DISCUSSION BY GEORGE E. McLEAN

Mr. Durkin's paper on group dental coverage is very timely. The rapid development of hospital-surgical-medical coverage in this country in the last twenty years may well have set a pattern which is about to be followed in the field of dental coverage.

In the perspective, there is very little with which to take issue. Mr. Durkin has done a rather commendable job of outlining the conditions which exist and which impinge on the question of providing group dental coverage. The objectives listed are sound, although I would make one additional point: Wherever there appears any indication of a void in the area of providing the public with health services of any sort, experience in other countries and the current thrust in our own country for adoption of the King-Anderson approach to providing health care for the aged clearly points to outright or attempted government intervention.

The industry and the prepayment plans may have been too late with too little in the way of offerings to avoid some form of participation by the federal government in providing care for the aged and it therefore is most imperative that we develop reasonable alternatives to government programs in the dental field in as much depth and as soon as possible.

Under Characteristics and Requirements, Chart I, citing similarities and differences between surgical-medical and dental care, I considered very well done and it included most of the important considerations.

In stating general conclusions, suggested by certain problems posed by Mr. Follman, this statement is made:

". . . This characteristic [budgeting versus insurance] also suggests the necessity of a large employer contribution, for otherwise a consumer of dental services will prefer to pay his own dental bills rather than paying an essentially stable charge for dental services plus a carrier expense charge as well. . . ."

On the face of it this seems like a logical assumption, but experience in several areas seems to indicate a certain consumer demand for enforced budgeting. One has only to look at the readiness to pay installment charges for what would once have been considered trivial purchases to confirm the public preference. Certainly some employer contribution would be helpful in marketing this coverage but I question whether that contribution needs to be substantial in order for the sale of this program to be successful.

With regard to service benefits, cited by the author as another desirable adjunct to the sale of this coverage, I heartily concur, having had first hand observation of its effect in the surgical-medical field.

Concerning utilization of dental services and Apprehension-of-Pain-Deterrent I should like to make several observations. I think that there possibly is some deterrent because of fear but this will gradually be overcome as experience with new techniques and anesthetics becomes recognized. In my view this argues for a relatively rapid rise in utilization for a number of years once coverage is instituted. In this case familiarity breeds confidence and confidence produces incidence.

In Table I it is interesting to note the close parallel beween the number of dental visits by range of family income and by range of education. I rather suspect that this is not entirely coincidental. There is a known correlation between the education of the family head and family income. In this case I believe that the paramount issue is family income and that the education factor merely underlies the income status.

The author has indicated that the budgeting of normal care may be the most appealing aspect of the coverage and I certainly concur. I do also agree that there is a problem of first year coverage due to back-log. The problem of concentrating the dental care into a month or two and then cancelling could be mitigated to some extent by the use of waiting periods as Mr. Durkin has cited and it seems to me that this is the most acceptable approach because the public has come to recognize this concept, particularly in the hospital-surgical-medical field on such items as maternity care.

Another possible approach is to offer limited benefits during the first year by means of coinsurance which would be successively reduced in each of the following years until it is eliminated. This would allow for a build-up in premium and would mean a greater participation in paying for back-log, while at the same time offering better coverage than a waiting period. The end result may be to discourage care during the first year, thereby leveling experience over the first several years.

The problem cited on orthodontia represents a question in my mind as to whether or not this coverage, together with certain very expensive optional procedures classified under regular dentistry, might best be handled in some sort of Major Dental rider, wherein special attention can be given to waiting periods and/or pre-existing conditions and coinsurance.

The methods presented to deal with the problem of pre-existing conditions probably represent a good outline of various approaches currently

in effect. Two of the approaches I would consider somewhat difficult to administer and they are the use of first year rates higher than renewal rates, and the amortization of high first year costs over a subsequent period. A high first year deductible, either in the form of a cash deductible or waiting periods, seems to me to be the most reasonable solution and one which could be most readily administered.

In his definition of classes and systems of coverage Mr. Durkin does admit some blurring of lines so I will not expand on that point, although in general I find his classification quite proper. As I stated earlier, it appears to me that restorative dentistry and orthodontia which the author has categorized as Class II and III services can best be handled by a Major Medical type of approach.

Under the heading of Rating the material presented is so general that it leaves little room for specific comment or criticism. I would merely observe that any attempt to establish rates based upon incidence of individual procedures is probably going to be relatively unrealistic in the beginning. Projection of total utilization and total cost for a particular program will probably provide more reliable rates, although the results could be compared with those obtained by projecting the utilization of individual procedures extending them at their individual costs and summing the resulting requirements.

In the last paragraph under Rating Mr. Durkin indicates that experience rating and cost plus rating systems will very likely be the practice. Certainly the basic coverage (i.e., that encompassing Class I services) lends itself to experience rating because it is a relatively high volume, low average claim cost business which should produce highly credible experience.

Moving now to the conclusions, I would agree with all except conclusion five which states that large groups and substantial contributions to cost are two primary requirements. I fully believe that if sound coverage is developed and properly rated that participation of smaller groups and even those with very modest employer contributions may become possible. In his final conclusion Mr. Durkin states that the future of dental coverage depends upon: a) the future course of the economy; b) the policy decisions of management and labor; c) the policies and practices adopted by insurers and prepayment plans. I would add one last condition and one which may be the most significant of all: the penetration, if any, by the federal government into this area of medical care, particularly with regard to government clinics for lower income persons.

While not much in the way of actuarial treatment has been included in this paper, and while I disagree with a few of the author's positions, in the main I found it an extremely thoughtful and carefully organized presentation of a problem which is going to become very pressing for the industry and the prepayment plans in the immediate future.