table I. Where data are shown as cross-classifications of two characteristics, use the larger factor.

The standard errors estimated from these tables are not directly applicable to differences between two sample estimates. In order to estimate the standard error of a difference, the tables are to be used somewhat differently in the following situations:

1. For a difference between two sample figures, the standard error is approximately the square root of the sum of the squares of the standard errors of each estimate considered separately. This formula will represent the actual standard error quite accurately for the difference between estimates of the same characteristics in two different areas, or for the difference between separate and uncorrelated characteristics in the same area. If, however, there is a high positive correlation between the two characteristics, the formula will overestimate the true standard error.

2. For a difference between two sample estimates, one of which represents a subclass of the other, the tables can be used directly with the difference considered as the sample estimate.

Notes and Brief Reports

Compulsory Health Insurance in Hawaii*

On January 1, 1975, Hawaii became the first State to have a mandated health insurance program in effect. The law, enacted June 12, 1974, requires employers to provide protection against the costs of hospital and medical care for their employees. The employer may purchase an insurance policy or arrange for a medical or nonprofit organization either to furnish services to employees or to defray costs or reimburse employees for the expenses of health care.

COVERAGE

In Hawaii, all employers with one or more regular employees are covered by the law except the following: Government employees, agricultural seasonal employees, employees who work less than 20 hours a week or whose monthly wages are less than 86.67 times the prevailing State minimum hourly wage, employees covered by a Federal program or receiving public assistance, individuals who depend on prayer or spiritual means for healing, individuals in family employment, and insurance and real estate salesmen or brokers paid solely on commission. Coverage is compulsory, and workers cannot waive the protection provided by the law.

If an individual works concurrently for more than one employer, the one who pays the most wages will be the principal employer and will be responsible for providing health care coverage. The employee, however, may select a different principal employer if he works at least 35 hours weekly for an employer who does not pay the most wages. If he works for a government agency and a private employer, the former will be deemed the principal employer. If an employee's dependents are themselves employed, they may choose to be covered under the plan at their own place of employment.

ELIGIBILITY

A worker is covered as soon as he has had 4 or more consecutive weeks of employment. If an employee is unable to work because he is sick, protection continues for 3 months following the month in which he became ill.

BENEFITS

The employer's prepaid group health care plan meets the requirements of the law if it provides health care benefits equal to, or medically reasonably substitutable for, the benefits offered by prepaid health plans of the basic types[1] with the

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[1] A prepaid health care plan is (a) any medical group or organization that provides health care benefits (the Kaiser Medical Center, for example), (b) any nonprofit organization that defrays or reimburses in whole or in part the expenses of health care (such as the Hawaii Medical Services Association), or (c) any commercial insurer that defrays or reimburses in whole or in part the expenses of health care (the Aetna Life Insurance Company, for example).

largest number of subscribers in the State. The Director of the Department of Labor and Industrial Relations, with the advice of an advisory group, determines whether a plan complies with these standards. Exceptions are permitted when the plan is deemed to provide sound health benefits at a premium commensurate with the benefits after taking into account coinsurance features, deductibles, limitations on reimbursability, and dependents' benefits.

The plan's protection must include hospital benefits of at least 120 days' confinement in each calendar year; outpatient hospital care; surgical and diagnostic benefits; home, office, and hospital visits by a physician; and maternity benefits (applicable to employees with at least 9 months' coverage before delivery).

Employees are free to bargain collectively for different prepaid health care coverage or for a different allocation of the costs. Employers are in compliance with the law if they provide health care services under a collective bargaining agreement and if the services are provided for employees not covered by such an agreement.

FINANCING

An employer may pay the entire premium cost or share it with his employee. If the cost is shared, the employee's portion is limited to half the premium cost but not more than 1.5 percent of his wages. When the employee pays less than half, the employer is responsible for the entire remainder. No employee is obligated to pay more than he would have had to contribute if the employer had elected coverage under a comparable plan with the largest number of subscribers in the State. To cover health services for his dependents, however, an employee may consent to pay a higher contribution.

To help relieve small employers of the new program's financial burden, the State subsidizes—from general revenues and penalty fines—the premiums of an employer with less than 8 employees if (1) the employer's share exceeds 1.5 percent of total wages payable to employees and (2) the amount of the excess is greater than 5.0 percent of the employer's income before taxes directly attributable to the business. A formula in the law determines income for this purpose. A special premium supplementation fund is used to pay the subsidy for an employer's share of a premium that exceeds the limits specified above. Employers' penalty fines for failure to comply with the law are deposited in the special fund.

OTHER PROVISIONS

The Department of Labor and Industrial Relations administers the program. A seven-member advisory council—appointed by the Director of the Department—assists in determining whether a prepaid health care plan qualifies. The council members represent the medical and public health professions, consumer interests, and the prepaid health care field.

The law specifies that the new program will terminate upon passage of a Federal mandated national health insurance program or enactment of a Federal voluntary health insurance program that provides for health care "at least as favorable" as that provided by the new State program.

Veterans' Legislation, 1975*

The Veterans Disability Compensation and Survivor Benefits Act of 1975 (P.L. 94–71, signed August 5, 1975) provided cost-of-living increases in the monthly payments to disabled veterans, and their dependents and to certain survivors of veterans who died of service-connected causes. Its provisions, which became effective as of August 1, 1975, apply to nearly 2.2 million disabled veterans and 280,400 veterans' survivors.

Veterans' compensation is paid in accordance with the degree of service-connected disability and is based on the average impairment of earning capacity resulting from such injury. The cost-of-living increase amounts to 10 percent for veterans with disabilities rated from 10 percent to 50 percent and to 12 percent for veterans with disabilities rated higher (table 1). The added amounts range from $3 a month for a 10-percent disability to $71 for a 100-percent disability. Allowances to dependents of a veteran whose disability is rated at 50 percent or more went up

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