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MATERNITY BENEFIT PROVISIONS

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WOMEN'S BUREAU BULLETIN 272 • 1960

UNITED STATES DEPARTMENT OF LABOR
James P. Mitchell, *Secretary*

WOMEN'S BUREAU
Mrs. Alice K. Leopold, *Director*

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Beyeh, Sylva Sternoff.

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UNITED STATES DEPARTMENT OF LABOR

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FOREWORD

In these days, when one woman in three contributes to the national economy through her employment, and more than half of all women workers are married, the provision of maternity benefits for employed women is a matter of vital importance.

The present survey of existing provisions in the United States, both voluntary and legislative, supersedes an earlier bulletin (No. 240) published by the Labor Department's Women's Bureau in 1952. A major legislative advance was made in 1959 when Congress enacted a law providing that the Federal Government shall participate in the cost of health insurance (including maternity benefits) for its employees and their families.

For employees in private industry, maternity benefits are provided chiefly through voluntary health and insurance plans. These have made great progress since 1952, both in the number of employees covered and in the scope of benefits provided. Because these plans depend on the initiative of private citizens—employers, employees, medical personnel, and commercial insurance companies—there are wide variations in the type and amount of benefits provided, and some workers are not covered by any plan. The large majority of women in the United States who need maternity care, however, are covered by at least some of the programs described here.

This report was prepared and written by Sylva S. Beyer, under the general direction of Stella P. Manor, Chief of the Division of Program Planning, Analysis, and Reports in the Women's Bureau of the United States Department of Labor.

Grateful acknowledgment is given to the many specialists in other Government agencies who provided basic materials and offered valuable suggestions.

Alice K. Leopold,
*Assistant to the Secretary of Labor
and Director, Women's Bureau.*

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THE BACKGROUND

Growth of Maternity Benefit Plans in the United States

Millions of women in the United States are eligible for maternity benefits through health and insurance programs provided under voluntary plans or, in some cases, through legislative action. These benefits may take the form of cash payments to meet part or all of the expense of obstetrical care; or they may provide medical and hospital services. For women workers, they may also include maternity leave provisions and cash payments to compensate in part for loss of wages during disability.

“Voluntary” plans are those originated and maintained by the voluntary action of private individuals or groups. They include a great variety of job-related prepayment or insurance plans and health programs that provide maternity care for women workers.

The cost of these programs may be paid entirely by the employer, shared by employer and employees, or, in some cases, may be paid entirely by the employees. Whether or not she is covered by a job-related plan, a woman worker or her family may enroll in a plan not related to employment; or may purchase commercial insurance against loss of wages and the cost of medical care. In addition, maternity leave may be the subject of specific union-management contract clauses (as distinguished from provisions in union-management negotiated health plans). In companies where no plan is in effect and no union contract is in operation, provisions for maternity leave and pay during leave may be established by formal or informal company personnel policy.

The phenomenal growth of voluntary programs since World War II is an outstanding characteristic of health protection (including maternity protection) in the United States. About two-thirds of all workers are protected by employee health benefit plans of some type. Maternity benefits are provided by 90 percent of existing plans that were negotiated between unions and management, and by an unknown percentage of other job-related plans.

The trend in the United States toward voluntary programs is in sharp contrast to the trend in many other countries which has been

chiefly in the direction of legislated social insurance or health and maternity programs, either for groups of employed persons or as a public service for citizens in general (see chapter V). In the United States, also, some groups of women workers are covered by legislative or regulatory maternity provisions (see chapter IV). These groups include women workers in six States and Puerto Rico; women in the railroad industry; and (after July 1, 1960, on a voluntary basis) women employed by Federal agencies. Many women, whether employed or not, are eligible for maternity benefits as wives of men employed by Government agencies or men in the Armed Forces.

Number of Women Workers Eligible for Maternity Care

Over 90 percent of all women in the United States marry at some time in their lives. About 35 percent of all women 14 years of age and over—but only about 30 percent of married women living with their husbands—were in the work force in 1958.

Because of the great preponderance of married women in the population, however, more than half of all women workers are married. In March 1958, according to estimates of the Census Bureau, 11.8 million out of a total of 22 million women in the work force were married and lived with their husbands. Of these married women, 4.2 million were 45 years of age or over. This left 7.6 million women workers in the age groups (14 through 44 years) when most women have their children. In addition, 1.2 million women workers (all ages) were married to men who were temporarily absent for service in the Armed Forces or for other reasons. Between March 1958 and October 1959, the number of women in the work force increased from 22 million to 23½ million. At a conservative estimate, therefore, there were then some 9 million women workers for whom maternity care was potentially important. From 93 to 95 percent of the women workers are employed; the remainder are unemployed, but actively seeking work.

In any one year, the percentage of pregnancies among employed women is relatively small. According to various studies made during and after World War II, about 4 percent of employed women need maternity care in a given year.¹ It is possible that the percentage has

¹ A Women's Bureau field survey of 43 firms in 1950 found that the number of women who had left their jobs in the preceding year, giving pregnancy as their reason, averaged 4 percent. A large commercial insurance company estimated that about 4 percent of the employed women insured with them under health insurance plans that included maternity benefits received such benefits during the preceding year. Among women qualified to receive maternity benefits under the Railroad Unemployment Insurance Act (see p. 22), the incidence ranged from 3 percent in 1947-48 to 5 percent in 1956-57.

risen slightly in recent years, perhaps to $4\frac{1}{2}$ or 5 percent.² This means that there may be as many as a million maternity cases among employed women in a year's time, or one for every nine married women workers under 45 years of age.

In general, however, women who work tend to have smaller families than women who do not work. This is because many women drop out of the work force when their first—or perhaps their second—baby is born. Of the women with children under 6 years of age, only one in five was in the work force in 1958, compared with two in five of the women whose children were 6 to 17 years of age. The decision to return to work is a matter of choice, made by the woman and her family on the basis of family income, individual preference, local job opportunities, and various other factors. As a result, the women in the work force are likely to be those who have few children or no children.

Beneficiaries of Maternity Care Plans

In 1957, some form of health insurance was held by 67 percent of all women in the United States, according to the Health Insurance Institute.³ This figure agrees closely with that of the Social Security Administration of the Department of Health, Education, and Welfare, for 1956,⁴ which estimated that 70 percent of all women 14 through 64 years of age had health insurance of some sort. At that time, two-fifths of all insured women were in the work force.

Many job-related plans provide benefits for workers' dependents as well as for the workers themselves. It may happen, therefore, that a wife who is not employed or who, though employed is not covered by such a plan, is eligible for maternity benefits by virtue of her husband's coverage at his place of employment. Her benefits as wife are usually less in amount than those of covered workers, and of course they do not include payments to compensate for income loss.

² Census estimates indicate a rise of 31 percent from 1950 to 1957 in the number of children ever born per 1,000 women workers, 15 through 44 years of age, who were or had been married. This is greater than the increase (18 percent) among women not in the work force.

³ *A Profile of the Health Insurance Public*, published by Health Insurance Institute, 438 Madison Ave., New York, N.Y., 1959. P. 7.

⁴ See Agnes W. Brewster, Division of Program Research, Social Security Administration, U.S. Department of Health, Education, and Welfare, I. *Health Insurance Coverage by Age and Sex, September 1956*, Research and Statistics Note No. 13, 1958; and II. *Characteristics of the Population with Hospitalization Insurance, September 1956*, Research and Statistics Note No. 14, 1958.

VOLUNTARY BENEFIT PLANS

Types of Maternity Benefits for Employees

Maternity benefits made available to groups of women workers through voluntary plans are of several types: Maternity leave; payments to compensate for wages lost (known as accident and sickness benefits); payments for obstetric care; and the provision of medical and hospital services. A plan may provide for one or more of these benefits.

Voluntary plans, as distinct from legislative programs, include plans negotiated between unions and management; commercial insurance plans; plans operated by associations of hospitals or physicians; and cooperative plans operated by the members.

Maternity Leave

Maternity leave actually involves several things: (a) a relatively short leave period, (b) an extended leave period, and (c) job security. Job security, too, needs to be considered under more than one heading: (1) security against immediate dismissal because of pregnancy; (2) security against dismissal during leave—i.e., assurance of reemployment; (3) assurance of the same or an equivalent job—i.e., retention of seniority; and (4) accumulation of seniority for a limited period, or throughout the whole leave period.

In practice, provisions for maternity leave are many and varied. They may, as already noted, be spelled out in a negotiated or non-negotiated employee health plan; in clauses of union-management contracts other than health plan contracts; in a company's formal personnel policy; or they may be informal, tailored to the employee's need and the company's requirements. Union contract maternity leave clauses are found in 28 percent of union contracts.⁵ A contract clause may state, for example, what plant official the employee is to notify, under what circumstances leave will be granted and for how long, whether reemployment is guaranteed, whether and how long seniority will remain in force, or whether seniority will accumulate.

⁵ *Collective Bargaining Negotiations and Contracts, Vol. 2, Contract Clause Finder*, 62: 241-245, Washington, D.C. Bureau of National Affairs, Inc., loose leaf, March 21, 1958.

The National Industrial Conference Board recently analyzed the maternity leave provisions of 112 firms (11 unorganized, 101 under union contract).⁶ About half the firms specified the maximum time during which the employee may continue to work—generally up to the fifth or sixth month of pregnancy. About a fourth also stipulated a definite period before the employee could return to work, usually not sooner than the second or third month after delivery.

Duration of leave of absence (without pay) ranged up to 2 years, with only 1 company allowing less than 3 months. Over one-third of the companies granted 6 months; one-fourth, 12 months. About one-half allowed an extension of the original leave period. Three-fourths of the companies provided “for some degree of seniority protection,” but only one-fourth guaranteed reemployment in the same or a similar job. An earlier study by the National Industrial Conference Board covered personnel practices, including maternity leave, in over 400 companies.⁷ Almost three-fourths of these companies granted maternity leave without pay to workers paid on an hourly basis (production workers) and almost one-half, to certain salaried workers. At that time, quite a number of firms required pregnant employees to resign.

Compensation During Leave

Payments to compensate in part for wages lost because of disability are known as “accident and sickness benefits” or “temporary cash disability payments.” These payments are almost always less than full wages—usually a given percent of wages, or scaled according to wage brackets, although they may also be set according to occupational group or scaled to length of service.

With few exceptions, accident and sickness benefits are the same for women as for men. Most often, and increasingly, the amount of the benefit is the same for maternity cases as for other types of disabilities; but almost always the benefit is available for a shorter period for maternity disabilities than for other disabilities.

Accident and sickness benefits are provided under many health and insurance plans and programs. Frequently, however, an employer provides these benefits under a “sick leave plan,” separately from any health and welfare insurance plan which may be in force. The employer generally finances the sick leave plan through operating funds set aside for the purpose, usually on a self-insured basis. Employers without a formal plan may pay cash maternity disability

⁶ National Industrial Conference Board, Inc., *Management Record*, July-Aug. 1959, Vol. XXI, Nos. 7-8, “Maternity Leaves of Absence,” pp. 232-234, 260-263.

⁷ *Personnel Practices in Factory and Office*, National Industrial Conference Board, Inc., 247 Park Ave., New York, N.Y. Studies in Personnel Policy, No. 145. 1954. Pp. 29 and 80.

benefits on an individual basis. Employees themselves sometimes purchase commercial insurance for such benefits.

The accident and sickness benefits for maternity disabilities through union-management plans are discussed under "Beneficiaries of Maternity Care Plans," page 3.

Medical and Surgical Care

Maternity care is often included in the medical and surgical care of insurance purchased by individuals, families, or groups of individuals or families. The group may be made up of fellow employees, members of a community cooperative association, members of a union, of a professional association, or of a variety of other associations. A majority of workers have protection under some form of employee benefit plan or program, the cost of which is most often paid for or shared by the employer. Some persons are covered by more than one plan or form of insurance.

All insurance plans and programs for medical care protection have this in common: They are prepaid; that is, payments are made before the expense of medical care is incurred. And all are insurance in the sense that they provide against a contingency and spread the financial risk.

Types of Insurance Plans

There are basically two types of insurance: (1) commercial individual and group insurance that provides cash indemnity benefits; and (2) service plans that provide, not cash, but the medical care itself. Service plans again may be divided into (a) Blue Cross and Blue Shield plans, operated by associations of hospitals and of physicians respectively, and (b) independent plans which are not associated with the other types of plans or with each other. Insurance company payments represented 47 percent of the total hospital, surgical, and medical benefits paid in 1957; Blue Cross-Blue Shield accounted for 47 percent; and independent plans for the remaining 6 percent.⁸

Blue Cross

Blue Cross is a nonprofit association providing hospital benefits through voluntary prepayment plans. In 1959, it had 79 plans operating in the United States through which 56 million Americans in 48

⁸ Health Insurance Council, *Twelfth Annual Survey, The Extent of Voluntary Health Insurance Coverage in the United States* as of December 31, 1957. New York, N.Y., August 1958.

States and the District of Columbia were protected for hospital care. Some plans served complete States; some, metropolitan areas.

To earn the right to use the Blue Cross symbol a plan must comply with Standards of the American Hospital Association. In addition, most plans are supervised by some State agency, usually the department of insurance, and in most States must comply with statutory requirements specifically applicable to such plans.

Typically, the hospital service benefits offered include care in semi-private rooms for varying periods (depending on the subscription charges paid), and a full range of hospital services.

Subscription rates vary from area to area, depending on the comprehensiveness of the services offered, the local cost of the services, and claims experience in the area.

Blue Shield

Generally, Blue Shield plans provide for surgical, including obstetrical, care; many also provide for home or office calls.

About 79 percent of persons covered by Blue Cross (in 1959) were also covered by Blue Shield. The two associations have grown up side by side; they work closely together and the administration frequently is in Blue Cross hands.

The 67 plans in the United States which were members (when this study was made) of the National Association of Blue Shield Medical Care Plans cover more than 42 million persons. Most plans are statewide, some citywide. The largest had over 5 million enrollees, the smallest about 10,000. Participating in the plans were 120,000 doctors.

Fifty-three of the plans were service plans under which doctors agree to accept a stipulated sum in full payment for their services if the member's or family's income did not exceed a specified annual amount.

All plans are required to meet overall standards of care.

Independent Plans

Independent plans show wide dissimilarities in the scope of the benefits they provide their membership. Some independent plans include hospitalization among their benefits; others, only hospital benefits; some do not provide this benefit at all. The same is true with respect to surgical services, medical care in and out of the hospital, and out-patient diagnostic benefits.

The 1957 Survey of Independent Plans showed an enrollment of close to 9 million persons in independent plans in 1956.

The Labor Health Institute of St. Louis⁹ is an example of a comprehensive independent plan. It provides hospitalization; medical and surgical care in the hospital; medical, diagnostic, and preventive services in the clinic; medical care in the home; visiting nurse services; drugs at cost; ambulance service; and so forth. Institute services, which include full maternity care, are available to employed persons covered by collective bargaining contracts with industrial companies; dependents of workers; and other members of the community. The employer pays the full cost of coverage for his employees.

At the other end of the scale are small hospital associations that provide only cash indemnity benefits for a limited number of days in the hospital. A number of these plans are designed to round out the medical benefits already available to their membership through group insurance or Blue Cross-Blue Shield; these plans may therefore omit hospitalization and/or surgical expense insurance and provide, instead, such items as outpatient physicians' services, diagnostic services, physicians' visits to the home, and drugs.

About two-fifths of the enrollees in independent plans receive some benefits, if not all, through group-practice arrangements. An example of such plans is the Group Health Association of the District of Columbia. Organized late in the 1930's by Federal employees, the plan now admits other members from within the greater metropolitan area. Complete obstetrical services are provided. The member pays the first \$125 of the maternity hospital bill, but prenatal and post partum medical visits are covered by the monthly dues. Nominal charges are made for laboratory examinations and diagnostic tests.

Other examples of group-practice plans are the Health Insurance Plan of Greater New York (see page 37), and the Kaiser Foundation Health Plan. The Kaiser Plan provides medical care and hospitalization to over half a million persons in the West Coast States. A charge of \$60 is made for complete medical care for mother and child during confinement. In cases of interrupted pregnancy, the charge is no more than \$40.

Membership in group-practice plans most commonly occurs through participating groups organized chiefly on a union or company basis. Dependents are eligible for coverage. Benefits vary. The following benefits are provided for employees covered by programs reported on by the Bureau of Labor Statistics in 1958:¹⁰ In-

⁹ Franz Goldman, M.D. and Everts A. Graham, M.D., *The Quality of Medical Care Provided at the Labor Health Institute, St. Louis, Missouri*, Labor Health Institute, St. Louis, Mo., 1954. Also, St. Louis Labor Health Institute *Handbook of Rules and Regulations*, Jan. 1, 1958.

¹⁰ U.S. Department of Labor, Bureau of Labor Statistics, Bull. No. 1236, *Digest of One Hundred Selected Health and Insurance Plans Under Collective Bargaining, Early 1958*, Washington, D.C., 1958.

hospital care by physicians, including surgeons and specialists; doctor's care at the office, including consultations and treatment by specialists; follow-up calls by doctors (with a \$2 charge for first home visit) and visiting nurses; unlimited emergency services; full hospital care and services, including private rooms and private-duty nursing when needed.

An example of a wholly employer-financed plan is that of the Endicott Johnson Corporation.¹¹ Complete services, including maternity care, are offered for employees and their family dependents on a group-practice basis. Hospitalization, at a community hospital, is fully covered. Physicians' care is available at the clinic operated by the plan, at home, or in the hospital. All the medical specialties are represented, including obstetrics and gynecology.

A number of unions operate their own plans. The United Mine Workers' Welfare and Retirement Fund, for example, maintained through employer contributions, provides services for mining families in a number of States. The fund operates 10 hospitals with out-patient clinics and, in addition, has made arrangements with a number of group-practice clinics owned or operated by physicians.

A number of self-insuring union trust funds purchase some of the benefits provided their membership from other independent plans. Several in New York City, for example, self-insure their hospitalization benefits but secure their surgical and medical coverage through a contract with the Health Insurance Plan of Greater New York.

¹¹ Federal Security Agency, Public Health Service, *Medical Care Programs in Industry*, reprinted from the *Industrial Hygiene Newsletter*, official publication of the Division of Industrial Hygiene, U.S. Public Health Service, 1949.

Analysis of Health and Insurance Plans Under Federal Protective Legislation, 1937-1938. Bureau of Labor Statistics Bulletin 1251 (Nov. 1937); and Health and Insurance Plans Under Federal Protective Legislation, 1937-1938. Bureau of Labor Statistics Bulletin 1252 (Jan. 1938). The 1937 study included information on various types of maternity benefits for both working women and dependent wives. The 1938 study covers maternity, accident, and sickness benefits available only to active workers—including women.

Results of the Bureau of Labor Statistics studies of maternity benefit plans under collective bargaining agreements—those in effect in 1937—were not available when this Women's Bureau bulletin was being prepared, but are being published by the Bureau of Labor Statistics during 1939. Analysis of maternity benefit plans for both working women and dependent wives are covered in Health and Insurance Plans Under Federal Protective Legislation, Bulletin 1252, Bureau of Labor Statistics, Bulletin 1252, 1938. This bulletin will provide information on maternity benefit plans under collective bargaining agreements in effect during the two years of 1937.

UNION-MANAGEMENT PLANS

Particularly characteristic of the American mind-set are the voluntary health and insurance plans negotiated between unions and management, most of which include maternity benefits. Only active workers are eligible for some of the benefits (such as accident and sickness benefits) provided by these plans; and for some other types of benefits, dependent wives of working men are eligible. Because of their special interest to the woman worker, the plans affecting her are given here in more detail than those covering dependent wives. Information on all the types and amounts of benefits provided is available from Bureau of Labor Statistics bulletins covering union-management plans in operation in 1955 and 1958.¹²

Maternity Accident and Sickness Benefits

Cash benefits for disabilities resulting from pregnancy are provided for women workers under many health and insurance plans negotiated between unions and management.

Of the plans studied in 1958, 232 provided accident and sickness benefits and 75 percent of these included accident and sickness benefits for disabilities resulting from pregnancy. Of the plans studied in 1955, 239 provided accident and sickness benefits, but only 60 percent of these included maternity benefits. Accident and sickness benefits were provided under most of these plans through group insurance

¹² "Analysis of Health and Insurance Plans Under Collective Bargaining, Late 1955," Bureau of Labor Statistics Bulletin 1221 (Nov. 1957); and "Health and Insurance Plans Under Collective Bargaining—Accident and Sickness Benefits, Fall 1958," Bureau of Labor Statistics Bulletin 1250 (June 1959). The 1955 study includes information on various types of maternity benefits available for both working women and dependent wives; the 1958 study covers maternity accident and sickness benefits available only to active workers—including women.

Results of the latest Bureau of Labor Statistics studies of maternity benefit plans under collective bargaining agreements—those in effect in 1959—were not available when this Women's Bureau bulletin was being prepared, but are being published by the Bureau of Labor Statistics during 1960. Analysis of *maternity hospital benefits* for both working women and dependent wives are covered in "Health and Insurance Plans Under Collective Bargaining: Hospital Benefits, Early 1959" Bureau of Labor Statistics Bulletin 1274, 1960. Further study results to be published by the BLS in 1960 will provide information on *maternity surgical and medical benefits* under collective bargaining agreements in effect during the late summer of 1959.

policies, although some depended on self-insurance by the employer. The employer paid the full cost of financing the plans in 59 percent of the plans in 1958, compared with 57 percent in 1955.

Qualifying Period

In addition to the period required for a new employee to become insured (which in nearly all the plans was 4 months or less), a waiting period was required in the majority of plans before an employed woman was qualified to draw maternity benefits. As shown in the following summary, fewer plans made maternity benefits available immediately in 1958 than in 1955:

	Year	
	1958	1955
Plans providing maternity benefits.....	168	166
For all insured women (benefits immediately available).....	47	53
For women whose pregnancy commences while insured.....	76	66
For women who have been insured for a definite period (usually 9 months).....	45	47

Amount of Accident and Sickness Benefits

Most of the plans (162 in 1958) provided for weekly cash benefits. Of these, all but one (where benefits were based on employee's length of service) provided either a uniform (flat) weekly benefit or a weekly benefit scaled to earnings. The flat benefits ranged from \$9 to \$55 a week in the plans studied in 1958; the median amount being \$35. The benefits scaled to earnings, for women earning \$57.70 a week (equivalent to \$3,000 a year), ranged from \$10 to \$48 a week. The median was 60 percent of earnings—\$35 a week at the \$3,000 level. The following tabulation shows the number of plans of each type providing weekly benefits of specified amounts in 1958 and also in 1955:

Amount of weekly maternity benefit for women earning \$3,000 a year	Number of plans providing—			
	Flat amount		Graduated amount	
	1958	1955	1958	1955
Total.....	87	94	74	70
Under \$20.....	4	6	1	1
\$20 exactly.....	2	6	---	---
\$20.01 to \$24.99.....	1	4	2	5
\$25 exactly.....	8	7	2	2
\$25.01 to \$29.99.....	1	---	12	16
\$30 exactly.....	22	22	7	14
\$30.01 to \$34.99.....	4	5	6	7
\$35 exactly.....	7	5	18	13
\$35.01 to \$39.99.....	2	3	9	6
\$40 exactly.....	12	31	4	4
\$40.01 to \$44.99.....	1	---	10	2
\$45 and over.....	23	5	3	---
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Only two of these plans providing weekly benefits paid women a smaller amount for pregnancy disabilities than for other types of disability; one paid \$5 less and the other \$6 less, per week. (A few accident and sickness plans paid lower benefits to women than men for disabilities of any type. There were 11 of these in 1958, out of a total of 230 plans; and 13 in 1955. Information is not available to show whether any of these plans included maternity benefits.)

That the general trend in the amount of maternity accident and sickness benefits is upward is indicated by the tabulation below:

<i>Amount of maternity benefit</i>	<i>Percent of plans paying—</i>			
	<i>Flat amount</i>		<i>Graduated amount</i>	
	<i>1958</i>	<i>1955</i>	<i>1958</i>	<i>1955</i>
\$25 and over.....	92	83	96	91
\$30 and over.....	82	76	77	66
\$45 and over.....	26	5	4	0

Duration of Benefits

In 1958 as in 1955, the predominant maximum period for which maternity accident and sickness benefits were payable was 6 weeks. Of the 162 plans providing maternity benefits in 1958, only 1 had a maximum duration period as long as that for nonmaternity disabilities—26 weeks under this particular plan. A comparison of the duration of 1955 and of 1958 benefit follows:

<i>Duration of maternity benefit</i>	<i>Number of plans</i>	
	<i>1958</i>	<i>1955</i>
All plans.....	162	166
4 weeks.....	1	1
6 weeks.....	158	159
8 weeks.....	2	—
13 weeks.....	—	4
26 weeks.....	1	2

Comparison of Plans Studied in 1958 and 1955

Of the plans with cash accident and sickness benefits, a slightly larger proportion in 1958, than in 1955, provided these benefits for disabilities resulting from pregnancy. In plans requiring an additional qualifying period for pregnancy or maternity benefits, the benefits were more likely in 1958 than in 1955 to be available on the basis "if pregnancy commences while worker is insured." This provision covers the contingency of disabilities arising from an interrupted pregnancy.

On the whole, the maternity benefits provided were somewhat more liberal in 1958 than in 1955. This does not necessarily mean, however, that the benefits were increased as much as the costs of medical care increased during the 3-year period.

Other Maternity Benefits Provided (1955)

The 1955 report on 300 health and insurance plans negotiated between unions and management (see footnote 12) includes extensive information on various types of maternity benefits available through these plans, in addition to the cash accident and sickness benefits discussed in the previous section. Maternity benefits of some kind were available for women employees in 90 percent of the plans and for the wives of men employees in 88 percent of the plans.

Types of Benefits

Under some plans, a general lump sum allowance was provided as the entire maternity benefit. Generally, however, coverage was in the form of specific allowances or services—that is, hospitalization, surgical (obstetrical), and medical benefits; and the weekly accident and sickness benefits to compensate for wages lost, which have already been discussed in some detail.

The following tabulation shows the number of plans providing specific types of benefits for women employees and for wives of men employees:

<i>Maternity benefits available</i>	<i>Number of plans covering—</i>	
	<i>Women employees</i>	<i>Wives of men employees</i>
Hospital -----	239	230
Surgical -----	233	210
Medical -----	16	14
General lump sum allowance-----	30	34
Weekly accident and sickness-----	166	0

For both women workers and wives of men employees, the single maternity benefit most frequently provided was hospitalization, followed closely by surgical benefits.

The most frequently provided combination of benefits was: For women workers, weekly cash accident and sickness payments, hospitalization and surgical benefits; for wives as dependents, hospitalization and surgical benefits.

Qualifying Period

Many plans required a qualifying period—beyond any waiting period necessary to become eligible for insurance—before maternity benefits became available.

The extent to which a qualifying period was required for women employees under plans providing maternity hospital, surgical, medical, and lump sum allowance is shown in table 1. In some cases, these benefits became available to workers immediately on being insured,

but under the majority of plans, a qualifying period (usually 9 months) was required.

Table 1. Availability of Specified Maternity Benefits for Women Employees, 1955

[Based on 300 health and insurance plans]

Plan	Weekly accident and sickness	Hospital	Surgical	Medical	Lump sum allowance
Plans providing benefit.....	166	239	233	16	30
For all insured women ¹	53	42	40	8	10
For women whose pregnancy commences while insured.....	66	72	79	-----	11
For women who have been insured for a definite period:					
8 months.....	1	10	8	-----	-----
9 months.....	37	88	85	1	5
10 months.....	3	18	11	4	3
12 months.....	1	5	6	1	-----
Other periods.....	5	4	4	2	1

¹ Benefits immediately available.

Similar provisions existed for wives of men employees, with an even higher proportion of plans requiring a qualifying period of 9 months or longer for hospital benefits.¹³

Hospital Benefits for Maternity Care

More than two-thirds of the 239 plans with hospital benefits for maternity provided cash benefits for women employees; about one-fourth provided service benefits; a few provided both cash and service benefits.

Cash plans.—A flat amount (e.g., \$100) for all expenses in the hospital was provided in nearly half the 166 cash plans covering workers for this benefit.

Separate allowances for daily room and board charges and for hospital extras or ancillary services were provided under more than two-fifths of these cash plans (less than one-fifth in the case of dependent wives).

A maximum daily allowance for room and board, with an overall maximum for all maternity hospital expenses, was provided by the remaining plans.

¹³ Benefits for wives of men employees are not discussed further in this bulletin. Detail on them can be found in Bureau of Labor Statistics Bulletin 1221, "Analysis of Health and Insurance Plans Under Collective Bargaining, Late 1955," and in BLS Bulletin 1274, "Health and Insurance Plans Under Collective Bargaining: Hospital Benefits, Early 1959."

Service plans.—Under service plans, women employees were assured specified service benefits rather than allowances toward the cost of benefits. Under a few plans they had to pay an initial maternity charge (e.g., the first \$60 of all hospital, surgical, and medical expenses incurred); thereafter, full service benefits were provided.

Duration.—Plans, other than those which provided a flat amount applicable to total hospital costs, stipulated the number of days available to women employees for maternity hospital benefits. (See table 2.) In two-thirds of these 149 plans, the maximum benefit period provided was shorter than for nonmaternity cases. Generally, the service types of plans stipulated longer benefit periods than did the cash types.

Only three plans stipulated less than 8 days as the maximum for hospital benefits. Two-fifths of the plans stipulated a 14-day maximum. Over a fourth provided for longer stays. Four plans provided extended coverage periods at reduced allowances.

Table 2.—Maximum Duration of Maternity Hospital Benefits for Women Employees by Type of Plan, 1955

[Based on 300 health and insurance plans]

Maximum duration of full-benefit period	Number of plans		
	All plans	Type of benefit	
		Cash	Service
Plans providing hospital benefits.....	239	173	66
Plans stipulating maximum duration.....	149	83	66
Under 8 days.....	3	2	1
8 days.....	8	3	5
10 days.....	35	12	23
11-13 days.....	2	2	-----
14 days.....	59	57	2
15-69 days.....	5	4	1
70 days.....	10	1	9
71-119 days.....	2	2	-----
120 days.....	21	-----	21
Over 120 days.....	4	-----	4
Duration not specified.....	90	90	-----

Hospital Daily Room and Board Maternity Benefits

Under Service Plans.—Under virtually all of the plans providing services, both workers and dependents were eligible for semiprivate accommodations—generally described as rooms having two beds or as having two and not more than four beds. If the patient occupied a private room, she was responsible for the difference in cost.

Under Cash Plans.—Ninety-four plans provided a fixed daily cash allowance for women employees toward the cost of hospital room

and board. Any charge in excess of this amount was paid for by the insured.

Only 10 of these plans provided a lesser daily cash allowance for maternity than for other cases. The average amount provided was \$11.17 a day. The most frequently provided daily allowances were in the ranges \$10 to \$10.99 and \$12 to \$12.99.

The total maximum room and board allowance (the daily cash allowance times the maximum number of days) ranged from under \$100 to more than \$250 in 72 cash plans covering women employees. Just under three-fourths of these cash plans provided total maximums ranging from \$100 to \$175:

<i>Total maximum room and board allowance</i>	<i>Plans</i>	
	<i>Number</i>	<i>Percent</i>
All cash plans specifying maximum-----	72	100
Under \$100-----	8	11
\$100 to \$124.99-----	17	24
\$125 to \$149.99-----	23	32
\$150 to \$174.99-----	13	18
\$175 to \$199.99-----	3	4
\$200 to \$224.99-----	2	3
\$225 to \$249.99-----	3	4
\$250 and over-----	3	4

Maternity Hospital-Extra Allowances

Hospital "extra" or ancillary maternity services include use of operating and delivery rooms, supplies (e.g., bandages, anesthetic materials), prescribed laboratory examinations, and specified drugs and medications. Not all health and insurance plans provided for these services; and for 79 plans covering women employees the value of extra services could not be computed because these plans provided a flat lump sum covering room and board and extra services. However, 160 plans made specific provision for hospital charges other than for room and board.

The various methods used in providing these benefits were the same for maternity and nonmaternity cases.

Cash plans provided for one of the following:

- (1) Payment of charges up to a fixed maximum.
- (2) Payment of the full cost of specified services.
- (3) Payment of the difference between the total hospital charges for room and board and the maximum specified under the plans.
- (4) Reimbursement in full of charges up to a certain level, and of 75 percent of the charges in excess of this level.

The great majority of these cash plans provided for methods (1) and (2); only about a tenth provided for method (3); and only 4 plans for method (4).

Service plans typically listed those benefits for which cost was covered (in full or in part), and those excluded. Virtually all plans provided the same services for maternity cases as for nonmaternity cases, except that some plans added nursery care for the newborn infant.

The methods used by all the plans to specify allowances for hospital extras were as follows:

<i>Extra hospital benefit allowance</i>	<i>Plans</i>	
	<i>Number</i>	<i>Percent</i>
All plans providing allowance.....	160	100
Allowance for expense incurred:		
Up to a fixed amount.....	65	41
Up to a fixed amount with additional reimbursement on a percentage basis.....	4	3
Up to a difference between room and board charges and a fixed amount.....	19	12
Other	4	3
Benefit provided on a service basis for entire benefit period..	68	43

The amounts allowed under cash plans providing full reimbursement up to a fixed level ranged from less than \$50 to over \$275. More than half the plans allowed less than \$125. The amounts most frequently provided ranged from \$100 up to (but not including) \$125.

<i>Maximum amount</i>	<i>Plans</i>	
	<i>Number</i>	<i>Percent</i>
All plans providing reimbursement of hospital extras up to a fixed amount.....	65	100
Under \$50.....	6	9
\$50 to \$74.99.....	6	9
\$75 to \$99.99.....	10	15
\$100 to \$124.99.....	15	23
\$125 to \$149.99.....	8	12
\$150 to \$174.99.....	6	9
\$175 to \$199.99.....	1	2
\$200 to \$224.99.....	6	9
\$225 to \$249.99.....	3	5
\$250 to \$274.99.....	1	2
\$275 and over.....	3	5

Lump Sum Allowance for Maternity Hospital Care

Frequently plans provided, as the total hospital cash benefit, a flat, lump sum which could be applied to any part of the hospital bill for room and board and special services. This approach was used in 79 plans covering women employees. The amounts ranged from \$50 to \$175; about three-fourths of the plans provided between \$75 and \$125.

<i>Amount</i>	<i>Plans</i>	
	<i>Number</i>	<i>Percent</i>
All plans providing a flat, lump-sum for hospitalization-----	79	100
\$50 to \$74.99-----	8	10
\$75 to \$99.99-----	29	37
\$100 to \$124.99-----	31	39
\$125 to \$149.99-----	6	8
\$150 to \$174.99-----	3	4
\$175 and over-----	2	3

Maternity Surgical Benefits

Surgical benefits for maternity cases were provided under 233 plans covering women employees. Benefits were in the form of a cash allowance under the overwhelming majority of plans. Only 11 plans made service benefits available.

Under all plans, the benefit was the same as that provided in non-maternity cases. However, of 40 cash plans which had an income limitation provision, 12 did not extend this provision to maternity cases.¹⁴

Amount of Surgical Benefits

Under Cash Plans.—Under cash surgical plans, the amount available for “normal delivery” usually was greater than for a miscarriage or abortion but less than for a caesarean section or ectopic pregnancy. The “normal delivery” allowance ranged from \$50 to \$175. The most frequent amounts, provided by nearly two-thirds of the plans, were \$50 and \$75. The amounts provided by all cash plans were as follows:

<i>Allowance for normal delivery</i>	<i>Plans</i>	
	<i>Number</i>	<i>Percent</i>
All plans providing a cash benefit-----	222	100
Under \$50-----	2	1
\$50-----	68	31
\$50.01 to \$59.99-----	1	(¹)
\$60-----	25	11
\$60.01 to \$74.99-----	18	8
\$75-----	72	32
\$75.01 to \$99.99-----	20	9
\$100-----	5	2
\$100.01 to \$124.99-----	4	2
\$125-----	6	3
Other-----	1	(¹)

¹ Less than 1 percent.

¹⁴ Under 40 plans utilizing Blue Shield, participating doctors agreed to accept the scheduled surgical or obstetrical allowance as full payment of their services unless the worker's income exceeded a specified amount; 12 plans did not apply this agreement to maternity cases.

Under Service Plans.—Service plans provided the full cost of surgical care, with this exception: Under a few such plans, workers had to pay an initial maternity charge (e.g., the first \$60 of all hospital, surgical, and medical charges incurred), but thereafter full service benefits were provided.

Maternity Medical Benefits

Only 16 plans provided medical benefits for pregnant women employees, i.e., provided for doctor's visits other than those of the doctor performing the surgical procedures.

Service Medical Benefits were provided by 12 plans. The majority of these plans made the benefits available regardless of where they were provided—at home, doctor's office, health center, or hospital. Two, however, provided medical care only in the hospital; and one, only in the medical center.

The 4 cash medical plans, unlike the majority of service plans, provided benefits only in the hospital, or only in the doctor's office. Two plans provided the same in-hospital medical benefit specified for nonmaternity cases; the others provided special allowances differing from those available in nonmaternity cases.

<i>Benefit provided for treatment</i>	<i>All plans</i>	<i>Cash plans</i>	<i>Service plans</i>
All plans-----	16	4	12
In hospital only-----	5	3	2
In hospital, doctor's office, home, and health center----	8	-	8
In hospital and health center-----	1	-	1
In health center only-----	1	-	1
In doctor's office only-----	1	1	-

General Lump Sum Allowance Toward Maternity Care

A specified sum of money, or general lump-sum allowance, was provided women employees under 30 plans.

Under 22 of these plans, this lump sum was provided in lieu of all other benefits. The remaining 8 plans allowed a lump sum in addition to one other benefit, e.g., accident and sickness benefit or hospital benefit.

As with the separate benefits, a waiting period was usually specified (see table 1).

The lump-sum provided ranged from \$50 to \$175. The amount most commonly specified was \$150, as shown in the summary on the following page.

Maternity Benefit Provisions

Amount of lump sum	Number of plans with general lump sum provided—		
	All plans	As only maternity benefit	In addition to another benefit
All plans providing lump sum-----	30	22	8
\$50 -----	4	4	—
\$75 -----	6	4	2
\$100 -----	6	4	2
\$125 -----	2	1	1
\$130 -----	1	1	—
\$150 -----	10	8	2
\$175 -----	1	—	1

IV

LEGISLATION AND REGULATION IN THE UNITED STATES

The United States has more legislation that provides maternity protection for women workers than is generally realized. Well-known laws are the Federal Railroad Unemployment Insurance Act providing weekly cash maternity benefits to women in the railroad industry; the Rhode Island Cash Sickness Compensation Act providing weekly cash maternity benefits to women workers in that State; and the laws of six States and Puerto Rico prohibiting employment for specified periods before and after childbirth—in Puerto Rico with half-pay.

Less familiar are laws and regulations making protection available to many thousands of other women workers. Included in these provisions are income tax deductions for sick pay received during illness in pregnancy; leave with pay for over half a million Federal civilian women employees; and maternity medical care for women in the armed services, in several Federal civilian agencies, and, after July 1, 1960, in all Federal civilian agencies.

Included also are provisions for women workers who benefit indirectly, i.e., not through their own connections with a job but as dependents. Such provisions apply to 98,000 employed wives of men in the armed services, to the working wives of men in certain Federal civilian agencies, and—after July 1, 1960—to the wives of all men in the Federal civilian Government who elect family coverage.

Still other women who benefit, also, not directly as workers but as “medically needy” when they must give up their jobs because of pregnancy, are thousands of beneficiaries of Federal, State, and local provisions for maternity medical care.

More detailed information regarding the above laws and regulations, as well as experience under them, follows.

Federal Legislation and Regulations

Federal Income Tax Deduction

Applicable to all women workers whose employment entitles them to sick pay is a provision of the Federal income tax law allowing a

deduction from taxable income for sick pay received while a worker is absent because of illness during pregnancy. Pay received for periods of absence due *solely* to pregnancy is not deductible; but if the absence is due to *illness during pregnancy*, part or all of the sick pay received is deductible, whether the illness was the result of pregnancy or of some other cause. There is a waiting period of 1 week for which sick pay is not deductible, unless the employee is hospitalized; if she is hospitalized even for a day, sick pay for the entire period of her absence from work is deductible. No more than \$100 a week is deductible, however, even if a larger amount of sick pay is received.

Railroad Unemployment Insurance Act¹⁵

The Railroad Unemployment Insurance Act provides for unemployment, sickness, and special maternity weekly cash benefits. The basic formula by which the amounts of benefits are determined is the same for all three types of benefits.

The Act has been amended several times, most lately on May 19, 1959, effective immediately.¹⁶ The main purpose of amendments after 1946 has been to raise benefits so that they would keep pace with earnings, and to adjust the financing of the program to the cost experience.

Under the 1959 Amendment, a woman must have earned at least \$500 of railroad wages in a base year (calendar year) in order to qualify for maternity benefits in the benefit year, which begins the following July 1. If her earnings were at least \$500 in 1958, she is qualified in the period July 1, 1959–June 30, 1960.

Her daily benefit rate will be determined in one of two ways, whichever will provide the higher rate, though in neither case may it exceed \$10.20. Her rate will either be:

- (a) Sixty percent of her daily rate of pay on her last railroad job in the base year; or
- (b) Based on the following schedule:

¹⁵ 52 Stat. 1094. As originally enacted in 1938, effective July 1, 1939, the law provided for the payment of benefits only to unemployed railroad workers who were "available for work." In 1946, effective July 1, 1947, the Act was amended (Public Law 572, 79th Cong., 2d sess., 1946) to provide weekly cash benefits for railroad workers who are unable to work because of sickness; also provided are special maternity benefits to women railroad workers.

¹⁶ June 23, 1948: 62 Stat. 576–578; Oct. 30, 1951: 65 Stat. 691; May 15, 1952: 66 Stat. 73; Aug. 31, 1954: 68 Stat. 1041; Aug. 12, 1955: 69 Stat. 716; May 19, 1959: Public Law 86–28, 86th Cong., 1st sess., (H.R. 5610), 1959.

<i>Employee's creditable base-year earnings</i>	<i>Daily benefit rate</i>
\$500 to \$699.99	\$4. 50
\$700 to \$999.99	5. 00
\$1,000 to \$1,299.99	5. 50
\$1,300 to \$1,599.99	6. 00
\$1,600 to \$1,899.99	6. 50
\$1,900 to \$2,199.99	7. 00
\$2,200 to \$2,499.99	7. 50
\$2,500 to \$2,799.99	8. 00
\$2,800 to \$3,099.99	8. 50
\$3,100 to \$3,499.99	9. 00
\$3,500 to \$3,999.99	9. 50
\$4,000 and over	10. 20

The new rates are retroactive to July 1, 1958.

There is no waiting period for maternity benefits. To receive benefits, the claimant must file pertinent information, including statements from a doctor on the expected and on the actual date of birth of her child.

Benefits are payable for a total of 116 days, or approximately 16½ weeks. They may begin 57 days (about 8 weeks) before the *expected* delivery date, but in no case may the claimant be paid for more than 84 days before *actual* childbirth. If the full 84 days before the date of delivery are paid, days paid after delivery may not exceed 31.

Since the first 14 days of the maternity period and the 14 days immediately after the birth of the child are paid for at 1½ times the daily rate, the total maximum benefit available is equal to 130 times the daily allowance. Total benefits available therefore range from \$485, payable to women with earnings between \$500 and \$699.99 in the base year, to \$1,326 to women who have earned \$4,000 or more.

During the 11 years the 1946 Amendment establishing sickness and maternity benefits has been operative,¹⁷ the number of women railroad workers who have received maternity benefits has fluctuated in a relatively small range centering around 4,000. In the 1957-58 benefit year they numbered 3,900, and they then represented about 4 percent of all qualified women.

Women are only a small proportion of all railroad workers—6 percent in 1956, or 97,800 out of a total of 1,627,900. The majority of these women (two-thirds in 1955) are office workers, and the great majority of maternity beneficiaries are office workers—in 1957, nine out of ten.

¹⁷ Information in this section on the operation of the maternity benefit provisions of the Railroad Unemployment Insurance Act are from: (1) Railroad Retirement Board, *The Monthly Review*, Feb. 1959; and (2) Railroad Retirement Board, *Annual Report 1958 for the Fiscal Year Ended June 30, 1958*.

The occupations of the 3,900 women who were beneficiaries in the 1957-58 benefit year were:

	<i>Occupation</i>	<i>Number of employees</i>
Office employees:		
	Executives, supervisors, and professionals.....	100
	Station agents and telegraphers.....	100
	Clerks and other office employees.....	3,400
	All other employees.....	300

The great majority of beneficiaries that year were under age 35 and were divided evenly between women 25 to 34 years old and those under age 25, as the following grouping shows:

	<i>Age group</i>	<i>Number</i>
	Under 25.....	1,700
	25-34.....	1,700
	35-44.....	400
	45 and over.....	100

The average duration of benefits, that is, the average number of days benefits were paid per beneficiary, have ranged from 102 to 113 (109 in 1957-58); and the average total amount of benefit has risen from \$456 in 1947-48 to \$963 in 1957-58. Benefits in 1957-58 were distributed as follows:

	<i>Amount of benefit</i>	<i>Maternity beneficiaries</i>	
		<i>Number</i>	<i>Percent</i>
Total	3,900	100
	Less than \$400.....	(1)	1
	\$400 to \$499.....	100	2
	\$500 to \$599.....	200	4
	\$600 to \$699.....	100	2
	\$700 to \$799.....	200	5
	\$800 to \$899.....	300	7
	\$900 to \$999.....	800	20
	\$1,000 to \$1,099.....	1,400	38
	\$1,100 to \$1,105.....	800	21

¹ Fewer than 50.

Eighty-one percent of the pregnancy claims were not terminated until completion of the 116 days' limitation period.

Maternity Leave for Federal Civilian Employees

Though Federal law does not refer to maternity leave as such for Government civilian employees, Public Law 233 does make paid sick leave available to them. Sick leave accrues at the rate of one-half day for each full biweekly pay period and may be accumulated without limit. A regulation of the Civil Service Commission, which administers this law, then permits such sick leave to be used as maternity

leave.¹⁸ In the interest of achieving some degree of uniformity in applying the regulation, the Commission's Interagency Advisory Group, composed of the personnel Directors of all Federal agencies, developed nonmandatory *Guides for Granting Maternity Leave*. The *Guide's* recommendations may be summarized as follows:

All absences on maternity leave should be medically certified.

Leave approved for reasons related to pregnancy and confinement may be charged to any combination of sick leave, annual leave, and leave without pay.¹⁹

The usual period of maternity leave authorized is approximately 14 weeks: 6 weeks before the expected date of delivery and 8 weeks after the actual date of delivery. These leave periods or an extension thereof should, when the request for them is medically certified, be charged to available sick leave. In those instances in which the request is not medically certified, or in which sick leave is or becomes exhausted, the charge should be to available annual leave; and when that is exhausted, to leave without pay.

Employees who plan to return to work may be granted leave without pay beyond a medically certified period.

As a general rule, absence due solely to the employee's responsibility for the care of her child should not be charged to sick leave.

Request for sick leave not yet accrued to be advanced for reasons of pregnancy should usually be denied.

Individual agencies may apply the foregoing recommendations narrowly or liberally. Granting 14 weeks of maternity leave is not mandatory. If granted to an employee with few years of service, but without the privilege of advanced sick leave, a considerable portion of the leave would probably be without pay.

On the other hand, if an employee who has accumulated sufficient sick leave and annual leave is permitted to use them and is advanced sick leave, she may be on maternity leave 3 months or more with pay throughout the whole period. If in addition, she is granted leave without pay, she could be absent from her job for a still longer period.

In any case, provided no rule of the employing agency has been infringed, women granted maternity leave have job security and may at the end of their leave return to the jobs they held.

¹⁸ U.S. Civil Service Commission, Federal Personnel Manual, Chapter L-1, "Regulations," sec. 30.401; Appendix C to Chapter L.

¹⁹ Under Title II of Public Law 233, 82d Congress, annual leave accrues to Government employees at the rate of 13 days each year during the first 3 years of employment, 20 days during the 4th through the 15th year, and 26 days thereafter; but no more than 30 days' annual leave may be carried over from one year to the next, unless more than 30 had been accumulated before the end of 1952. (Actually annual leave accrues by biweekly pay periods; hence, there may be similar slight variations in the number of hours of leave that accrue annually. Also, the leave-pattern is somewhat different for overseas civilian personnel recruited in the United States.) Sick leave is accrued as noted above. In cases of "serious disability or ailments and when required by the exigencies of the situation," up to 30 days of sick leave may be advanced an employee before he or she has actually earned it.

Agency Regulations

The separate agencies of Government have established their own maternity leave regulations that conform strictly to the Federal law on sick leave and to the Civil Service Commission regulation on the use of sick leave for pregnancy and confinement but vary in degree of conformity to the *Guides for Granting Maternity Leave*. Inasmuch as the Department of Defense employs nearly half of all Federal civilian women workers—not only in offices, but also in such military installations as arsenals, shipyards, aircraft overhaul and repair shops, etc.—its special regulations are of interest.

Within the Department of Defense, each of the three services—Army, Navy, and Air Force—has set up regulations.

The Army has set up *minimum* provisions to be observed throughout the Army Establishment in granting leave for maternity reasons.²⁰ Commanding officers may modify these provisions upward to meet local conditions but may not reduce them. Although medical certification determines whether sick leave shall begin before or after the period during which pregnant women should not be employed, normally maternity leave is considered as beginning with the 36th week of pregnancy. The Army also provides for a part-time tour of duty “where leave of absences is not appropriate, but, for reasons of pregnancy, it is not possible to utilize an employee’s services on a full-time basis.”

Certain Army maternity leave regulations are mandatory with respect to nontemporary employees who have completed their probationary period and who contemplate return to work, but discretionary with respect to other employees.

*Navy*²¹ regulations, in addition to providing for sick leave, annual leave, and leave without pay, stipulate:

Pregnancy shall not unjustifiably jeopardize an employee’s job or seniority.

Ordinarily, the employee should cease work not later than 6 weeks before the anticipated date of delivery.

Ordinarily, appointments will not be made during pregnancy. Commands of activities may, however, exercise discretion in the matter.

*Air Force*²² regulations relating to maternity leave include:

Normally, the period of absence for maternity reasons will be about 14 weeks; 6 weeks before the expected date of delivery and 8 weeks after delivery.

The initial authorization of absence for maternity leave will not exceed 6 months in any case. The total grant of leave will not exceed one year.

²⁰ Department of the Army, *Civilian Personnel Regulations*. “Leave,” CPR L1.4, pp. 23–24, Washington, D.C., April 1956. These regulations are current, 1959.

²¹ *Navy Civilian Policy Instruction* 115. 5–2. Oct. 25, 1957.

²² *Air Force Manual*, AF L1–3 TS 134. Mar. 31, 1959.

For employees who have completed 10 months' continuous service prior to the expected date of delivery, provisions for leave are somewhat more liberal than for other employees.

Maternity Care for Federal Civilian Employees

Seventy percent of Federal employees were protected in 1959 by some type of health benefit plans, most if not all of which included obstetrical benefits.²³ Except in a few agencies, employees paid the entire cost of prepayments or premiums. However, their employment enables them to obtain this protection as group protection, at less cost than if it were purchased individually.

Federal Employees Health Benefits Act of 1959

On September 28, 1959, President Dwight D. Eisenhower signed the *Federal Employees Health Benefits Act of 1959*, which made health insurance, partly paid for by Government, available to over 2 million Federal civilian employees and their dependents on a voluntary basis, effective the first pay period after July 1, 1960. Over a fourth of the employees are women.

Employees have free choice among health benefits plans in four major categories, each of which provides obstetrical benefits:

- (1) *A Government-wide service benefit plan*, such as is offered by Blue Cross-Blue Shield;
- (2) *A Government-wide indemnity benefit plan*, such as is offered by commercial insurance companies;

²³ On the West Coast, 70,000 Federal employees and their dependents are enrolled in the nonprofit, group practice, prepayment Kaiser Foundation Health Plan, e.g., groups at the Alameda Naval Air Station; San Francisco Naval and Mare Island Shipyards; Hamilton, Travis, Norton, and March Air Force Bases; Atomic Energy Commission, Public Health Service, Internal Revenue Service, Veterans' Administration and Veterans' Administration hospitals, Federal Bureau of Investigation, and the Customs Service. Most Federal employees in New York City are enrolled in the nonprofit, group-practice, prepayment Health Insurance Plan of Greater New York for medical and surgical benefits and in the nonprofit Blue Cross Plan for hospital benefits. In Washington, D.C., many Federal employee groups have subscribed to the Blue Cross hospital and Blue Shield surgical plans; others are members of the Group Health Association, a nonprofit, group-practice, community cooperative plan.

Agents of the Federal Bureau of Investigation a decade ago formed the Special Agents Mutual Benefit Association and bought health insurance coverage from a commercial carrier. The plan now includes clerical personnel of the FBI who elect this coverage. There is no collection of premiums by employees except among clerical staff; the Mutual Benefit Association has hired its own staff, established its own midtown office, and premiums are collected through individual billings. Obstetrical benefits for both FBI employees and wives, according to an officer of the association, compare favorably with those of Blue Cross and Blue Shield.

The National Federation of Post Office Clerks has a self-insured union plan operating in 7,500 cities and towns across the country. It provides maternity cash indemnity hospital benefits for members and wives of members.

(3) *One of several employee organization plans*, such as the health plans of the National Association of Letter Carriers and the National Federation of Post Office Clerks; and

(4) *A comprehensive medical plan*, which may be either a group-practice prepayment plan (such as the Kaiser Foundation Health Plan in California and the Group Health Association plan in Washington, D.C.), or an individual-practice prepayment plan (such as the Group Health Insurance Plan in New York).

The Government-wide service benefit plan and the Government-wide indemnity benefit plan include two levels of benefits, between which employees may choose. Thus, those already protected under plans of the types described are able to continue health protection with the Government meeting part of the cost.

The Civil Service Commission, which administers the program, has authority to execute contracts with the Government-wide service plan and indemnity plan carriers, and to make contracts or enter into agreements regarding the other types of plans. Publication of the benefits provided under the various plans is scheduled for May 1960.

Contracts are between the Commission and carriers for at least a year and, unless either party gives notice of termination, are automatically renewable. However, premium rates may be readjusted on the basis either of past experience or of adjustments in benefits.

The Government's contribution to the subscription charge for each enrolled employee is either 50 percent of the charge or an amount prescribed by the Commission, whichever is less. The approximate maximum biweekly amounts the Government can contribute are: \$1.82 for a self-only enrollment; \$4.42 for a family enrollment; and \$2.60 for a family enrollment which includes a nondependent husband.

Further, law and regulations provide in varying degree for other sharing of the cost of medical benefits, including obstetrical benefits, in specific Federal agencies, as follows.

Foreign Service Personnel

The Foreign Service Act of 1946 provides for medical care of overseas personnel (including 27,000 women) of the Departments of State and Agriculture, International Cooperation Administration, and United States Information Agency. Effective 1958, an amendment provided for the inclusion of dependents. The Act is administered by the Secretary of State. Under regulations of the Department of State, obstetrical care except in the case of certain complications is specifically excluded. However, obstetrical care may be obtained at

United States Government hospital facilities, when these are available in the area, at less cost than at most private facilities.

U.S. Public Health Service

Nurses and women physicians in the Commissioned Corps of the Public Health Service and the wives of male physicians are eligible for full maternity care at Government expense under the Medicare Program that serves members of the Armed Forces.

The restrictions that govern members of the Armed Forces regarding marriage, pregnancy, and support of dependents, however, do not apply in peace time to the commissioned nurses and women doctors of the Public Health Service. On Presidential declaration at the time of a national emergency, these officers become part of the Armed Forces.

Tennessee Valley Authority²⁴

TVA, a corporation of the United States and an independent Government agency, has broad powers to fix the compensation of its employees and negotiates matters affecting compensation and fringe benefits with its employee organizations on the basis of practices prevailing in the area.

A health program has been in effect at TVA since 1946. To make it possible for employees in small work-units and isolated locations to participate, and to decrease the administrative costs of the existing voluntary collection system, payroll deductions were inaugurated in 1949. Since 1955 separate medical insurance plans have been negotiated for the salary employees, represented by a panel of five white-collar unions, and for the trades and labor employees, represented by the Tennessee Valley Trades and Labor Council composed of 15 craft unions.

Salary employees are covered by a basic plan, the cost of which is borne 50-50 by the employee and TVA. The cost of major medical coverage is borne by the employee alone.

Trades and labor employees are insured with a commercial carrier. The TVA contribution is not a given percentage but is renegotiated once a year on the basis of an area wage survey.

TVA employs over 1,400 women, and the two health benefits plans provide obstetrical benefits for both workers and dependents. Under

²⁴ Hearings before the Subcommittee on Insurance of the Committee on Post Office and Civil Service on S.94. U.S. Senate, 86th Cong., 1st sess., Apr. 15, 16, 21, 23, 28, 30, 1959. Washington, D.C., 1959, pp. 233-242; 36-37.

the salary employees' plan, the benefits are those of Blue Cross and Blue Shield in Alabama, Kentucky, and Tennessee. The trades and labor employees' plan provides obstetrical benefits in a lump sum: Normal delivery, \$150; caesarean section, \$200; miscarriage, \$75.

Federal Deposit Insurance Corporation²⁴

FDIC, also a corporation and independent Government agency, meets its expenses from the earnings of the Corporation. Its insurance plan is underwritten by Health Service, Inc., involves Blue Cross and Blue Shield, and provides obstetrical care. FDIC pays the full cost of the premiums for the employees. Under the family plan, the employee pays the difference between individual coverage for the employee and coverage for the family.

Maternity Care for Women in the Armed Forces²⁵

There are about 32,000 women in the Armed Forces of the United States as members of the Army, Navy, Marine Corps, Air Force and Coast Guard. While married women except for Reserves, and in most cases women with dependents under 18 years of age, are not accepted as recruits in the Armed Forces, they may marry when they have completed their basic training. Half of the women in the Army Nurse Corps, for instance, are married. Women who become pregnant, however, are separated from the services.²⁶

Women who are pregnant at the time of separation from the Armed Forces, whether separation was because of pregnancy or for another reason, are eligible for maternity care at Government expense. This care includes prenatal care; hospitalization; confinement; postnatal care either in a hospital or as an outpatient for 6 weeks following delivery; and care for newborn infants while the mother is a patient in the medical treatment facility.

²⁴ See footnote on p. 29.

²⁵ See Department of the Army, Headquarters, Army Regulations, No. 601-124, "Personnel Procurement," January 1958; No. 601-139, "Personnel Procurement," July 1959; No. 40-108, "Medical Service," May 1959; No. 140-101, Army Reserve, October 1956; and Department of the Navy, Manual of the Medical Department, U.S. Navy, Chapter 21-20, "Former Members."

²⁶ There may be exceptions. For example, women on overseas naval duty who become pregnant are ordinarily returned to the continental United States by the first suitable means of transportation for separation from the service; if, however, the woman's or child's health would be endangered by such transportation, full medical care is provided overseas until both she and her infant are fit to travel, are returned to the United States and the mother separated from the service.

Maternity Care for Dependents of Men in the Armed Forces²⁷

Some 98,000 women workers (in 1958) had husbands who were in the Armed Forces and absent from home.²⁸ An indeterminable additional number of women workers are wives of servicemen who are stationed where they can live at home. These wives may or may not have maternity care benefits available to them in their own right as workers. They have full maternity care available in Medicare by virtue of their husbands' service in the Army, Navy, Marine Corps, Air Force, and Coast Guard.²⁹

The Medicare program utilizes both military and civilian medical facilities. The civilian facilities are made available through private insurance carriers, Blue Cross, Blue Shield, and arrangements with State Medical Societies. The maternity patient pays part of the hospital costs—a total of \$25, or \$1.75 per hospital day, whichever is greater; or pays \$15 if the child is delivered at home. The patient also pays part or all the difference between the cost of a semiprivate and private room, depending on whether a private room is prescribed or simply a convenience. She also pays the first \$100 plus 25 percent of charges over \$100 for private-duty nursing ordered by the physician, and pays for such items as baby name wrist bands, photographs, or footprints for identification. The Medicare program pays all other costs.

There were 259,600 births under Medicare in fiscal 1958—95,200 in Service hospitals, 164,400 in civilian hospitals. Maternity cases represented over 55 percent of all Medicare cases whose care was completed in that fiscal year. The average cost of 159,148 normal deliveries in civilian facilities was \$308 to the Government (\$184 for physicians' services, \$124 for hospitalization) and \$26 to the patient.³⁰ The average length of the hospital stay was 5.1 days.

²⁷ See: Department of Defense-Department of Health, Education, and Welfare *Joint Directive for Implementation of the Dependents' Medical Care Act* (P.L. 569, 84th Cong.), Reprint 6010.4 incorporating changes through Sept. 16, 1958, Washington, D.C. See also First and Second Annual Reports *Dependent's Medical Care Program*, prepared by the staff of the Office for Dependents' Medical Care, Department of Defense, June 1, 1958 and June 1, 1959 respectively.

²⁸ U.S. Department of Commerce, Bureau of the Census, Current Population Reports, *Labor Force*, Series P-50, No. 87, *Marital and Family Characteristics of Workers*, March 1958. January 1959.

²⁹ For history of events leading up to the *Medicare* program see The Army Almanac, Rev. ed. Harrisburg, Pa., Stackpole, Jan. 1959.

³⁰ *The Second Annual Report, Dependents' Medical Care Program*, June 1, 1959, contains "the first extensive data on the actual cost of hospitalized illness."

State Laws and Regulations

State Laws Prohibiting Employment

Six States have laws originally enacted 40 to 50 years ago that prohibit the employment of women for specified periods before and after childbirth.

	<i>Before childbirth</i>	<i>After childbirth</i>
Connecticut.....	4 weeks	4 weeks
Massachusetts.....	4 weeks	4 weeks
Missouri.....	3 weeks	3 weeks
New York.....	4 weeks
Vermont.....	2 weeks	4 weeks
Washington:		
In manufacturing, food processing and fresh fruit and vegetable packing industries.....	4 months	6 weeks.
In laundry, dry cleaning and dye works industry.....	4 weeks	4 weeks.

Puerto Rico prohibits employment 4 weeks before and 4 weeks after childbirth. Employers must also pay maternity benefits amounting to one-half of regular salary or wage during that period. An extension of 4 weeks' leave without compensation is allowed on presentation of a medical certificate, and a woman's job must be kept open for her.

State Temporary Disability Insurance Laws ³¹

Four States—California, New Jersey, New York, and Rhode Island—have provided for temporary disability insurance, or cash sickness compensation. Only in Rhode Island, however, are pregnancy benefits an integral part of the disability insurance program. No pregnancy benefits are paid in New Jersey; California provides such benefits only to the extent that the disability exists more than *28 days after the termination of pregnancy*; and New York permits payment only *after the return to covered employment for at least two consecutive weeks following termination of pregnancy*.

The Rhode Island Law

The Rhode Island Cash Sickness Compensation Act (passed in 1942; effective April 1943) was the first compulsory system of compensation for wage loss due to nonwork connected disability to be enacted in this country.

The original law made no reference to pregnancy. It was sometimes contended, therefore, that claims based on pregnancy should have been

³¹ Information on State temporary disability insurance laws, particularly the Rhode Island Cash Sickness Compensation Act, is from the following publications of the Bureau of Employment Security, U.S. Department of Labor: (1) *Rhode Island Disability Insurance Program*, July 1954; (2) *Significant Temporary Disability Insurance Data, 1957*; (3) *Comparison of Temporary Disability Insurance Laws*, December 1958. For Rhode Island's experience under its Cash Sickness Compensation Act, see especially (1).

denied on the grounds that, medically speaking, pregnancy is not a disease but a normal physiological condition. The temporary disability insurance statutory definition of "sickness," however, was not a medical one. Section 2(13) of the original law defined sickness as follows:

"(13) 'Sickness.' An individual shall be deemed to be sick *in any week in which, because of his physical or mental condition, he is unable to perform* any services for wages." This provision has been amended, but the italicized language has not been changed. The agency interpretation and ruling that pregnancy is compensable as a physical condition making the individual unable to work has, in effect, been upheld by subsequent legislation placing limitations on payments for pregnancy—limitations imposed primarily because pregnancy benefits were the major single factor in benefit costs, threatening the solvency of the Temporary Disability Insurance Fund.

The first specific restriction, added in 1946, reduced the period of payments from a maximum of 20-plus weeks to a maximum of 15 weeks for an uncomplicated pregnancy. Those weeks, however, could be drawn at any time during the pregnancy, provided that the woman was not working. Under the uniform base-period and benefit-year provisions in effect prior to 1950, wage credits might remain available for a long time after the termination of employment.

Further, in the interest of maintaining the Temporary Disability Insurance Fund on a self-sustaining basis, several changes were effected in the law in 1950 and 1951. Maximum duration of the benefit period for an uncomplicated pregnancy was decreased to 12 weeks; minimum qualifying wages were increased; and wage credits were based on an individual base period and benefit year, substantially shortening the length of time wage credits remain available after termination of employment. Moreover, if there is evidence of withdrawal from the labor market, particularly before the pregnancy is apparent, the woman is disqualified.

Some 4,900 claimants for maternity benefits—16 percent of all claimants for disability benefits—had qualifying wage credits in 1957. Information on the number who actually received benefits, and the amounts of those benefits, is not available.

From the beginning, the temporary disability insurance program has been administered in coordination with the unemployment insurance program. The present administrative agency is the Rhode Island Department of Employment Security.

The temporary disability insurance law covers the same workers as the unemployment insurance law—those of employers with one or

more workers at any time. Excluded from compulsory coverage are workers in domestic service, agriculture, Government and certain non-profit employments. State workers are included; local government and other excluded businesses may elect coverage. Qualifying employment or wages are 20 weeks in which weekly earnings are at least \$20, or \$1,200 earned in the course of the base year.

Duration of pregnancy claims is limited to 12 consecutive weeks, to begin 6 weeks before expected childbirth and to end not more than 6 weeks following childbirth, except for unusual complications.

No waiting period is required in pregnancy claims. Medical certification by a licensed physician is required for all initial claims, which must be filed by mail with the disability insurance division in Providence.

An important factor in the Rhode Island disability insurance program is the large proportion of women among the workers in that State. In 1954 it was estimated that 40 percent of the workers covered by the program were women. In June 1957, the State of Rhode Island Employment Bulletin reported, "Although the number of women workers in this State is at the lowest level in many months . . . the statewide percentage of female help remains one of the highest in the nation."

State Provisions for Their Own Employees ³²

Maternity Leave

Most of the States permit the use of annual and sick leave for pregnancy, and leave without pay may also be granted. Practices vary among States, and vary within States except where comprehensive civil service programs or merit rating systems covering most or large segments of the employees have been established. By 1958, at least 28 States (compared with 22 a decade ago) had such comprehensive merit systems, either through provisions in their State constitutions or by acts of their legislatures. States which did not have such comprehensive systems in operation covered at least those employees engaged in employment security programs and programs financed in part by Federal grants-in-aid.

Twenty-one of the 22 States with comprehensive merit systems provide 12 to 15 days of annual leave after one year of employment. In

³² See *The Book of the States* for the years 1948-49 through 1958-59, Chicago. The Council of State Governments, 1948 through 1958; "Section IV, Administrative Organization, 2. Personnel Systems;" William G. Torpey, *Public Personnel Management*, D. Van Nostrand Co., Inc., New York, N.Y., 1953, p. 95; O. Glenn Stahl, *Public Personnel Administration*, New York, N.Y., Harper and Bros., 1956, pp. 406-408, p. 398; Norman J. Powell, *Personnel Administration in Government*, Edgewood Cliff, N.J., Prentice-Hall, Inc., 1956, pp. 314-316.

18 States, including five which provide 10 days or less of annual leave, allowances increase with length of service. Sick leave is usually earned at the rate of 13 days a year and may be accumulated.

Most States do not in their laws refer specifically to maternity leave. One State, New York, that does, provides: ³³

“1. Maternity Leave:

A pregnant employee holding a position by permanent appointment shall be granted a leave of absence without pay for a period of six months which may be extended by the appointing authority up to one year.

The employee shall report to the appointing authority the existence of pregnancy not later than the end of the fourth month.

The appointing authority may thereafter place the employee on leave at any time when in its judgment, the interest of either the department or the employee would be best served by such action.

The employee may be allowed to reduce the six month period of leave without pay by the use of any or all earned credits.

A physician's statement as to the fitness of the employee for the performance of her duties may be required at any time before her leave commences, and may be required prior to her return to duty.”

Maternity Care

The idea of Government as employer contributing to the cost of employee group health insurance (which customarily covers maternity care) is rapidly taking hold (see footnote 32). In late 1957, only 8 States, Hawaii, Guam, and the Virgin Islands, made no provision for employee health insurance (see footnote 32). The remaining States and Puerto Rico have made hospital insurance, or medical or surgical insurance, or both, available to at least some group of their employees. A number of jurisdictions have assumed the cost of deducting premiums from pay rolls.

Of the 28 States with general merit system coverage, one provides for hospital insurance only, and 23 and Puerto Rico provide for both hospital and medical or surgical insurance. Most interestingly, four of these States (compared with only one State two years previously) pay all or part of the cost of both types of coverage; Puerto Rico, of hospital coverage (see footnote 32).

One of the most recent State-supported health insurance programs for State employees to go into effect is that of New York, on December 5, 1957.³⁴ The program provides what is known as the statewide plan but also offers employees in certain down-state counties the op-

³³ *McKinney's Consolidated Laws of New York, Annotated*, Book 9, Civil Service Law, “Attendance Rules for employees in New York State Departments and Institutions, as amended to August 5, 1959.” Rule 3. Leaves without pay, p. 488.

³⁴ State of New York, Laws of 1956, Chap. 461.

tion of two other plans in which many were already enrolled—the Health Insurance Plan of Greater New York (HIP) and Group Health, Inc. (GHI).³⁵

Maternity Care for New York State Employees

1. *The statewide plan.*—For this plan, contracts were made with Blue Cross for hospital benefits, with Blue Shield for surgical and in-hospital medical benefits, and with a commercial insurance company for major medical expense benefits. (Blue Cross, as a matter of fact, also provides the hospital benefits under the two optional plans.) The maternity benefits provided under the statewide plan are as follows:

Hospitalization.—The maximum basic allowances are:

Routine delivery-----	\$75.00
Caesarean section-----	87.50
Ectopic pregnancy-----	87.50
Miscarriage-----	25.00

In obstetrical cases other than those mentioned above, and where severe medical or surgical complications occur, hospitalization up to 120 days is available.

Surgical and In-Hospital Medical Care.—The maximum basic allowances are the same in amount as those listed above for hospitalization. That is, the total available for hospitalization and for surgical and in-hospital medical care in the case of a routine delivery is \$150, in the case of a caesarean section, \$175, etc. In-hospital medical care of the newborn is not provided.

An employee or dependent wife selects her own doctor. If he has entered into an agreement with Blue Shield, he will accept the schedule of allowances as full payment, provided the individual patient's income is not more than \$4,000, or the individual's and his dependent's income is not more than \$6,000. If incomes are higher, or if the doctor has not entered into an agreement with Blue Shield, charges may be greater and the patient is responsible for the difference.

Major Medical Expense Care.—In the case of severe medical or surgical complications arising out of a pregnancy, major medical expense benefits are available after Blue Cross-Blue Shield benefits have been exhausted. The patient pays an initial \$50 "deductible"; the plan then pays 80 percent of the remaining expenses, but not more than \$7,500 in any one calendar year or \$15,000 in a lifetime. The

³⁵ For detail of these plans see: State of New York Department of Labor, *Industrial Bulletin*, May 1959, pp. 12-19; U.S. Department of Health, Education and Welfare, Public Health Service, *Public Health Reports* April 1959, pp 341-347; *Health Insurance for Employees of Local Subdivisions in New York State*, booklet published for use of affected employees.

benefits provided include hospitalization, surgery, private duty nursing, X-rays, pharmaceuticals, blood transfusions, etc.

2. *The optional GHI plan*

Hospitalization.—The benefits are the same as those provided under the statewide plan.

Surgical and Medical Care.—Benefits include full prenatal care, delivery, and postpartum care of mother and child. Care is provided in the physician's office, the hospital, or the patient's home.

A patient chooses her own "family doctor." If he is a participating physician—one who has entered into agreement with GHI—he accepts the GHI schedule of allowances for medical and surgical care in the hospital, regardless of the patient's income, provided the patient uses semiprivate or ward accommodations. The doctor also accepts as full payment the GHI schedule of allowances for maternity care rendered in his office or the patient's home. Nonparticipating physicians may charge additional amounts, and the patient is responsible for the difference. The following payments for medical and surgical care in the hospital are made to any doctor:

Normal delivery.....	\$125
Caesarean section.....	200
Ectopic pregnancy.....	175
Miscarriage.....	75

Examples of other payments are: first office visit, \$4.00; subsequent visits, \$3.00; home visits, \$5.00.

3. *The optional HIP plan.*—Hospitalization benefits under the Health Insurance Plan of Greater New York are the same as those provided under the statewide plan. Medical and surgical care are provided through 32 medical groups consisting of family doctors and specialists. The enrollee first chooses one of the HIP medical groups serving the area in which she lives and then chooses one of the family doctors in the medical group as her personal physician. Care is given at home, at doctor's offices, at medical group centers, and in hospitals. There is no limit to the number of doctors' visits nor to the amount of medical care provided, including general health check-ups, laboratory tests, visiting (but not private-duty) nurse services, and private ambulance transportation. There is no exchange of money between patient and doctor.

Under the statewide plan, an employee pays half the premium for his or her own protection and 65 percent of the premium for dependents' protection; the State pays the rest. (For the contract year April 1, 1959–March 31, 1960, individual coverage costs the employee \$3.08 a month; family coverage, \$9.46.) Coverage costs more under

GHI and HIP and, since the State's contribution is the same under these plans as under the statewide plan, the employee's cost is necessarily somewhat higher under the two options.

At the end of 1958, premiums were being paid for 84,000 employees and their dependents, or a total of over 200,000 persons. When later employees of the State's "contract" colleges were included, 2,600 more people were added, plus their dependents.

State Laws Disqualifying Unemployed Pregnant Women For Unemployment Insurance Benefits

The District of Columbia and 35 States (14 more than in 1949) have special statutory provisions that either disqualify an unemployed pregnant woman for unemployment insurance benefits or consider her unavailable for employment.³⁶ In restriction of benefit rights, there is no distinction between the two types of provisions.

Disqualification is for a definite period in some States, ranging from 4 weeks before and 4 weeks after childbirth to 4 months before and 2 months after childbirth. In other States the period is indefinite, e.g., "duration of unemployment due to pregnancy," or until reemployed for a specified period or at specified wages.

Local Community Provisions for Their Own Employees

Maternity Leave

Information on maternity leave provisions in local government units was obtained only for teachers.³⁷

As long as a decade ago, national educators found, "In recent years the difficulty of obtaining qualified teaching personnel has led a number of local school systems to abandon rulings against the employment of married women as regular teachers. These school systems are, therefore, finding it necessary to establish definite policies with respect to maternity leave."

³⁶ As of October 10, 1959. See U.S. Department of Labor, Bureau of Employment Security, *Comparison of State Unemployment Insurance Laws as of January 1, 1958*, Washington, D.C., 1958, and Supplements thereto. The 15 States that have no legislative provisions of this type are: Alabama, Arizona, California, Florida, Georgia, Iowa, Kentucky, New Jersey, New Mexico, New York, Rhode Island, South Carolina, Texas, Virginia, and Wyoming.

³⁷ National Education Association of the United States, *Special Memo: Teacher Personnel Practice, Urban School Districts, 1955-56*, Washington, D.C., The National Education Association, 1956. American Association of School Administrators and Research Division of the National Education Association, *Educational Research Service Circular No. 6, 1948: Maternity-Leave Provisions in 157 School Systems in Cities over 30,000 in Population*, Washington, D.C., August 1948.

Among teachers, as among all employed women, the number who are married has continued to increase. Over two-thirds of urban school districts in 1956 (as compared with 5 percent in 1941) gave no preference in hiring to single women over married women teachers. Women who married in service continued in service on the same basis as single women in 97 percent of these school districts (as compared with 75 percent prior to 1951).

Two-thirds of the urban school districts in 1956 granted maternity leave. The size of the community had a direct bearing on maternity leave policy. The proportion of districts granting such leave ranged from all in large urban cities down to 61 percent in the smallest communities reporting.

Actual leave provisions, investigated earlier in cities of over 30,000 population, varied considerably. Only about three-fourths of the school systems had definite policies regarding leave before childbirth, and about the same proportion had definite provisions on leave after the child was born.

Provisions for leave before childbirth ranged from "immediately upon becoming aware of pregnancy," to 7 months. Eighty percent of the school systems agreed on 4 to 6 months, most often 5 months.

Several school systems allowed a teacher to return after the birth of her child on a physician's advice or at her own discretion. Among the systems that set definite time periods, 7 weeks was the earliest date at which return was permitted; more than half required that the child must be at least a year old; some, 3 years old.

About half the systems reported that if an employee's former position were not open upon her return, she would be placed at the level for which she qualified as soon as a suitable vacancy occurred.

Maternity Care

The idea of government as employer contributing to employee health insurance has been taking hold, particularly among municipalities. (See footnote 32.) Both New York City and San Francisco have comprehensive programs for their employees, that for San Francisco being compulsory. The New York City (HIP) includes personnel in the public school system.

A 1958 amendment to the law establishing New York's statewide plan for health insurance of State employees permitted local government subdivisions also to participate. By February 1, 1959, 24 local government applications had been approved. Other States also make health insurance available to local governments.

In certain areas, particularly in the West, local government units have made other provisions for their employees. In California, for instance, various cities and counties in the Bay Area have provided their employees a choice of the Kaiser Foundation Health plan or an optional plan.³⁸

Elsewhere cities and towns have banded together to provide protection for their employees at rates more favorable than would be available on an individual city basis: In Oregon, where there are only three cities with a population of 25,000 or over, the League of Oregon Cities established an insurance trust and in September 1958 inaugurated a group insurance program.³⁹ The plan includes medical, surgical, hospital, and major medical expense insurance. Benefits for maternity care, provided only under two-person and family agreements, are:

	<i>Hospital</i>	<i>Doctor</i>
Normal delivery.....	\$75.....	\$50
Caesarean section.....	\$75.....	150
Ectopic pregnancy.....	Regular service ben- efits	150

Benefits are available immediately in the event of an ectopic pregnancy, otherwise after 9 months' enrollment under the plan.

The total monthly premium rate is \$5.60 for employees, plus an additional \$7.65 for the first dependent or \$11.65 for two or more dependents. The League requires the employing city to pay all or a substantial share of the premium for the employee's coverage. In the spring of 1959, the plan covered 279 employees in 10 cities, all but one of which paid the full premium for their employees' coverage; in the tenth, the employees worked on the city's railroad and the contribution, by union agreement, varied between employees.

Similar group insurance arrangements are known to have been made by the Municipal Leagues of Arkansas, Colorado, Idaho, Kentucky, Louisiana, and Utah.

Federal-State-Local Provisions for Health and Maternity Protection as a Public Service

We have seen the range of laws and regulations that provide maternity cash benefits in lieu of wages, or maternity medical care, or both

³⁸ *Health Insurance Program for Federal Employees*: Hearings before Subcommittee on Insurance of the Committee on Post Office and Civil Service, United States Senate, 86th Cong., 1st Sess., on S. 94. April 15, 16, 21, 23, 28, and 30, 1959, pp. 208-210.

³⁹ Joseph Zisman, *The Employee Benefit Plan of the League of Oregon Cities*, Research and Statistics Note No. 11-1959. U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research, April 23, 1959.

for many women workers in their status as workers or as wives of workers.

However, Federal, State and local governments also provide health services including maternal health protection on a large scale for women workers *as a service to the public*. These provisions include (1) measures for the general public health, (2) measures for the general maternal health, and (3) direct maternal medical care.

Recipients of direct Federal, State and local maternity medical care include the needy (those on public relief rolls) and the medically needy (those who can manage to meet daily expenses but not the high cost of medical care).⁴⁰ Facilities providing such services frequently classify patients as full-pay, part-pay, or indigent, depending on income and family size. Costs to the medically needy are often scaled to family income.

Included among women who are or become medically needy are weekly wage workers in plants which have not elected to be covered by a health insurance plan. Many are day workers in homes to whom industrial health and insurance plans are not accessible. They include agricultural workers and many part-time workers. While these women could participate in voluntary health insurance plans, they usually have no maternity protection, either in the form of part-compensation for wages lost or against the costs of medical care, other than that provided by government.

Public General Health Services

The last 30 years have seen a very great expansion in Federal, State, and local provisions for the public health. These have both been brought about by, and have helped bring about, our rising standard of living, improved standards of sanitation, the conquest and control of epidemics and disease, the high caliber of our medical care, the introduction of antibiotics and other "miracle" drugs, and increased and better hospital and related facilities.

These measures have greatly heightened the healthfulness of our environment and the level of the Nation's health, and with them the level of maternal health. The United States, instead of having one

⁴⁰ See Bernhard J. Stern, *Medical Services by Government: Local, State and Federal*, New York, The Commonwealth Fund, 1946; Milton Terris, "Medical Care for the Needy and Medically Needy," in *The Annals of the American Academy of Political and Social Sciences*, Vol. 273, Jan. 1951.

of the highest maternal mortality rates, as it did 30 years ago, now has one of the very lowest.⁴¹

On the Federal level, the Public Health Service is the agency charged with responsibilities for protecting and improving the health of the Nation's people.⁴² In fiscal 1958 the Service expended \$613,720,000 (including \$174 million in aid to States) to conduct and support research and training, to provide medical and hospital services, to aid in the development of hospitals and community health services, to prevent and control disease, etc.

Public Maternal Health Services

Specific responsibilities for maternal and child health are lodged, on the Federal level, in the Children's Bureau of the U.S. Department of Health, Education, and Welfare.⁴³ Included in these responsibilities is administration—under title V, part 1, of the Social Security Act—of grants to State health agencies for extending and improving maternal and child health services. Services for which State agencies use these funds include maternity medical clinics and maternity nursing services for prenatal and postnatal care of mothers; also hospital in-patient maternity service, dental treatment for pregnant women, and the inspection and licensing of hospital maternity services. Maternal and child health services also include well-child conferences for infants and children, child health nursing service, and immunization programs. Not all these services are provided in all States, however, as the accompanying table shows.

⁴¹ Information was available for 26 countries in 1929-31: Australia, Belgium, Canada, Ceylon, Chile, Denmark, England and Wales, Estonia, France, Germany, Hungary, Northern Ireland, Irish Free State, Italy, Japan, Mexico, Netherlands, New Zealand (excluding Maoris), Norway, Palestine, Scotland, Sweden, Switzerland, Union of South Africa (Europeans), United States, Uruguay; of these, only Ceylon and Chile had a higher maternal mortality rate (deaths per 1,000 live births) than the United States. Jacob Yerushalmy, "Infant and Maternal Mortality in the Modern World," in *The Annals of the American Academy of Political and Social Sciences*, Jan. 1945, pages 134-141. Data for 1957 from U.S. Department of Health, Education, and Welfare, Children's Bureau.

Health Information Foundation, *Progress in Health Services*, "Advances in Maternal Health," Vol. VII, No. 9, Nov. 1958.

⁴² For pertinent legislation, see *U.S. Government Organization Manual*, 1958-59, Washington, D.C. For activities of Public Health Service, see U.S. Department of Health, Education and Welfare, *1958 Annual Report*, Washington 25, D.C., pp. 83-151.

⁴³ For pertinent legislation, see *U.S. Government Organization Manual*, 1958-59, Washington 25, D.C. For activities of the Children's Bureau, see U.S. Department of Health, Education, and Welfare, *1958 Annual Report*, pp. 53-69.

<i>Type of service</i>	<i>Number of States providing service</i>	<i>Number of mothers receiving service</i>
Maternity medical clinic service-----	35	240,630
Maternity nursing service-----	53	446,843
Dental treatment during pregnancy-----	12	3,583
Hospital in-patient care-----	13	39,562

Source: Maternal and Child Health Services, 1957. Children's Bureau, U.S. Department of Health, Education, and Welfare, Statistical Series No. 53. 1959.

Expenditures for the maternal and child health services program, 1956-57, were \$64.6 million—with \$15.7 million contributed by the Federal Government, and \$48.9 million in matching funds by State and local governments.⁴⁴ In 1958, the Federal appropriation was raised from \$16.5 million to \$21.5 million. These funds are used to extend and improve health services for mothers and children. No cash payments are made to individuals under this program.

Other Children's Bureau responsibilities for maternal care—the costs of which are included in overall Children's Bureau expenditures—include medical consultation service to State agencies; a clearing-house of research; and publications on prenatal care which are of inestimable value to women everywhere.

Every State makes special provisions for the health of mothers and children, as do most cities.⁴⁵ Federal grants-in-aid to State agencies are allocated to local units; the ultimate application of medical care services is local.

Local facilities are, however, also operated by Federal or State agencies. Examples are the U.S. Public Health Service's operation of Freedmen's hospital, where a record 3,227 births took place in 1958 without a single maternal death; the Service's provisions for Indian mothers;⁴⁶ and its recently launched 5-year study of 40,000 pregnant women and their children in which the National Institutes of Health and 16 medical centers throughout the country are cooperating.

On the State level, almost all States provide, or subsidize local agencies to provide, direct maternity clinic services. At least half the States provide hospital delivery services; some provide home delivery services. State university hospitals are used to furnish much of the clinical and hospital care.

⁴⁴ U.S. Department of Health, Education, and Welfare, *Social Security Bulletin*, Annual Statistical Supplement, 1957, p. 13.

⁴⁵ U.S. Department of Health, Education, and Welfare, *Distribution of Health Services in the Structure of State Government*, 1950, Washington, 25 D.C., 1954, p. 209.

⁴⁶ U.S. Department of Health, Education, and Welfare, *1958 Annual Report*, pp. 111, 118.

The practice of midwifery continues in some States because of the inability of many patients to afford physicians' services; in others because of an inadequate number of physicians in the area; and occasionally as a preferred traditional practice.⁴⁷ Another important State function, therefore, in addition to licensure of hospitals and other maternal medical facilities, is licensure of midwives.

⁴⁷ *Distribution of Health Services in the Structure of State Government, 1950*, pp. 217, 220.

In 1950, the number of midwives was steadily decreasing. A new trend is indicated by increased training and employment of nurse midwives, stimulated by a steady increase in the annual number of births and no commensurate increase in the number of physicians. Training programs, for which only registered nurses may qualify, usually run from 8 months to 1 year, and stress the clinical side of obstetrics—examination, history taking, management of labor and delivery, and recognition of complications. Before 1953 there were only three schools of nurse midwifery in the United States. In 1953 Johns Hopkins became the first university teaching center in the United States to undertake nurse midwife training, since then Columbia, Yale, and New York State University have instituted nurse midwife curricula and other medical centers are making plans for them. "Today nurse midwives are employed directly by hospitals, clinics, and individual physicians." *Public Health Economics*, Vol. 16, No. 8, Aug. 1959, pp. 390-392.

INTERNATIONAL STANDARDS FOR MATERNITY PROTECTION

For perspective on the picture of maternity benefits for women workers in the United States, it is useful to consider international standards in the same field. In the United States, the approach has been chiefly through voluntary health and insurance plans of various types. Although limited groups of workers (including railroad workers, Government employees, and, in two States, employees of private industry) are covered by legislative provisions, comprehensive coverage of all women workers through national legislation has not been sought.

In most other countries, by contrast, the approach is primarily legislative and administrative. A total of 59 countries (including the United States) had established some kind of maternity insurance or related program by 1958, usually as an integral part of health insurance programs. This was twice the number of countries reporting such provisions in 1940. The pattern for most of the maternity protection programs is set by the Maternity Protection Convention of the International Labor Organization.

The International Labor Organization Convention

The Maternity Protection Convention and accompanying Resolution ⁴⁸ adopted in 1952 by the International Labor Organization was a revision of an earlier Convention, adopted at the first session of the ILO in 1919. Prior to 1951, the Convention had been ratified by 18 countries.

The revised Convention is broader in scope and carries more extensive provisions than the earlier one. It applies to women in industrial and commercial undertakings and also in nonindustrial and agricultural occupations, and includes women wage earners working at home. The provisions require that an employed woman shall have

⁴⁸ Convention No. 103 concerning maternity protection (revised 1952) and Recommendation No. 95 concerning maternity protection.

maternity leave for at least 12 weeks at the time of her confinement. At least 6 weeks of this period shall follow the birth of her child. During this maternity leave, she shall be entitled to cash and medical benefits provided as a matter of right by social insurance or public funds. She shall also be given time off from work to nurse her child without any loss of wages. It shall be unlawful for the employer to discharge her during her leave.

The Recommendation, which supplements the Convention, proposes that the period of maternity leave should be lengthened to 14 weeks when a woman's health makes such an extension desirable. It also suggests that the maternity benefit should be as high as the woman's earnings, that nursing breaks should total an hour and a half daily, that seniority rights should be preserved during maternity leave, and that pregnant and nursing women should be prohibited from work which is prejudicial to health and from working overtime or at night.

The ILO Convention came into force in 1953 on ratification of the required number of countries.⁴⁹ Each country that has ratified the Convention must report annually on progress made toward putting the standards into effect. In addition, countries belonging to the ILO that have not ratified the Convention may be requested at intervals to file special reports on laws and practices in relation to the standards established by the Convention.

The influence of the ILO Convention is undoubtedly much greater than the number of ratifications would imply. By 1959, the minimum period of maternity leave for women workers had been set at 12 weeks (the ILO standard) in 30 countries, and the discharge of a woman worker during maternity had been forbidden in 40 countries.

Maternity Protection in Other Countries

Maternity protection provisions are included in a report on social security systems in 59 countries in 1958, published by the Social Security Administration of the United States Department of Health, Education, and Welfare.⁵⁰ The following summary is based on that report.

⁴⁹ By June 1959, Convention No. 103 had been ratified by seven countries: Byelorussia, Cuba, Hungary, Ukraine, Uruguay, Union of Soviet Socialist Republics, and Yugoslavia.

⁵⁰ Social Security Programs Throughout the World—1958. Washington, D.C., 1959. The 59 countries included are: Albania, Argentina, Australia, Austria, Belgium, Bolivia, Brazil, Bulgaria, Burma, Canada, Chile, China (Nationalist), China (Communist), Colombia, Costa Rica, Cuba, Czechoslovakia, Denmark, Dominican Republic, Ecuador, El Salvador, France, Germany (West), Germany (East), Greece, Guatemala, Honduras, Hungary, Iceland, India, Iran, Iraq, Ireland, Israel, Italy, Japan, Libya, Luxembourg, Mexico, Netherlands, New Zealand, Nicaragua, Norway, Panama, Paraguay, Peru, Philippines, Poland, Portugal, Rumania, Spain, Sweden, Switzerland, Turkey, Union of Soviet Socialist Republics, United Kingdom, United States of America, Venezuela, Yugoslavia.

Types of Systems

The great majority of the national programs reported are social insurance programs, under which both cash benefits and medical services are provided. These programs are financed in considerable measure from special insurance contributions paid by employees, employers, or both, and eligibility for benefits and services is normally linked to payment of contributions or coverage in insured employment during a specified minimum period. Eligibility for medical services as well as cash benefits under most of these programs is contingent upon coverage under social insurance.

A somewhat different arrangement prevails in about a sixth of the countries. In these, only cash benefits for maternity are provided through social insurance. Medical services, in contrast, are furnished by the government under a separate program to all residents, rather than only to social insurance contributors. These programs, under which a variety of medical services are furnished, in effect as a public service by the government, are in some countries referred to as a national health service. A few countries provide cash benefits for wage loss, but no medical-care services.

Coverage

The risks of income loss from maternity exist mainly for persons working for the account of another. They are present to a much lesser degree for self-employed persons working for their own account. The coverage of nearly all of the cash benefit programs is limited to employees in general, or to particular classes of employees. Some of the newer systems apply only to employees of larger firms in industry, commerce, and related branches. A few countries also exclude higher paid salaried employees.

The provision of health and maternity benefits in some countries is organized around membership in various types of mutual sickness clubs, societies, or funds. Membership in such societies is usually made compulsory for specified categories of employees. Members' contributions are paid to the societies, which also receive government subsidies and sometimes employer contributions as well. The societies in turn provide benefits at levels which may not be below certain statutory minimum standards.

Nearly a fifth of the countries are introducing their health and maternity insurance systems gradually. Typically, benefits are first provided in the capital city and perhaps certain other centers, and are then gradually extended to other urban or rural areas. The pace of the extension is usually controlled by the rapidity with which new

clinics and hospitals can be financed and erected in different regions, for the furnishing of medical benefits.

Source of Funds

In the large number of countries relying on social insurance, the usual methods of financing this insurance are used also in the financing of their health and maternity insurance programs. That is, a fixed percentage of earnings is generally payable as a contribution by employers and employees. These contributions go into a central fund from which all benefits, including both cash and medical benefits, are financed.

A majority of these countries also provide for some type of government contribution or subsidy to the social insurance system, so that tripartite financing is numerically the most common arrangement. There are, however, various other combinations of revenue sources. Some countries use only employee and employer contributions. In others, particularly where benefits are provided through mutual sickness societies, only employees and the government participate in the financing. In contrast, certain countries rely on employer contributions exclusively.

In most countries where medical care is provided to all residents, by means of some type of national health service, the government usually pays all or the greater part of the cost of this service.

A number of countries place a ceiling on the amount of earnings on which an individual worker must pay contributions.

Cash Sickness Benefits

Cash sickness payments are paid under all but four of the programs when women are prevented from working owing to pregnancy. Four other programs provide only maternity but not other types of cash sickness benefits. Under more than a third of the programs, maternity cash sickness benefits are at a higher rate than other types of cash sickness benefits, and under a third of the programs, they are the same. The rates at which maternity benefits are paid are almost always something less than full wages, although under about a fifth of the programs they are 100 percent of wages. Most often benefits range between 50 and 75 percent of wages.

Duration of benefits, however—that is, the number of weeks during which benefits are payable—is almost always shorter in the case of maternity cash sickness benefits than in the case of other types of cash sickness benefits. For maternity benefits, the most common provision is 12 weeks; for other sickness benefits, 26 weeks.

To obtain maternity benefits, a woman must abstain from paid work during the period that benefits are received, must suffer an actual loss of wages, and usually must take advantage of the prenatal and postnatal care provided by the system.

Medical Care Benefits

Most foreign social security programs that provide cash sickness benefits provide medical benefits as well. It is possible in general to distinguish three main patterns. Under one general method, insured patients pay the bills of doctors, hospitals, druggists, and so forth, themselves, and then later receive reimbursement from the social insurance system. Under a second method, the social insurance system pays the doctors and hospitals directly. The third general method, used in some countries, is for the social insurance system to acquire its own dispensaries, clinics, and hospitals, as well as its own medical staff, and to provide services directly to the insured population it covers.

Where medical benefits are provided in the form of reimbursement for bills paid by the patient, or in the form of direct payments to doctors and hospitals, the payment by the social insurance system may cover the whole cost or only a part of the cost, e.g., 75 percent, with the patient bearing the remaining part of the cost. Where medical services are provided directly by the social insurance system or as a public service, patients are sometimes required to pay a fixed fee per visit or prescription, in addition.

Nearly all the programs that provide medical benefits for sickness also provide prenatal care to working women covered by the insurance system as well as obstetrical and postnatal care. The obstetrical care may in some cases be limited to that furnished by a midwife, although care by a doctor is usually available if required. In addition, care in a maternity home or hospital is usually furnished where necessary, as well as essential medicines.

Qualifying Conditions

Nearly all health and maternity insurance programs require that claimants for cash benefits, in addition to being incapacitated, must have completed some kind of a minimum qualifying period of contribution or insured employment. The length of the qualifying period for cash maternity benefits is usually somewhat longer than for other cash benefits, ranging up to 10 months or more.

As regards medical care benefits, the qualifying period is also most commonly longer for maternity than for other types of disability

benefits. There is, of course, no qualifying period required under those programs which furnish medical care as a public service.

Administration

The largest number of countries provide for the administration of health and maternity insurance programs by some type of self-governing semi-autonomous institution, under government supervision. Some of these institutions own and operate their own medical facilities, through which at least a part of the medical benefits provided under the program concerned are furnished.

In some countries, responsibility for most of the detailed administration of the program is placed in the hands of a large number of local or occupational sickness funds or societies, which workers are required to join. These bodies collect contributions from their members, pay cash benefits, and also arrange for the furnishing of medical care to their members, often through contracts with doctors and perhaps hospitals in the region. These smaller funds in a number of countries are affiliated in turn with larger federations, which may carry on various coordinating activities at the national level.

Health and maternity insurance programs in most of the remaining countries are administered by government departments. Such administration is often linked with that of other types of social security benefits, the entire range of benefits being administered as a single integrated program.

