible that the participation rates for private FLI plans has increased since 2021, since many insurers have devoted significant resources to expanding their paid family leave insurance products over the past couple of years. The 2021 statistics from New Jersey represent the most recent publicly available data as of the writing of this report.

Claim Experience

There is no public data or any information on PFML claim experience for private plans, as this information is proprietary to the insurers and third-party administrators. It is therefore very challenging to compare the experience of private plans to the state plan.

To the extent that large employers are more likely to use private plans than smaller employers, it is possible that claim incidence (i.e., utilization) rates for private plans would be higher than the state plan because incidence rates tend to increase with employer size. Table 8 below shows New York PFL claim incidence rates from 2018 through 2022 based on employer size. The incidence rates increase with employer size and are significantly higher in the largest size segment than the other segments. These statistics suggest that the state plan could have lower incidence rates than private plans if large employers were to provide benefits predominantly through private plans.

Table 8[6] New York PFL Incidence Rates 2018 – 2022					
Employer Size (Covered Workers)	**2018**	**2019**	**2020**	**2021**	**2022**
< 50	1.06%	0.87%	0.86%	1.10%	1.18%
50 - 499	1.38%	1.62%	1.69%	1.93%	2.01%
500 +	2.04%	2.33%	2.29%	2.45%	2.59%

On the other hand, to the extent that employers with high wage workers are more likely to use private plans than other employers, it is possible that incidence rates for private plans would be lower than the state plan due to occupational risk factors (e.g., high wage workers typically perform less physical labor than lower wage workers which mitigates disability risk) and other

[6] https://www.dfs.ny.gov/reports_and_publications/pfl

economic and social factors (e.g., diet and lifestyle differences between high wage and lower wage workers).

There could be adverse selection into the state plan if insurers can underwrite and set premium rates based on risk characteristics such as industry, whereas the state rate is a single rate that applies equally to all employers. In other words, employers with higher incidence rates may find the lowest cost option to be the state plan, whereas employers with lower incidence rates may find lower cost options in private plans. These dynamics can exacerbate adverse selection risk and lead to higher incidence rates for the state plan.

In performing an actuarial analysis of the FAMLI program, we began with PFML claim experience from states with mandated benefits, and we adjusted the experience to reflect differences in benefit design, industry, birth rates, etc. between Maryland and the other states. This process was used to develop the morbidity assumptions we used to project FAMLI benefits. We did not make an adjustment to the morbidity assumptions for employers who elect to opt-out of the state plan because it is not obvious whether incidence rates and claim durations would be higher or lower for the state plan, and because these dynamics are already reflected in the underlying experience from states with existing PFML programs which was used for developing the morbidity assumptions.

Section 4 – Self-Employed Opt-In

Most states, except for Rhode Island and New Jersey, allow self-employed workers to opt-in to the PFML program. The requirements for opting in typically include filing an application, submitting documentation of wages, and committing to participate in the program for a minimum period specified by the state (e.g., three years is a common threshold). The programs in District of Columbia and New York also include 12-month and 24-month waiting periods, respectively, for self-employed workers who did not opt-in when they first began self-employment. This means that self-employed workers in New York, for example, who did not elect to participate initially and subsequently opted-in to the program would only qualify for benefits 24 months after the enrollment date.

Contribution rates for self-employed workers vary by state. In some states (e.g., Massachusetts), the contribution rate for self-employed workers (0.63%) is equal to the sum of the employer rate (0.31%) and employee rate (0.32%). In other states, the rate is either equal to the employee rate (e.g., 0.58% in Washington) or equal to the employer rate (e.g., 0.26% in District of Columbia). In California, the rate for self-employed workers is 6.9% of taxable wages, which is significantly higher than the 0.9% overall contribution rate.

These different requirements and contribution rates may impact the levels of participation among self-employed workers in different states. There may be other factors that impact a self-employed worker's decision to participate. Actual participation rates tend to be low. For example, according to the 2022 Washington PFML Annual Report, there were 2,907 self-employed participants as of June 30, 2022, representing approximately 0.1% of covered workers.

The following table shows the number of self-employed workers that have opted-in to PFML programs in different jurisdictions, reported by Center for American Progress. The percentages in the last column represent the take-up rates among self-employed workers in each of the jurisdictions.

Table 9[7]
Number of Self-Employed Opt-ins versus Number of Non-Employer Small Businesses

PFML Jurisdiction	Number of Self-Employed Opt-ins	Number of Non-employer Small Businesses	Approximate Take-up[8] Rates
California	1,945	3,458,667	0.06%
New York	70,000	1,806,664	3.87%
Massachusetts	42,631	576,528	7.39%
Washington	2,907	500,954	0.58%
Washington, D.C.	73	61,721	0.12%
Connecticut	3,364	292,009	1.15%
Total	**120,920**	**6,696,543**	**1.81%**

The lowest take-up rate in Table 9 is 0.06% corresponding to California, which is not surprising because the contribution rate for self-employed workers in California is much higher than the rate

[7] Self-Employed Workers' Access to State Paid Leave Programs in 2023, Center for American Progress, August 10, 2023.
[8] The take-up rates in this table represent the reported number of self-employed opt-ins divided by the reported number of non-employer small businesses.

for other covered workers. The highest take-up rate is 7.39% corresponding to Massachusetts, and the overall take-up rate across all jurisdictions is 1.81%.

Section 5 – Data, Assumptions, and Analytical Methods

The estimated claims, benefit payments, and expenses in Section 2 were derived from the financial projections that we developed in our prior analysis, when we estimated contribution rates and analyzed funding levels for the FAMLI program. Detailed documentation of the data, assumptions, and methods we used for developing the financial projections was included in the July 19, 2023 report.

To split the estimated claims, benefit payments, and administrative expenses by leave type, we researched PFML experience in states with paid leave mandates, from which we derived the distributions shown below in Tables 10A and 10B. The percentages are different between claims and benefits due to differences in average claim durations. For example, we assume 78.9% of family claims are due to bonding, representing 80.6% of family benefit payments because bonding claims tend to have longer durations than other family claims.

Table 10A
Assumed Distribution of Family Claims by Leave Type

Leave Type	% Claims	% Benefits
Bonding	78.9%	80.6%
Family Care	20.9%	19.3%
Military Exigency	0.2%	0.2%
Total	**100.0%**	**100%**

Table 10B
Assumed Distribution of Medical Claims by Leave Type

Leave Type	% Claims	% Benefits
Maternity	20.4%	18.9%
Non-Maternity	79.6%	81.1%
Total	**100.0%**	**100%**

We applied these percentages to the projections developed in our prior analysis – which were developed in aggregate for family and medical claims – to estimate FAMLI claims and benefit payments by leave type. We assumed the same distribution of claim and benefit payments by leave type throughout the projection period.

The projection of administrative expenses assumes expenses equal to 5.3% of benefit payments for family claims and 7.5% of benefit payments for medical claims. These assumptions were developed from PFML experience in other states with existing mandates and are uniform throughout the projection period. Start-up expenses were not included in the projections in Tables 3A and 3B because we assumed these expenses would be incurred before 2026, consistent with our prior analysis.

Appendix A – Reliance Items

In performing the analysis, we relied, without audit, on data and information from University of Baltimore, as well as data from publicly available sources. To the extent any of the data or other items were incomplete or inaccurate, the results of our work may be affected and may need to be revised. The principal items on which we relied included the following:

- Maryland Senate Bill 275, Chapter 48, Labor and Employment – Family and Medical Leave Insurance Program – Establishment, 2022
- Maryland Senate Bill 828, Family and Medical Leave Insurance Program – Modifications, 2023
- Study of Maryland Family and Medical Leave Insurance Program, Spring Consulting Group, February 2023
- Maryland Monthly Labor Review, September 2022, copyrighted by the Maryland Department of Labor
- US Census Bureau QWI Explorer, filtered for 2022 Maryland employment statistics
- The Economic Outlook for 2023 to 2033 in 16 Charts, US Congressional Budget Office, February 2023
- 2021 American Community Survey, US Census Bureau
- Publicly available reports from the Washington PFML Advisory Committee Meetings published on a monthly basis (e.g., Advisory Committee Meeting, May 19, 2022, Washington Employment Security Department)
- Publicly available monthly data from California State Disability Insurance and Paid Family Leave programs (e.g., https://data.edd.ca.gov/Disability-Insurance/Disability-Insurance-DI-Monthly-Data/29jg-ip7e/data).
- Publicly available annual data for the New Jersey Temporary Disability Benefits and Family Leave Insurance programs (e.g., Annual Report for 2019 Family Leave Insurance and Temporary Disability Insurance Programs, New Jersey Department of Labor and Workforce Development).
- Publicly available annual data for the Rhode Island Temporary Disability Insurance and Temporary Care Insurance programs (e.g., Statistical & Fiscal Digest 2021, Rhode Island Department of Labor and Training)
- Publicly available quarterly data for the New York Paid Family Leave program (e.g., New York State Paid Family Leave Report 2018 – 2022, New York Department of Financial Services).
- Publicly available annual data from the Massachusetts PFML program (e.g., FY2021 Annual Report for the Massachusetts Paid Family and Medical Leave, Department of Paid Family and Medical Leave).
- Publicly available annual data from the Connecticut PFML program (e.g., Supporting Connecticut Workers, Families, and Businesses. Connecticut Paid Leave Annual Report, 2023)
- Publicly available rating manuals used by insurance companies for pricing short-term disability benefits (obtained through SERFF queries).
- Birth rates by state reported by the US Center for Disease Control (e.g., https://www.cdc.gov/nchs/pressroom/sosmap/fertility_rate/fertility_rates.htm)
- Paid Family and Medical Leave and Employer Private Plans, The Center for Law and Social Policy, July 2021
- Self-Employed Workers' Access to State Paid Leave Programs in 2023, Center for American Progress, August 10, 2023.

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