From the appropriate base in table VI determine the standard error of a 50-percent characteristic, (2) add to and subtract from 50 percent the standard error determined in step 1, and (3) the confidence interval for the median corresponding to the two points established in step 2 are then read off the distribution of the characteristic A two-standard-error confidence limit may be determined by finding the values corresponding to 50 percent plus and minus twice the standard error shown in table VI

To illustrate, the median total income in 1971 of the 2,075,000 widows who were primary beneficiaries was $2,111

1 From table VI, the standard error of 50 percent of these widows expressed as a percentage is about 1 4 percent

2 As interest usually centers on the confidence interval for the median at the two standard-error level, it is necessary to add and subtract twice the standard error obtained in step 1 from 50 percent This procedure yields limits of 47 2 and 52 8 (rounded to 47 and 53)

3 Since 46 percent of the women had total incomes below $2,000 and 18 percent had total incomes between $2,000 and $2,499, the dollar value of the lower limit may be found by linear interpolation to be

$$\frac{(47 - 46 \times \$500)}{18} + \$2{,}000 = \$2{,}028$$

4 The dollar value of the upper limit may be found by linear interpolation to be

$$\frac{(53 - 46 \times \$500)}{18} + \$2{,}000 = \$2{,}194$$

Thus, the chances are about 95 out of 100 that a census would have shown the median to be greater than $2,028 but less than $2,194

Notes and Brief Reports

Health Maintenance Organization Amendments of 1976*

The first amendments to the Health Maintenance Organization Act of 1973 [1] were enacted on October 8, 1976 as Public Law 94–460 An alternative to the predominant fee-for-service form of health care, health maintenance organizations (HMO's) offer a comprehensive range of medical and health care services to subscribers in return for a fixed periodic fee determined and paid in advance

The aim of the 1973 act was to stimulate interest in the HMO concept on the part of both consumers and providers and to make health care delivery under this form available and accessible Financial assistance from the Federal Government was made available to HMO's that meet specified criteria Since the act's inception, however, progress in implementation has been slow The 1976 amendments are intended to provide HMO's with greater flexibility, improve the administration of the program, and correct deficiencies in the original law that placed HMO's at a competitive disadvantage with traditional insurance programs and health delivery systems To accomplish these goals, the new legislation relaxes some of the original act's more stringent requirements regarding open enrollment, community rating, the benefit package that must be offered, the dual-choice provisions under employee health benefit plans, and the availability of Federal loan guarantees

Mandatory Health Services

HMO's seeking to qualify for Federal assistance must provide basic health services Hospital, surgical, and physicians' care, diagnostic, radiological, and home health services, short-term mental health care, preventive health services, and treatment for alcohol and drug abuse The 1973 act also required that, under certain conditions, the HMO's were to provide supplemental

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[1] For a description of the original legislation, see Marjorie Smith Mueller, "Health Maintenance Organization Act of 1973," *Social Security Bulletin*, March 1974, pages 35–39

health services not covered in the basic category —care in intermediate- and long-term care facilities, vision care, dental services, rehabilitative services, and drugs, for example

The new law makes these supplemental benefits optional with the HMO and moves preventive dental care for children from the basic to the supplemental category At the same time, the list of basic services has been expanded to include immunizations, well-child care from birth, and periodic health evaluations for adults HMO's are permitted to include in the basic benefit package they require that their members purchase any supplemental services

Open-Enrollment Requirements

The requirements in the original act have been modified to reduce the possibility that open-enrollment will jeopardize the economic viability of HMO's by encouraging the enrollment of a disproportionate number of high-risk individuals Adverse selection is a potential problem because HMO's have been required to enroll persons who are broadly representative of the various age, social, and income groups within the areas they serve The 1973 act stipulated that each HMO must have an annual open-enrollment period of at least 30 days, during which it must enroll, up to its capacity, individuals in the order in which they apply without respect to preexisting illness or medical condition

The 1976 amendments limit application of the open-enrollment requirement to HMO's that have not incurred a financial deficit in a recent year and either have been in existence for at least 5 years or have a minimum of 50,000 members, whichever occurs first The 30-day requirement for the open-enrollment period may be suspended as soon as subscriptions obtained during the HMO's annual open-enrollment period equal at least 3 percent of the total net increase in subscribers for the preceding calendar year

Moreover, an HMO is not required to enroll certain individuals who are institutionalized and it may require a 90-day waiting period between application and the time benefits begin As before, the Secretary of Health, Education, and Welfare may waive compliance with the open-enrollment requirement if the HMO can demonstrate that open enrollment will jeopardize its financial stability

Community-Rating Requirements

Another change involves the provision in the original act that required prepaid enrollment fees to be fixed uniformly under a community rating system without regard to the experience of any group To accommodate HMO's that over the years have developed variations in community rating in specific marketing situations, the new law delays the application of the community-rating provision to existing prepaid plans for 4 years after qualification The Secretary of Health, Education, and Welfare is also given authority to waive the community-rating requirement The law further permits an HMO, in establishing rates, to take into account differences in marketing costs Applications for qualification, however, must contain assurances that the community-rating requirement will be met when it is required

Dual-Choice Provisions

Under the 1973 act, employers with 25 or more workers who offer health benefit plans for their employees were required to include the option of membership in a qualified HMO serving the area, if the HMO so requested The 1976 amendments make it clear that the HMO must be serving an area in which at least 25 employees reside and defines the term employer to exclude the Federal Government (but not State and local governments) and certain nonprofit organizations such as churches

The new law also specifies that employers must offer the HMO option first to the employees' union, in cases where one exists If the union accepts the option, each employee still has the individual option of accepting HMO membership or continuing with traditional health insurance If the union refuses the option, the employer's obligations under the law are fulfilled

Loan Guarantees and Direct Assistance

The 1976 amendments make Federal loan guarantees for planning and development available

to nonprofit HMO's as well as to profitmaking ones Under the previous law, such loans were restricted to profitmaking HMO's that serve medically underserved populations Loan guarantees are now available to nonprofit HMO's regardless of location, though priority is to be given to those that will serve medically underserved populations As before, nonprofit HMO's (but not profitmaking entities) may be directly assisted by means of loans, grants, and contracts

Under other revised financial provisions, the maximum amount of Federal assistance for a feasibility survey under any single grant or contract has been raised from $50,000 to $75,000 a year and the amount for any single planning project goes to $200,000 from $125,000 Additional assistance will be provided for development in noncontiguous or new service areas

The period during which loans to meet initial operating costs may be available has been increased from 3 to 5 years, and the time for earmarking sums for planning the establishment or expansion of HMO's in nonmetropolitan areas has also been extended Appropriation authorizations for HMO development have been revised downward for fiscal year 1977 from $85 million to $45 million For the following 2 fiscal years, the amounts allotted are $45 million and $50 million

Organizational Requirements

The requirement in the original law that physicians in a medical group must devote more than 50 percent of their professional time to HMO practice has been changed to a requirement that such physicians must individually engage in coordinated group practice as their principal professional activity and collectively take substantial responsibility for the delivery of medical services to HMO enrollees A substantial portion—at least 35 percent—of the entire group's services must be devoted to the care of HMO members, although HMO's need not meet this requirement for 3 years after they become financially qualified and that period can be extended through waivers by the Secretary of Health, Education, and Welfare

Under the original act, an HMO could only provide services in three ways—through its own staff, through a medical group, or through individual practice associations The amendments permit HMO's to provide services through any combination of staff, medical groups, individual practice associations, or professionals under contract

Moreover, HMO's may now contract directly for the services of individual health professionals or groups of health professionals that do not qualify as medical groups or individual practice associations The amount contracted for, however, may not exceed 30 percent of the dollar value of the HMO's physician services in rural areas or 15 percent in nonrural areas This provision gives HMO's more flexibility in delivering the services of particular medical specialties, especially those that are in short supply

A new section provides that the law is to be administered through a single identifiable administrative unit of the Department of Health, Education, and Welfare The provisions for program evaluation by the Comptroller General of the United States have been revised Instead of requiring evaluation of the operation of at least 50 HMO's for which Federal funding has been provided, the law now reduces the number to 10, or one-half, whichever is greater, with a deadline of June 30, 1978 As of August 1976, approximately 20 HMO's were federally qualified

Amendments to the Social Security Act

Public Law 94–460 also contains amendments to the Social Security Act that coordinate the definitions of an HMO in the HMO Act with those contained in the Medicare and Medicaid laws This step makes the provisions and definitions dealing with HMO's in the Social Security Act more consistent with those in the HMO Act Previously, the Social Security Act defined and set forth requirements for HMO's without reference to the definition of an HMO found in the HMO Act

Determinations as to whether an organization qualifies as an HMO will be made by the Secretary of Health, Education, and Welfare through the Assistant Secretary for Health, an HMO need thus apply to only one office The Commissioner of Social Security continues to be responsible for administering the other provisions involving HMO's under Medicare

As before, to qualify as an HMO under Medicare, an organization must have at least half of its enrolled membership composed of persons under age 65 and must have an open-enrollment period during which it will accept Medicare beneficiaries to the limits of its capacity in the order in which they apply (with provisions for waivers and exceptions) The HMO premium rate or other charge to Medicare enrollees need not be community-rated but can be based on the actuarial value of the Medicare deductible plus any coinsurance

The new law continues the requirement that the services an HMO must provide to Medicare beneficiaries are those covered under that program's hospital insurance and supplementary medical insurance rather than the "basic health services" defined in the HMO Act The requirement in the Social Security Act that an HMO must provide both primary care and specialty care physicians for its members has been eliminated

Now, in determining the amounts payable to it under a risk-sharing contract with the Secretary of Health, Education, and Welfare, an HMO may include reinsurance costs stemming from any underwriting of catastrophic risks Previously, only reinsurance costs relating to out-of-area services were allowed

Medicaid provisions have been amended to include a definition of HMO's that corresponds to the definition in the HMO Act in all respects except that "basic health services" are defined as referring to mandatory Medicaid services Unless the provision is waived, no more than half the enrolless in an HMO may be covered under Medicare or be recipients of Medicaid

The new law tightens up the provisions for Federal matching payments to States for Medicaid services provided by organizations on a prepaid or capitation at-risk basis No payments will be made unless the organization providing inpatient hospital services, any other mandated Medicaid service, or any three other Medicaid services on a prepaid risk basis has qualified as an HMO Exempted from this requirement are organizations that have received community health center or migrant health service grants of specified amounts and nonprofit rural health care entities that have received specified grants under the Appalachian Regional Development Act The requirement will not apply to organizations that contracted for the provision of services before 1970

Research Grants Studies

Section 702 of the Social Security Act provides for general research studies relating to the Social Security Administration's areas of responsibility to for-profit and nonprofit organizations Extramural research grants have been awarded under this provision A summary of a completed project (Contract No 74-98) is presented below[1] From time to time, the BULLETIN publishes similar summaries as projects are completed

FORMER WELFARE FAMILIES INDEPENDENCE AND RECURRING DEPENDENCY

This study of 354 New York City families who left the welfare rolls because of changes in their economic circumstances was directed by Anne N Shkuda of the Center for New York City Affairs at the New School for Social Research Data for the study were obtained from personal interviews conducted about 1 month after their welfare cases had been closed About 6 months after the closing date, 300 families were reinterviewed

SAMPLE CHARACTERISTICS

Several characteristics of the families in the study sample distinguish them from the open welfare caseload and provide indications of their relative economic strength Most striking is the presence of two parents among the former welfare recipients 45 percent of the families had

[1] For the full report, see Anne N Shkuda, *Former Welfare Families Independence and Recurring Dependency*, New School for Social Research, Center for New York City Affairs, 1976