EXPANDED DEPENDENT DENTAL CARE UNDER THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

A Problem Solving Thesis

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Lieutenant Colonel Jon L. Daniels, DC

Waco, Texas

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APPROVED BY THE U.S. ARMY MEDICAL FIELD SERVICE SCHOOL:

Director of the Program

APPROVED BY THE THESIS COMMITTEE:

Chairman

APPROVED BY THE GRADUATE COUNCIL:

Dean of the Graduate School

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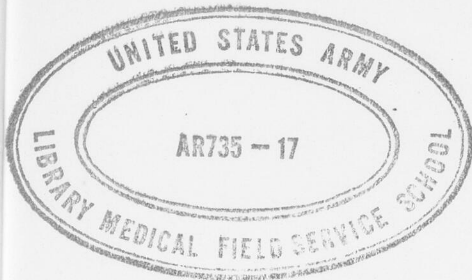
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CHAPTER I

INTRODUCTION

Statement and Development of the Problem

The problem is to determine an acceptable expanded dependent dental care program to be administered under the Civilian Health and Medical Program of the Uniformed Services.

Dental care for dependents of active duty armed forces personnel is not a regularly available benefit. Except for properly certified adjunctive care and orthodontics in certain cases, the only benefit provided for by regulation is emergency dental care. Within the continental United States dependent dental care is available only at specially designated installations.[1] These installations provide care only on a space available basis. Military dental clinics are planned, built, and staffed for provision of care to military personnel. Any dependent care provided is done at the expense of resources provided for the treatment of the serviceman or woman. Existence and use of the Veterans Administration program of dental care for Vietnam veterans is evidence that the dental resources could be more fully utilized for the serviceman while on active duty.[2]

Limited availability of dependent dental treatment at some stations in the United States and in accompanied tour areas overseas leads to the possibility of a system - fostered decline of dependent dental health. If care is available at a given station, but facilities

are crowded, patients will of necessity have to wait for service. This results in worsening dental conditions. An apparent satisfaction of moral need is accomplished by placement on a call list, even if the predicted waiting time might exceed the sponsor's remaining assignment. Fully operational systems of dependent care do exist at some installations, to be sure. However, in the writer's experience, various methods are often used in regulating the resources available for dependents. The result is that the dependents needing care are, by one means or another, deferred for varying periods.

Decline of dental health also results from the individual's failure to accept responsibility for obtaining private care when military care is not available. The writer has many times been confronted with questions such as, "What am I supposed to do about this child's teeth if you (military dental system) can't take care of them?" and "I tried to get appointments for them last year, but the phone was always busy," and so on, indicating complete dependence on the military system for direction to care if not for the actual care. A transfer of blame to the military system for deterioration of dental health is often attempted by individuals not willing to accept their responsibility for well-being. The children of the characterized parents quoted are, in the meantime, receiving only "crisis care" in military clinics or private offices. Availability of care would prevent countless dental problems of a more serious nature.

The care required by military dependents is not universally available in either military clinics or under the existing provisions of the Civilian Health and Medical Programs of the Uniformed Services

(CHAMPUS). Legislation supported by the Special Subcommittee on Military Dental Care of the House Committee on Armed Services is presently before Congress to enact dependent dental care. Should this legislation be passed, the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), as now organized, would be unable to perform the required administrative functions to implement it.[3]

Review of the Literature

Development of dental care prepayment plans has been the subject of many authors. Approaches to prepaid dental care and the development of packages of care have ranged from elaborate operations research studies[4] to rather simplistic studies to design packages for small consumer groups. Historically, the early studies published by the United States Department of Health, Education, and Welfare have been the primary foundations upon which the present plans are based. Specifically the works: An Experiment in Dental Prepayment: The Naismith Plan, Dental Care in a Group Purchase Plan, and Report on the Dental Program of the ILWU-PMA, the First Three Years, all by Quentin M. Smith and others, have formed the base of experience for the establishment of a majority of plans now in effect. Prior to the mid-fifties, dental care was thought to be uninsurable and not amenable to prepayment plans due to the prevalence of dental disease. These studies showed, however, that the insured seldom took full benefit of coverage provided, therefore dental hazards could be insured in a broadly based group insurance or prepayment program.

Publications by the Dental Service Corporations reporting the establishment of plans have also been used by many authors in developing bases for the prepayment structures as they now exist. The states of

Washington and California have been leaders in publication of their results. Valuable studies have come also from New York from the Group Health Dental Insurance, Inc., a non-profit community plan centered in the Greater New York area. A book entitled Insured Dental Care by Helen H. Avnet and Mata K. Nikias, D.D.S., M.P.H. published in 1967, has been of particular value in matters of utilization figures in the preparation of this paper.

Although the matter of dental care for the military dependent is not precisely insurance nor prepayment, the development of a package of dental care to be provided them follows the same steps. These steps are: determination of those eligible, selection of kinds of care to be made available, determination of the providers, the administrative mechanism for the program, and, of course, the costs to be expected. The process is not entirely new. There have been attempts at passage of dental care legislation in Congress in the past. A report entitled "Dental Care for Dependents of Uniformed Services Personnel" by the Dental Advisory Committee to the Office for Dependent's Medical Care was made in July, 1958. There is a similarity in the approach taken by the civilian dental service corporations, the approach advised by the Dental Advisory Committee, and the proposal in Congress for enactment.

Although similar proposals have been made, this approach has the benefit of experience gained from earlier studies. Cost and utilization figures not available earlier have been incorporated. Additionally, the organization of Delta Dental Plans Association as a national coordinating organization is recent. The development of dental service corporations in the various states is at a higher level than before. The existence

of these organizations is significant because they are envisioned as the administrative agents for the provision of the dental care packages to the military dependents in the various states.

Problem-Solving Methodology

Determination of those eligible for the package of dental care proposed is the first question to be addressed. Eligibility is prescribed by regulations for receipt of CHAMPUS care. The benefits available to dependents of active duty personnel differ from those for retirees and their dependents. Inasmuch as the Congressional recommendations in the past have considered limiting dental care to dependents of active duty personnel, this paper will provide for, but not necessarily recommend, that limitation.

Selection of the kinds of care to be made available is the issue that Congress and the Department of Defense will have to ultimately decide. It is the intent of this paper to show the range of benefits now provided in the civilian prepayment sector, and to present the various packages as approaches with varying costs. The selection of care packages will be developed out of the literature and experience.[4]

Selection of the providers of the care envisioned must be made. The available pool of professional manpower nationwide is limited. In order to provide dentists for active duty dependents at the national average of 1,693 population per dentist there would be a requirement for an additional 2,030 dentists added to the 7,932 on active duty at present.[5] There can be no logical alternative but to select the civilian dental profession as the provider of the care.

The determination of the administrative mechanism for providing the dental care is a problem to be addressed in this paper. The issues to be considered in this determination are the estimated number of the recipients in the various states and the existence of an active Delta Dental Plan in that state with capability to administer the program. Lacking an active plan, what alternatives are available? In considering these questions, the approach taken was by inquiry of the Executive Director of Delta Dental Plans Association as to the extent of organization of active plans in the various states. In those states where no plan is active, inquiry was made as to alternatives available through the national organization.

Anticipated costs of a program of dental care for CHAMPUS recipients was developed. A typical package of care, utilization factors, and computed future costs were applied to the number of recipients to determine the costs. These cost figures were developed mathematically by trend analysis and extrapolation.

Footnotes

[1]U.S. Army, AR 40-121, Medical Services Uniformed Services Health Benefits Program (Washington, D.C.: Government Printing Office, September 1970), p. 4.

[2]U.S., Veterans Administration, Summary of Benefits for Veterans with Service Since January 31, 1955, VA Pamphlet 20-67-1 (Washington, D.C.: Government Printing Office, July 1968), p. 4.

[3]The inability of the existing organization at OCHAMPUS to administer a vastly expanded program of dependent dental care is stated explicitly in the original problem statement from the Executive Director.

[4] Operations Research Group, Design of Prepaid Dental Plans (Cleveland, Ohio: Case Institute of Technology, 1964).

[5] American Dental Association, Distribution of Dentists in the United States by State, Region, District and County (Chicago: American Dental Association, Bureau of Economic Research and Statistics, 1971), p. 4.

CHAPTER II

DISCUSSION

Eligibility

Determination of eligibility for CHAMPUS benefits is based upon several factors. Status of the military member in question is first. Distinction is made between active duty and retired members and their dependents. Distinction is further made in the case of active duty members in the matter of residence with or apart from the member. Eligibility of retired members and their dependents to receive benefits under the Social Security Health Insurance Program for the Aged is a determinant. Distance from uniformed service facility is considered for dependents of active duty personnel. Whether care is to be inpatient or outpatient has a bearing on eligibility for active duty dependents as does issuance of statements of non-availability (see Table 1).

The actual determination of eligibility is not as complex as it might appear, because the majority of recipients fall clearly into the category of either eligible or non-eligible. Some lesser known distinctions arise in the provision of certain care categories, for example, care under the provisions of the program for the handicapped is limited to spouses and children of active duty members.

TABLE 1

AN ABBREVIATED DIGEST OF ELIGIBILITY FOR MEDICAL CARE UNDER THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) AND AT UNIFORMED SERVICE FACILITIES

Persons eligible	Inpatient and outpatient treatment at uniformed services facilities	Financial support for handicapped or mentally retarded dependents	Inpatient treatment at civilian hospitals	Outpatient treatment by civilian practitioners
Dependents of Active Duty Personnel				
Spouse and dependent children residing with sponsor	Yes	Yes	Yes	Yes
Spouse and dependent children residing apart from sponsor	Yes	Yes	Yes	Yes
Dependent parents or parents-in-law	Yes	No	No	No
Retired Personnel, Their Dependents, and the Dependents of Deceased Personnel				
Retired personnel currently entitled to retired pay	Yes	No	Yes	Yes
Spouses and dependent children of retired personnel	Yes	No	Yes	Yes
Dependent parents and parents-in-law of retired	Yes	No	No	No
Widows and dependent children of deceased active duty and deceased retired	Yes	No	Yes	Yes
Dependent parents or parents-in-law of deceased active duty and deceased retired	Yes	No	No	No

Adapted from CHAMPUS information charts A and B, January, 1970

For the purposes of this paper, persons eligible for receipt of care are considered to be in two basic groups: dependents of active duty personnel; and all eligible recipients. Limitation of care to dependents of active duty personnel is a measure of assurance of limitation of costs. It is also assurance that the retiree will feel the services have abrogated their responsibility. In many cases it would be breaking promises of lifelong care for himself and his eligible dependents as a service benefit. The addition of dependent dental care as an entitlement will enhance the volunteer service concept, but further enhancement would accrue in the granting of benefits for the retiree and his dependents that closely match those available during active duty. The value of this further enhancement is intangible without exhaustive survey, but the tangible benefit to the individual now retired is readily discernible. In spite of the apparent benefits to be gained by including the retiree and his dependents in the dental care plans, the legislation strongly recommended by the subcommittee excluded the retiree and his dependents.[1]

The Design of the Care Packages

The civilian organizations in the business of providing prepaid dental care to groups of recipients typically offer a selection of care packages. The benefits payable under the plan are established, and the costs correspond to the benefits chosen. Available plans range from emergency care of traumatic conditions incurred on the job, to comprehensive plans covering total dental care with virtually no exclusions. Others giving similar ranges of benefits limit liability in matters such as replacement of missing teeth to those lost after enrollment in the plan.

Certain plans require completion of major restorative work prior to enrollment, then assume liability for virtually any occurrence. The majority of plans offered by the commercial insurance companies must have some means of limiting their liability in order to make the offering profitable. Some provisions and exclusions have to be made, which for the present consideration would be unacceptable. Consideration will be given to plans offered by the dental service corporations, which, as non-profit organizations, are theoretically motivated by a desire for service and the furtherance of a high state of dental health.

The least extensive dental care package is minimal care. As an example of a minimal care plan, the Colorado and Southern Railways Employees Hospital Association offers radiographs, extractions, and emergency care. A plan for Pratt and Whitney employees in East Hartford, Connecticut offers a minimal care package consisting of examinations and radiographs, emergency care, consultation, recall and referral, and oral health education.[2]

Basic care packages provide generally the same benefits as do the minimal plans, adding certain features, such as routine restorations and prophylaxes. A union plan in Washington, D.C. provides examinations, radiographs, prophylaxes, restorations, extractions, and surgery not requiring hospitalization. Another in Baltimore provides in addition to the usual features, periodontal treatments. One in Baltimore offers crowns as a part of its basic package.[3]

The next step in the progression of benefits is the partial dental care plans. One in California for members of a union offers examinations, radiographs, prophylaxes; restorations, including inlays;

extractions and emergency care; crowns; and root canal therapy. Another combines extractions, oral surgery, full and partial dentures, and periodontal treatment in a partial coverage plan.[4]

Comprehensive dental care, according to the definition in the *Digest of Prepaid Dental Care Plans*[5], includes basic benefits, plus prosthetic services and in most instances one or more specialty services, e.g., periodontics, orthodontics, endodontics, or elective oral surgery.

The selection of a dental care package depends upon two primary factors: how much service will be provided, and how much the desired package will cost. An acceptable plan of benefits must be made available to the recipients at an acceptable cost to the financing group, be it union, employer, or governmental agency.

Without question, the more comprehensive the plan, the greater the potential benefit to the recipient. On the other hand, some care provided in a prepaid plan is better than none. Military dependents are now eligible for emergency care as stated earlier. Radiographs may be taken for dependents at the request of civilian dentists. Preventive clinics are held to aid in reducing caries. Since emergency care is now available, provision of a basic care package for military dependents would serve no particular purpose. In order to give a significant benefit one of the more comprehensive plans would have to be adopted. The desire to provide total dental care would indicate selection of a comprehensive plan. Should this be beyond the cost ceiling determined by Congress and the Department of Defense, the total projected cost can be reduced by the use of deductibles or co-payments, rather than by limiting care. In selecting a plan, a balance must be made between care provided and projected costs, regardless of the size of the group of recipients.

Selection of Providers

A typical dental service plan allows the patient to select any duly licensed dentist as his provider. This dentist may or may not belong to the plan. There are certain benefits accruing to the individual dentists by belonging to the various plans, but these have to do with the state organizations and as such should be left to them.

Within the state dental plans review committees may be established to provide for a measure of control over matters of possible dispute. The matters of fee establishment and quality of performance fall within the scope of review by such a committee.

It is important to avoid creating situations in which the patient can play the military dentist against the civilian dentist or vice versa. Certain people are inclined to "shop" for what they have decided they want in a particular situation. Well intentioned advice received on emergency basis from military sources, if taken out of context, can create impressions in the mind of a patient that can be used in such a play between dentists.

The Administrative Mechanism

The administrators of dental plans of any nature have certain functions in common to be performed. Eligibility of the patient submitting a claim must be determined. That claim must be examined for allowability of the treatment provided, and the fee allowable under the program. Verification of satisfaction of any deductible or copayment is required. The administrator then must pay the proper claim.

The administrator would be expected to acquire and maintain a profile of fees by dentists who regularly participate in the programs. Fees are, in most modern plans, based on the "usual and customary" fee charged by the dentist. This prevents the possible abuse of improper charges against a third party.

Eligible recipients of the programs of care under the provisions of CHAMPUS are identified primarily by an identification card, DD Form 1173 with a statement in item 15b authorizing care in civilian facilities. It is anticipated that the development of a form for use in claims submission would provide for certification by the patient (or parent) and verification by the dentist as to the eligibility as evidenced by the possession of the valid identification card. The processing of the claim by the state office would include verification of proper authentication by the dentist and patient. The usual procedure now followed in processing claims for existing civilian plans is checking claims against lists of eligible recipients of given programs. However, in the case of the military dependent, no valid lists are maintained, nor is their preparation feasible.

Distribution of Recipients

There are no census figures maintained by state for dependents of active duty personnel. The statistics division of Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) has prepared an estimate of the distribution of dependents taking numbers of military personnel on active duty in the various states, and multiplying by 47.1% (the average number of DOD personnel married), and multiplying

that figure by 1.52 (average number of children per military family). The total of military wives and children is then multiplied by a factor of 1.71 to compensate for dependents residing in the United States whose sponsors are overseas. The number of retirees in a given state was multiplied by 87.9% to give the number of wives, the resulting figure was then multiplied by 1.3 (average number of children per retired family). The figures were then added to give the number of retired and their dependents. The estimated number of dependents of active duty is 3,452,000. Retired and dependents are estimated at 2,191,800. No estimate is made of the number of eligible recipients who were dependents of sponsors now deceased. Estimates of 69,000 for the number of dependents of Public Health Service (PHS), Coast Guard (CG), and Environmental Sciences Services Administration (ESSA) were made, but no state-by-state distribution was listed. Similarly, retirees of these services and their dependents were estimated at 101,000, but no distribution was listed. State distribution ranges from 919,300 in California to 3,800 in Vermont. (See Table 2)

Dental Service Organizations

The Delta Dental Plans Association, (DDPA) formerly the National Association of Dental Service Plans, is the coordinating agency for the nation's voluntary, not-for-profit state dental society sponsored service plans, providing prepaid dental care benefits to subscribers and their families throughout the United States. The purpose of the organization is to increase the availability of dental services to the public by encouraging the expansion of dental prepayment programs administered through dental society approved service plans, and to assist in the development of

TABLE 2

THE STATES, BY ESTIMATED NUMBER OF CHAMPUS ELIGIBLE RECIPIENTS

State	Number	State	Number
1. California	919,300	27. Tennessee	64,400
2. Texas[a]	512,500	28. Mississippi[b]	59,200
3. Florida[a]	320,100	29. New Mexico	51,500
4. North Carolina[b]	253,500	30. Arkansas[b]	40,700
5. Virginia	230,500	31. Indiana[a]	39,300
6. Georgia	219,500	32. Connecticut[a]	37,000
7. D.C. Metro Area[b]	196,700	33. Nebraska[b]	36,100
8. Washington	186,900	34. Alaska[a]	29,400
9. New Jersey	163,500	35. Oregon	29,100
10. Illinois	157,300	36. Nevada	28,300
11. Maryland	144,400	37. Minnesota	27,600
12. South Carolina	144,000	38. North Dakota[a]	27,200
13. New York	136,800	39. Rhode Island	27,100
14. Colorado	128,400	40. Maine	23,500
15. Kentucky	112,900	41. Wisconsin	23,100
16. Missouri	104,900	42. New Hampshire	20,700
17. Pennsylvania	104,700	43. Delaware[a]	18,700
18. Oklahoma[a]	104,000	44. Montana	17,700
19. Louisiana	102,300	45. Idaho[a]	16,400
20. Alabama	102,200	46. Utah	15,900
21. Massachusetts	96,900	47. South Dakota	15,000
22. Kansas[a]	95,300	48. Iowa	13,300
23. Ohio	91,500	49. Puerto Rico[a]	11,500
24. Arizona[a]	88,100	50. West Virginia	10,500
25. Hawaii	65,400	51. Wyoming	9,900
26. Michigan	64,600	52. Vermont	3,800

[a]No Dental Service Corporation.

[b]Inactive Dental Service Corporation.

multistate and national group coverage. DDPA was established by the American Dental Association (ADA) to serve as the coordinating agency for the dental service plan system. DDPA is organized legally separate from the ADA. DDPA has concerned itself with encouraging the formation and development of dental service plans in states presently without them and to serve as a coordinating agency in marketing of multistate and national account programs.[2]

State dental service plans or corporations affiliated with the DDPA are called Delta Dental Plan of (state), or (state) Delta Dental Plan. Their organizational objectives are similar to those of the Colorado Dental Service.

The following objectives and basic principles are quoted from the "Dentist Handbook" of the Colorado Dental Service (CDS), a Delta Dental Plan.

> Objectives of CDS. To establish, maintain and promote pre-paid dental care programs whereby dental care may be provided to residents of Colorado and to do all things necessary and proper for the purpose of promoting, establishing, and operating such pre-paid dental care programs.
>
> Basic Principles of CDS:
>
> 1. Any licensed dentist may participate in CDS programs.
> 2. The patient and dentist shall have free choice in providing or accepting dental care. No patient shall be denied care because of race, color, or national origin.
> 3. The charge for services should be based upon the usual, customary and reasonable fee and should not be influenced by the source of reimbursement.
> 4. All programs should encourage the maintenance of a high standard of dental treatment.
> 5. The administration of the professional phase of a program should be entirely within the control of dentists. Professional standards and treatment should not be controlled by non-dental administrators.
> 6. Adequate provisions for sound dental health education should be provided.

The executive director of the Delta Dental Plans Association has stated in an interview that the Colorado Dental Service is one which is used as a reference for organizations developing new plans, and can be considered typical. The following excerpts of pertinent items from the CDS manual are made in order to show some of the functions regularly performed by this dental service plan.

> CDS Membership. All dentists licensed in the state of Colorado are eligible for membership in CDS. The Board of Trustees of CDS is elected by the general membership.
>
> The Participating Dentist Agreement. Under the laws of the state of Colorado, CDS must demonstrate to the Department of Insurance its ability to deliver dental services. . . .
>
> Pre-Filing of Fees. The House of Delegates of the Colorado Dental Association, approved a resolution initiating a voluntary confidential system of pre-filing of usual, customary and reasonable fees with CDS.
>
> Individual Consideration. It is impossible to establish fees for all services and also impossible to list all possible procedures that could be done. In any of these situations, indicate the procedure, the fee for the service, any supporting statements, and these will be reviewed by the Dental Director of the Colorado Dental Service.
>
> Changes in Treatment. Indicate minor changes in treatment when presenting forms for payment. Major changes should be resubmitted. Colorado Dental Service will notify whether or not the changes have been approved by the Dental Director.
>
> Radiographs. Colorado Dental Service may from time to time request the submission of radiographs for review. All radiographs which are submitted to Colorado Dental Service will be viewed by a staff dentist and returned as quickly as possible. In order to expedite the processing of forms involving more comprehensive treatment plans, it will help to routinely submit appropriate radiographs with the prestatement of cost form. CDS may request, at its own expense, postoperative films of completed cases.
>
> Usual, Customary, and Reasonable Fees. The "usual" fee is that regularly charged for a given service. A fee is "customary" when it is within the range of usual fees charged by dentists of similar training and experience for the same service within that same specific and limited geographical area or socio-economic area of a society. A fee is "reasonable" when it meets the above two criteria and when, in the opinion of the Review Committee of the responsible dental society, it is justifiable considering the special circumstances of the case in question.

> Prior Authorization. Emergency treatment, prophylaxis and radiographs do not require prior authorization--most other procedures do. CDS cannot accept responsibility for payment for other services it has not authorized. If the patient is not eligible for benefits, or the service performed is not a benefit, the cost of treatment is the responsibility of the patient.

Cost limitation is a consideration in the development of a dental care plan, particularly one the size of that required for military dependents. A recurrent fear exists of over-use of expensive gold inlays and crowns when amalgam would suffice. This is not unknown in the administration of dental service plans, and the CDS has provided for limitations on other potentially expensive services which could get out of hand.

> If a tooth can be properly restored with amalgam, silicate or plastic, only payment for such procedures will be made toward the cost of any other more complex procedures. The balance of the treatment cost is borne by the patient.

> Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances satisfactory are provided. Prosthodontic appliances will be replaced only after five years have elapsed following any prior provisions of such appliances under any CDS program.

There are several other limitations applied by CDS to all its programs, all designed to prevent misuse of prepaid programs for provision of optional services, optional materials, or cosmetic services. There are few restrictions placed on the provision of complete required care, but many on the luxury options.

These illustrations and examples are brought out to indicate the willingness and capability of a dental service plan to aid in the limitation of costs of a given plan of dental care. The successful limitation, however, depends upon pre-authorization in cases requiring care estimated beyond an established dollar limit.

Active state dental service corporations exist in twenty-nine states, and eight states have inactive corporations. Of the inactive ones, three are currently preparing to re-activate. Of the fourteen states without plans, three are actively planning to form them. Of the fifty states plus District of Columbia, there are thirty-five with active, organizing or re-organizing plans. The Executive Director of Delta Dental Plans Association stated that he feels the establishment of a dependent dental care plan to be administered by the Delta Dental Plans of the various states would serve to re-activate the now inactive plans. He further stated that it would probably induce the formation of some plans in states where there are now no inclinations to do so. Unfortunately, the situation in some states is such that they have consistently voted down attempts to organize dental service plans. The states of Texas and Florida are among these. They rank numbers two and three as to numbers of CHAMPUS recipients (see Table 2).

When asked specifically if the Delta Dental Plans could accept the administration of nationwide dependent dental care, the Executive Director of DDPA stated he felt they could, and that suitable alternatives could be satisfactorily worked out in the states without plans. He further stated that it would take on the order of six months to a year to get into operation. The administration of plans in the problem states could be handled by other state plans with the capability of equipment and personnel, but the review mechanism would be lacking. The review mechanism, it should be noted, is a feature of the dental service plans which serve as a quality control and appeal device. The insurance companies engaged in providing dental prepayment plans do so without review mechanisms.

Anticipated Costs

Costs of a program of dental care for the eligible CHAMPUS recipients are significant. The anticipated costs have been the factor in preventing the passage of legislation providing dental care. Cost figures of as high as 240 million dollars appear in the record of hearings before the Special Subcommittee.[6] A program of this magnitude should not be undertaken without significant consideration and evaluation. Selection from one of the means of limiting costs would allow significant program cost reduction.

In order to arrive at anticipated costs for a dental care program it is first necessary to establish certain criteria. Used in this determination were:

1. Estimated number of eligible recipients.
2. Location of those recipients.
3. A fee index by state. (Fees vary significantly from state to state.)
4. Calculated average cost per visit.
5. Estimation of utilization, within what is considered the relevant range.
6. Calculated probable utilization.

The fee index by state is derived from figures published in The Journal of the American Dental Association taken from fee surveys conducted by the Bureau of Economic Research and Statistics every three years. The reports used were for the years 1956, 1959, 1962, 1965, and 1968. (The 1971 report was not published at the time of writing.) The composite fee reported by states was adjusted to give the same reporting base, and the

index derived from analysis of the indicated trend projected 1971 through 1974. (Table 3, column 3.)

The calculated average cost per visit was obtained by dividing reported gross income of dentists by the reported number of patient visits per year. By comparison of fee index ratios, the calculated costs per visit for the future years was calculated.

The utilization rate in terms of number of visits per eligible person per year, is adapted from the book by Avnet and Nikias.[7] Figures reported for all ages, male and female, do not give an accurate representation of the population of military dependents. For more accuracy, the rate for children to age 19 was taken (199.6 per exposure-years) and weighted with a factor of 1.52 for number of children in the military family which resulted in 303.4. Next, the rate was taken for females ages 20 to 54 representing wives of service members (215.9 per 100 exposure-years) and averaged with a result of 259.7. It was noted that low and high figures were reported for various occupational, educational, and other demographic factors. A low mean of 1.823 visits per person per year, and a high mean of 3.3 visits per person per year were observed. To compensate for variations in rates, the calculated 2.597 (259.7/100) was multiplied by 4, the result added to 1.823 and 3.3, the sum divided by 6 to arrive at what is referred to as the "most probable use rate" of 2.581, which is used in the computations for active duty dependents. (See Table 3 A.)

Age distributions were not attempted for the retirees and their dependents due to the considerable range in which they fall. The rate used for the retiree and dependents was that for all ages and both sexes, 1.823.[8] (See Table 3 B.)

TABLE 3 A

ANTICIPATED COSTS FOR DEPENDENTS OF ACTIVE DUTY

State	Number	Fee Index	1971	1972	1973	1974
Alabama	61,600	$574.79	$1,677,600	$1,741,100	$1,808,100	$1,871,700
Alaska	25,700			(Not determined)		
Arizona	55,500	734.78	1,932,100	2,005,300	2,082,500	2,155,600
Arkansas	18,000	561.54	478,900	497,000	516,200	532,300
California	512,700	874.79	21,249,500	22,054,400	22,903,200	23,708,100
Colorado	91,300	708.39	3,064,200	3,180,300	3,302,700	3,418,800
Connecticut	9,400	688.72	306,800	318,300	330,600	342,200
Delaware	13,000	696.03	428,700	445,000	462,100	478,300
D.C.	168,200	805.28	6,417,300	6,660,400	6,916,700	7,159,800
Florida	155,100	696.01	5,114,600	5,308,300	5,512,600	5,706,300
Georgia	155,600	621.02	4,578,200	4,751,600	4,934,500	5,107,900
Hawaii	52,800	708.71	1,722,900	1,840,000	1,910,900	1,978,000
Idaho	10,400	631.20	311,000	322,800	335,200	347,000
Illinois	100,500	688.40	3,277,800	3,402,000	3,532,900	3,657,100
Indiana	14,200	631.19	424,600	440,700	457,700	473,800
Iowa	900	622.39	26,600	27,600	28,600	29,600
Kansas	74,300	648.81	2,283,900	2,370,400	2,461,700	2,548,200
Kentucky	89,100	552.56	2,332,600	2,420,900	2,514,100	2,602,500

TABLE 3 A--Continued

State	Number	Fee Index	1971	1972	1973	1974
Louisiana	68,700	$661.11	$2,151,800	$2,233,300	$2,319,300	$2,400,800
Maine	13,200	520.02	325,200	337,600	350,600	362,800
Maryland	90,500	669.41	2,986,000	3,099,100	3,218,400	3,331,500
Massachusetts	44,000	687.96	1,434,200	1,488,500	1,545,800	1,600,100
Michigan	29,000	694.34	954,000	990,100	1,028,200	1,064,400
Minnesota	7,900	654.79	245,100	254,400	264,200	273,400
Mississippi	40,400	561.19	1,074,100	1,114,700	1,157,600	1,198,300
Missouri	65,000	648.75	1,997,900	2,073,600	2,153,400	2,229,000
Montana	12,400	650.95	382,400	396,900	412,200	426,700
Nebraska	25,500	675.16	815,700	846,600	879,200	910,100
Nevada	19,100	811.99	734,800	762,600	792,000	819,800
New Hampshire	11,100	647.45	340,500	353,400	367,000	379,900
New Jersey	107,100	776.59	3,940,600	4,089,800	4,247,200	4,396,500
New Mexico	34,900	721.22	1,192,600	1,237,700	1,285,300	1,330,500
New York	45,600	748.03	1,616,100	1,677,300	1,741,800	1,803,100
North Carolina	211,500	587.02	5,882,200	6,105,000	6,340,000	6,562,800
North Dakota	25,000	657.15	778,400	807,900	838,900	868,400
Ohio	39,900	642.55	1,214,700	1,260,700	1,309,200	1,355,200
Oklahoma	72,000	651.84	2,223,600	2,307,800	2,396,600	2,480,800

TABLE 3 A--Continued

State	Number	Fee Index	1971	1972	1973	1974
Oregon	5,500	$711.92	$185,500	$192,500	$199,900	$207,000
Pennsylvania	29,600	616.76	864,900	897,700	932,300	965,000
Rhode Island	14,400	651.74	444,600	461,500	479,200	496,000
South Carolina	107,300	576.21	2,929,300	3,040,200	3,157,200	3,268,200
South Dakota	11,400	635.91	343,500	356,500	370,200	383,200
Tennessee	30,300	572.25	821,500	852,600	885,400	916,500
Texas	347,100	715.50	11,766,400	12,212,100	12,682,100	13,127,800
Utah	7,500	619.78	220,200	228,600	237,400	245,700
Vermont	400	594.03	11,300	11,700	12,100	12,600
Virginia	121,300	637.81	3,665,500	3,804,300	3,950,700	4,089,600
Washington	116,800	761.80	4,215,600	4,375,300	4,543,700	4,703,400
West Virginia	700	558.72	18,500	19,200	20,000	20,700
Wisconsin	3,700	662.84	116,200	120,600	125,200	129,600
Wyoming	7,000	671.76	222,800	231,200	240,100	248,600
Puerto Rico	9,200	696.03	303,400	314,900	327,000	338,500
PHS, CG, ESSA dependents	69,000		2,561,300	2,668,700	2,771,400	2,868,800
Totals:	3,452,300		$114,681,800	$119,025,800	$123,606,700	$127,950,700

TABLE 3 B

ANTICIPATED COSTS FOR ALL RECIPIENTS

State	Number	Fee Index	1971	1972	1973	1974
Alabama	102,200	$574.79	$2,458,500	$2,551,600	$2,649,800	$2,742,900
Alaska	29,400			(Not determined)		
Arizona	88,100	734.78	2,733,700	2,837,200	2,946,400	3,050,000
Arkansas	40,700	561.54	905,500	939,800	975,900	1,010,200
California	919,300	874.79	33,152,300	34,408,100	35,732,300	36,988,100
Colorado	128,400	708.39	3,943,700	4,093,100	4,250,600	4,400,000
Connecticut	37,000	688.72	942,800	978,500	1,016,200	1,051,900
Delaware	18,700	696.03	561,500	582,700	605,200	626,400
D.C.	196,700	805.28	7,185,300	7,457,500	7,744,500	8,016,700
Florida	320,100	696.01	8,957,600	9,296,900	9,654,700	9,994,000
Georgia	219,500	621.02	5,906,100	6,129,900	6,365,800	6,589,500
Hawaii	65,400	708.71	2,071,700	2,150,200	2,232,900	2,311,400
Idaho	16,400	631.20	437,700	454,300	471,800	488,400
Illinois	157,300	688.40	4,586,300	4,760,000	4,943,200	5,116,900
Indiana	39,300	631.19	954,800	991,000	1,029,100	1,065,300
Iowa	13,300	622.39	284,800	295,600	307,000	317,800
Kansas	95,300	648.81	2,739,900	2,843,700	2,953,100	3,056,900
Kentucky	112,900	552.56	2,772,700	2,877,700	2,988,400	3,093,500

TABLE 3 B--Continued

State	Number	Fee Index	1971	1972	1973	1974
Louisiana	102,300	$611.11	$2,895,200	$3,004,800	$3,120,500	$3,230,100
Maine	23,500	520.02	504,500	523,600	543,700	562,800
Maryland	144,400	669.41	4,242,100	4,402,800	4,572,200	4,732,900
Massachusetts	96,900	687.96	2,652,000	2,752,500	2,858,400	2,958,900
Michigan	64,600	694.34	1,781,200	1,848,600	1,919,800	1,987,300
Minnesota	27,600	654.79	676,700	702,400	729,400	755,000
Mississippi	59,200	561.19	1,427,100	1,481,100	1,538,100	1,592,200
Missouri	104,900	648.75	2,864,100	2,972,600	3,087,000	3,195,500
Montana	17,700	650.95	497,900	516,700	536,600	555,500
Nebraska	36,100	675.16	1,055,200	1,095,200	1,137,300	1,177,300
Nevada	28,300	811.99	984,800	1,022,100	1,061,400	1,098,700
New Hampshire	20,700	647.45	548,500	569,300	591,200	612,000
New Jersey	163,500	776.59	5,406,300	5,611,100	5,827,000	6,031,800
New Mexico	51,500	721.22	1,593,200	1,653,500	1,717,200	1,777,500
New York	136,800	748.03	3,899,000	4,046,700	4,202,400	4,350,100
North Carolina	253,500	587.02	6,707,200	6,961,300	7,229,200	7,483,300
North Dakota	27,200	657.15	826,700	858,100	891,100	922,400
Ohio	91,500	642.55	2,324,200	2,412,200	2,505,100	2,593,100
Oklahoma	104,000	651.84	2,921,600	3,032,200	3,148,900	3,259,600

TABLE 3 B--Continued

State	Number	Fee Index	1971	1972	1973	1974
Oregon	29,100	$711.92	$747,700	$776,100	$805,900	$834,300
Pennsylvania	104,700	616.76	2,415,000	2,506,400	2,602,900	2,694,400
Rhode Island	27,100	651.74	721,600	749,000	778,000	805,100
South Carolina	144,000	576.21	3,636,900	3,774,700	3,920,000	4,057,700
South Dakota	15,000	635.91	420,100	436,000	452,800	468,700
Tennessee	64,400	572.25	1,474,500	1,530,400	1,589,300	1,645,100
Texas	512,500	715.50	15,726,700	16,322,400	16,950,600	17,546,300
Utah	15,900	619.78	394,400	409,400	425,100	440,100
Vermont	3,800	594.03	78,800	81,800	85,000	88,000
Virginia	230,500	637.81	5,996,200	6,223,300	6,462,800	6,690,000
Washington	186,900	761.80	6,002,700	6,230,100	6,469,800	6,607,200
West Virginia	10,500	558.72	201,800	209,400	217,500	225,100
Wisconsin	23,100	662.84	546,500	567,200	589,000	609,700
Wyoming	9,900	671.76	288,000	298,900	310,400	321,300
Puerto Rico	11,500	696.03	357,000	370,500	384,700	398,300
PHS, CG, ESSA Dependents	101,000		3,785,100	3,928,400	4,079,700	4,223,000
Totals:	5,644,100		$167,195,200	$173,528,400	$180,207,000	$186,540,100

There is no particular detrimental effect if a program does not require as much money as anticipated, but it does create funding problems if costs exceed those anticipated. In order to visualize the effects of utilization beyond the expected rate, a factor of 3.3 (the highest reported in the general sample by Avnet and Nikias) was used for the CHAMPUS recipients in the several years.

To determine the costs for the program, the number of recipients in each state was multiplied by the use rate and the calculated cost per visit for that state. The adjusted state fee index was multiplied by the projected cost per visit for the year and divided by the constant 791, (which is the projected national average composite fee, adjusted, for the base year 1971), to give the amount per visit in a given state. The cost for a program in a state equals the number of recipients times rate, times adjusted state fee index, times projected cost per visit, divided by 791.

Totals for the years 1971 through 1974 giving most probable use rate and high rate for each year appear in Table 4.

Means of cost reduction

The quite considerable costs may be reduced in several ways. The method involving reduction of benefits covered is widely used in the civilian prepayment plans. Exclusion of certain dental procedures, however, results in fragmentation of complete care, leaving the patient with a recognized need and desire for a professional service initiated by the system, without a means for completing the treatment.

The use of co-payment is another device of cost reduction found in prepayment plans. This is a percentage sharing between patient and third

TABLE 4

ANTICIPATED PROGRAM COSTS

YEAR	EXPECTED[a] (Active duty Dependents)	HIGH RATE[b] (Active duty Dependents)	EXPECTED[a] (All Recipients)	HIGH RATE[b] (All Recipients)
1971	$114,681,800	$165,420,400	$167,195,200	$267,136,500
1972	119,025,800	171,686,300	173,528,400	277,225,300
1973	123,606,700	168,294,000	180,207,000	287,928,100
1974	127,950,700	184,560,000	186,540,100	298,044,800

[a]The expected cost is based upon a use rate formula combining one-sixth low rate, four-sixths adjusted rate, and one-sixth the high rate.

[b]The high rate figures are not calculated using the weighted population figures by state and do not employ the fee index. They are calculated for the totals of active duty dependents by multiplying 3,452,300 by the high use rate of 3.3 and the projected fee per visit for each year; for all recipients by multiplying 5,644,100 by the same figures. The high rate figures are quoted as extremes, and not to be construed as representing the upper end of a range of costs.

party, with usual ratios running fifty, seventy, and eighty per cent paid by the third party, the balance by the patient. This plan involves the patient in every service provided, and has the advantage of making him a participator in determination of treatment and its costs. The major disadvantage of the plan is associated with the administration costs. The bill for appointment or visit has to be administravely processed, and it has been estimated that the administrative costs for a program which processes 3,000 claims per month would run $3.10 per claim. This estimate is from the pilot program between OCHAMPUS and Colorado Dental Service Corporation in which CDS administers the existing program for

the handicapped.[9] It is illogical to submit a five or ten dollar claim and incur processing costs equal to that of a fifty dollar claim. Limiting mechanisms may be placed requiring accrual of small claims prior to submittal for payment.

The use of deductibles is common, and is the method now used in the administration of the programs under CHAMPUS. Under the present system, a sliding scale of monthly deductibles is employed, based upon the grade of the sponsor. (Table 5.) A means must be established to verify the satisfaction of the deductible amounts, and to cross-check for payment of all or part of it under other CHAMPUS programs. This system has the significant advantage resulting from the elimination of all minor claims from the administrative procedure. Families with few

TABLE 5

SLIDING SCALE DEDUCTIBLE

PAY GRADE	AMOUNT
E-1 through E-5	$ 25
E-6	30
E-7 and 0-1	35
E-8 and 0-2	40
E-9, 0-3, W-1, and W-2	45
W-3, W-4, and 0-4	50
0-5	65
0-6	75
0-7	100
0-8	150
0-9	200
0-10	250

Source: DA Pam 360-505, Revised Uniformed Services Health Benefits Program

problems would not encounter costs satisfying the deductible, and would bear the entire cost. This would allow the administrators to deal only with the costs in excess of the deductible, with a resulting reduction in administrative cost, and cost of the program in its entirety.

Other cost limitation means depend upon agreement of the provider to accept a lower, or fixed fee for a service as the total for that service. A schedule of reimbursable fees is prepared, reducing the amount payable for services by a percentage, and requiring the provider to accept it or lose the provider status under the program. Significant problems arise when a wide disparity exists between allowable fees and the usual and customary fees of a practitioner or of a region. Providers may not accept patients under the program, or the service provided may suffer as a result of the inadequate fee.

Combinations of the means of limiting costs are used. Maximum amounts payable for a given service, as mentioned in the section on design of the packages, is a means of avoiding the high cost optional services. When coupled with a deductible, this serves to provide adequate care to the patient, avoiding the high cost of administration and the hazard of election by the patient of a cosmetic or luxury reconstruction.

Determination of costs under the percentage co-payment is straightforward. Determination of the cost under the other means is not. Utilization figures listing the number of visits per person per year are available, as are figures of averages in dentists' income and patients seen, allowing reasonable estimates of total costs to be based on the large number of recipients. Determining the mix of services that would be required to satisfy a deductible and estimate the remaining services to be

paid under a program is beyond the established limits of this paper. An estimate done by Mr. Ferris M. Hoggard, of the Dental Economics Section, Division of Dental Health, Public Health Service, reported a reduction of forty and fifty per cent for fifty and one hundred dollar deductible plans.

See Table 6 for estimated reduced costs of a program applying Hoggard's reduction figures of forty and fifty per cent to the dependent population.

A common disadvantage shared by any system of cost reduction applied to a plan for military dependents results from the mobility of the group. Dependents who move from one state to another during the progress of treatment or accumulation of fees to satisfy a deductible will create special problems to the administrators of the programs. This sort of movement is to be expected in the military dependents as routine.

A disadvantage in a dental plan for military dependents occurs due to the continually changing membership of the group of eligible recipients. Normally the costs for a given individual would decline in years subsequent to the first in which treatment was completed. In a relatively stable population of recipients, it is likely that a significant decline and stabilization would apply to costs. In the military dependent population, however, there is a high percentage of newly eligible recipients each year, and although stability of costs will doubtless occur, they will not likely decline and stabilize. A possible solution to this disadvantage is to restrict dental care to dependents of personnel identified as "career" individuals. As an incentive for volunteer services, this device might have appeal, however it creates "classes" of dependents which lacks appeal

TABLE 6

REDUCED COSTS

YEAR	FULL COST	20% CO-PAY	30% CO-PAY	$50 DEDUCT	$100 DEDUCT
		Active Duty Dependents			
1971	$114,681,800	$ 91,745,400	$ 80,277,300	$ 68,809,100	$57,340,900
1972	119,025,800	95,220,600	83,318,100	71,415,500	59,512,900
1973	123,606,700	98,885,400	86,524,700	74,164,000	61,803,300
1974	127,950,700	102,360,600	89,565,500	76,770,400	63,975,400
		All Recipients			
1971	167,195,200	133,756,200	117,036,700	100,317,100	83,597,600
1972	173,528,400	138,822,700	121,460,900	104,117,000	86,764,200
1973	180,207,000	144,165,600	126,144,900	108,124,200	90,103,500
1974	186,540,100	149,232,100	130,578,100	111,924,100	93,270,100

Note:

The figures for the $50 and $100 deductible are based solely upon percentage reduction figures, not upon the estimated mix of patient services by the eligible recipients, and are not intended to be represented as such.

for other reasons. The imposition of benefit ceilings offer another means of limiting benefits and as a corollary, reducing total costs of the program.

Footnotes

[1]Robert S. Horowitz, *Army Times*, July 8, 1970, p. 1.

[2]U.S., Department of Health, Education and Welfare, *Digest of Prepaid Dental Care Plans, 1963*, (Washington, D.C.: Government Printing Office, 1964), PHPS No. 585.

[3]*Ibid.*

[4]*Ibid.*

[5]*Ibid*, 23.

[6]U.S., Congress, House of Representatives, *Dental Care Needs of Military Dependents*, Hearings before the Special Subcommittee on Military Dental Care of the Committee on Armed Services, House Doc. 18, 90th Cong., 1st sess., 1967, p. 4240.

[7]Helen H. Avnet and Mata K. Nikias, *Insured Dental Care* (n.p.: Group Health Dental Insurance, Inc., 1967), p. 112.

[8]*Ibid.*

[9]Colorado Dental Service, "The Ongoing Cost," Denver, March 31, 1971. (Xeroxed.)

CHAPTER III

CONCLUSION

There has probably never been a better time to implement dependent dental care. The impetus for the all-volunteer army is strong. There seems to be an increased awareness toward all aspects of health care requirements throughout the country. Pressures to equalize pay and benefits for the military serviceman are at a relatively high level, despite the frequent criticism to which the services are subjected.

Measures before Congress to implement dental care for dependents have been defeated due to the cost expected. The costs have not decreased. As most costs they have inexorably increased. According to present findings, however, the costs presented to Congress in the past have been overstated. The cost figures presented in 1967 exceed those developed in this study, which allow for the increase in prices. No conclusive evidence is shown herein that the method used to determine costs has resulted in an accurate estimate, and no determination of costs will be accepted as valid and accurate as hypothesized without testing and verification. However, the study selected as a basis for the utilization rates appears to represent the population of military dependents to a reasonable degree and care was taken in the preparation of the figures to insure accuracy within the context of method used.

Congressional action will be required to authorize dependent dental care. With a means of cost limitation--to be shown--coupled

with the desire for all-volunteer services and an organization capable of administering the program, it is hoped that such enabling legislation will be passed.

It is therefore recommended that a dental plan under the Civilian Health and Medical Program of the Uniformed Services be established. It should be accorded eligible dependents of active duty; retired personnel and their dependents; widows, widowers, and dependent children of deceased active and retired personnel. It should be a truly comprehensive service benefit which lasts from induction until retirement and continuing until death. The inducement to an individual to elect a career in military service should be one which complements retirement benefits rather than detracting from them. Although retirement benefits may not be high on the list of recruiting inducements at the beginning of military service for a twenty-year old, the veteran of ten or twelve years considering the future is capable of looking considerably farther in his deliberations. At this junction, the presence of retirement benefits assumes importance.

The design of the care package should provide adequate dental care for the recipients in order to fulfill the objectives. Provision of a plan which, in reality, provides false hopes for financial relief of dental bills is short of the intent. It is recommended that a plan of comprehensive dentistry be chosen to best serve the dental health of the recipients. All specialties of dentistry should be included in the benefits, with the exception of orthodontics which is already provided in qualifying cases under the CHAMPUS Program for the handicapped. Examinations, radiographs, restorations (including crowns, gold, porcelain, and combination), dentures, bridges, periodontal treatments, endodontic

treatment, oral surgery, pedodontic services (including space maintainers), and preventive services all should be provided. Prosthetic repairs should also be covered, (although under the cost reduction measures recommended, few would actually be paid).

Selection of the provider, as pointed out in Chapter II, should be essentially left up to the patient. The provider must possess a current license to practice dentistry in the state, and should practice non-discrimination policy. The state dental societies and their dental service organization requirements would essentially be met by those criteria. It is recommended that the review committees in the state plans have a military member named and called to sit in deliberation of cases involving CHAMPUS recipients. It is felt particularly important to have this military member sitting on the review board when there is a review involving conflicting opinions between civilian and military dentists regarding treatment plans or methods. There is but one profession of dentistry in the United States, but there are varying valid viewpoints within that profession. This recommendation is aimed at avoiding polariziation of military and civilian elements of the profession by lack of communication. This can readily result from differing points of view communicated from one dentist to the other by a third, non-professional party, the patient.

In the area of anticipated costs and means of reduction to levels acceptable to the Congress, the following measures are recommended:

1. A benefit ceiling placed on a sliding scale dependent upon time in service. (This parallels vacation and other benefit programs common in civilian industry.)

a. Less than 3 years service, an annual ceiling of $350 per person, $1050 per family per year.[1]

b. Between 3 and 10 years service, an annual ceiling of $400 per person, $1200 per family per year.

c. From 10 years on, including retirees and the other eligible recipients, $500 per person per year, no family limitation.

The ceiling feature provides for adequate dental care for the vast majority of families and individuals, but avoids rehabilitation of the dental "cripple" to the tune of several thousand dollars during a sponsor's initial obligatory tour of duty, and also would serve to fend off enlistment of any such individuals for a minimum tour to obtain such services at government expense.

2. A deductible feature, on an annual or fiscal year basis, based on the existing CHAMPUS deductible schedule for outpatient care.

a. For one beneficiary, $50 in any year.

b. For more than one beneficiary, $100 per year.

c. In the case of dependents of deceased active or retired, and in cases of unusual circumstances, appeal for relief from the deductible should be made available.

Verification of the satisfaction of the deductible will, as stated in Chapter II, be a problem. No perfect solution is evident. An attempt should be made to educate the recipients to maintain all receipts in addition to any document that is developed to verify the deductible satisfaction.

In the selection of an administrator, it is recommended that Delta Dental Plans Associations be chosen. Although not active in every

jurisdiction under consideration, enactment of CHAMPUS dental care would provide impetus to form active dental service corporations in some states now lacking them.

Should the issue be taken up by Congress and passed into law, the dental service organizations will then form or not form, as the case will be. The Executive Director of the Delta Dental Plans Association feels that the organizations existing, or that will form, will be able to administer the programs for the states lacking organizations. Beyond that is speculation.

There are ways to administer the program other than by a professional service organization. The medical programs of CHAMPUS are administered in many states by Blue Cross, (analogous to DDPA) but in some states they are administered by commercial insurance companies. Avoidance of commercial enterprise in the dental system is recommended. No particular point is served in patient benefits by utilization of a profit-making organization, and the costs are increased. There can be no question of partiality when dealing with a professional service organization, and no private profit motives would be served.

The administrative functions to be done by the administrators in the states are their standard ones. A series of forms must be developed for use in the program. The existing forms used by the Delta Dental Plans may be suitably modified to be satisfactory for the primary document for the dentist-patient information. In the pilot program between OCHAMPUS and Colorado Dental Service, the standard CDS form (Pre-statement of cost form--Rev. 1-71) has been modified slightly, and joined with a modified DA form used in the program for the handicapped (DA Form 1863-3)

to create "Proposed DA Form 1863-5." (The forms appear in Appendix B.) Additional forms will be required to fill the many and varied needs of communication between the administrators and OCHAMPUS, and among the administrators in dealing with the problems peculiar to the administration of the military program. These will have to be developed out of experience in detail from both the present administrators and OCHAMPUS as the program develops.

Distribution of recipients among the active duty dependents will inevitably change. As installations close, are reduced or increased in size, the dependent populations will vary. It is recommended that the program attempt to determine significant changes with enough lead time so as to avoid undue cost and hardships on the administrators by over-preparing for the military program. If a closure is eminent, or reduction in size is forecast, it would make little sense to advocate initiation of a system to maintain records and patient information by a dental service organization.

In summary, the recommendations are that dental care be provided all CHAMPUS recipients eligible for outpatient care, and that they have a $50 per person deductible with a $100 family limit. During a service member's first three years of active duty, his dependents should be limited to $350 a year individual benefits, but with a family limit of $1050. In the next seven years, the limits would be $400 per individual and $1200 family limit. In the eleventh and succeeding years until the termination of eligibility, a $500 individual annual limitation would be placed, with no family restriction. Further, it is recommended that Delta Dental Plans Association be

selected as the administrator for the program nationally, insuring coverage in states lacking programs at inception of the plan.

Footnote

[1] The $350 per person per year was selected because within that amount, plus the deductible, complete dentures may be obtained in the majority of practices. Dentures, when necessary for an individual of limited resources, represent a difficult financial hurdle, one which this is designed to aid.

APPENDIX A

GLOSSARY

GLOSSARY

AMALGAM. A common type of restorative material, silver filling.

BENEFICIARY. A person eligible for benefits under a plan. Synonyms: eligible individual; recipient.

BENEFITS. Services provided under a plan. Synonym: coverage.

CARE. The total of diagnostic, preventive, restorative and therapeutic services rendered.

CARE PACKAGE. The components of care provided under the plan as determined by negotiation between the providers and the financial agency.

CARIES. Dental decay.

CO-PAYMENT. An arrangement by which the beneficiaries pay part of the cost of services provided. The balance is paid by the financing agency through an administrator.

COSMETIC DENTISTRY. A dental service performed primarily to improve appearance, such as crowns to make teeth even.

COVERAGE. Services provided under a plan.

CROWN. Total coverage of the visible portion of a tooth with a dental material. Used are gold, porcelain, acrylic, and combinations of gold and porcelain. Commonly, cap.

DEDUCTIBLE. In some plans that amount of each claim which must be paid by the patient before the financing agency assumes any responsibility.

DENTAL PLAN. Any organized method for the financing of dental care. Also prepayment plan.

DENTURE. Artificial replacement for missing natural teeth, either complete or partial. Popularly, false teeth.

ENDODONTICS. The branch of dentistry dealing with diseases of the dental pulp. Synonym: root canal therapy.

ORTHODONTICS. The branch of dentistry dealing with improper alignment of teeth. Provide the service popularly called braces.

PERIODONTICS. The branch of dentistry dealing with the diseases of the gums and bony structures supporting the teeth.

PREAUTHORIZATION. Approval of proposed treatment by an agent of the financing agency prior to rendering of the treatment.

PREPAYMENT PLAN. Any arrangement by which periodic, specified payments are made in advance and used to pay for health services when the need arises.

PROPHYLAXIS. The removal of calculus (tartar) and stains from the teeth by scaling and polishing.

PROTHODONTICS (PROSTHETICS). The branch of dentistry dealing with the replacement, by artificial means, of missing teeth and oral structures.

RADIOGRAPH. X-ray picture.

RECIPIENT. A beneficiary, one eligible to receive services under a program.

RESTORATION. The replacement of the missing part of a tooth by an artificial material, and subsequently that substance. Used are amalgam, silicate (synthetic porcelain), acrylic, gold, composites, and cements. Crowns are also considered to be restorations.

ROOT CANAL. A space or channel within the root of the tooth normally containing tiny blood vessels, nerve, and connective tissue, called the pulp or "nerve."

ROOT CANAL THERAPY. Treatment for diseases of the pulp, usually involving removal of the pulpal contents and placement of an inert filling material.

APPENDIX B

CDS COST FORM

DA FORM 1863-3

PROPOSED DA FORM 1863-5

COLORADO DENTAL SERVICE
1732 High Street, Suite 105
Denver, Colorado 80218
Phone 399-0193

A Delta Dental Plan

NOTICE OF PAYMENT THROUGH YOUR GROUP DENTAL PROGRAM CDS HAS MADE PAYMENT ON YOUR BEHALF TO THE DENTIST NAMED IN ITEM 13 BELOW. BENEFITS OF YOUR PROGRAM HAVE BEEN OUTLINED IN THE GROUP BROCHURE. A PORTION OF THE AMOUNT SHOWN AS PAID BY CDS WAS CONTRIBUTED BY YOUR DENTIST TO SUPPORT BETTER DENTAL HEALTH.

A. TOTAL CHARGES	B. CDS PAYMENT	C. PATIENT PAYS (DIFF. BETWEEN A&B)	EDIT NUMBER
$	$	$	

SHADED AREA FOR CDS USE ONLY

TYPE OR PRINT – YOU ARE PREPARING MULTIPLE COPIES

1 EMPLOYEE OR GUARDIAN NAME | 2 SOCIAL SECURITY NO | 3 CDS GROUP DENTAL PROGRAM NAME

4 EMPLOYEE MAILING ADDRESS | 5 CDS GROUP NO | 6 LOCATION (LOCAL)

7 CITY STATE ZIP | 8 EMPLOYER NAME

9 PATIENT NAME | 10. PATIENT RELATIONSHIP TO EMPLOYEE | 11. PATIENT BIRTHDATE MO. DAY YEAR | 12. DATE PATIENT FIRST VISIT (CURRENT SERIES)

13. DENTIST NAME | 14. LICENSE NO.

16. DENTIST MAILING ADDRESS | 17. PHONE NO.

19. CITY STATE ZIP

	YES	NO
15. IS PATIENT COVERED BY OTHER PLAN? IF YES, ENTER NAME OF OTHER PLAN AND CONSULT DENTIST'S HANDBOOK FOR HANDLING DUAL COVERAGE CLAIMS		
18. IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?		
20. TREATMENT RESULT OF ACCIDENT? IF YES, DATE OF ACCIDENT		
21. RESULT OF OCCUPATIONAL INJURY?		
24. ARE X-RAYS ENCLOSED? (IF YES, HOW MANY?)		

22. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES | NO (IF NO, REASON FOR PLACEMENT) | 23. DATE OF PRIOR PLACEMENT

* DENTIST SOC. SEC. NO.

PAR ____ N PAR ____
UCR ____ TAB ____

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH #1 THROUGH TOOTH # 32

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	DENTIST FEE	BASIC BENEFIT	OPTIONAL BENEFIT

FACIAL
LINGUAL
UPPER LOWER
RIGHT LEFT
PRIMARY PERMANENT
LINGUAL
FACIAL

SURFACES
M - MESIAL
O - OCCLUSAL
D - DISTAL
L - LINGUAL
I - INCISAL
F - FACIAL

A I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE IN MY PROFESSIONAL JUDGMENT NECESSARY FOR THE ABOVE NAMED PATIENT AND I WILL PERFORM ALL WORK DESCRIBED THEREIN AS APPROVED AND ACCEPT PAYMENT FROM CDS ON ACCOUNT THEREOF ALL IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS SET FORTH ON THE REVERSE HEREOF.

DENTIST'S SIGNATURE ______ DATE ______

B I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

PATIENT, PARENT, GUARDIAN SIGNATURE ______ DATE ______

C ABOVE SERVICES APPROVED FOR PAYMENT UPON COMPLETION THRU ______

COLORADO DENTAL SERVICE BY ______ DATE ______

D I HEREBY CERTIFY THAT THE APPROVED SERVICES LISTED ABOVE HAVE BEEN PERFORMED IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS ON THE REVERSE HEREOF AND PAYMENT THEREFORE IS DUE.

DENTIST'S SIGNATURE ______ DATE ______

TOTAL			
DEDUCTIBLE	XXX		
BENEFITS	XXX		
CDS PAYS	TOTAL	= ← +	←
PATIENT PAYS	TOTAL	XXX	XXX
	OPR FEE	COB BAS	COB OPT

PRE-STATEMENT OF COST FORM – REV. 1-71

SEE INSTRUCTIONS ON REVERSE

SERVICES AND/OR SUPPLIES - HANDICAPPED PROGRAM (ACTIVE DUTY DEPENDENTS ONLY)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

For use of this form, see AR 40-121; the proponent agency is Office of The Surgeon General.

CASE NUMBER

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA | SERVICE MEMBER DATA

1. NAME *(last, first, middle initial)*
2. DATE OF BIRTH
3. ADDRESS *(Include Zip Code)*
4. PATIENT IS A *(Check one)* ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON
5. IDENTIFICATION CARD *(DD Form 1173)* CARD NO. — EFFECTIVE DATE / EXPIRATION DATE — MONTH DAY YEAR
6. NAME OF SPONSOR *(last, first, middle initial)*
7a. SERVICE NUMBER
7b. SOCIAL SECURITY ACCOUNT NUMBER
8. PAY GRADE
9. ORGANIZATION AND DUTY STATION *(Home Port for Ships)*
10. SPONSOR'S BRANCH OF SERVICE ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN ☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA
11. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. The handicapped case has been accepted by OCHAMPUS or appropriate overseas commander. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

Name (print or type) | Relationship to Patient | Date | Signature

SECTION II *(To be completed by Source of Care)*

12. NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code*
a. SOURCE OF CARE LOCATION CODE
b. TYPE OF FACILITY ☐ (1) PUBLIC OR STATE ☐ (2) PRIVATE NON-PROFIT ☐ (3) PRIVATE PROFIT
c. TYPE OF CARE ☐ (1) HOSPITAL ☐ (2) INSTITUTION ☐ (3) OUTPATIENT
13. NAME AND TITLE OF INDIVIDUAL ORDERING CARE
14. DIAGNOSIS *(Use standard nomenclature)*
a. 12-BREAK CODE
b. INTL STAT CODE
c. INCLUSIVE DATE OF CARE FROM / TO

15. DATES OF SERVICE	a. ITEM OR DESCRIPTION OF SERVICE	b. CHARGES	c. PROCEDURE CODE
		$	
d. TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$	
e. (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$	
f. DUE FROM GOVERNMENT TO SOURCE OF CARE		$	
g. DUE PATIENT OR SPONSOR, REIMBURSEMENT		$	

16. CERTIFICATION BY SOURCE OF CARE

I certify that the services and/or supplies listed hereon were performed or authorized by the attending physican, dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and /or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) | Title | Date | Signature

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

17. FISCAL ADMINISTRATOR USE ONLY

DA FORM 1 JUN 67 1863-3 (Handicapped)

Form Approved Comptroller General, U.S., 22 Sep 67

DENTAL PROGRAM

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I (*To be completed by patient or other responsible family member. Please print or type*)

PATIENT DATA

1. NAME (*last, first, middle initial*)
2. DATE OF BIRTH
3. ADDRESS (*Include Zip Code*)
4. PATIENT IS A (*Check one*)
   ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE
5. IDENTIFICATION CARD (*DD Form 1173, DD Form 2 or PHS Form 1866-3*)

CARD NO.		MONTH	DAY	YEAR
	EFFECTIVE DATE			
	EXPIRATION DATE			

6. BASIS FOR CARE - ACTIVE DUTY DEPENDENTS ONLY (*Check one*)
   ☐ (1) RESIDING APART FROM SPONSOR ☐ (2) RESIDING WITH SPONSOR DD FORM 1281 ATTACHED
   ☐ (3) OUTPATIENT ☐ (4) OTHER (*Specify*)

SERVICE MEMBER DATA

7. NAME OF SPONSOR (*last, first, middle initial*)
8. SERVICE NUMBER OR SOCIAL SECURITY NUMBER (*as applicable*)
9. GRADE
10. ORGANIZATION AND DUTY STATION (*Home Port for Ships*) (*Address for Retired*)
11. SPONSOR'S OR RETIREE'S BRANCH OF SERVICE
    ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN
    ☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA
12. STATUS
    ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

13. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that (*Check appropriate box*) (*Delete portion in parenthesis not applicable*)

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) ______ (Relationship to Patient) ______ Date ______ Signature ______

SECTION II (*To be completed by Source of Care*)

14. NAME AND ADDRESS OF SOURCE OF CARE (*Include Zip Code*)
    a. SOURCE OF CARE LOCATION CODE
    b. PROVIDER OF SERVICES
       ☐ (1) ATTENDING DENTIST
       ☐ (2) OTHER (*Specify*)
    c. PATIENT STATUS
       ☐ (1) INPATIENT
       ☐ ☐ (2) OUTPATIENT
15. NAME AND TITLE OF INDIVIDUAL ORDERING CARE
16. INCLUSIVE DATES OF CARE

	MONTH	DAY	YEAR		MONTH	DAY	YEAR
FROM				TO			

17. DIAGNOSIS (*Use standard nomenclature*)
    a. INTL STAT CODE
    b. 12-BREAK CODE

(*Check when applicable*) ☐ *services were necessary for treatment of a bonafide dental emergency*

18. RELATED HOSPITALIZATION (*If applicable*)
    FROM ______ TO ______

19. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

LINGUAL — LINGUAL — LABIAL — RIGHT — LEFT

* INDICATE MISSING TEETH WITH AN "X"

a. TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED	$
b. (PAID BY) OR (DUE FROM) PATIENT (*Cross out one*)	$
c. DUE FROM GOVERNMENT TO SOURCE OF CARE	$
d. DUE PATIENT OR SPONSOR, REIMBURSEMENT	$

20. CERTIFICATION BY SOURCE OF CARE

I certify that the services and/or supplies listed hereon were performed or authorized by the attending dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and/or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) ______ Title ______ Date ______ Signature ______

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

PROPOSED DA FORM 1863-5

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ABSTRACT

EXPANDED DEPENDENT DENTAL CARE UNDER THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Lieutenant Colonel Jon L. Daniels, DC

August 1972 54 Pages

A copy of this document may be obtained from University Microfilms, University of Michigan, Ann Arbor, Michigan 48108.

The study was designed to determine an acceptable expanded dental care program for service dependents and an organization capable of implementing such a program.

Comprehensive dental care for the military dependent and retiree was considered a desirable benefit. It was stated that provision of dental care as a benefit incident to active duty could well enhance the volunteer service concept.

Cost of a dental care program was held to be a major obstacle. A cost limitation method was therefore proposed. Several tables of cost and distribution figures were included in the paper. They considered increasing costs, projected state fee indices, probable utilization, and distribution of recipients.

It was recommended that comprehensive dental care be provided eligible CHAMPUS recipients. The program recommendation included an annual deductible feature and benefit limits. The limits recommended begin at $350 per person per year and increase to $500. Family limits were also recommended, beginning at $1050 in the early years of military service, and no limit in later years.

It was further recommended that Delta Dental Plans Association be selected to administer the program under CHAMPUS. The service organizations were found interested and capable of performing the necessary functions of administration.