social sciences

MDPI

Article

Paid-Leave Availability and Public Health and Nutrition Program Participation Following a Birth in the U.S.

Marci Ybarra [1,*], Alexandra B. Stanczyk [2] and Dylan J. F. Bellisle [3]

[1] Sandra Rosenbaum School of Social Work, University of Wisconsin-Madison, Madison, WI 53706, USA
[2] Mathematica Inc., Washington, DC 20002, USA
[3] School of Social Work, Dominican University, River Forest, IL 60305, USA
* Correspondence: ybarra@wisc.edu

Abstract: This study examines the relationships between state-provided paid-leave availability and enrollment in public health and nutrition programs (SNAP, Medicaid, WIC) among single low-income women following a birth in the U.S. We hypothesize that women in paid leave states will be less likely to participate in publicly available health and nutrition programs. Data are from the Survey of Income and Program Participation (SIPP), a nationally representative panel survey data set (N = 1168). Descriptive tests of significance and probit regression models are used to examine the relationship between paid-leave availability and participation in SNAP, Medicaid, and WIC following a birth. A descriptive analysis suggests significantly lower enrollment in SNAP but not Medicaid or WIC for single low-income women in paid-leave states compared to those in non-paid-leave states. The finding of significantly lower post-birth SNAP participation in paid-leave states holds in probit models that include potentially relevant mother, household, and state controls.

Keywords: paid leave; SNAP; WIC; Medicaid; mothers and infants

check for updates

Citation: Ybarra, Marci, Alexandra B. Stanczyk, and Dylan J. F. Bellisle. 2024. Paid-Leave Availability and Public Health and Nutrition Program Participation Following a Birth in the U.S. *Social Sciences* 13: 126. https://doi.org/10.3390/socsci13030126

Academic Editor: Neil Gilbert

Received: 21 December 2023
Revised: 29 January 2024
Accepted: 4 February 2024
Published: 22 February 2024

Copyright: © 2024 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

1. Introduction

Scholarship demonstrates that the implementation of paid family leave (PFL) programs in the U.S. is associated with reductions in cash welfare enrollment among low-income women in the period surrounding a birth (Houser and Vartanian 2012; Ybarra et al. 2019). While cash welfare participation tends to be relatively short in duration, other public assistance programs, health and nutrition programs in particular, are typically longer in duration for low-income families and are associated with improved maternal and child health in the perinatal period (Bitler and Currie 2005; Hoynes et al. 2011; Cook et al. 2004; Hoynes et al. 2016). Thus, examining whether PFL implementation is associated with reductions in public health and nutrition program participation following a birth is critical to understanding economic hardship and maternal and child health more broadly.

To contribute to this gap in knowledge, this study explored the relationship between state-sponsored PFL availability and enrollment in the Supplemental Nutritional Assistance Program (SNAP), Medicaid, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program among low-income women in the U.S. following a birth. We used a nationally representative U.S. sample of low-income women who had recently given birth from the Survey of Income and Program Participation (SIPP) to examine the relationship between public health and nutrition program enrollment and state-sponsored PFL availability immediately and one-year postbirth.

2. Background and Prior Literature

Paid Leave in the U.S.

The U.S. is the only industrialized nation that does not offer a national maternity leave program for mothers to take paid time off work following a birth. Some U.S. states do offer

paid-leave (PL) programs in the form of PFL and temporary disability insurance (TDI). These PL programs offer wage replacement during time off from work for pregnancy and postbirth recovery (TDI) and bonding with an infant (PFL). Currently, California, New Jersey, New York, and Rhode Island have PFL and TDI programs in effect; Massachusetts, the state of Washington, the District of Columbia, and Connecticut have PFL programs but not TDI, and Hawaii has a TDI program but not PFL. PL programs vary across states on a host of policy levers, including eligibility and benefit levels. The policy characteristics of states with PL during our study's timeframe are outlined in Table 1.

Table 1. Characteristics of state paid-leave programs available during the study timeframe.

	California	Hawaii	New Jersey	New York	Rhode Island
Temporary Disability Insurance					
Earnings eligibility (base period[1])	$300	$400	$8400[2]	n/a[3]	$11,520[4]
Average time off (weeks) for pregnancy-related disability	4[5]	n/a	10 weeks[6]	7 weeks[7]	n/a[8]
Wage replacement rate	55%	58%	66%	50%	55%
Minimum weekly benefit	$50	$14[9]	None	None	$69
Maximum weekly benefit	$1011	$524	$572	$170[10]	$719
Job protection	No	No	No	No	Yes
Paid Family Leave					
Earnings eligibility (one year base period)	$300	x	$8400 (see note 2 above)	x[11]	$11,520[12]
Time off (weeks)	6	x	6	x	4
Wage replacement rate	55%[13]	x	66%	x	55%
Minimum weekly benefit	$50	x	None	x	$72
Maximum weekly benefit	$1173	x	$595	x	$752
Job protection	No	x	No	x	Yes

Research to date on PL programs has focused on the relationship between these programs and leave-taking and work primarily among women. In general, this line of research demonstrates that U.S. PFL programs are associated with longer leaves from work and greater job stability, and there is some evidence of modest earnings increases over time among mothers (Baum and Ruhm 2016; Rossin-Slater et al. 2013). Although research on TDI and mothers' economic outcomes is more dated, results also suggest an association between TDI and increased postbirth leave-taking, and pre- to postbirth job continuity among women (Bond et al. 1991; Wever 1996).

Despite evidence of the positive effects of PL on mothers' leave length and postbirth employment, there remains concern that PL programs, on their own, may not curtail economic deprivation among single low-income women in the period surrounding a birth. For instance, a recent study found little evidence that PFL in California significantly reduced poverty or bolstered income among single mothers shortly after a birth, although improvements in these outcomes do seem to develop over time (Stanczyk 2019). Also studying the California PFL policy but not restricting the analysis to mothers, Das and Polachek (2015) found that the program increased employment—but also the likelihood and duration of unemployment spells—among young women in the state. Finally, studies in California and New Jersey have found that lower-income, single, Black, and Latina individuals are significantly less likely to know about PFL programs (Milkman and Appelbaum 2013; Houser

and White 2012), and evidence from California administrative data suggests low-income mothers of infants enroll in the state's PFL program at lower rates than higher-income mothers (Pihl and Basso 2015). Taken together, these studies suggest that low-income women, especially single mothers, may be at a particular economic disadvantage following a birth, even when PL programs are available.

3. Paid Leave and Public Benefit, Health, and Nutrition Programs

While research on PL use suggests economically disadvantaged women are less likely to enroll in PL programs, there is limited evidence on explanations for the use or nonuse of PL—or public assistance programs more generally—following a birth, despite their potential importance to these families. However, an evaluation of PFL in California suggests incomplete and incorrect information on the program among low-income women helps explain differential enrollment rates; low-income women reported confusion about the rules and requirements of PFL in California and, in some instances, reported employers giving incorrect information on PFL participation (Winston et al. 2017). Related research points to additional mechanisms that might influence low rates of public assistance use more generally, including in the period following a birth. The stigma associated with cash welfare and Medicaid is associated with reduced safety net participation (Stuber and Kronebusch 2004), although stigma is more strongly associated with reductions in cash welfare participation (Stuber and Schlesinger 2006). The administrative burdens involved in applying for and receiving public benefits such as meetings with caseworkers and bureaucratic demands have also been found to divert program participation (Anderson et al. 2004; Moffitt 2003; Herd and Moynihan 2019), including in public health and nutrition programs (Barnes and Riel 2022). Given the stigma and hassle involved in accessing public benefit programs, it may be that some women forgo public benefits following a birth when PL programs are during short maternity leaves from work. Taken together, research suggests multiple factors likely contribute to lower rates of participation in PL and public benefit programs among low-income women with infants, which is particularly concerning given that research suggests economic deprivation around a birth is not uncommon for this group (Stanczyk 2019).

Examining the relationship between PL programs and women's work and earnings is important but does not capture other important resources low-income women might use to support not only time off from work but also maternal and child well-being. To this end, research has investigated the relationship between PL availability and enrollment in some U.S. safety net programs following a birth. In general, the evidence suggests an association between reductions in cash welfare use and the availability of PL programs (Houser and Vartanian 2012). Related research considers the effects of safety net programs and PL on families' economic well-being. One study investigated whether cash welfare participants who had recently given birth in Wisconsin would receive more resources from PFL or cash welfare and found that, on average, most would be better off receiving cash welfare (Ybarra 2013). More recently, scholars examined the relationship between PL, cash welfare, and the material well-being of low-income single mothers following a birth and found mixed relationships between cash welfare generosity and PL availability and reductions in material hardship (Ybarra et al. 2019).

4. Significance: The Importance of Public Health and Nutrition Programs around a Birth

Economic deprivation is an important metric to consider in the period surrounding a birth, hence the focus on PL and cash welfare in past research. There are, however, also critical public health and nutrition programs that are particularly salient to expectant and new mothers and their infants. For instance, Medicaid provides subsidized health insurance coverage to low-income expectant and new mothers and covers all care related to pregnancy, delivery, and related complications that occur during pregnancy and up to 60 days postpartum. The WIC program supports and encourages breastfeeding among expectant and new mothers and provides nutritional support for eligible participants

and children under six. SNAP, formerly known as food stamps, although not specifically targeted to low-income expectant or new mothers, is intended to reduce food insecurity by supporting the purchase of food. In addition to the important resources these programs provide, families are also more likely to rely on them for longer periods compared to cash welfare. The cash welfare's federal time limit is five years, and many states impose shorter time limits (Rowe et al. 2010). Unlike cash welfare, Medicaid and SNAP have no time limits and are two of the largest safety net programs in the U.S., while the WIC program allows eligible families with a child five years or younger to participate without additional time restrictions, suggesting these programs are likely important to maternal and child well-being in the near and long term.

Substantial research demonstrates that low-income women commonly rely on the safety net in the period surrounding a birth (Bitler and Currie 2005; Edin and Kefalas 2005; Markus et al. 2013), and participation in these programs is associated with enhanced family resources and maternal and infant health outcomes. For instance, WIC participation is associated with increased breast-feeding, routine infant follow-up care (Chatterji and Brooks-Gunn 2004), child immunization (Luman et al. 2003), and infant birth weight (Bitler and Currie 2005). Further, Hoynes and colleagues (Hoynes et al. 2011) found that WIC participation improved infant birth weight among low-income families in general, mothers with very low levels of education, and those who resided in highly concentrated areas of poverty. WIC participation is also associated with improved infant mortality rates among Black families (Khanani et al. 2010).

Similarly, the Medicaid program is also associated with positive maternal and child health outcomes. For instance, Medicaid expansions in the late 1980s led to improved prenatal care among pregnant women who participated in the program (Howell 2001). More recently, scholars have found a significant increase in smoking cessation prior to pregnancy for women enrolled in Medicaid compared to those who were not (Adams et al. 2013). A number of states have also expanded Medicaid provisions to low-income expectant and new mothers in the form of the Medicaid Infant Health Program (MIHP), which provides home visitation to address infant and maternal well-being. Evaluations of MIHP have found significant improvements in infant mortality among program participants (Meghea et al. 2015) and improved birth weights among infants with HIV-positive mothers (Turner et al. 2000).

Similar positive effects have been observed with SNAP participation during the perinatal period. Almond and colleagues (Almond et al. 2011) found expectant women who received SNAP benefits three months prior to birth had infants with higher birth weights and lower mortality rates compared to infants with mothers who did not receive SNAP. Another study found that SNAP benefits attenuated food insecurity and poor health among infants and toddlers (Cook et al. 2004). Among mothers, a loss of SNAP benefits, as well as cash welfare, was linked to an increased likelihood of maternal depression in the period surrounding a birth (Casey et al. 2004). There is also evidence that the effects of SNAP during early life extend into adulthood; Hoynes and colleagues (Hoynes et al. 2016) found that SNAP participation during pregnancy and early childhood was associated with reductions in obesity, high blood pressure, and diabetes and a greater likelihood of reporting good health in adulthood.

Scholars are increasingly concerned about the relationship between resource deprivation and children's development (Heckman 2006) as poverty during pregnancy and infancy has been linked to poorer infant brain development and associated outcomes in adulthood (Hackman and Farah 2009; Walker et al. 2011; Johnson et al. 2016). Given evidence of the association between PL availability and lower rates of cash welfare use following a birth (Houser and Vartanian 2012; Ybarra et al. 2019), it is critical that scholars and policymakers understand if a similar relationship exists between PL availability and public health and nutrition program participation in the perinatal period.

5. The Present Study

The goal of this study was threefold: (1) document differences in enrollment in public health and nutrition programs among single low-income mothers in PL states and those in non-PL states; (2) examine the relationship between PL availability and enrollment in public health and nutrition programs shortly following a birth (within 3 months); and (3) examine the relationship between PL availability and enrollment in public health and nutrition programs within one-year postbirth. We considered outcomes at 3- and 12-months postbirth to distinguish between short delays in program participation versus longer-term diversions. We distinguished between short and longer-term diversions because short but not longer-term diversions suggest that families might delay, rather than forgo, participation. Following existing evidence of lower rates of cash welfare participation in PL states, we hypothesized that single low-income women residing in PL states would be significantly less likely to enroll in public health and nutrition programs than those in non-PL states following a birth during both study timeframes.

6. Materials and Methods

6.1. Data

The individual-level data for this study were from the 1996 to 2008 panels of the Survey of Income and Program Participation (SIPP), which is administered by the U.S. Census Bureau. Each panel of the SIPP provides a nationally representative sample of the U.S. civilian noninstitutionalized population. Sample households are followed over a period of between 2.5 to 4 years, depending on the panel, and data are collected through interviews conducted in waves, which occur every four months. Monthly information on household structure, income, work, and public program participation, including SNAP, Medicaid, and WIC are collected in each wave. In addition to the individual-level data from the SIPP, we also included state-level average annual unemployment rates from the U.S. Bureau of Labor Statistics (BLS n.d.a, n.d.b).

We did not include later SIPP panels for several reasons. First, SIPP changed its design in 2014 (the next available SIPP panel). These changes impacted our ability to use later panels due to the elimination of relevant topical modules and surveying individuals once per year rather than three times per year (NASEM 2018). An NAS report found that the SIPP redesign led to some improvements including better measures of assets and dividends (2018); however, these income sources are of little relevance to low-income households (Donovan et al. 2016). SIPP's 2014 panel was also found to underperform compared to earlier panels in areas that "include participation early in the calendar year, overall underreporting of income from programs such as Supplemental Security Income, family assistance (Temporary Assistance for Needy Families and General Assistance), unemployment insurance, and Supplemental Nutrition Assistance Program, and underreporting of transitions in program participation", (NASEM 2018, p. 3). Given this study's focus on participation in means-tested provisions following a birth, using later SIPP panels would have precluded us from robustly analyzing our specific areas of interest and within-year differences in program participation. Moreover, during the study's period and its aftermath, there were few changes to safety net programs (Chang et al. 2021).

6.2. Sample

The study sample included births that occurred during the SIPP panels. Following related research using the SIPP (Ybarra et al. 2019), we included births if the infant's biological mother was present in the household during the birth month and was between 18 and 45 years old at the time of birth. Observations with inconsistent information on the infant's birth month or mother's identification were dropped, and we further limited the sample to mother-births with adequate prebirth and postbirth observations on all study variables. As the focus of the present study was on the experiences of low-income, single mothers, the study sample included only mothers who reported prebirth family income at or below 200 percent of the federal poverty line and who reported being single (never

married, widowed, divorced, and separated) in the birth month. Finally, similar to past research, we excluded mother-births in low-population states from our analyses (Shaefer and Ybarra 2012). Mother-births were assigned state-level variables (yearly unemployment rate) based on the birth year and birth state.

In analyses examining the relationships between SNAP, WIC, and Medicaid use immediately following a birth, the analytic sample included all mother-births corresponding to the abovementioned restrictions (n = 1168). In analyses examining the relationships between SNAP, WIC, and Medicaid participation in the year following a birth, the analytical sample was restricted to mother-birth observations with at least eleven months of postbirth month data (n = 771). Analysis comparing differences in mother and household characteristics between these two analytical samples found no statistically significant differences.

Table 2 illustrates the characteristics of the sample overall as well as between women in PL and non-PL states. Chi-square and F tests of significance were conducted to estimate between-group differences. On average, our sample was about 25 years old, had worked prior to giving birth (57 percent), and had never been married (75.6 percent). Racial and ethnic categories were more dispersed; 41.7 percent were White, 30.5 percent were Black, 22.8 percent were Latina, and the remaining 5.1 percent were of "other" racial/ethnic origins. Most of the sample had a high school diploma (39.3 percent) or less (29.3 percent). On average, respondents averaged about $1,250 in monthly prebirth family income. There were some descriptive differences in characteristics between women who resided in PL states compared to those who resided in non-PL states. For instance, 45.6 percent of women in PL states were employed before giving birth compared to 59.7 percent in non-PL states. There were also differences in racial/ethnic makeup; 27.1 percent of women in PL states were White compared to 45.1 percent in non-PL states; 22.1 percent of women in PL states were Black compared to 32.4 percent in non-PL states; and 45.4 percent of women in PL states were Latina compared to 17.2 percent in non-PL states. There were also differences in education; 40 percent of women in PL states had less than a high school diploma compared to 26.8 percent in non-PL states, and 27.2 percent of women had a high school diploma in PL states compared to 42.1 percent in non-PL states. These descriptive differences suggest PL states have a higher share of women who are disadvantaged.

Table 2. Sample characteristics.

	All States	Paid-Leave States	Non-Paid-Leave States
	Mean (SD) or Proportion	Mean (SD) or Proportion	Mean (SD) or Proportion
	N = 1168	N = 193	N = 975
Individual and household characteristics			
Age, birth month	25.32 (0.19)	25.65 (0.48)	25.25 (0.20)
Employed prebirth	0.570	0.456 **	0.597
Marital status in the birth month:			
Widowed, divorced, separated	0.244	0.208	0.252
Never married	0.756	0.792	0.748
Race and ethnicity:			
White, non-Hispanic	0.417	0.271 **	0.451
Black, non-Hispanic	0.305	0.221 *	0.324
Hispanic	0.228	0.454 **	0.172
Other	0.051	0.044	0.053
Education at birth month:			
Less than high school	0.293	0.4 **	0.268
High school	0.393	0.272 **	0.421
Some college	0.026	0.311	0.279
BA or above	0.026	0.017	0.028

Table 2. *Cont.*

	All States	Paid-Leave States	Non-Paid-Leave States
	Mean (SD) or Proportion	Mean (SD) or Proportion	Mean (SD) or Proportion
Prebirth monthly family income ($100)	12.51 (0.38)	12.90 (1.18)	12.42 (0.37)
Number of other adults in household at birth month	0.88 (0.04)	1.14 (0.14) *	0.82 (0.03)
Number of other children in the family at birth month	1.40 (0.04)	1.33 (0.10)	1.42 (0.05)
State-provided paid-leave policies			
PFL policy in effect	0.044	0.232	0
TDI policy in effect	0.190	1	0
State unemployment rate	6.27 (0.08)	6.63 (0.20) *	6.19 (0.09)

Sources. Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels; Urban Institute Welfare Rules Database; Bureau of Labor Statistics. Notes: Policy variables reflect state policy in July of each year. All dollar values are in year 2011 dollars. Descriptive statistics are weighted using SIPP person weights. Numbers of observations are unweighted. ** $p < 0.01$, * $p < 0.05$ indicates statistically significant differences between PL and non-PL states.

7. Measures

7.1. Dependent Variables: Postbirth SNAP, WIC and Medicaid Participation

To measure SNAP, Medicaid, and WIC participation immediately following a birth, we created indicator variables equal to one for each program if the household (SNAP and WIC) or the mother (Medicaid) participated in the program in the birth month or any of the three months following a birth. To measure participation in the year following a birth, we created similar indicator variables equal to one if the household had participated in the 12 months after the birth month.

7.2. Policy-Independent Variables: Availability of PL

The indicator variable for PL availability equaled one if the mother gave birth in a state that provides PL, including TDI only or TDI and PFL. This included births in California, Hawaii, New Jersey, New York, and Rhode Island. Because TDI programs in these states are available throughout the study period, only the state of birth determined PL availability in our study.

7.3. Control Covariates: Individual and Household Characteristics and State Economic Context

There are a number of individual and household characteristics that may be related to study outcomes. Therefore, we included covariates in the multivariate analyses to capture the mother's age, race, the number of other adults and children living in the household, and whether the birth was a mother's first birth. We included a control for first births because women without other children might have less knowledge of public benefits, which might reduce program use. These variables were measured at the birth month and were constructed as illustrated in Table 3. Controls for the mother's prebirth work status and family income were measured during the earlier part of the pregnancy to reduce the likely influence pregnancy had on these variables (Desai and Waite 1991). To measure the mother's prebirth work status, we created an indicator variable equal to one if the mother was employed for at least one week between eight to five months before the birth. We calculated the average monthly family income over the same four months to measure prebirth family income. The annual state-level unemployment rate at the birth month was used as a proxy for the local labor market and economic environment, which could influence postbirth SNAP, WIC, and Medicaid use.

Table 3. Postbirth participation in public health and nutrition programs among low-income single mothers at 3 months, by availability of paid leave.

	All States	PL Available	PL Not Available
	N = 1168	N = 193	N = 975
SNAP	0.629	0.522 **	0.654
Medicaid	0.790	0.788	0.790
WIC	0.855	0.815	0.865
Prevalence of Postbirth Public Benefit Participation among Low-Income Single Mothers at 12 months, by Availability of Paid Leave			
	All States	PL Available	PL Not Available
	N = 771	N = 136	N = 635
SNAP	0.661	0.55 **	0.69
Medicaid	0.815	0.788	0.822
WIC	0.886	0.88	0.888

Sources. Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels; Urban Institute Welfare Rules Database; Bureau of Labor Statistics. Notes: Descriptive statistics are weighted using SIPP person weights. Numbers of observations are unweighted. ** $p < 0.01$, * $p < 0.05$ indicate statistically significant differences between PL and non-PL states using chi-square tests of significance.

8. Analytic Strategy

We use weighted descriptive statistics to obtain the prevalence of postbirth SNAP, WIC, and Medicaid use among low-income single mothers and by residence in a PL state. We then used a series of multivariate probit models to examine the relationship between the availability of PL and postbirth public benefit use, controlling for the covariates previously mentioned. To control for nationwide trends over time in the study's dependent variables, we included year-fixed effects in all of our models. All of our models were estimated with robust standard errors clustered at the state level and were weighted using the SIPP individual weights.

9. Results

Descriptive Results

Table 3 reports the prevalence of SNAP, Medicaid, and WIC participation at 3 and 12 months following a birth for the overall sample and between women residing in PL and non-PL states. Immediately following a birth, 62.9 percent of the sample reported receiving SNAP, 79 percent reported participation in Medicaid, and 86 percent reported receiving WIC. Participation in these public health and nutrition programs slightly increased twelve months following the birth to 66.1 percent receiving SNAP, 81.5 percent participating in Medicaid, and 88.6 percent receiving WIC (Table 2). We used chi-square tests of significance to examine differences in public health and nutrition program participation at 3 and 12 months between women in PL states and women in non-PL states. We found a statistically significant difference in SNAP participation between women in PL states and women in non-PL states at 3 and 12 months postbirth. Three months following a birth, 52.2 percent of women in PL states reported receiving SNAP compared to 65.4 percent of women in non-PL states. There were no statistically significant differences in WIC and Medicaid use between women in PL and non-PL states.

10. Probit Models

SNAP, WIC, and Medicaid Participation Immediately Postbirth

Table 4 presents the results of probit regression models that examined the relationship between SNAP, WIC, and Medicaid participation and paid-leave availability immediately postbirth. The results from these multivariate analyses largely mirrored the descriptive findings. Living in a PL state was related to a significantly lower likelihood of participating

in SNAP ($p < 0.01$). We also found that, after including controls, living in a state with PL was associated with a significantly greater likelihood of participating in Medicaid ($p < 0.05$). However, we found no significant relationship between living in a PL state and participating in the WIC program. A number of individual-level characteristics were also associated with the likelihood of participating in public health and nutrition programs in that time period. For instance, working prebirth was associated with a lower likelihood of participating in all three programs. Black women, compared to White women, were significantly more likely to participate in SNAP and WIC but not Medicaid, while Latina women were significantly more likely to participate in WIC but less likely to participate in Medicaid compared to White women. Women with less than a high school diploma were significantly more likely to participate in SNAP but less likely to participate in WIC. Prebirth family income and other adults in the household were also significantly associated with lower probabilities of participating in SNAP and Medicaid, while more children in the household was significantly associated with a greater probability of participating in all programs.

Table 4. Probit models public health and nutrition program enrollment at 3 months postbirth.

	Model 1	**Model 2**	**Model 3**
	SNAP	WIC	Medicaid
Paid leave	−0.237 **	−0.125	0.199 *
	(0.063)	(0.118)	(0.101)
State unemployment rate	0.117 **	0.013	0.065
	(0.036)	(0.050)	(0.050)
Age, birth month	−0.021 *	−0.002	−0.029 **
	(0.010)	(0.011)	(0.011)
Employed prebirth	−0.242 **	−0.203 *	−0.341 **
	(0.092)	(0.100)	(0.086)
Widowed, divorced, separated	0.005	−0.400 **	−0.167
	(0.123)	(0.119)	(0.116)
Black, non-Hispanic	0.710 **	0.441 **	0.132
	(0.123)	(0.147)	(0.102)
Hispanic	−0.119	0.294 *	−0.239 *
	(0.099)	(0.130)	(0.121)
Other	0.104	0.099	−0.185
	(0.216)	(0.207)	(0.215)
Less than high school	1.011 **	0.839 **	0.297
	(0.238)	(0.281)	(0.249)
High school	0.718 **	0.593 *	0.307
	(0.276)	(0.254)	(0.265)
Some college	0.497 +	0.531 *	0.113
	(0.259)	(0.253)	(0.241)
Prebirth monthly family income ($100)	−0.014 **	0.001	−0.013 **
	(0.004)	(0.005)	(0.005)
Number of other adults in household in birth month	−0.190 **	−0.147 *	−0.152 **
	(0.040)	(0.060)	(0.058)

Table 4. *Cont.*

	Model 1	Model 2	Model 3
Number of other children in the family in birth month	0.321 **	0.165 **	0.120 *
	(0.044)	(0.054)	(0.048)
First birth	0.028	0.184	−0.169
	(0.094)	(0.127)	(0.107)
Intercept	−0.639	0.152	1.332 *
	(0.463)	(0.552)	(0.593)
Log-likelihood	−619.96	−429.76	−542.57
Observations	1168	1168	1168

Notes: All dollar values are in 2011 dollars. Analyses are weighted using SIPP person weights. All models include year-fixed effects and are estimated with robust standard errors clustered by state. ** $p < 0.01$, * $p < 0.05$, + $p < 0.1$.

Table 5 presents the multivariate results for SNAP, WIC, and Medicaid participation twelve months following a birth. Similar to our findings on participation in public health and nutrition programs immediately postbirth, results in Table 5 show a significantly lower probability of participating in SNAP in the year following a birth ($p < 0.05$), but we did not find significant associations between living in a PL state and participation in WIC or Medicaid, although the coefficient for Medicaid participation remained positive. We also found similar associations in individual characteristics in the year following a birth as those outlined above at three months postbirth.

Table 5. Probit models public health and nutrition program enrollment at 12 months postbirth.

	Model 1	Model 2	Model 3
Variables	SNAP	WIC	Medicaid
Paid leave	−0.218 *	0.049	0.121
	(0.091)	(0.211)	(0.149)
Age, birth month	−0.027 *	0.013	−0.039 **
	(0.010)	(0.015)	(0.013)
Employed prebirth	−0.257 *	−0.371 **	−0.401 **
	(0.129)	(0.132)	(0.129)
Widowed, divorced, separated	−0.018	−0.399 **	−0.267 +
	(0.158)	(0.129)	(0.146)
Black, non-Hispanic	0.761 **	0.465 **	0.127
	(0.123)	(0.180)	(0.114)
Hispanic	−0.111	0.415 +	−0.139
	(0.122)	(0.231)	(0.127)
Other	0.319	−0.108	−0.126
	(0.255)	(0.281)	(0.367)
Less than high school	0.830 **	0.622 *	0.164
	(0.302)	(0.298)	(0.308)
High school	0.474	0.341	0.185
	(0.295)	(0.290)	(0.280)
Some college	0.372	0.492 +	0.036
	(0.283)	(0.269)	(0.288)

Table 5. *Cont.*

	Model 1	Model 2	Model 3
Prebirth monthly family income ($100)	−0.010 **	0.004	−0.010 *
	(0.004)	(0.006)	(0.005)
Number of other adults in household in birth month	−0.202 **	−0.133 *	−0.241 **
	(0.046)	(0.067)	(0.081)
Number of other children in the family in birth month	0.310 **	0.169 *	0.124 *
	(0.073)	(0.078)	(0.054)
First birth	0.043	0.141	−0.040
	(0.176)	(0.196)	(0.132)
State unemployment rate	0.076 *	−0.015	0.051
	(0.034)	(0.061)	(0.061)
Intercept	−0.014	0.430	1.950 **
	(0.549)	(0.682)	(0.666)
Log-likelihood	−392.67	−237.08	−319.81
Observations	769	769	771

Notes: All dollar values are in 2011 dollars. Analyses are weighted using SIPP person weights. All models include year-fixed effects and are estimated with robust standard errors clustered by state. ** $p < 0.01$, * $p < 0.05$, + $p < 0.1$.

11. Sensitivity Analysis

Women with greater labor market attachment or higher-quality jobs prior to giving birth may have higher earnings and receive higher benefit amounts from PL because these benefits are based on preleave earnings. Therefore, we conducted a series of tests to assess the sensitivity of the study results relative to using a dichotomous measure of prebirth employment. First, we included a categorical variable of work intensity: (zero) no reported work; (one) part-time (less than 35 h per week) work, and (two) full-time (35 or more hours per week) work prior to birth. Second, we included a dichotomous variable equal to one if the mother worked a full-time job and zero if the mother worked part-time or did not work at all before the birth of a child. Finally, we ran models including controls for the mother's average monthly prebirth income rather than household income. All sensitivity test results were robust to the models presented, suggesting our main models were not sensitive to prebirth employment and income measures.

Since PFL was only available in California and New Jersey for our study timeframe, we also examined if omitting either of these states from the analysis impacted the study results at three and twelve months. Again, results were substantively unchanged in analyses that dropped California and then New Jersey, suggesting study findings were not driven by any one state.

12. Discussion

This study investigated the relationship between PL availability and postbirth SNAP, WIC, and Medicaid participation within three months and one year of a birth. Similar to other research (Houser and Vartanian 2012), we found modest but consistent associations between PL availability and reductions in SNAP participation at three and twelve months following a birth, including in multivariate analyses accounting for a number of potentially relevant controls. While we did not find a relationship between PL availability and WIC participation immediately following or one year postbirth, we did find a modestly significant positive relationship between Medicaid participation in PL states, which may at first glance appear counterintuitive. However, it may be that PL states are doing a particularly good job of connecting low-income women to Medicaid. Moreover, since most

of the study births came from California, it is worth noting that California is known for relatively generous expansions of public health provisions including the Medi-Cal program, which covers low-income expectant and new mothers, provides presumptive eligibility for pregnant women, and offers coverage to some individuals up to 300 percent of the federal poverty line. It is also worth noting that all PL states may be considered "generous" in some areas of public assistance. For instance, all PL states have maximum monthly cash welfare benefits above the national median (Huber et al. 2015). Moreover, the only states to implement PFL programs are those with existing TDI programs. Therefore, our results may not hold for states that adopt PL programs in the future with less generous public assistance provisions or without TDI programs.

The states' economic context and a number of individual-level characteristics were associated with the use of public health and nutrition programs following a birth. First, women who resided in states with higher unemployment rates were significantly more likely to participate in SNAP at three and twelve months postbirth, which suggests that SNAP access among new mother families is responsive to state-level economic contexts. There was no association between unemployment rates and participation in WIC or Medicaid. We also found evidence that low-income working women and those with potential help from other adults in the household were less likely to participate in public health and nutrition programs following a birth. Women with stronger prebirth work histories and other adults in the household were significantly less likely to participate in all three programs at three and twelve months postbirth and women with higher prebirth incomes were significantly less likely to participate in SNAP and Medicaid at both postbirth periods. On one hand, this might suggest that these families have less need for public health and nutrition programs following a birth. On the other, it might also suggest that such programs may need to do more outreach to low-income women who might, along with their infants, benefit from public health and nutrition programs in the perinatal period.

13. Implications for Future Research

We added to previous research by considering short-term (at three months) and longer-term (at twelve months) program participation by including attention to WIC and Medicaid, as well as by using a larger nationally representative sample and controls that were more extensive. While lower rates of SNAP enrollment may be favorable from a state and federal fiscal perspective, scholars and policymakers should keep in mind that PL benefits are short in nature while SNAP benefits are often longer-term for eligible families. Therefore, if PL programs are associated with SNAP diversions, this might come with costs to family well-being, particularly in the areas of food insecurity and maternal and child health (Almond et al. 2011; Cook et al. 2004). Therefore, future research should consider direct links between PL availability, SNAP participation, and maternal and child health in the near and long term.

Although we did not find evidence of a relationship between PL availability and WIC or Medicaid participation, this could be related to the relatively small study sample size. Future research, when possible, should consider similar research with a larger sample. Moreover, the current administration has signaled interest in advancing PL programs in the U.S., which would align the U.S. with the rest of the developed world in providing such support to working families. At the same time, the introduction of PL in states with less generous public assistance programs or low take-up of such programs might lead to qualitatively different family outcomes. Thus, if PL expansion occurs, scholars and policymakers should consider potential state-level variations in reductions to vital public nutrition and health programs after PL implementation.

Finally, there is little evidence regarding how low-income women package PL and public assistance benefits in the perinatal period. It may be that low-income women forgo some public benefits when PL programs act as a substitute for these resources. It may also be that some low-income women are unaware of their eligibility for PL and other supports. Emerging evidence on the pandemic's short-term PL program, funded through

the Families First Coronavirus Response Act, available between April and December 2020[14], is instructive, as early evidence suggests low take-up of the program with suggestive evidence that low rates of program knowledge were a factor (Jelliffe et al. 2021). To these ends, future research should consider low-income mothers who recently gave birth, their motivations for participating or not in these programs, and if diversion during the perinatal period results in long-term diversions.

14. Limitations and Contributions

The primary limitation of the present study is its correlational nature. While we controlled for a variety of potentially relevant individual and state characteristics in our analyses, we can only speculate on the causal relationships between PL availability and study outcomes. Significant differences in observable individual characteristics between women in PL and non-PL states suggest unobserved differences in mothers' characteristics, and relevant differences in state PL provisions and economic contexts may contribute to study results. Additional limitations include the relatively small sample size and the period of the data. Future research should draw on larger and more recent datasets, when available, as an important next step in understanding how state PL programs matter for participation in health and nutrition programs following a birth. Larger sample sizes will allow researchers to conduct more rigorous analyses, including a larger set of state policy controls, interactions between PL availability and individual-level characteristics, and fixed effects, which have been found to influence safety-net participation (Bellisle and Ybarra, forthcoming), but we were unable to do so given our small N, overall and in some states. Despite these limitations, this study is the first that we know of to consider the relationship between PL implementation and participation in important health and nutrition programs among single, low-income women who have recently given birth. Moreover, our results suggest an association between PL availability and lower rates of postbirth SNAP participation among this group, which has broader implications for maternal and child health. Study findings add nuance to our understanding of the role of PL in public health and nutrition program participation and its related meaning to family well-being.

Author Contributions: Conceptualization, M.Y. and A.B.S.; methodology, M.Y., A.B.S. and D.J.F.B.; validation, M.Y. and A.B.S.; formal analysis, A.B.S. and D.J.F.B.; investigation, M.Y., A.B.S. and D.J.F.B.; resources, M.Y.; data curation, A.B.S.; writing—original draft preparation, M.Y. and A.B.S.; writing—review and editing, M.Y. and D.J.F.B.; supervision, M.Y.; project administration. M.Y. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: No additional IRB approval was needed; all data were obtained from publicly available secondary sources and exempt from IRB.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study by the Census Bureau who conducts the Survey of Income and Program Participation.

Data Availability Statement: Data from the Survey of Income and Program Participation is available online at: https://www.census.gov/programs-surveys/sipp.html (accessed on 7 February 2024). Data from the Welfare Rules Database can be found online at: https://wrd.urban.org/wrd/databook.cfm (accessed on 7 February 2024).

Conflicts of Interest: Author Alexandra Stanczyk was employed by the company Mathematica Inc. The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Notes

1 In general, base periods for all states are defined as the four quarters before a claim is submitted.

2 Alternatively, 20 weeks of earnings in the base period.

[3] Full-time employed workers are eligible after four consecutive weeks of employment. Part-time employed workers are eligible after 25 days of regular, part-time employment.

[4] May still be eligible if earned at least $1920 in one base period quarter, total base period earnings are at least one and one-half times your highest quarter of earnings, and base period taxable earnings equal at least $3840.

[5] Average time off in California for women with typical births.

[6] Twelve weeks if birth occurs via cesarean section.

[7] The duration of pregnancy claims is typically six weeks for normal delivery and eight weeks for a cesarean delivery.

[8] The average duration of TDI use in Rhode Island is ten weeks for recipients.

[9] For employed applicants with an average weekly wage of less than $26, the weekly benefit amount is 100 percent of the average weekly wage up to a maximum of $14.

[10] Employers may elect to provide enhanced benefits up to five times this rate, or $850.

[11] New York's paid family leave program was implemented after our study timeframe (2018). Therefore, we do not display New York's PFL policy rules.

[12] See Note 4 above.

[13] Increases to 66% in 2018.

[14] See: https://www.dol.gov/agencies/whd/pandemic/ffcra-employer-paid-leave, accessed on 27 January 2024.

References

Adams, E. Kathleen, Sara Markowitz, Patricia M. Dietz, and Van T. Tong. 2013. Expansion of Medicaid covered smoking cessation services: Maternal smoking and birth outcomes. *Medicare & Medicaid Research Review* 3: E1–E23. [CrossRef]

Almond, Douglas, Hilary W. Hoynes, and Diane Whitmore Schanzenbach. 2011. Inside the war on poverty: The impact of food stamps on birth outcomes. *The Review of Economics and Statistics* 93: 387–403. [CrossRef]

Anderson, Steven G., Anthony P. Halter, and Brian M. Gryzlak. 2004. Difficulties after leaving TANF: Inner-city women talk about reasons for returning to welfare. *Social Work* 49: 185–94. [CrossRef] [PubMed]

Barnes, Carolyn, and Virginia Riel. 2022. 'I don't know nothing about that': How "learning costs" undermine COVID-related efforts to make SNAP and WIC more accessible. *Administration & Society* 54: 1902–30. [CrossRef]

Baum, Charles L., and Christopher J. Ruhm. 2016. The effects of paid family leave in California on labor market outcomes. *Journal of Policy Analysis and Management* 35: 333–56. [CrossRef]

Bellisle, D. J. F., and M. Ybarra. Forthcoming. Ethnoracial differences in income and safety net patterns among low-income postpartum families before and during the Great Recession. *Poverty & Public Policy*.

Bitler, Marianne P., and Janet Currie. 2005. Does WIC work? The effects of WIC on pregnancy and birth outcomes. *Journal of Policy Analysis and Management: The Journal of the Association for Public Policy Analysis and Management* 24: 73–91. [CrossRef] [PubMed]

Bond, J. T., E. Galinsky, M. Lord, G. L. Staines, and K. R. Brown. 1991. *Beyond the Parental Leave De-Bate: The Impact of Laws in Four States*. New York: Families and Work Institute, pp. 39–42.

Chang, Yu-Ling, Jennifer Romich, and Marci Ybarra. 2021. Major means-tested and income support programs for the working class, 2009–19. *The ANNALS of the American Academy of Political and Social Science* 695: 242–59. [CrossRef]

Casey, Patrick, Susan Goolsby, Carol Berkowitz, Deborah Frank, John Cook, Diana Cutts, Maureen M. Black, Nieves Zaldivar, Suzette Levenson, Tim Heerenand, and et al. 2004. Maternal depression, changing public assistance, food security, and child health status. *Pediatrics* 113: 298–304. [CrossRef]

Chatterji, Pinka, and Jeanne Brooks-Gunn. 2004. WIC participation, breastfeeding practices, and well-child care among unmarried, low-income mothers. *American Journal of Public Health* 94: 1324–27. [CrossRef]

Cook, John T., Deborah A. Frank, Carol Berkowitz, Maureen M. Black, Patrick H. Casey, Diana B. Cutts, Alan F. Meyers, Nieves Zaldivar, Anne Skalicky, Suzette Levenson, and et al. 2004. Food insecurity is associated with adverse health outcomes among human infants and toddlers. *The Journal of Nutrition* 134: 1432–38. [CrossRef] [PubMed]

Das, Tirthatanmoy, and Solomon W. Polachek. 2015. Unanticipated effects of California's paid family leave program. *Contemporary Economic Policy* 33: 619–35. [CrossRef]

Desai, Sonalde, and Linda J. Waite. 1991. Women's employment during pregnancy and after the first birth: Occupational characteristics and work commitment. *American Sociological Review* 56: 551–66. [CrossRef]

Donovan, Sarah A., Marc Labonte, and Joseph Dalaker. 2016. *The US Income Distribution: Trends and Issues*. CRS Report. Washington, DC: US Congressional Research Service.

Edin, Kathryn, and Maria Kefalas. 2005. *Promises I Can Keep: Why Poor Women Put Motherhood before Marriage*. Berkeley: Univ of California Press.

Hackman, Daniel A., and Martha J. Farah. 2009. Socioeconomic status and the developing brain. *Trends in Cognitive Sciences* 13: 65–73. [CrossRef] [PubMed]

Heckman, James J. 2006. Skill formation and the economics of investing in disadvantaged children. *Science* 312: 1900–2. [CrossRef] [PubMed]

Herd, Pamela, and Donald P. Moynihan. 2019. *Administrative Burden: Policymaking by Other Means*. New York: Russell Sage Foundation.

Houser, Linda, and Karen White. 2012. *Awareness of New Jersey's Family Leave Insurance Program Is Low, Even as Public Support Remains High and Need Persists*. New Brunswick: Center for Women and Work at Rutgers, The State University of New Jersey, Issue Brief.
Houser, Linda, and Thomas Paul Vartanian. 2012. *Policy Matters: Public Policy, Paid Leave for New Parents, and Economic Security for US Workers*. New Brunswick: Rutgers Center for Women and Work.
Howell, Embry M. 2001. The impact of the Medicaid expansions for pregnant women: A synthesis of the evidence. *Medical Care Research and Review* 58: 3–30. [CrossRef]
Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2016. Long-run impacts of childhood access to the safety net. *American Economic Review* 106: 903–34. [CrossRef]
Hoynes, Hilary, Marianne Page, and Ann Huff Stevens. 2011. Can targeted transfers improve birth outcomes?: Evidence from the introduction of the WIC program. *Journal of Public Economics* 95: 813–27. [CrossRef]
Huber, Erika, Elissa Cohen, Amanda Briggs, and David Kassabian. 2015. *Welfare Rules Databook: State TANF Policies as of July 2014, OPRE Report 2015–81*. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services.
Jelliffe, Emma, Paul Pangburn, Stefan Pichler, and Nicolas R. Ziebarth. 2021. Awareness and use of (emergency) sick leave: US employees' unaddressed sick leave needs in a global pandemic. *Proceedings of the National Academy of Sciences* 118: e2107670118. [CrossRef]
Johnson, Sara B., Jenna L. Riis, and Kimberly G. Noble. 2016. State of the art review: Poverty and the developing brain. *Pediatrics* 137: 1–16. [CrossRef]
Khanani, Intisar, Jon Elam, Rick Hearn, Camille Jones, and Noble Maseru. 2010. The impact of prenatal WIC participation on infant mortality and racial disparities. *American Journal of Public Health* 100: S204–S209. [CrossRef]
Luman, Elizabeth T., Mary Mason McCauley, Abigail Shefer, and Susan Y. Chu. 2003. Maternal characteristics associated with vaccination of young children. *Pediatrics* 111: 1215–18. [CrossRef] [PubMed]
Markus, Anne Rossier, Ellie Andres, Kristina D. West, Nicole Garro, and Cynthia Pellegrini. 2013. Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform. *Women's Health Issues* 23: e273–e280. [CrossRef]
Meghea, Cristian I., Zhiying You, Jennifer Raffo, Richard E. Leach, and Lee Anne Roman. 2015. Statewide Medicaid enhanced prenatal care programs and infant mortality. *Pediatrics* 136: 334–42. [CrossRef]
Milkman, Ruth, and Eileen Appelbaum. 2013. *Unfinished Business: Paid Family Leave in California and the Future of U.S. Work-Family Policy*. Ithaca: Cornell University Press.
Moffitt, R. 2003. The role of nonfinancial factors in exit and entry in the TANF program. *Journal of Human Resources* 38: 1221–54. [CrossRef]
National Academies of Sciences, Engineering, and Medicine (NASEM). 2018. *The 2014 Redesign of the Survey of Income and Program Participation: An Assessment*. Washington, DC: National Academies Press.
Pihl, A., and G. Basso. 2015. *Paid Family Leave, Job Protection and Low Take-Up among Low-Wage Workers*. Davis: Center for Poverty Research, University of California, Davis.
Rossin-Slater, Maya, Christopher J. Ruhm, and Jane Waldfogel. 2013. The effects of California's paid family leave program on mothers' leave-taking and subsequent labor market outcomes. *Journal of Policy Analysis and Management* 32: 224–45. [CrossRef] [PubMed]
Rowe, Gretchen, Mary Murphy, and Ei Yin Mon. 2010. *Welfare Rules Databook: State TANF Policies as of July 2009*. Washington, DC: The Urban Institute. Available online: http://www.urban.org/url.cfm (accessed on 7 November 2023).
Shaefer, H. Luke, and Marci Ybarra. 2012. The welfare reforms of the 1990s and the stratification of material well-being among low-income households with children. *Children and Youth Services Review* 34: 1810–17. [CrossRef]
Stanczyk, Alexandra Boyle. 2019. Does paid family leave improve household economic security following a birth? Evidence from California. *Social Service Review* 93: 262–304. [CrossRef]
Stuber, Jennifer, and Karl Kronebusch. 2004. Stigma and other determinants of participation in TANF and Medicaid. *Journal of Policy Analysis and Management* 23: 509–30. [CrossRef]
Stuber, Jennifer, and Mark Schlesinger. 2006. Sources of stigma for means-tested government programs. *Social Science & Medicine* 63: 933–45. [CrossRef]
Turner, Barbara J., Craig J. Newschaffer, James Cocroft, Thomas R. Fanning, Sue Marcus, and Walter W. Hauck. 2000. Improved birth outcomes among HIV-infected women with enhanced Medicaid prenatal care. *American Journal of Public Health* 90: 85. [CrossRef] [PubMed]
U.S. Bureau of Labor Statistics. n.d.a. Local Area Unemployment Statistics Map. Available online: http://data.bls.gov/map/MapToolServlet?survey=laU.S. (accessed on 7 November 2023).
U.S. Bureau of Labor Statistics. n.d.b. Local Area Unemployment Statistics: Unemployment Rates for States, Annual Average Ranking. Available online: http://www.bls.gov/lau/home.htm (accessed on 7 November 2023).
Walker, Susan P., Theodore D. Wachs, Sally Grantham-McGregor, Maureen M. Black, Charles A. Nelson, Sandra L. Huffman, Helen Baker-Henningham, Susan M. Chang, Jena D. Hamadani, Betsy Lozoff, and et al. 2011. Inequality in early childhood: Risk and protective factors for early child development. *The Lancet* 378: 1325–38. [CrossRef] [PubMed]
Wever, Kirsten S. 1996. *Assessing Temporary Wage Replacement for Family and Medical Leave*. Cambridge: Radcliffe Public Policy Institute, Radcliffe College.

Winston, Pamela, Ariel Pihl, Lincoln Groves, Colin Campbell, Elizabeth Coombs, and Sharon Wolf. 2017. *Exploring the Relationship between Paid Family Leave and the Well-Being of Low-Income Families: Lessons from California*; Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation Office of Human Services Policy. Available online: https://aspe.hhs.gov/pdfreport/exploring-relationship-between-paid-family-leave-and-well-being-low-income-familieslessons-california (accessed on 3 July 2017).

Ybarra, Marci. 2013. Implications of paid family leave for welfare participants. *Social Work Research* 37: 375–87. [CrossRef]

Ybarra, Marci, Alexandra Stanczyk, and Yoonsook Ha. 2019. Paid leave, welfare, and material hardship after a birth. *Family Relations* 68: 85–103. [CrossRef]

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.