Medicare: Uniformed Services Program for Dependents

by MAJOR GENERAL PAUL I. ROBINSON, M.C.*

When the Dependents' Medical Care Act went into effect on December 7, 1956, it signaled the end of the diverse and rule-of-thumb system for dependent care that had held sway in the military services for 72 years. Except in minor respects the new law left essentially unchanged the medical care for dependents provided through service facilities, merely assuring uniform benefits among the different services. The use of civilian facilities for dependent medical care is a new and important development. Most of the following article is therefore devoted to this portion of the new law, describing how the program was implemented to provide benefits through civilian facilities and giving an idea of the problems that have arisen and the trends anticipated.

UNTIL the Dependents' Medical Care Act [1] was passed in 1956, medical treatment of military dependents was accorded under the statutory authority of 1884. Congress in that year had stated, "The medical officers of the Army and contract surgeons shall whenever practicable attend the families of the officers and soldiers free of charge." Under this statute, regulations affecting medical care for dependents were issued by the services as the need dictated. The Navy received specific congressional sanction for taking care of dependents in 1943, when the Seventy-eighth Congress passed Public Law No. 51—an act "to provide expansion of facilities for hospitalization of dependents of Naval and Marine Corps personnel."

Background

In recent years the expansion in the uniformed services, their widespread activities, and the increasing number of dependents all combined to create a pressing need for a workable and equitable dependents' medical care program. Theoretically, dependents could go to a medical facility of one of the services in case of emergency, sickness, or injury. According to estimates from the Department of Defense, however, about 40 percent of the slightly more than 2 million dependents were unable to use Government medical facilities for various reasons. These 800,000 dependents lost out chiefly because (1) they were too far from a military or Public Health Service hospital, (2) nearby facilities were already overtaxed, or (3) the treatment needed was not available at the service medical center.

The situation had grown progressively worse over the years. In addition, what was actually a fringe benefit for attracting and keeping career personnel was steadily losing its appeal. The liberal medical care policy of the military services has been at least partly matched in recent years by the health insurance offered by an increasing number of private firms to employees and their dependents at nominal and in some instances no cost.

Hoover Commission.—Basically, the desire to provide an expanded medical care program was in line with the traditional service policy of "taking care of its own." In the late 1940's the Commission on Organization of the Executive Branch of the Government—popularly known as the Hoover Commission—issued a report that recognized this fact and also urged uniformity among the services in their medical care programs. "The right to medical care for dependents is an inducement to remain in the armed services and is a morale factor," the report stated. The Commission also recommended that "Congress should define the beneficiaries entitled to medical care from the Government and prescribe how this care should be given." Furthermore, the Hoover Commission observed, medical care for dependents need not necessarily be provided in Federal hospitals.

The Moulton report.—The Hoover Commission's report was one of the first stirrings for a national and uniform program for dependents, whether or not they were living near a military establishment. Several years passed before more definite progress was made. In 1953 the Department of Defense set up the Citizens Advisory Commission on Medical Care of Dependents. Headed by Harold Moulton, of the Brookings Institution, the Commission studied the problem intensively and after several months released its recommendations. The "Moulton report" detailed the scope and type of medical care that should be given to dependents. There was opposition, however, to the recommendation that such care, whenever possible, should be given in service facilities. Critics claimed this would put the Department of Defense into the business of hospital building and physician recruiting and detract from the main medical job of taking care of Armed Forces personnel.

Legislative history of H.R. 9429.—The Moulton report was shelved, and other avenues for legislative relief were sought. Early in 1956, H.R. 9429—a bill to provide medical care for dependents—was introduced into the House of Representatives, and congressional hearings were held. At one session before the Senate Com-

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[1] Public Law No. 569, Eighty-fourth Congress, second session.

mittee on Armed Services, Carter L. Burgess, Assistant Secretary of Defense, summed up the need for the bill:

I am convinced that devoted service to our country is still the paramount motivation of the officers and men who choose military service as a life career. And I know the military services cannot match the stability and unlimited opportunities offered by many segments of civilian industry. But we can encourage more men to enter and remain in military service if we remove existing inequities and offer them more of the benefits that have become standard in our civilian way of life.

In his statement, Mr. Burgess pointed out that private business was offering its workers the inducements of health insurance:

It is particularly significant, that almost four times as many workers in industry are covered by some type of company-sponsored health insurance as were covered in 1948. But of even greater interest is the fact that more than 70 percent of the covered workers are also offered health insurance for their dependents. And for 38 percent of these the employer assumes the full cost of dependent coverage.

To provide medical care regardless of their location for the 2 million wives and children of servicemen, the bill authorized contracting for medical care from civilian sources, a major new provision. This authorization carried out, in part, the American Medical Association's recommendation that the dependent care program should utilize civilian hospitals and the services of civilian physicians.

The bill was passed and signed by President Eisenhower on June 7, 1956. The Dependents' Medical Care Act specified that the program was to become effective 6 months later—a provision allowing time to set up contracts for the civilian medical care aspect of the program.

The law on dependents' medical care covers the Nation's uniformed services—a group that takes in not only the military forces, including the Coast Guard, but also the commissioned members of the U. S. Public Health Service and the Coast and Geodetic Survey.

Implementation

The law places responsibility for providing for medical care for dependents with the Secretary of Defense. He is directed to consult with the Secretary of Health, Education, and Welfare on the contracts and on any limitations, additions, exclusions, definitions, and related provisions. For the civilian portion of the dependents' medical care program (popularly called "Medicare"), the Secretary of Defense delegated his authority to the Secretary of the Army as the executive agent. In turn, responsibility for contracting for civilian care was delegated along the chain of command to the Army Chief of Staff, then to the Deputy Chief of Staff for Logistics, to the Office of the Surgeon General, and finally to the Executive Director of the newly created Office for Dependents' Medical Care.

A task force began drafting a joint directive that would guide the Department of Defense and the Department of Health, Education, and Welfare in implementing the program. While this guide was being drafted, the Office for Dependents' Medical Care was set up to contract for the necessary civilian care authorized by the law.

In implementing Public Law No. 569, as in implementing any new law, difficulties were encountered. Now, after 5 months of operation, the program is on a sound footing. One reason that it has been possible to put so extensive a program into operation in such a short time was the early recognition of the need for a public relations and public information program. The Armed Forces induct thousands of men into the services each month. Material explaining what Medicare provides for their dependents had to be prepared to reach this group at the induction centers. Families scattered all over the United States, many of them separated from the serviceman by reason of his overseas tour of duty or sea duty, had to be made aware of their eligibility for the benefits and given some understanding of the nature of the program. As part of this task, a film explaining the benefits is being prepared that will be shown not only at induction centers but at motion picture theaters throughout the country.

Information explaining the exact nature of the hospital benefits had to be placed in the hands of hospitals; the physicians who might be treating dependents also needed information on the benefits. The Office for Dependents' Medical Care relied on the medical societies and organizations administering payments to physicians and hospitals to do much of that part of the information task involving them. Staff members of the Office for Dependents' Medical Care have made many personal appearances at medical society meetings and at various national conferences of interested professional organizations, as well as at service installations, to disseminate information about the program.

Eligibility

Civilian medical and hospital care is authorized for certain dependents of service members who are on active duty for a period exceeding 30 days. For the purposes of receiving civilian medical care, eligible dependents are defined as follows:

(1) Lawful wife.

(2) (a) Unmarried legitimate child (including stepchild or adopted child) who has not yet reached his twenty-first birthday; (b) unmarried legitimate child under age 23 who is taking a full-time course of study at a recognized college and is dependent on the sponsor for more than half his support; and (c) unmarried legitimate child over age 21 who is dependent on the sponsor because of a mental or physical incapacity suffered before his twenty-first birthday.

(3) Lawful husband who is dependent on a service wife for more than half his support.

Medical care in service facilities is also available to the three groups of dependents just listed. Three additional groups are eligible for care in service facilities but not from civilian sources. They are:

(1) Widows and the dependent children of deceased members of the uniformed services whose death oc-

curred while on active duty or in a retired status.

(2) Parents and parents-in-law, if they are in fact dependent on the service member (or the retired member) for more than half their support and living in his household.

(3) Unremarried widower who, due to a mental or physical incapacity, was dependent on the member or retired member for more than half his support.

Identification.—The eligibility of the dependent is ascertained by the physician and hospital by the best means available at the present time. Usually, the dependent has some service identification or privilege card currently in use. Corroborating evidence, such as a driver's license, social security card, or letters, is used. All the uniformed services are now in the process of issuing DD Form 1173, *Uniformed Services Identification and Privilege Card.* One of the blocks on the card shows the eligibility of the dependent to receive civilian medical care. By January 1, 1958, this card will serve as the primary means of identification for dependents seeking civilian medical care. It bears the photograph and signature of the dependent and will be issued to dependents aged 10 and over.

Benefits

Civilian treatment authorized.—Medical, surgical, and hospital care authorized under the program includes the following:

1. Treatment of acute medical and surgical conditions.

2. Treatment of acute exacerbations and complications of chronic diseases only during hospitalization.

3. Complete maternity and obstetrical care, including prenatal and postnatal care.

4. Treatment of contagious diseases during hospitalization.

5. Services required of a physician or surgeon before and after hospitalization for a bodily injury or surgical operation.

6. Treatment in a hospital of acute emergencies constituting a threat to the life, health, or well-being of the patient. Acute emotional disorders are included, but not mental or nervous disturbances.

7. Dental care is authorized only as a necessary adjunct to the medical or surgical treatment for which the dependent is hospitalized. Such treatment, which may not include removable or fixed prosthodontic restorations, must be rendered in the hospital to a dependent who is a hospital inpatient.

8. Semiprivate accommodations up to 365 days for each admission.

All diagnostic tests and procedures performed in connection with necessary medical and surgical care during hospitalization are paid for by the Government.

Although the dependents' medical care program essentially provides for professional services during hospitalization, certain limited outpatient care is authorized. Outpatient treatment by a physician for bodily injuries, such as fractures, dislocations, lacerations, and other wounds, is included in the program.

The Government will pay, up to a maximum of $75, for tests or procedures performed or authorized by the attending physician before hospitalization for the bodily injury or before surgical procedure. Posthospitalization charges for tests or laboratory examinations for the same types of care will be paid in an amount not to exceed $50. This monetary limitation on laboratory tests and examinations does not apply to maternity cases.

Medical care not authorized.—Medical treatment not provided under Medicare includes treatment or hospitalization for chronic diseases (except acute exacerbations), elective medical or surgical treatment, treatment for nervous or mental disorders, domiciliary care, ambulance service, and medical care normally considered to be of an outpatient nature.

Dependents' charges.—The dependent does not pay the physicians' fees under the full-service concept of the program. The only extras for which the patient may have to pay are tests and procedures performed before and after the hospitalization period that exceed the maximum allowances of $75 and $50 paid by the Government.

Certain nominal charges are paid by the patient when hospitalized. He makes payment directly to the hospital on the basis of a $25.00 minimum charge or $1.75 a day, whichever is greater. Thus a dependent will pay $25.00 if he stays in a hospital 14 days or less; for 15 days or more, he pays $1.75 a day. If a dependent is discharged after 20 days, for example, he would pay $35.00, at the $1.75 rate.

The patient is entitled to semiprivate accommodations (2, 3, or 4 beds in a room). If the attending physician certifies that a private room is needed for proper treatment of the case, the dependent will pay, in addition to the $25.00 or $1.75 rate, 25 percent of the difference between the private-room charge and the weighted average cost of the semiprivate room. If, however, a private room is secured only on the request of the patient or sponsor, the dependent will have to pay the entire difference between that cost and the charge for the semiprivate room.

Part of the cost for private-duty nursing is borne by the Government if the service is requested by the physician. The Government pays 75 percent of the charges in excess of the first $100. If private-duty nursing is requested by the patient or family, the dependent meets the full cost of the expense.

Outpatient services.—When a patient is treated for bodily injuries by a physician and is not hospitalized, the dependent pays the first $15 of the physician's fee. If a hospital's outpatient facility is used in the case of a bodily injury, the Government pays that cost in full. The Government pays the costs of related laboratory tests and pathology or radiology examinations authorized by the attending physician or surgeon up to a maximum of $75.

A maternity case, when delivery is made at the home or at the physician's office, costs the dependent the first $15 of the charges if she is not hospitalized later. The $75 limitation on outpatient diagnostic tests and procedures does not apply, however, to this type of case.

Treatment authorized in service facilities.—The care provided in serv-

ice facilities does not come under the Office for Dependents' Medical Care but remains under the jurisdiction of the Surgeons General of the various services. The medical care authorized is essentially the same under both programs, except that nonemergency outpatient care is provided in service facilities. The charge for hospital care is $1.75 a day, as it was before the Dependents' Medical Care Act was passed. Provision of care is subject to the availability of space and facilities and the capabilities of the professional staff. The law provides for cross-utilization of service medical facilities.

Since the new law makes no basic change in or departure from the former system of providing treatment in service facilities, the remainder of this article deals only with the new civilian program and the activities of the Office for Dependents' Medical Care.

Contract Negotiations

After organizing the staff in Washington, the Office for Dependents' Medical Care began scheduling negotiation sessions with medical societies on that part of the program that would provide physicians' services for dependents. Similar sessions were scheduled with the organizations that could provide hospitalization and that could administer the payments to hospitals.

Representatives from State medical societies met with the Government negotiating teams to settle on schedules of allowances that would specify the maximum liability. The Government's position was that the fees should be reasonable and in line with charges customarily made to persons with an income of $4,000–$5,000 a year. This consideration reflected the average earnings of 9 out of every 10 service members, who earn less than $5,000 a year. The amounts paid to the providers of the service were to be accepted as full payment; there was to be no supplementary billing made to the patient.

Starting on October 23, 1956, negotiation teams conferred with representatives of each of the State and Territorial medical societies. About 1,700 items had to be reviewed and agreed upon for each contract. Maximum fees beyond which the Government would not pay were set in all but one State. The maximum fee would not necessarily, however, be the physician's charge in each case, since it was expected that the physician would charge his usual rate if it was lower than the fee schedule.

When the Dependent's Medical Care Act was passed, there was some concern among physicians that the program could be a step in the direction of socialized medicine, since it seemed to involve fees fixed nationally that would have to be accepted in full payment of physicians' charges. The negotiation were conducted, however, with the individual State medical societies, and the schedule of allowances adopted for one State had no bearing on the schedule adopted for another State. As a result, the agreed-on fee schedules show wide variations (table 1).

The negotiators for the Government used as guides a calculated schedule based on the *Relative Value Schedule,* developed by the Committee on Fees of the Commission on Medical Services of the California Medical Association, as well as the Blue Shield schedules from many States. There are, however, many variations from State to State in the different items, resulting in part from the use of different negotiation teams. It is clear there is no national fee schedule.

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Chart 1.—*Medicare hospitalization contracts with Blue Cross plans and insurance companies, by State*

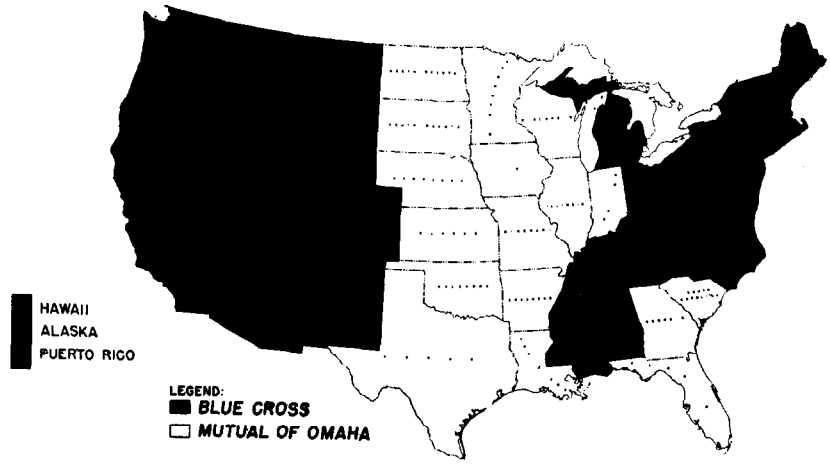


Table 1.—*Schedule of allowances to physicians: Range of allowable fees for the 16 most frequently encountered procedures and number of States with modal fee*

Procedure	Allowable fees				Number of States with modal fee
	Low	High	Average	Mode	
Appendectomy	$125.00	[1] $175.00	$147.25	$150.00	34
Blood culture (aerobic and anaerobic)	3.25	15.00	8.00	10.00	25
Bronchoscopy (removal of foreign body)	70.00	125.00	107.00	100.00	12
Classic cesarean	110.00	300.00	203.00	200.00	11
Consultation (with complete examination)	15.00	50.00	30.00	35.00	19
Fracture, radius (head, simple, closed)	40.00	75.00	51.00	50.00	21
Gastrojejunostomy	150.00	250.00	210.00	200.00	16
Hemorrhoidectomy (internal and external)	75.00	150.00	111.00	100.00	19
Herniorrhaphy (femoral, unilateral)	100.00	180.00	138.00	150.00	17
Mastoidectomy	150.00	390.00	266.00	250.00	10
Nephrolithotomy (calculus removal)	175.00	420.00	282.00	300.00	15
Obstetrical delivery (including prepartum and postpartum care)	120.00	180.00	128.00	150.00	30
Strabismus operation	75.00	300.00	199.00	200.00	9
Thyroidectomy	150.00	300.00	217.00	225.00	13
Tonsillectomy	42.50	75.00	64.00	65.00	15
X-ray, diagnostic (spine, complete)	25.00	60.00	42.00	45.00	27

[1] Represents the high for the continental United States only.

fees were conducted with 52 separate medical societies, the contracts for hospitalization ultimately involved only the national organization of Blue Cross plans and one insurance company, Mutual of Omaha.

To obtain some cost comparisons, it was decided by Congress to divide the administration of hospital payments between Blue Cross plans and the insurance companies. The division authorized by the Secretary of Defense gave the Midwestern States, in general, to the insurance companies and the States in the East and West, as well as the Territories, to the Blue Cross plans (chart 1). Although this arrangement was not to the complete satisfaction of either Blue Cross or the insurance carrier, it was accepted as a modus operandi.

The Blue Cross Commission of the American Hospital Association was the spokesman for the Blue Cross plans in the States assigned to Blue Cross. It has established a central office to coordinate the program for the plans involved and to consolidate their billings.

Insurance companies were invited to enter into negotiations with the Government, but the only company showing interest in being a prime contractor was Mutual of Omaha. This company therefore took over the administration of the hospitalization benefits in 17 States, later subletting contracts in three States to other insurance companies.

The entire program, whether payments to physicians or to hospitals are involved, is on a nonprofit (cost-plus) basis. The administrative costs actually incurred and the costs of the services are paid by the Government to the respective fiscal agents; these costs are subject to audit by the Department of the Army.

Claims Procedure

In general, the operation of the program involves separate payments to hospitals and physicians for care given to eligible dependents. To administer the payments to physicians, the medical societies of each State, the District of Columbia, and the three Territories have appointed a fiscal agent. This agent is usually the Blue Shield plan of the particular area. Some State medical societies are represented by an insurance company, and in other States the program is administered by the medical society itself (chart 2).

Presentation of DA Form 1863, *Statement of Services Provided by Civilian Medical Sources,* is the basis for payment of claims. A supply of these forms has been provided to physicians and hospitals by their fiscal agents. The dependent fills out two of these—one for the physican's claims and the second for the hospital's claims. The physician sends the completed copy of DA Form 1863 to the State fiscal agent (Blue Shield, the insurance company, or the phy-

Chart 2.—*Physicians' contracts under Medicare, by type of agent administering payments and by State*

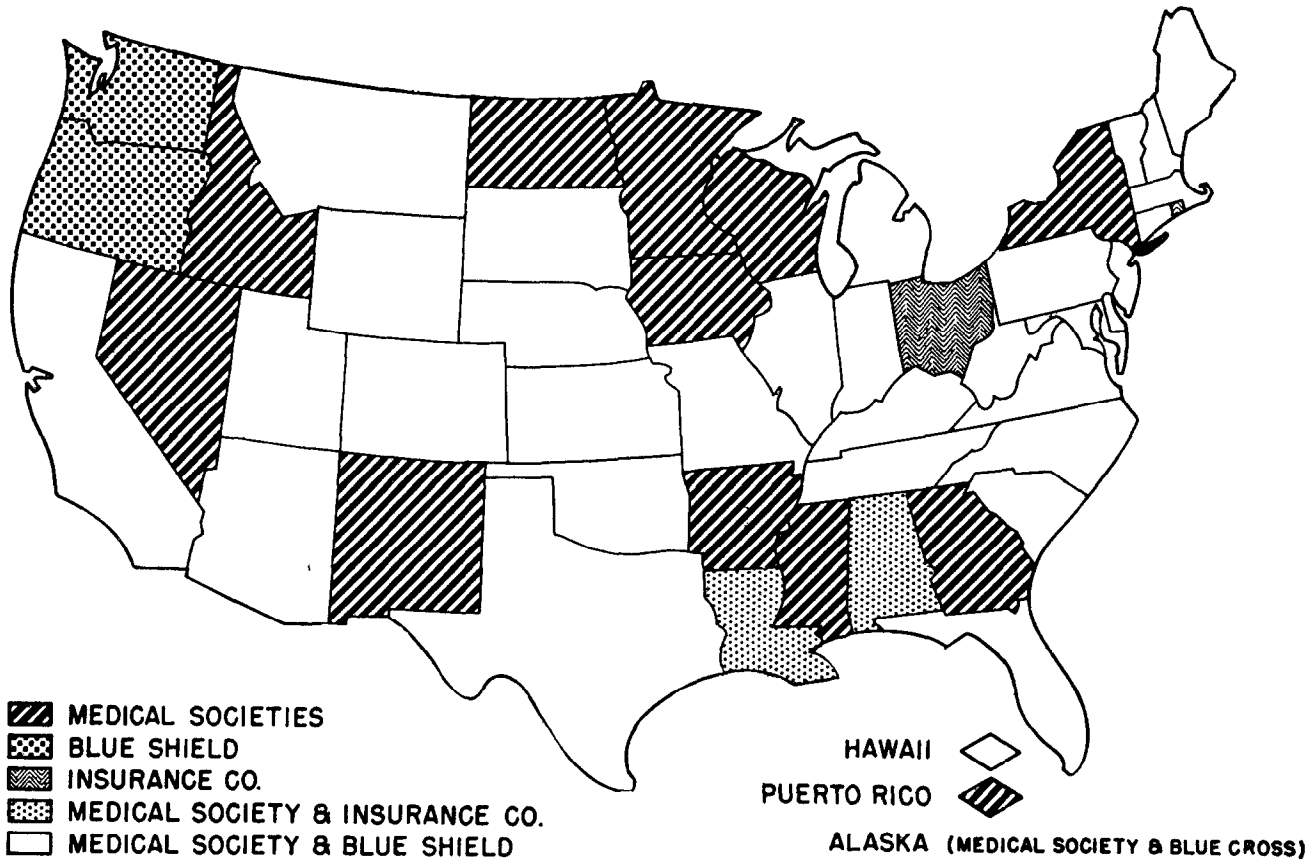
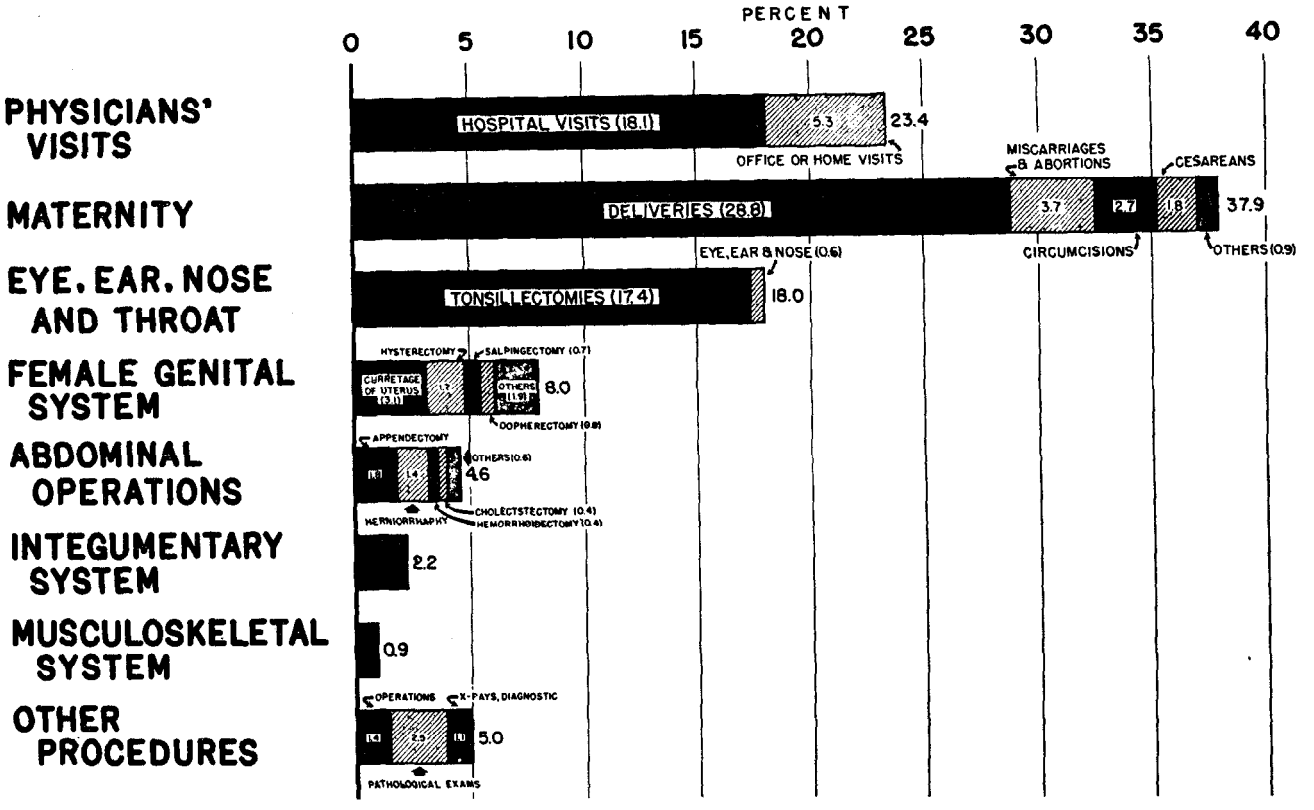


Chart 3.—*Percentage distribution of claims from physicians for Medicare payments, by type of procedure*



SOURCE: ODMC
MARCH 1957

sician's own authorized agent), which pays the claim and sends monthly billings to Washington. The Government reimburses the agents, dealing in this instance with 51 offices.

In the States under Blue Cross plans, the hospitals submit their claims to the local plan, which pays them and forwards the cumulative billings to the Blue Cross central office in Chicago. This office, in turn, sends cumulative billings to Washington.

In the States where Mutual of Omaha is the administrator, the hospitals send DA Form 1863 either to that company or to one of its three subcontracting insurance companies. Again these claims are accumulated and sent to Washington. Mutual of Omaha also pays physicians' claims in those States[2] where the medical society did not enter into a contract with the Office for Dependents' Medical Care.

In the States where the Blue Cross plan reimburses the hospitals, the negotiated rates for computing hospital charges used for other Blue Cross patients apply to the service dependents. Mutual of Omaha pays the regular hospital billing that would apply to a private patient, or it pays this amount minus an arranged discount. Under either system the hospital collects directly from the patient, usually on admission, the $25.00 deductible amount (or $1.75 a day times the number of days hospitalized) for which the dependent is responsible.

Similarly, when the patient has to pay the first $15 of the cost of outpatient physician's services, he pays it directly to the physician. Any excess of charges over the $75 allowed for diagnostic tests is also collected directly by the attending physician.

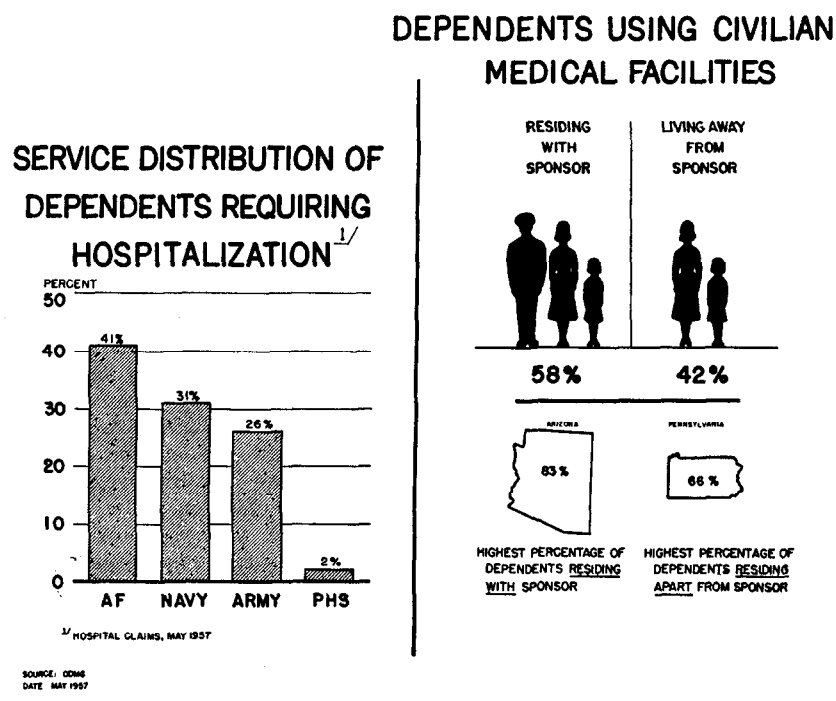
Problems Encountered

Various problems relating to the civilian benefits came to light only after the program was started. The Office for Dependents' Medical Care provides clarification of many of them through a newsletter, issued from time to time.

There have been problems in providing both hospital and physicians' care. In the hospitalization field, one of the first problems that confronted Medicare was the fact that many of the best hospitals in the Nation have no semiprivate accommodations, and the law and the directive both provide for semiprivate accommodations. Payment of nurse anesthetists, other anesthetists, and physical therapists who are not employees of the hospital has presented difficult problems. The hospital hesitates to pay them a fee and charge the Government for that amount. This matter is being further studied with representatives of the American Hospital Association. Some

[2] At present, physicians are paid through Mutual of Omaha only in Ohio and Rhode Island.

Chart 4.—*Percentage distribution of Medicare claims for dependents' hospitalization, by branch of uniformed service, and for dependents' use of medical facilities, by residence or nonresidence with sponsor*



of the large clinics that also operate qualified hospitals under the program are having difficulty in billing for their services because they cannot readily divide normal hospital and physician charges. A change in the directive will probably be made to permit a single billing from these clinics.

Shortly after the program got under way, there were literally hundreds of questions concerning what was included and what was not included in complete maternity care, methods for calculating prenatal care, and what fee the physician should receive. Questions arose as to what constituted treatment for a chronic disease and what was elective surgery.

In the Schedules of Allowances for Physicians' Fees there have been questions about nomenclature and about the inclusion of postoperative care and, if included, how much postoperative care. Many of the States with a higher fee schedule included more postoperative care than did those with lower fee schedules. The question of whether the fee for a cesarean section includes preoperative, prenatal, postnatal, and postoperative care has also come up.

Program Operations

A survey of claims received from hospitals shows that the Office for Dependents' Medical Care has paid $3,562,297 for the 36,922 claims received at Medicare headquarters from December 7, 1956, to May 7, 1957. The average cost per hospitalized case was $96.48. In a study of 19,489 cases, the average length of hospitalization for dependent patients was 4.8 days. The majority of the claims were for maternity care, tonsillectomies, and adenoid operations, and hospital stay was thus comparatively short.

For the same 5-month period, claims from physicians numbered 53,802. The total charges came to $3,666,583, or an average of $68.15 per claim.

Because the dependents are mainly young wives and young children, most of the medical treatment has revolved around illness or care typical of these two groups. This concentration is amply illustrated by a survey made of 5,000 claims from physicians (see chart 3). Maternity care accounted for some 37 percent of the dependent care from civilian sources, and tonsillectomies were the next most common procedure recorded (17 percent).

Administration.—Before the program was inaugurated, the Office for Dependents' Medical Care borrowed from the Department of the Army seven lawyers, seven contracting officers, seven auditors, and six physicians and from the Department of the Navy, one physician. This staff made up the seven teams that handled the negotiations with the medical societies. In the future, because renegotiations are to be staggered, one team will be able to handle all of them.

The estimated cost of processing claims was part of the contract with Blue Cross and Mutual of Omaha. Actual costs have exceeded these amounts. Since they are subject to postaudit procedures and may level off as administration becomes more routine, it appears to be too early to publish them.

Future Developments

What have been the trends noticeable since the program started in December? First of all, there has been a general acceptance on the part of the dependents themselves. Cooperation from physicians and from hospital authorities has been widespread. Despite the many problems inherent in implementing such a program in such short order, present indications show that the program is workable.

Contracts with the State medical societies were originally signed for a period to end June 30, 1957. The contracts have been extended, however, and are now staggered to allow five of them to terminate each month beginning January 1958. This action has been taken to allow the Office for Dependents' Medical Care time to study the fee schedules and work out equitable arrangements with the medical societies that can be incorporated into the next contracts.

The distribution of claims among the various services based on the use of hospitals is shown in chart 4. The original estimate of the extent to which dependents were not residing with their sponsors has been

borne out by the claims. About 42 percent of the dependents whose cases have been handled so far have not been residing with their sponsors because of the exigencies of service in the Armed Forces. It appears probable that this situation will continue.

Currently, a committee has been authorized by the Secretary of Defense that will consider the question of dental care for dependents. Recommendations will be incorporated in a report and submitted to the Secretary of Defense for his action.

Dependents of Army personnel—and Air Force dependents to a lesser extent—previously received dental care when dentists were available to give such care. The other services were not dispensing dental treatment to any great extent, and its being "taken away" did not affect their dependents as much as it did in the Army.

The purpose of the Dependents' Medical Care Act was "to create and maintain high morale throughout the uniformed services by providing an improved and uniform program of medical care for . . . dependents." Its intent was to aid in attracting and keeping the serviceman in the service. How well it is doing this job, it is too early to ascertain. A recent survey, however, of dependents who had availed themselves of civilian medical care showed that the vast majority of them were well pleased with the service they had received. Whether recruiting and reenlistments will, in turn, be stimulated is at best a difficult question to answer. In recruitment drives and reenlistment posters, the program is being featured as a benefit for service personnel.

As experience is obtained, it is possible that the protection of the program can be extended to include care for mental and nervous disorders and dental care—types of care that are limited under the present plan. A continuing study looking toward improvement and extension of medical care for service dependents is under way. A report from the Committee on Armed Services that accompanied the medical care bill when it reached the floor of the House of Representatives stated:

> It should be noted that the minimum requirements do not preclude additional benefits being provided if in the course of developing such program, the addition of benefits is both administratively and economically feasible.
>
> Those of us charged with the responsibility of administering this program have found it a challenging experience. It could not have become an effective program had it not been for the cooperation and good will we have met in every phase of its implementation. The principle, inherent in this program, of using private insurance organizations as the agents for providing service benefits has proved workable.

Notes and Brief Reports

State and Local Government Employment Under OASDI, January 1957*

Old-age, survivors, and disability insurance coverage of State and local government employees has continued to rise. In January 1957, almost 2 million of these workers were covered through voluntary agreements made by the States with the Federal Government—a slight increase from the number in October 1956.

The coverage added during the 3-month period amounted to somewhat more than 50,000, only about half the increase in the preceding quarter. In most States the number of employees covered in January 1957 was higher than in October 1956. For only a few States, however, was the increase marked. Sixty percent of the coverage added during the quarter was concentrated in four States—Michigan, Oregon, Texas, and West Virginia.

Of all State and local employees (other than those under compulsory coverage), slightly less than two-fifths have been covered through the voluntary agreement provisions. With the availability of new data from the Bureau of the Census, it has been possible to shift from October 1955 to October 1956 the base used in relating coverage to total employment. Consequently, the approximate coverage percentages for January 1957 cannot be compared with those for the preceding quarter for purposes of measuring the change between October 1956 and January 1957. The total for all employment in State and local governments was nearly 220,000 higher in October 1956 than in October 1955. Shifting to the more up-to-date base therefore tends to reduce the coverage index slightly. The 38 percent that represents the current approximate percentage for the continental United States would have been 40 percent if the old base had been used. The percentages shown in table 1 for each State are likewise affected, but the influence for some may be in the other direction.

In general, the States with the largest total employment in State and local governments have relatively small proportions of their employees covered. Seven States, each with more than 200,000 employees, account for almost half the total employment but for less than one-fifth of the covered employment. Approximately 16 percent of the aggregate employment of these seven States is covered, in contrast to 57 percent in the remaining 41 States.

The following tabulation shows the number of States distributed by the proportion of employment covered in January, separately for total employment and each type of government.

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* Prepared by Dorothy McCamman, Division of Program Research, Office of the Commissioner, from estimates developed in the Division of Program Analysis, Bureau of Old-Age and Survivors Insurance. More detailed data by State and type of government appear in a quarterly statistical report, *State and Local Government Employment Covered by Old-Age and Survivors Insurance under Section 218 of the Social Security Act* (Division of Program Analysis, Bureau of Old-Age and Survivors Insurance).