both may be used to estimate standard errors not specifically shown. Table 1 shows, for example, that 50 percent of the 163,429 former beneficiaries whose benefits terminated at age 18 were male. Table II indicates that one standard error is 2.3 percent. Thus, with 95 percent confidence the percentage of male beneficiaries in this group lies between 45.4 and 54.6.

The following procedure may be used to make a rough determination of the statistical significance of the difference between two independent percentages:

> Find estimates of the standard errors of the percents in question, using table I. Square these standard errors to get variances and add the variances. Take the square root of this sum to get the standard error of the difference If the absolute difference between the two percentages in question is greater than twice the standard error of the difference, they are said to be significantly different from one another at the 5-percent level.

Notes and Brief Reports

Health Maintenance Organization Act of 1973*

The Health Maintenance Organization Act of 1973 (P.L. 93–222), signed by President Nixon on December 29, 1973, is the first major health legislation enacted by the 93d Congress. The new measure commits the Federal Government to a limited, trial-period support of the development of health maintenance organizations (HMO's). Its major purpose is to stimulate interest by consumers and providers in the HMO concept and to make health care delivery under this form available and accessible in the health care market.

HMO's, an alternative to existing fee-for-service medical care, bring together a comprehensive range of medical or health care services in a single organization. They are responsible for providing such services, as needed, to their subscribers in return for a fixed monthly or annual payment periodically determined and paid in advance. The HMO's are rooted in well-established prototypes some of which have been in existence for as long as 40 years—the Kaiser Foundation health plan in Oakland, California (1942), the Roos-Loos Medical Clinic in Los Angeles (1929), Group Health Association in Washington, D.C. (1937), the Group Health Cooperative of Puget Sound (1947), and the Health Insurance Plan of Greater New York (1947). About 7 million persons or roughly 3 percent of the population were enrolled as of the end of 1972 in such plans.

REQUIREMENTS FOR HMO'S

Federal assistance under the new legislation will be granted to public or private entities only if the HMO's meet the definitional and organizational requirements of the act.

Definitional Requirements

Health maintenance organizations are defined as entities which provide basic health services to their enrollees, and, for an additional payment, supplemental health services. Prepaid enrollment fees for the basic and supplemental health services must be fixed uniformly under a community rating system—without regard for the medical history of any individual or family.

The basic health services that must be provided by the HMO to its enrollees are:

—physicians' services (including consultant and referral services by a physician)

—inpatient and outpatient hospital services

—medically necessary emergency health services

—short-term (not to exceed 20 visits) outpatient evaluative and crisis-intervention mental health services

* Prepared by Marjorie Smith Mueller, Division of Economic and Long-Range Studies.

—medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs

—diagnostic laboratory and diagnostic and therapeutic radiologic services

—home health services

—preventive health services (including voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

The HMO must provide the following supplemental health services, if the necessary health manpower is available and if the member has contracted for such services:

—services of intermediate and long-term care facilities

—vision care not included as a basic health service

—dental services not included as a basic health service

—mental health services not included as a basic health service

—long-term physical medicine and rehabilitative services, including physical therapy

—drugs prescribed in connection with the provision of basic or supplemental health services.

The legislation permits an HMO to charge an enrollee nominal payments in addition to the prepaid enrollment fee for basic services. The additional payments, to be made at the time of receipt of services, must be fixed in accordance with regulations by the Secretary of Health, Education, and Welfare. Such payments would not be required if, as determined under regulations of the Secretary, they were a barrier to attainment of health care.

Basic services (and supplementary services when contracted for) must be provided by the HMO staff of professionals or through "medical groups" or "individual practice associations," unless the health professionals' services are determined to be unusual or infrequently used or, because of medical necessity, they cannot be provided through the HMO. When basic (and supplementary, if contracted for) services are medically necessary, they must be available and accessible 24 hours a day and 7 days a week.

A member must be reimbursed for his expenses in securing these services outside the area if it was medically necessary that they be rendered before he could return to such area. Thus, the HMO enrollee is assured of obtaining services in an appropriate and convenient way, whenever he needs them.

Organizational Requirements

Medical groups must be organized as a partnership, association, or other group and must, as their principal professional activity and as a group responsibility, engage in coordinated practice for an HMO. The medical group must pool its income from the HMO practice and distribute it among themselves, according to a prearranged salary or other plan, share records and substantial portions of major equipment and of professional, technical, and administrative staff, and arrange for and encourage continuing education for its members.

The majority of the medical group must be licensed to practice medicine or osteopathy, but it may include such other professionals as dentists, optometrists, and podiatrists and utilize such other professionals, allied health, and other health personnel as are necessary to provide the services for which the group is responsible. Individual practice associations are defined by the act to mean a partnership, corporation, association, or other legal entity that has entered into a services arrangement or arrangements with persons licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health professions in a State. The majority of such persons must be doctors of medicine or osteopathy. The arrangement must provide for continuing education of such persons and include a compensation arrangement. Requirements for utilization of additional professional, allied health personnel, and for sharing of records and staff are similar to those applicable to medical groups.

OTHER REQUIREMENTS

Financial responsibility.—The HMO must have a fiscally sound operation and adequate provisions against the risk of insolvency. It must assume full financial risk on a prospective basis for the provision of basic health services, with the right to obtain insurance or make other arrangements for (1) the cost of providing to any member basic health services the aggregate value of

which exceeds $5,000 in any year, (2) the cost of basic health services provided out of the area because of medical necessity, and (3) not more than 90 percent of the amount by which its costs in any fiscal year exceed 115 percent of fiscal-year income. This arrangement allows the HMO to protect itself against an unpredictably high rate of illnesses among its members and still retain financial responsibility for the provision of basic health care services to its enrollees—one of the basic characteristics of a prepaid capitation mechanism of financing health care services.

Open enrollment and membership.—HMO's are required to enroll persons who are broadly representative of the various age, social, and income groups within the areas they serve. The HMO may not draw more than 75 percent of its enrollment from a medically underserved population unless the area is also a rural area.

The HMO must have annual open enrollment periods. Waivers are permitted (1) if such open enrollment would result in enrollment of a population not broadly representative of the various groups in the service area or (2) if the HMO can demonstrate that it has enrolled or will be compelled to enroll a disproportionate number of high-risk individuals and if enrollment during an open enrollment period of an additional number of such individuals will jeopardize its financial stability. An HMO may not refuse to enroll or re-enroll any member for reasons concerning his health status or needs for health services.

Consumer participation.—The HMO must be organized to assure that at least one-third of the members of the policymaking body are enrollees in the HMO and that the members from the medically underserved populations it serves will have equitable representation on the policymaking body. Consumers may thus have a role in determining such matters as operating hours, location of satellite facilities, acceptability of health care personnel, and the range of benefits.

Meaningful procedures for hearing and resolving grievances between the HMO (including the providers) and the enrollees must also exist. In this way, consumers have the opportunity to influence the policy of the HMO and obtain prompt and equitable resolution of their grievances.

Health education.—HMO's are required to provide medical social services for their members and to encourage and actively provide health education services, including education in methods of personal health maintenance and in the use of health services. It is expected that such a program will help patients to recognize and carry out their responsibility for proper diet, exercise, and use of medications and, in many cases, to perform certain health services for themselves. Thus, enrollees can contribute to their improved health at lower cost.

Quality control.—An HMO must have an ongoing quality assurance program for its health care services. The program must emphasize health outcomes and provide for physician review and for review by other health professionals.

Data reporting.—HMO's must adopt procedures for developing and reporting to the Secretary of Health, Education, and Welfare data relating to cost of operations, utilization patterns, and the availability, accessibility, and acceptability of its services and on other matters as required by the Secretary. To the extent practical, information is to be reported on developments in the health status of the HMO members.

FINANCIAL ASSISTANCE

To aid the development of HMO's the legislation authorizes a total appropriation of $375 million for a 5-year period. Grants and contracts for public or nonprofit private organizations are authorized for (1) surveys or other activities to determine the feasibility of developing and operating or expanding the operation of an HMO, (2) planning projects to establish HMO's or to expand the membership of an HMO or the area that it serves, and (3) projects to initially develop HMO's.

For public or nonprofit private HMO's, loans to meet initial operating costs in excess of revenues during the first 36 months of their operation are authorized under the law. Loans are also authorized if there is a significant expansion in the membership or area served.

Aid to private profitmaking entities for planning projects to establish or expand HMO's or

for initial operating costs (in the amount and for the period authorized for public and nonprofit private HMO's) is to be limited to loan guarantees. Eligibility for aid is contingent on planned enrollment of medically underserved populations.

Priority for grants and contracts for feasibility and planning studies will be given to applicants who can assure that the HMO at the time it first becomes operational has at least 30 percent of its members from medically underserved populations.

The aggregate appropriation includes $50 million for research and evaluation studies of quality assurance.

Total appropriations authorized in the law are shown in the tabulation below.

Purpose	Amount (in millions) authorized in fiscal year—				
	1974	1975	1976	1977	1978
Grants and contracts for:					
Feasibility studies, planning, and initial development	$25	$55	$85	------	------
Initial development	------	------	------	$85	------
Capitalization of initial operating loan revolving fund	[1] 75	------	------	------	------
Independent study of quality assurance	[2] 10	------	------	------	------
Research and evaluation of quality assurance (Department of Health, Education, and Welfare)	4	8	9	9	$10

[1] For fiscal years 1974 and 1975

[2] The law does not state a fiscal-year limitation. A final report giving the results of the study must be submitted to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Senate Committee on Labor and Public Welfare by January 31, 1976

OTHER FORMS OF ASSISTANCE

The act gives, in addition to limited financial support, several other forms of assistance designed to aid in HMO development. This kind of encouragement and stimulus was felt by Congress to be essential if HMO's are to have the opportunity to prove themselves in the competitive health care market.

Restrictive State laws.—First and probably most important, the Federal legislation supersedes certain restrictive State laws to the extent that they impede the development of HMO's meeting the definitional and organizational requirements of the act. Some existing State legal barriers relate to physicians' control, open physician participation in HMO's, and the prohibition or restriction of group practice. (Congress had already authorized group-practice carriers under the Federal Employees Health Benefits Act to underwrite prepaid group practice without regard to State restrictions.)

Employees' health benefits plans.—HMO's are given an opportunity to compete in the labor marketplace with other health insurance plans, under a provision of the law that requires employers of 25 or more workers who receive health insurance benefits to give their employees an HMO option to traditional health insurance, if there is an HMO in the areas that meets the definitional and organizational requirements of the new law.

Regulation for quality care assurance.—The assurance of quality care by HMO's is aided by the authority given to the Secretary of Health, Education, and Welfare to continue to regulate HMO's receiving financial assistance under the legislation. Compliance with the provisions of the law may be enforced through a civil action by the Secretary in the appropriate United States district court.

RELATION TO MEDICARE AND MEDICAID

The law exempts HMO's from the definitional requirements of the act with respect to Medicare and Medicaid enrollees, for whom health care services continue to be those allowed under the two programs. Reimbursement for Medicare is by the capitation method—either through incentive reimbursement or cost reimbursement—as provided in the Social Security Amendments of 1972. For Medicare and Medicaid purposes, the HMO is not subject to the reinsurance ceilings imposed by the new law but can have insurance against any risk involved in covering Medicare and Medicaid enrollees.

HEALTH SERVICES FOR INDIANS AND MIGRATORY WORKERS

The Secretary of Health, Education, and Welfare is authorized, with the consent of the Indian people served, to contract with private or other non-Federal health agencies or organizations to provide health services to Indians on a fee-for-service basis or on a prepayment or other similar basis.

The new legislation also authorizes the Secretary to arrange for the provision of health services through HMO's for domestic agricultural migratory and seasonal workers who are eligible for health services under already existing authority (except under section 310 of the Public Health Services Act) and for the families of such workers.

QUALITY CARE ASSURANCE PROGRAMS

The legislation calls for research and evaluation programs, to be conducted by the Secretary of Health, Education, and Welfare through the Assistant Secretary for Health, on the effectiveness, administration, and enforcement of quality assurance programs for health care. Annual reports are to be made to Congress and the President on the quality of health care in the United States, the operation of quality assurance programs, and advances made through research and evaluation of such programs.

The Secretary is also directed to contract with an appropriate nonprofit, private organization for an independent study of health care quality assurance programs. The study is to include the development of a set of basic principles to be followed by an effective health care quality assurance system that will relate to such matters as the scope of the system, methods for assessing care, data requirements, and specifications for developing criteria and standards concerning desired outcomes of care. The organization designated must have a national reputation for objectivity in the conduct of studies for the Federal Government, expertise, and a history of interest and activity in health policy issues related to such study.

EVALUATION OF PROGRAM

An evaluation of the operation of the HMO program is to be conducted by the Comptroller General of the United States. At least 50 of the HMO's that have been receiving Federal funding and that have been operational for 3 years are to be evaluated. The Comptroller General will report the results of the evaluation to Congress within 90 days of its completion and include findings on the ability of these HMO's to (1) operate on a sound fiscal basis without continued Federal financial assistance, (2) continue to meet the organizational and operational requirements of the act, (3) provide the required basic and supplemental health services, (4) include indigent and high-risk individuals in their memberships, and (5) provide health services to medically underserved populations.

The Comptroller General is also required to conduct a study and to report to Congress within 36 months after enactment of the legislation, on the economic effects on employers of their compliance with the provision on employees' health benefits plans. He is also directed to evaluate the operations of the HMO's—by category in comparison with each other and as a group, in comparison with other forms of health care delivery —and to evaluate the impact that HMO's individually, by category, and as a group, have on the health of the public. The results of this evaluation are also to be reported to Congress not later than 36 months after enactment of the law.

Veterans' Pensions Increased*

On December 6, 1973, President Nixon signed Public Law 93-177 granting a 10-percent cost-of-living increase to veterans, widows, and children receiving non-service-connected disability and death pensions, and to dependent parents receiving service-connected dependency and indemnity compensation. About 2.5 million veterans and survivors are affected by the law, which went into effect on January 1, 1974.

Receipt of veterans' pensions is predicated upon financial need. For persons entering the rolls on or after July 1, 1960, the amount of pension received depends on the amount of income received from other sources, with higher payments going to veterans with low incomes and more dependents.[1] When income increases, the veterans' pension payment is reduced. The new law is designed to restore most of the reduction

* Prepared in the Interprogram Studies Branch, Division of Economic and Long-Range Studies.

[1] For pensioners on the rolls before July 1, 1960, who chose to stay under the "old" system, the benefits payable are flat-rate amounts with single income limitations. The new legislation does not increase these amounts. Presently, 10.7 percent of all pensioners continue to receive benefits under the "old" system.