Pathway to value

Perspective on how to chart a path that meaningfully accelerates the shift to value-based dental care

HealthScape Advisors
A CHARTIS COMPANY

nadp National Association of Dental Plans

CareQuest Institute for Oral Health®

Value-based care (VBC)—both the phrase and the movement—has permeated the healthcare industry for years.

The Centers for Medicare & Medicaid Services (CMS) has committed to all Medicare beneficiaries being covered under value-based constructs by 2030.[1] Some programs, like Medicare Shared Savings and Accountable Care, provide opportunities to improve health outcomes and financially reward participating physicians for their role in improving quality and lowering overall care costs.[2] While there are promising indications, the move to VBC has not happened at scale across the medical landscape.

To date, the phrase "VBC" has spread throughout the dental industry, but defining and quantifying it as a movement is difficult. Additionally, and importantly, implementing and scaling VBC doesn't happen in a vacuum. The convergence of dental market factors—a broader healthcare affordability crisis, a maturing product landscape, a consolidating payer landscape, an evolving provider landscape, and a rapid acceleration of dental-specific technology—is creating an opportunity for the dental industry to accelerate its journey toward VBC.

DENTAL MARKET FACTORS CREATING AN OPPORTUNITY TO ACCELERATE TOWARD VBC:

Maturing product offering

88% of the US population has dental benefits through either the commercial market (57%) or a publicly funded source (31%).[3]

Consolidating payer landscape

The recent volume of transaction activity has led to limited acquisition targets. Plans can no longer buy their way to growth, and VBC can differentiate plans from competitors.

Evolving provider landscape

13% of all dentists were affiliated with a dental service organization (DSO) in 2022. That figure increases to 23% when considering only dentists that have been out of dental school for less than 10 years.[4]

Accelerating dental-specific technology

Artificial intelligence (AI) and teledentistry solutions are maturing and have started to play a more critical role in dental practices and at dental plans.

HealthScape Advisors, in collaboration with the National Association of Dental Plans (NADP) and CareQuest Institute for Oral Health (CareQuest Institute), conducted a market survey and follow-on qualitative interviews of dental payers and multisite dental providers to assess payers' and providers' perspectives on, and experience with, the transition of dental reimbursement from a traditional fee-for-service (FFS) model to a VBC model. The ultimate objective of this paper is to promote dialogue and illustrate where organizations could effectively collaborate to define and advance more meaningful implementation of VBC.

Respondent landscape

PAYERS

40+ respondents

100M commercial members

70M government members

PROVIDERS (DSOs)

10+ respondents

3,400 locations

48 states

Key survey takeaways

- Despite significant dialogue across the dental industry on the topic of "value-based care," there remains no clear definition or standard. The phrase also elicits varying sentiments between payers and providers, even among organizations with similar attributes and levels of experience.
- For payer respondents without VBC experience, the attributes of those likely to explore implementation of VBC models in the near term include health plans (i.e., plans that offer both medical and dental coverage), larger organizations, and organizations with modern or modernized technology.
- A less clear picture emerges for provider respondents that have not yet participated in VBC. Patient mix, organization size, and technology platform do not appear to be determining factors in a provider's intent to implement VBC in the next 2 to 5 years.
- Payers and providers, regardless of level of experience and interest in VBC, are skeptical of the other's motivations, as both groups perceive that the other is driven primarily by financial gain. Even after years of pilots and implementations, the most significant barrier remains "people," particularly interest level, resource availability, and incentive alignment.
- Despite this perception, the survey shows that payers and providers are aligned in a commitment to enhancing patient care and outcomes. Using this as a launching point and building on lessons learned to date, both parties can play a prominent role in shaping the future of VBC.

You need to know where you are to know where you are going

What is value-based care? The term “value-based care” may mean something different to each organization and even to different people or functions within an organization. To define options for a path forward, we first needed to assess the degree of definitional alignment within the payer and provider cohorts and across the industry.

We asked respondents to provide three to four phrases describing VBC. At first glance at the word clouds of payer and provider sentiment below, you may notice many of the same phrases, such as "quality" and "improved outcomes," referenced by both payers and providers. While this may indicate some level of definitional alignment, when you take a closer look, you may start to identify differences in sentiment between payers and providers. We will dig into the reasons why throughout this paper.

For the purposes of this survey, we defined VBC as any reimbursement model that is not limited to payments based solely on the quantity of services rendered for a set fee, but instead is influenced by a factor linked to quality, value, or outcome.

Payers

Elevated network Aligned incentives Results
Good for patients Prevention Appropriateness
Dental home Evidence-based Aspirational
Cost and work involved in implementation
Value Everybody wins Provider push back
Ethical treatment encouraged Pay for performance
ROI Improved oral health outcomes
Quality of care Well-intended
Provider engagement Patient-centered care
Alignment with dentists Risk management
Not well received by providers Lower medical cost
Network development Reward dentists
Wishful thinking Capitation-based payments
Different reimbursement methodology
Financial incentives Limited usability today

Providers

Patient-centered care Justification for payment
Collaborative care Less money Cost efficiency
Reimbursement with strings attached Children
Meeting needs of patients Medicaid More work
Longevity Capitation-based payments
Proxy for utilization management Quality
Preventive care
Improved oral health outcomes
Financial incentives Accountability
Cost-effective treatment today for tomorrow
Provider reluctance and skepticism
Drive care goals Reduce overall healthcare costs

The first step is the hardest

We hypothesized that the way in which an organization describes its experience with, and outlook on, VBC would be influenced by its organization type, size, technological infrastructure, and business mix. This hypothesis held true in the survey results and supplemental qualitative interviews, but not in all the ways we expected.

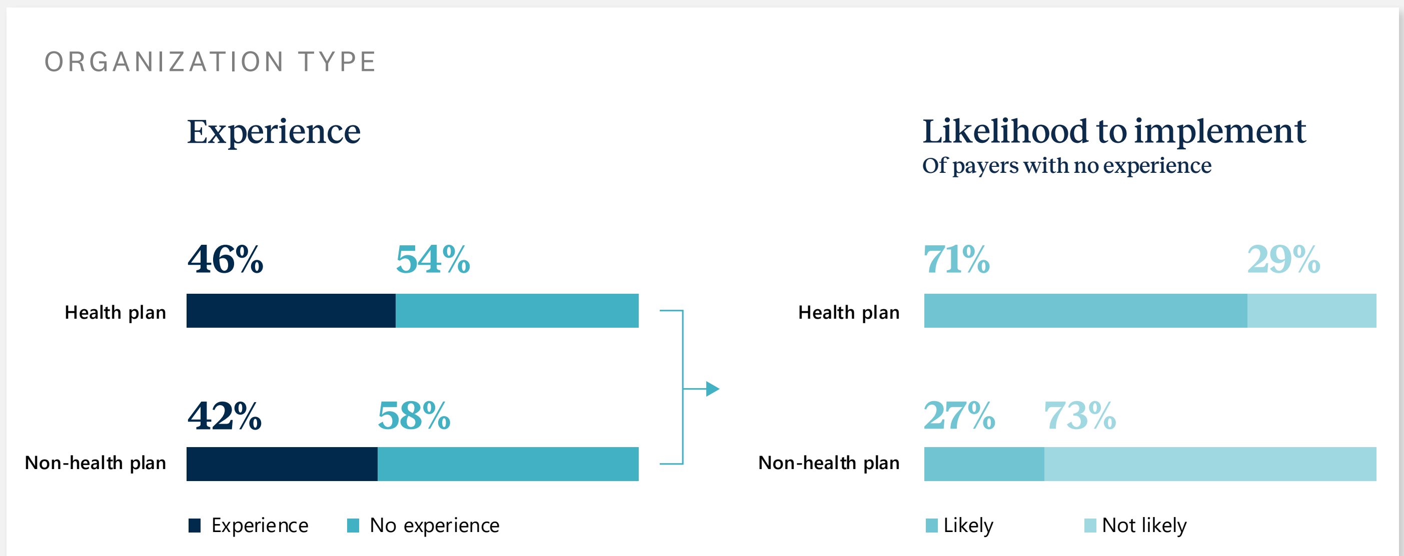
Our findings emphasize that the journey is long and winding, and the destination is far off for most organizations.

In the sections that follow, we break down payer and provider respondents' reported experience in VBC and likelihood to implement it by distinguishing characteristics. For payers, the characteristics included organization type, size, business experience, and technology infrastructure. For providers, the characteristics included organization size, patient base, and technology infrastructure. The graph below on the left shows the attributes of payers or providers based on their historical experience with VBC, while the graph below on the right segments payers or providers with no prior VBC experience based on their likelihood to implement VBC in the next 2 to 5 years.

Payer experience and likelihood to implement

ORGANIZATION TYPE

For clarity, we use the term "health plan" to describe dental plans that are a subsidiary, or an affiliated entity, of a health plan (i.e., offers medical as well as dental) and "non-health plan" to describe dental plans not associated with a medical offering (i.e., stand-alone dental plans and multi-line plans).



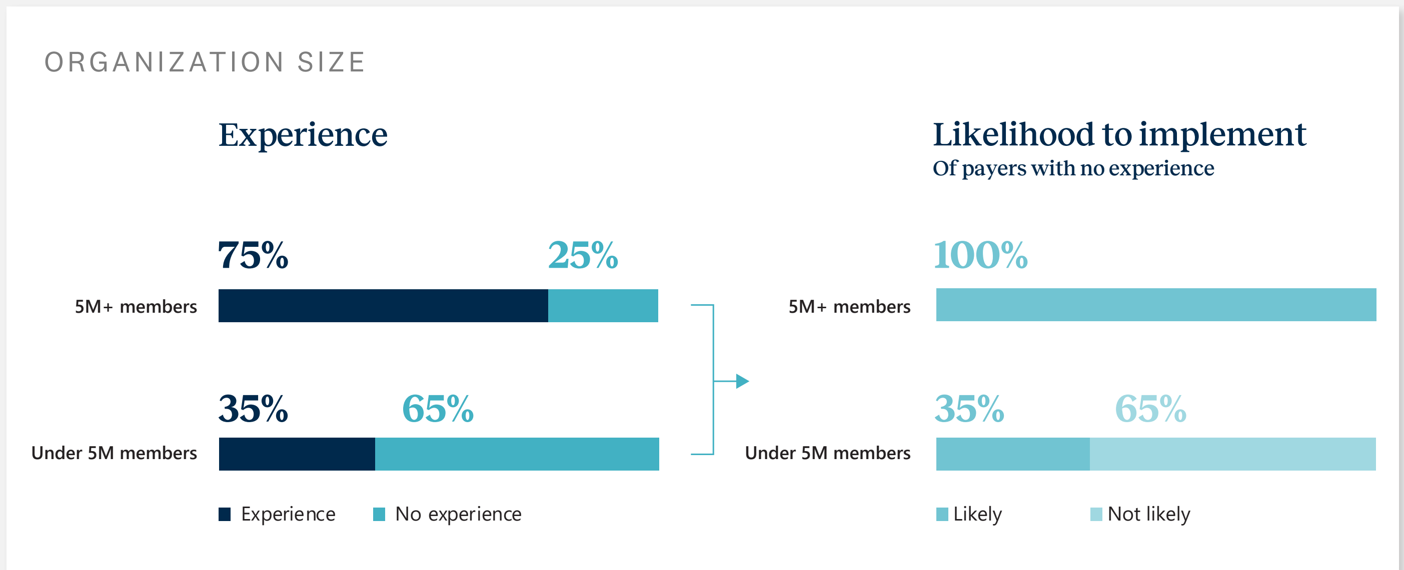
> Between ***40%*** and ***50%*** of both health plan and non-health plan respondents indicated that they have at least some prior experience with VBC.

When considering the future for those with experience, all health plan respondents and most non-health plan respondents (91%) indicated that they are extremely, very, or moderately likely to continue to implement VBC in the next 2 to 5 years. Said differently, those that have already taken the first step plan to continue their journey toward VBC.

This contrasts with those plan respondents without experience, which reported they were overall less likely to implement VBC in the near-term. The contrast is particularly pronounced in the non-health plan cohort, where only 27% of respondents indicated they were likely to implement VBC. One potential reason for the divide is that health plans, generally speaking, are very focused on transforming their medical business from FFS to VBC to address the unsustainable rise in healthcare costs.[6] Therefore, dental segments within health plans see opportunity to align with broader organizational objectives and may leverage VBC in dental as a way to strive for internal relevance and investment within a broader ecosystem with competing priorities. Additionally, dental segments within health plans may more readily have access to medical cost of care data that can support justification for dental value-based investments.

ORGANIZATION SIZE

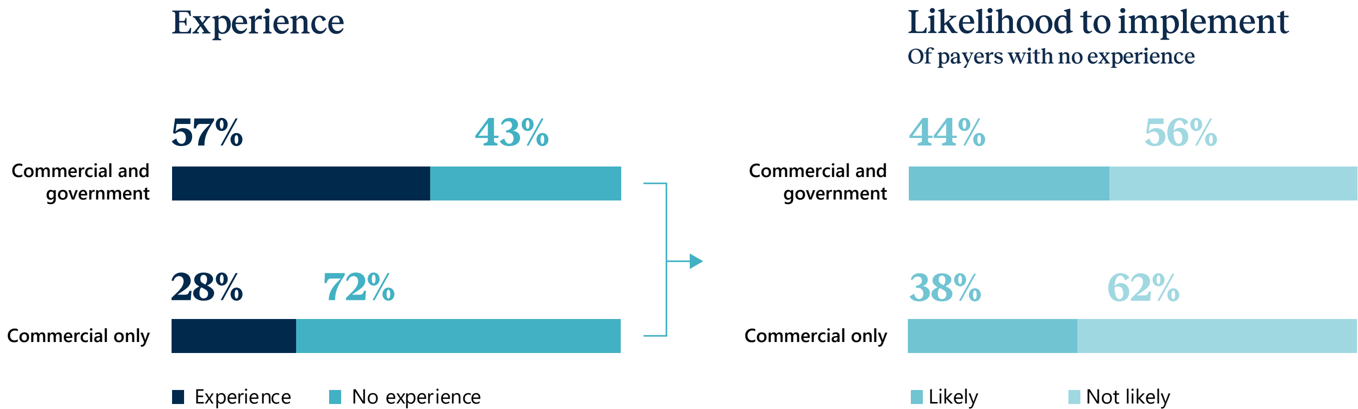
75% of large plan respondents (defined as having 5 million or more dental members) have experience with VBC, as compared to only 35% of smaller plan respondents (defined as having less than 5 million dental members). Regardless of experience level, all large plan respondents expect to implement VBC in the next 2 to 5 years. Many small plan respondents without prior experience, however, do not. Only 35% of small plan respondents without prior experience report some likelihood to implement VBC in the near term.



> Only ***35%*** of small plan respondents without prior experience report some likelihood to implement VBC in the near term.

LINE OF BUSINESS MIX

It is not surprising that plan respondents that participate in government lines of business (i.e., Medicare Advantage, managed Medicaid) have more experience with VBC than plan respondents that only offer commercial products. Regulators in certain government markets have encouraged, and in some cases mandated, such progress. For example, Florida's Medicaid program recently implemented a statewide incentive program for eligible general and pediatric dentists. Those that meet or exceed defined quality metrics for access and preventive services receive higher financial compensation. Florida Medicaid is requiring its managed care plans to participate.[7] Similarly, Texas Medicaid has required its dental vendors to participate in the Pay for Quality (P4Q) incentive-based quality program since 2012, and also included dental vendors in requirements to grow use of risk-based reimbursement programs.[8]



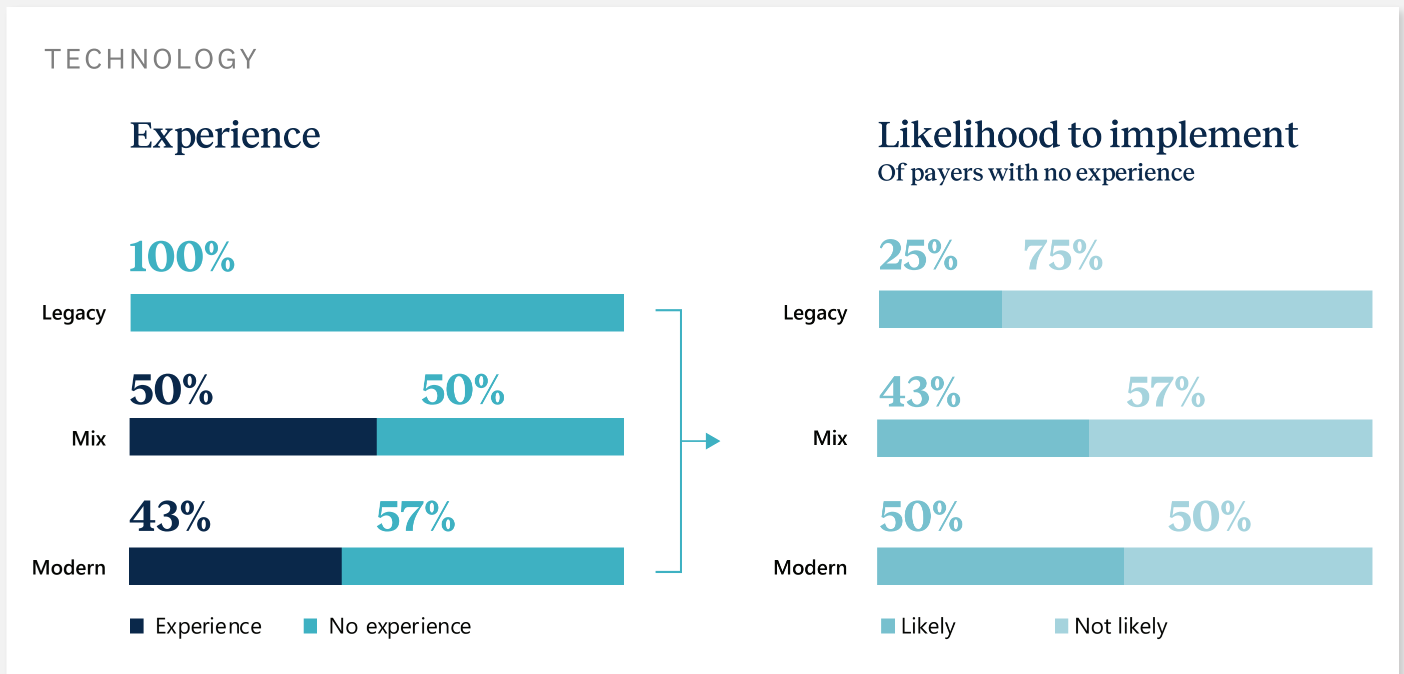
Despite a lack of regulatory pressure in the commercial market, there is clear interest. Nearly 40% of plan respondents that only offer commercial products and do not have prior experience with VBC reported that they are at least moderately likely to implement VBC in the near term. Certain commercial-only plans may view value-based programs as a potential differentiator in a highly competitive environment with increasingly sophisticated buyers. Supplemental research into broker and employer stakeholder points of view (not explored in this survey but a point of future research) may help further inform this perspective as we hypothesize there are barriers with each of those stakeholders.

Additionally, in certain geographies, commercial-only plans may be interested in exploring value-based arrangements in response to recent loss ratio reporting and monitoring legislation.

Nearly ***40%*** of plan respondents that only offer commercial products and do not have prior experience with VBC reported that they are at least moderately likely to implement VBC in the near term.

TECHNOLOGY

Technology and systems infrastructure may impact whether a plan has experience with or is likely to implement VBC. In the survey, no plan respondents that reported having a legacy core administrative platform, such as an AS400 or mainframe, have experience with VBC, and only 25% with legacy platforms reported a likelihood of implementing VBC in the near term. In contrast, roughly half of plan respondents with modern systems or that have pursued modernization efforts reported a likelihood of implementing VBC in the near term.

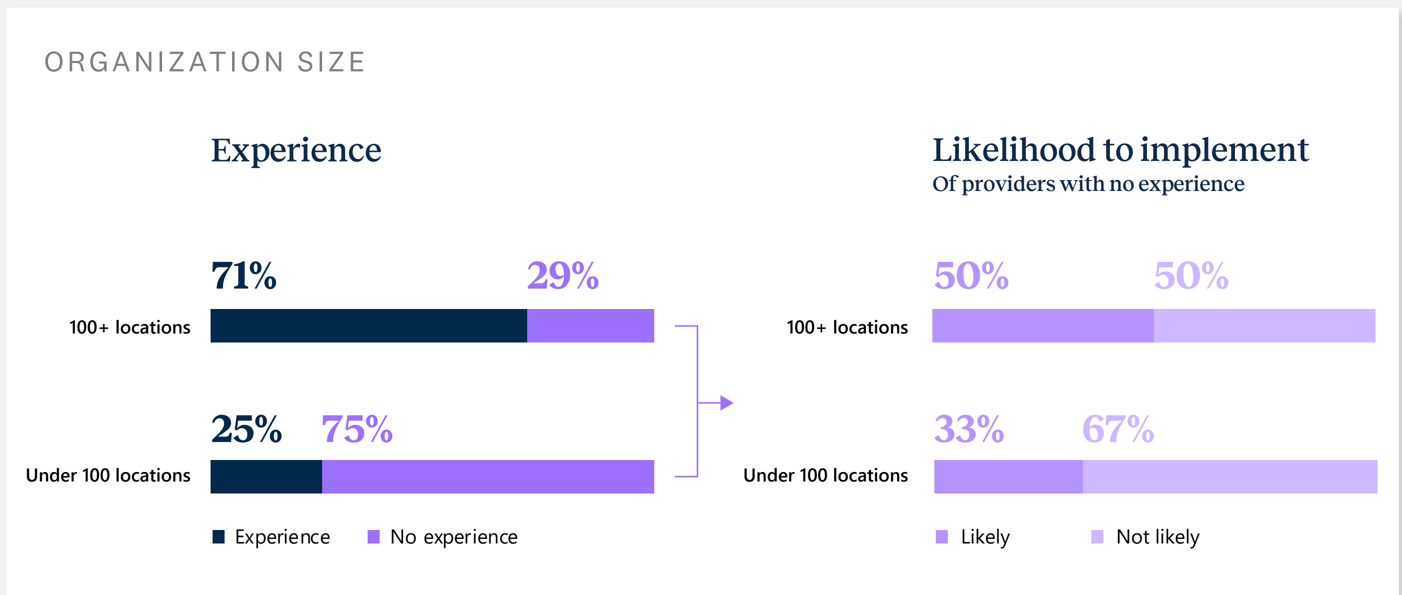


Roughly ***half*** of plan respondents with modern systems or that have pursued modernization efforts reported a likelihood of implementing VBC in the near term.

Provider experience and likelihood to implement

ORGANIZATION SIZE

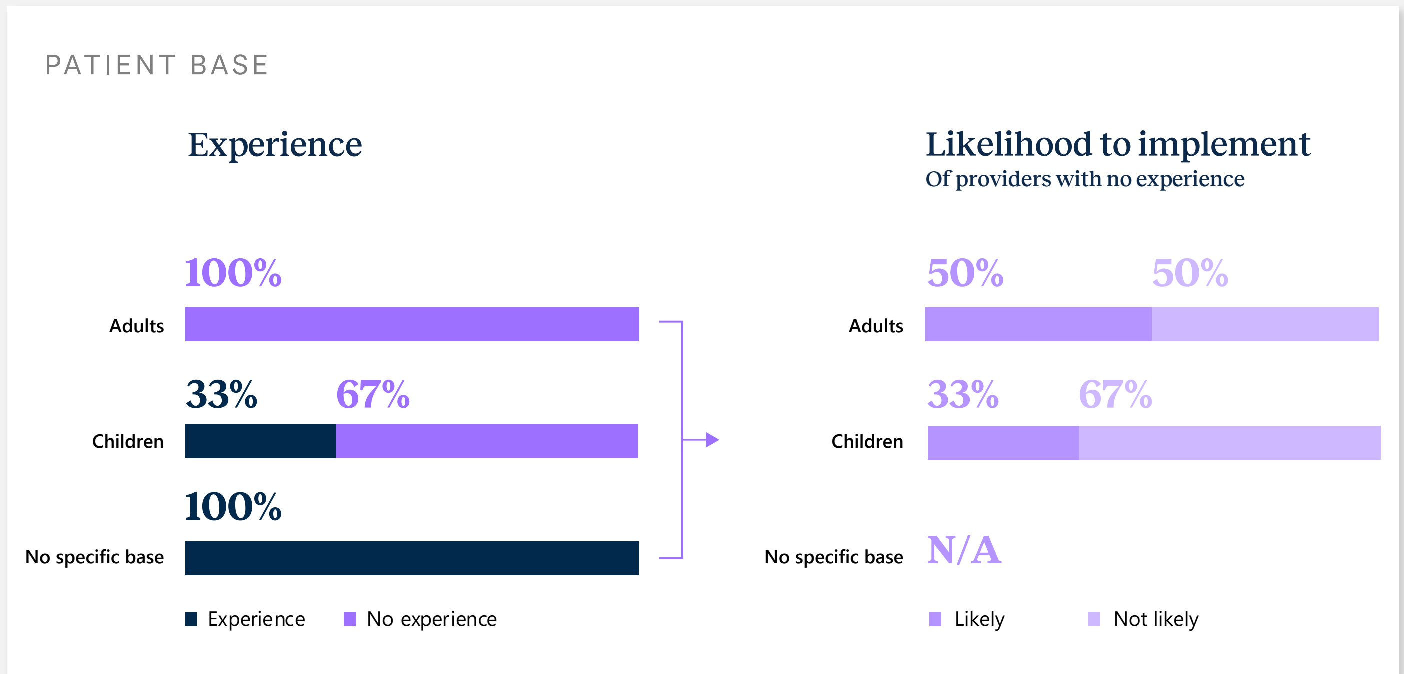
More than 70% of large provider respondents (defined as having 100 or more locations) report experience with VBC, as compared to only 25% of smaller provider respondents (defined as having fewer than 100 locations). That said, size does not appear to be a determining factor in a provider's likelihood of implementing VBC in the next 2 to 5 years. Feedback received during qualitative interviews with certain provider respondents suggests that larger and smaller providers may face different challenges influencing their likelihood to implement VBC. For example, larger provider respondents that have grown via an acquisition strategy may experience system integration and compatibility challenges across their practices, complicating the rollout of a value-based construct. Smaller provider respondents indicated they may not have capital to invest in the people, processes, and technology required to support value-based programs at scale.



More than ***70%*** of large provider respondents report experience with VBC, as compared to only ***25%*** of smaller provider respondents.

PATIENT BASE

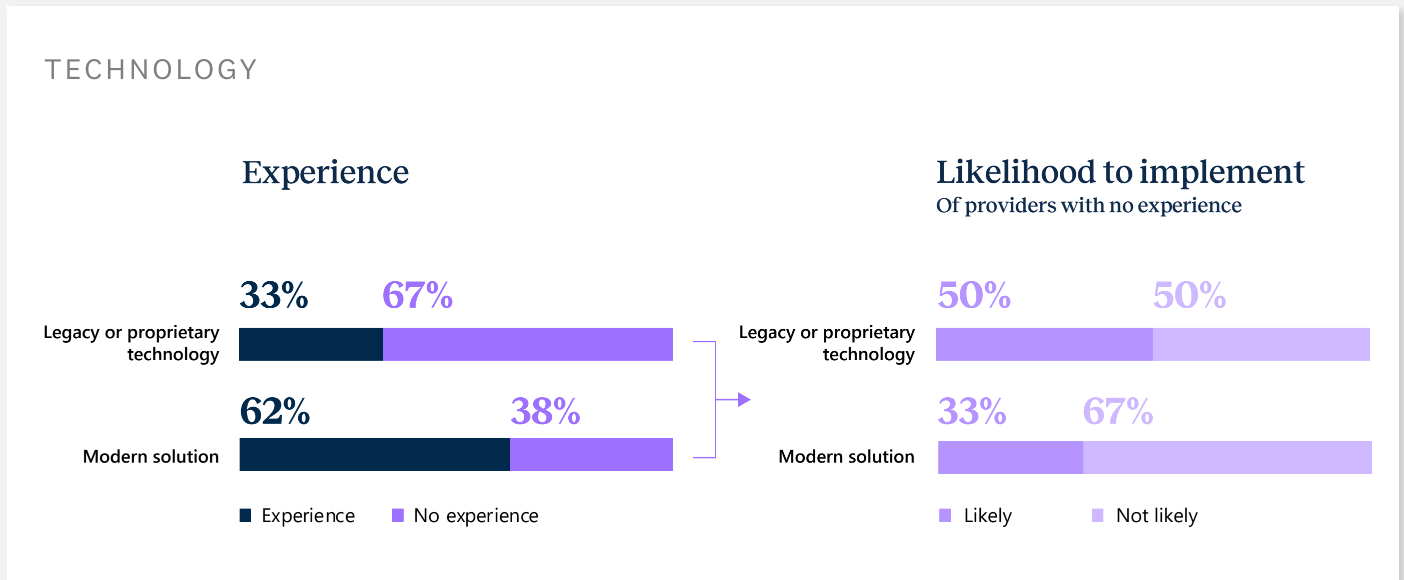
Provider respondents that treat primarily children and those that see a mix of children and adults are more likely to have experience with VBC. This may be because provider respondents indicated that many existing VBC pilots and programs are concentrated in managed Medicaid markets, where comprehensive dental coverage is consistent for child populations. Among such efforts, VBC objectives have typically focused on prevention rather than delivering more complex, problem-focused care.[9,10] That said, provider respondents interested in implementing VBC may be open to programs for all patient populations.



> Provider respondents that treat primarily children and those that see a mix of children and adults are more likely to have experience with VBC.

TECHNOLOGY

Technology and systems infrastructure do not appear to influence whether a provider has experience with or is likely to implement VBC to the same extent that it influences payers. Interviews indicated that providers, particularly DSOs, are likely more accustomed to handling the complexities of technology in their day-to-day operations (e.g., managing multiple practice management platforms). Additionally, payers must configure systems to contract, administer, manage, and report on value-based payment models, whereas providers are likely using their practice management systems in a manner consistent with their everyday practice.

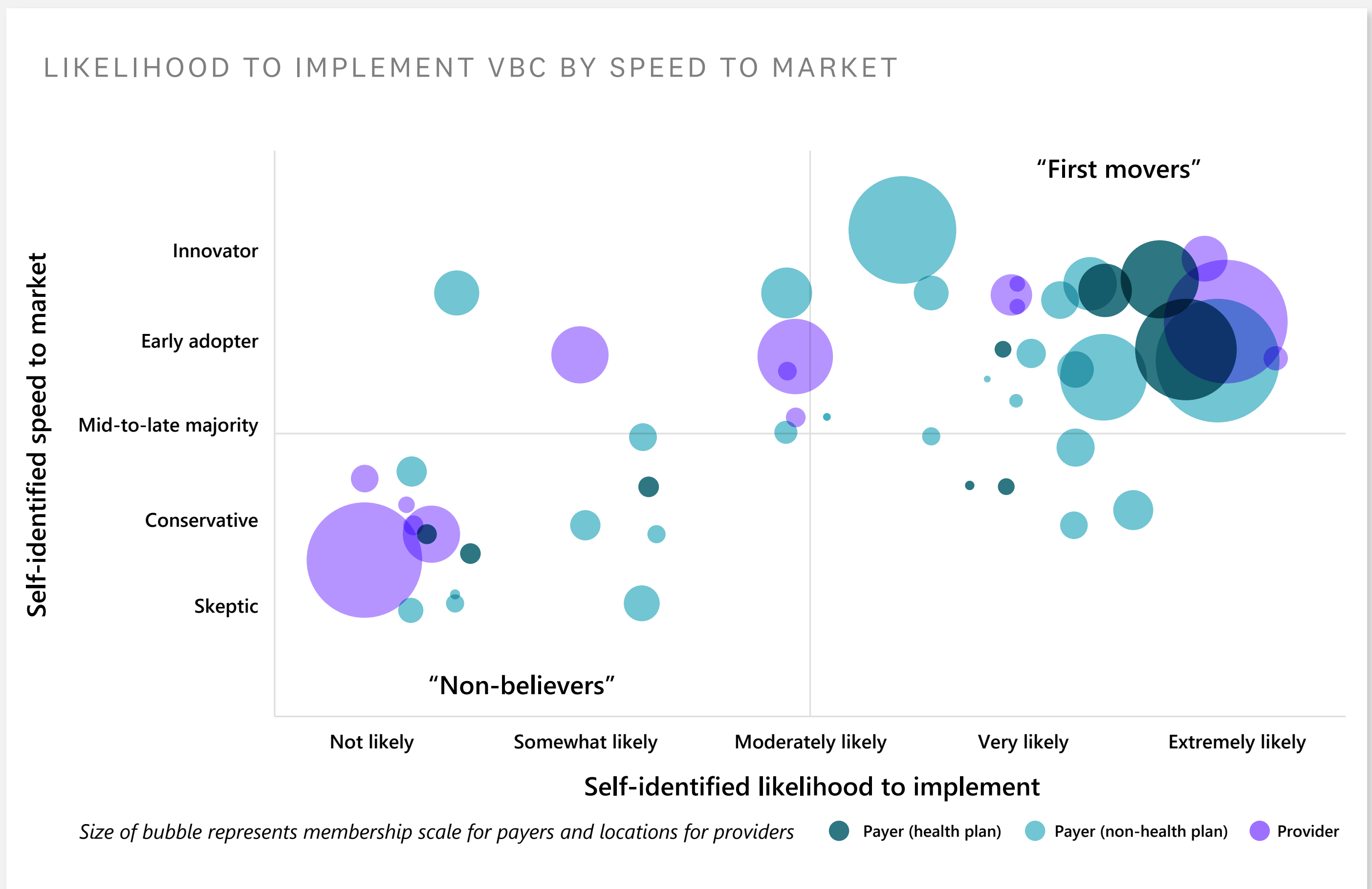


> Technology and systems infrastructure do not appear to influence whether a provider has experience with or is likely to implement VBC to the same extent that it influences payers.

Speed to market

Across both payer and provider respondents, there is a pronounced divide between self-identified "innovators" and "early adopters" versus "skeptics" and "late adopters" regarding the transition to value-based programs. With few exceptions, larger dental payer respondents integrated with broader healthcare organizations, and larger provider respondents are more inclined to consider themselves "innovators" or "early adopters." In contrast, stand-alone and multi-line dental payer respondents with fewer members and smaller provider respondents with fewer locations tend to self-identify as "skeptics" or "late adopters."

The "first movers" identified in the upper right-hand quadrant of the graph below are the organizations most likely to shape the future of VBC in the dental industry.



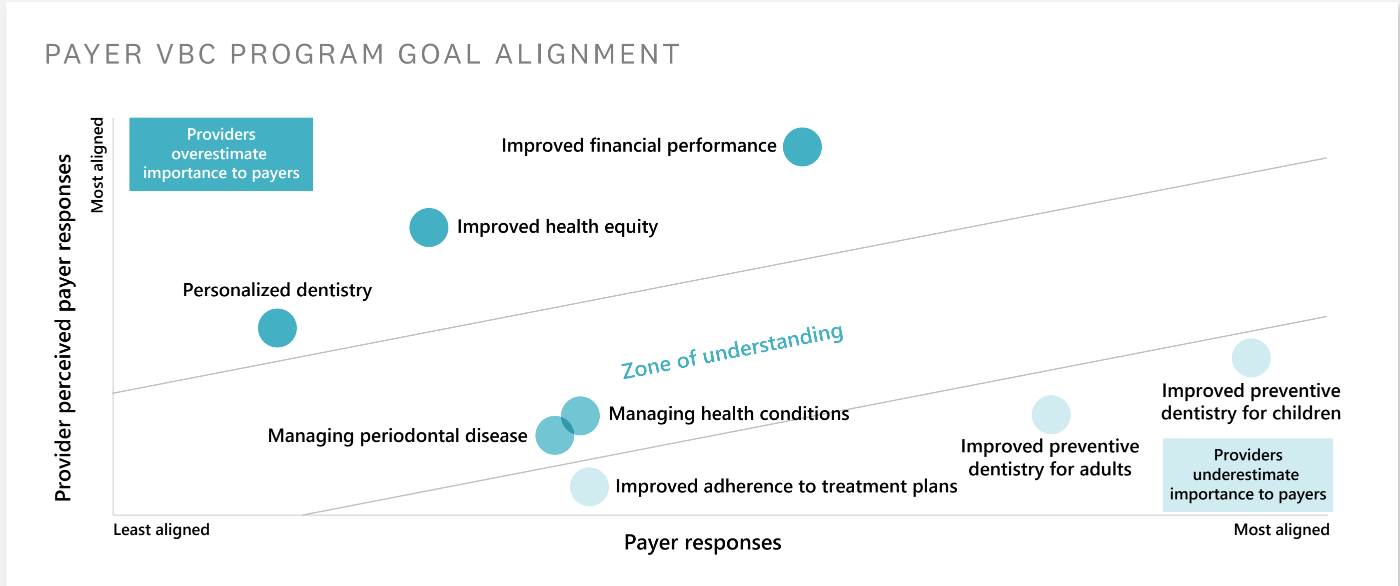
Trust must be earned throughout the journey

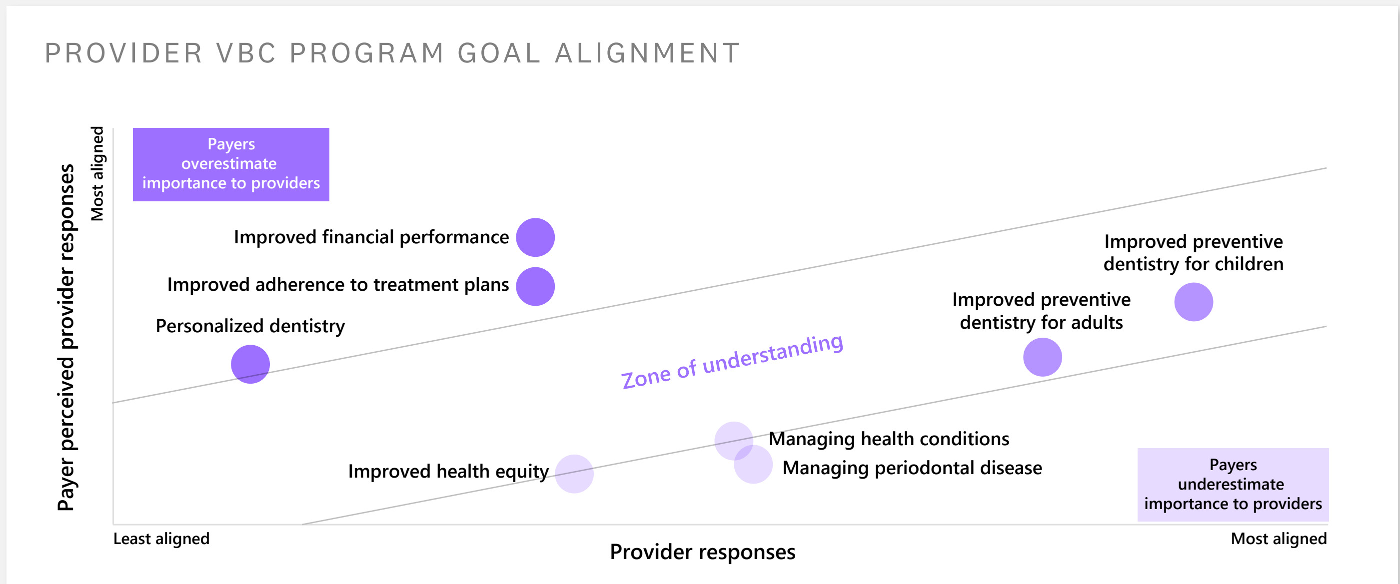
The dental industry has been talking about VBC for a long time, but many stakeholders feel that the industry doesn't have much to show for it. A lack of published evidence on dental payment transformation supports this belief.[11] Survey respondents and supplemental interviews reported that the slow progress on VBC implementation to date, despite extensive discussions and expansive research, has led to a feeling of "fatigue." Over time, payers and providers have become increasingly skeptical of the other's commitment to actual change.

This significant trust deficit is highlighted in our survey results. Both groups perceive that the other group is motivated primarily by financial gain (i.e., providers believe this to be true of payers, and payers believe this to be true of providers), rather than better patient care and quality outcomes.

Where could payers and providers intersect on VBC?

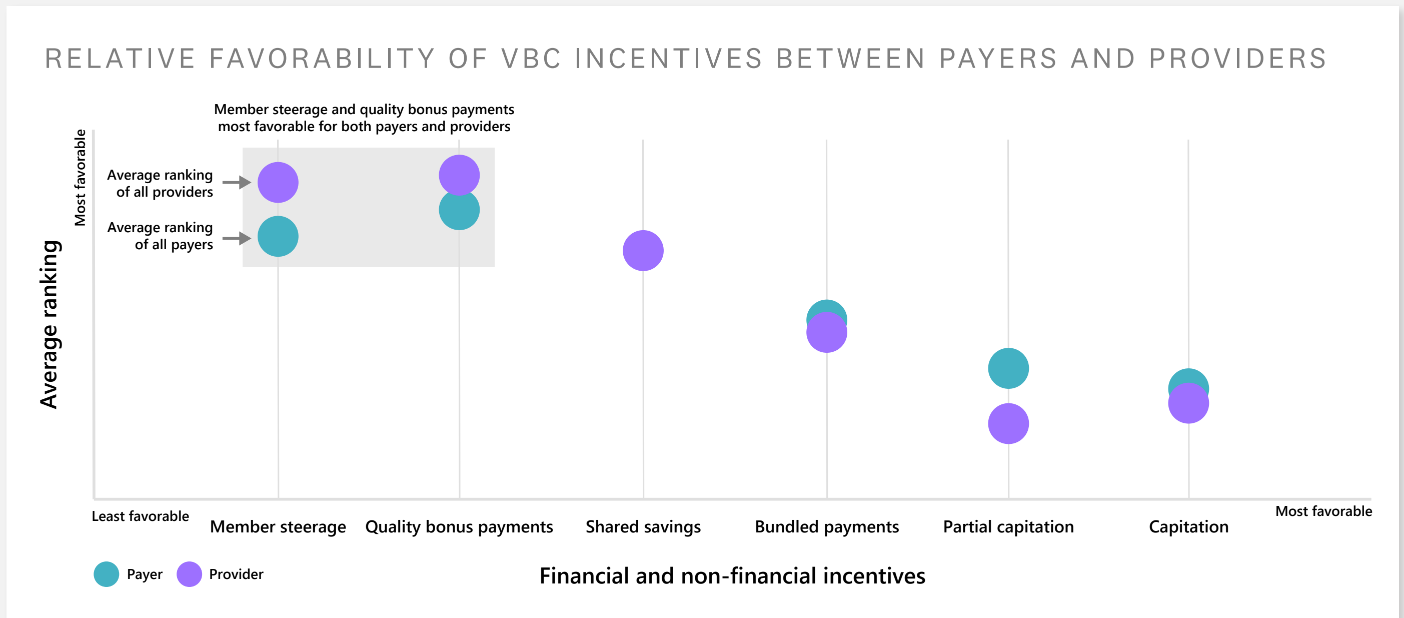
Identifying commonalities and shared desires is crucial to consensus building and overcoming any previous trust deficits as it pertains to VBC for payers and providers. The following visuals compare the prioritization of payer goals in VBC with provider perceptions of payer goals for VBC, and vice versa. Despite the perception that the other party is most interested in improved financial performance, responses from payers and providers revealed a surprising level of alignment on key aspects of VBC.





Both payers and providers cite improving preventive dentistry for children and improving preventive dentistry for adults as the VBC goals with which their organizations are most aligned.

The fact that both parties identify the improvement of preventive dentistry for children and adults as the top priorities underscores a linked commitment to enhancing patient care and outcomes. Furthermore, payers and providers also value the same incentives. As an example, both groups support quality bonus payments as the top incentive to reward high-quality care.

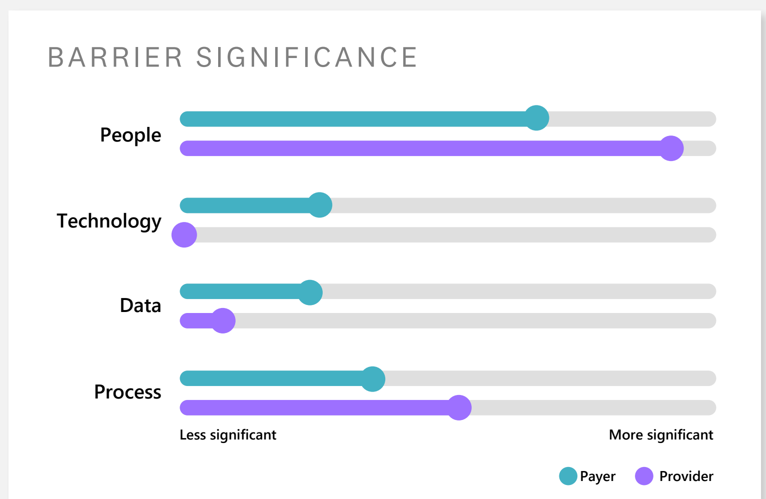


In addition to common goals of improving preventive dentistry for children and adults, payer and provider respondents also show some consistency in VBC incentive favorability. Quality bonus payments and member steerage are perceived favorably by both groups, and both groups view partial capitation and capitation as less favorable incentives. The alignments highlighted above demonstrate a mutual understanding and could serve as one starting point for building trust going forward.

Expect to navigate speed bumps and detours

The continued shift from FFS models toward VBC in the dental industry has not been without significant challenges.

Even after payers and providers have partnered over the years to implement VBC (via pilot programs or operating at scale in certain scenarios) with various levels of success, both parties still identify the largest obstacle to true VBC transformation as related to "people," particularly interest-level, resource availability, and incentive alignment.



If you've seen one VBC program, you've seen one VBC program. Existing VBC models in the market tend to target different populations, deploy different tactics, monitor different measures, and manage to achieve different outcomes. The lack of "process" standardization among constructs exacerbates the administrative burden associated with managing and participating in VBC programs. Both payer and provider respondents acknowledge that these operational complexities (e.g., additional exchange of information, more and different documentation, performance reconciliation) can be overwhelming. That said, provider respondents view "process" challenges as a larger barrier than payer respondents, likely because providers are participating in multiple programs run by different payers, compounding operational process complexities.

Lastly, the challenge of ensuring that technology systems can effectively support participation in VBC remains a barrier. For example, provider respondents, particularly those that have grown through acquisition, indicated that they face difficulties navigating the complexities of using several practice management systems with varying degrees of integration. However, these systems are essential for the efficient operationalization of VBC programs and often require substantial capital investment to support necessary capabilities and interoperability with payer platforms.

Wherever you are, it's time to start your journey

Regardless of where your organization lands on the transformation continuum from innovator to skeptic, you can play a role in unlocking the potential of VBC.

- **Take stock of your current position:** Each payer and provider sits at a different mile marker on the pathway to VBC transformation. Therefore, all organizations should immediately and honestly evaluate their respective experience, capabilities, and challenges. Organizations should assess where they sit relative to peers and clearly identify their future-state goals (whether VBC is one of them or not). With a destination in mind, all organizations can begin to build a roadmap for the journey tailored to their organizational realities, risk tolerance, and strategic objectives. These efforts must encompass a cross-functional team and have executive leadership support.

- **Predict your journey by creating it:** As an industry, we should not wait for regulators to force change. History has shown regulators were a catalyst of VBC transformation in the medical space, as legislation (e.g., Affordable Care Act, Medicare Access, and CHIP Reauthorization Act) solidified the role of value-based payment in government markets. Commercial insurers then followed suit. There is immense value for dental payers and providers to find accord on the foundational elements of dental VBC and align ourselves before any future potential regulatory changes mandate the approach.

- **Learn from those further along on the journey:** There are lessons to be learned from the mistakes of the past, and rather than reject these experiences entirely, we should learn from them. Many plans and providers have already implemented pilot programs or are operating VBC at scale, and it is imperative to use the lessons learned to the collective industry's advantage. While the path is certain to be long and winding, there are likely shortcuts to be discovered along the way. That said, those who have experience must be willing to share successes.

- **Foster a focused and positive environment:** Developing a cross-industry coalition of stakeholders (e.g., insurers, providers/clinicians, industry societies, academics, quality organizations) to drive consensus on foundational elements of VBC (e.g., clinical practice guidelines, quality metrics) and identify a proposed starting point is necessary to create momentum. Building on any relevant work started to date, providers could potentially take the lead on setting the clinical practice guidelines and proposing the conditions, measures, and outcomes that are most impactful. They must collaborate with payers and other industry stakeholders to ensure a shared understanding and generate buy-in. Ultimately, defining the foundation will allow all stakeholders to optimize other functions (e.g., reporting capabilities) accordingly. We should seek to understand, and then vocalize, collectively, where emerging technologies can further enable the ability to align, track, and report on specific disease states.

- **Visualize success and what is possible beyond:** Contemporary VBC approaches in dental can be a waypoint on a longer journey toward care integration (which is a concept that we purposely did not explore as part of this effort). When paired with various data sharing, benefit enhancements, and broader disease management programs, VBC can impact both dental and medical outcomes.

The differences in readiness and willingness to transform are shaped by unique organizational size, market positioning, resource availability, and inherent operational model considerations. These factors highlight the complex dynamics that each industry participant must evaluate. That will help them determine how to approach this shift and how to be successful within the parameters of their current position.

Survey methodology and limitations

In the spring of 2024, we invited a selection of dental payers and dental services organizations (DSOs) to participate in a voluntary web-based survey on VBC in the dental industry. All dental payers received and responded to the same set of questions, and all DSOs received and responded to the same set of questions.

We received 40+ responses from dental payers, representing approximately 100 million commercial members and approximately 70 million government program members. Dental payer respondents included standalone dental plans, health plans, and multi-line plans. We received 10+ responses from DSOs, representing more than 3,400 locations across 48 states. Independent practices and small group practices not affiliated or associated with a DSO were not represented.

Qualitative interviews were held with a subset of dental payer and DSO respondents to further supplement and enrich the web-based survey results.

Glossary

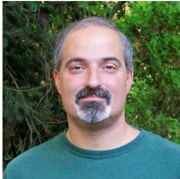
Term	Definition
Core administrative platform	The central system or software suite that manages administrative functions within a plan (e.g., claims processing, enrollment, billing, reporting).
Improved preventive dentistry for children	Focus on adherence to essential preventive dental treatment such as regular exams, cleanings, sealants, and fluoride treatments.
Improved preventive dentistry for adults	Focus on adherence to essential preventive dental treatment, including exams, x-rays, cleanings, scaling, root planing, and fluoride treatments.
Personalized dentistry	Ability to tailor benefits based on an individual's specific oral health needs (e.g., enhanced periodontic coverage for individuals with deeper pockets or bone loss).
Managing periodontal disease	Focus on better managing periodontal disease through consistent non-surgical treatment (e.g., scaling, root planing) and improved at-home oral hygiene practices.
Improved adherence to treatment plans	Focus on increasing the percentage of patients who are compliant with or complete dental treatment plans.
Managing health conditions	Focus on better managing chronic health conditions—such as cardiovascular disease, diabetes, and respiratory conditions—through improved oral health.
Improved health equity	Working to ensure all individuals have a fair and just opportunity to attain their highest level of health.

Term	Definition
Improved financial performance	Focus on delivering appropriate, high-quality, and cost-effective care leading to better overall financial performance (e.g., decreased cost of care for plans and increased revenue for practices).
Member steerage	Tactics to direct members to high-quality providers. Non-exhaustive examples include quality score publication (e.g., DentaQual®), preferred provider locator positioning, Center of Excellence distinction, and tiered networks.
Quality bonus payments	Payment incremental to FFS payment, contingent upon meeting quality measures or performing certain activities. Non-exhaustive examples include treatment plan completion, completion of Caries Risk Assessment, completion of oral hygiene/health coaching, taking blood pressure, and participation in an interdisciplinary care team.
Shared savings	Program in which providers “share” in a portion of any total dental cost savings achieved as compared to a benchmark for a defined patient population. In shared savings programs, providers may or may not be required to “refund” plan for exceeding benchmark costs.
Bundled payments	Set payment for a clinically defined episode of care with a defined start and end. In a bundled payment program, providers do not receive additional payment above the set amount regardless of cost of services rendered. If providers deliver services valued less than the set reimbursement, they still receive the full bundled payment amount.
Partial capitation	Model that prospectively provides providers with a per-member per-month (PMPM) payment for a defined patient population and limited range of services (e.g., preventive care). Providers receive FFS reimbursement for services outside of the defined range.
Capitation	Model that prospectively provides providers with a PMPM payment for a defined patient population and defined range of services. Providers receive no reimbursement for actual use of services. In this model, providers are also expected to meet defined quality measures.
People	Human resources responsible for completing VBC activities or administering VBC arrangements.
Process	Way in which tasks related to VBC activities or administration are carried out by resources.
Technology	The platforms, systems, and/or software used to enable resources to perform VBC activities and administration.
Data	The facts, measures, or statistics used to inform VBC activities or arrangements.

Sources

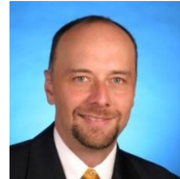
1. CMS, “Innovation Center Strategy Refresh,” October 2021, https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.
2. Daniel K. Shenfeld, PhD, Amol S. Navathe, MD, PhD, and Ezekiel J. Emanuel, MD, PhD, “The Promise and Challenge of Value-Based Payment,” JAMA Internal Medicine, May 2024, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2818630.
3. Daniel K. Shenfeld, PhD, Amol S. Navathe, MD, PhD, and Ezekiel J. Emanuel, MD, PhD, “The Promise and Challenge of Value-Based Payment,” JAMA Internal Medicine, May 2024, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2818630.
4. NADP, “2023 Dental Benefits Report: Enrollment,” December 2023, https://knowledge.nadp.org/products/2023-dental-benefits-report-enrollment.
5. Kelly Ganski, “More Dentists Affiliating with DSOs,” ADA News, June 2023, https://adanews.ada.org/ada-news/2023/june/more-dentists-affiliating-with-dsos/.
6. Cynthia Cox, et al, “Health Care Costs and Affordability,” KFF, May 2024, https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction.
7. Florida Agency for Health Care Administration, “Dental Provider Incentive Program,” 2024, https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/current-smmc-program/dental-provider-incentive-program.
8. Texas Health and Human Services, “Value-Based Care,” 2024, https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care.
9. CareQuest Institute, “Medicaid Adult Dental Coverage Checker,” 2024, https://www.carequest.org/Medicaid-Adult-Dental-Coverage-Checker.
10. NADP, “2023 Dental Benefits Report: Enrollment,” December 2023, https://knowledge.nadp.org/products/2023-dental-benefits-report-enrollment.
11. Caroline McLeod, Danielle Apostolon, Paige Martin, Andrea Clark, Renee Clark, Kelly Schroeder, Hannah Cheung, and Rebekah Mathews, “Unlocking Value in Alternative Payment Models: The Power of Readily Available Information,” CareQuest Institute, July 2024, https://www.carequest.org/resource-library/unlocking-value-alternative-payment-models

Authors



Mike Adelberg

Executive Director at NADP



Jerry Berggren

Director of Research at NADP

Rebekah Mathews, MPA

Vice President, Health Transformation at CareQuest Institute for Oral Health

Andrea Clark, MS

Director of Healthcare Economics at CareQuest Institute for Oral Health

Eric P. Tranby, PhD

Director of Analytics & Data Insights at CareQuest Institute for Oral Health

Brian Goetsch

Senior Partner at HealthScape Advisors

Caitlin Walsdorf

Partner at HealthScape Advisors

Will Kleinrichert

Associate Partner at HealthScape Advisors

About NADP

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP members provide dental HMO, dental PPO, dental indemnity, and dental savings plan products to more than 200 million Americans with dental benefits. NADP members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national, regional, and single state companies, as well as companies organized as non-profit plans.

About CareQuest Institute

CareQuest Institute for Oral Health® is a national nonprofit championing a more equitable future where every person can reach their full potential through excellent health. CareQuest Institute does this through their work in philanthropy, analytics and data insights, health transformation, policy and advocacy, and education as well as their leadership in dental benefits and innovation advancements. CareQuest Institute collaborates with thought leaders, health care providers, patients, and local, state, and federal stakeholders, to accelerate oral health care transformation and create a system designed for everyone.

About HealthScape Advisors

HealthScape Advisors, a Chartis Company, is a management consulting firm dedicated to helping organizations solve the most challenging business problems in healthcare. HealthScape supports health plans, providers, specialty health companies, investors, and innovators as they embark on their most important initiatives, helping them to grow profitably, improve performance, and transform their businesses. Purpose-built for healthcare, HealthScape brings its clients a deep and broad understanding of the ever-changing complexities that make up the healthcare marketplace. It is because of this expertise and experience that clients rely on HealthScape as a trusted strategic advisor and thought partner.

© 2024 The Chartis Group, LLC. All rights reserved. This content draws on the research and experience of Chartis consultants and other sources. It is for general information purposes only and should not be used as a substitute for consultation with professional advisors.