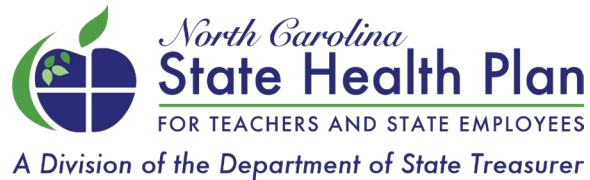




State Health Plan Board of Trustees Meeting

October 27, 2026





Executive Administrator Update

Open Enrollment Update *(as of 10/23/2026)*

Enrollment is underway with an extra week to allow members more time to process new information.

it's time...

Open Enrollment

for the 2027 benefit year

www.shpnc.gov

October

12

NOW

EXTENDED

UNTIL

November

6



North Carolina

State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

ACTIVITY

Logins	Online	Call Center	Total Daily Activity	Total Distinct Participants
184,262	78,108	19,097	97,205	83,109

PLAN MOVEMENT

Standard PPO Plan	Plus PPO Plan	70/30 Medicare	Humana Base Medicare Advantage	Humana Enhanced Medicare Advantage
275,257*	59,846*	13,100*	184,383**	19,252**

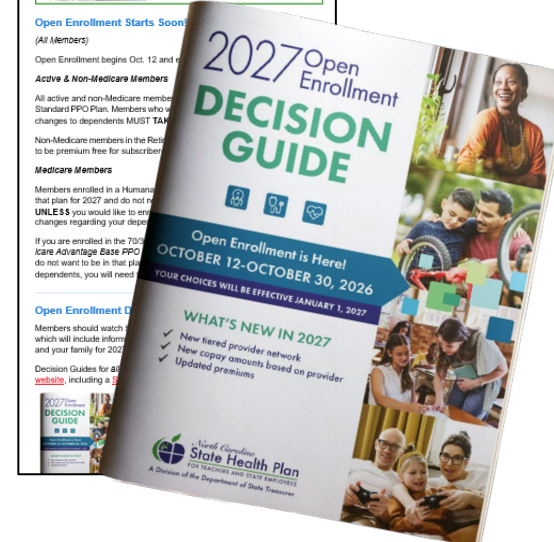
*Standard, Plus and 70/30 counts are subscriber only counts

** Medicare Advantage stats include all members (Subscribers and any enrolled dependents)

Open Enrollment Communications Strategy

The Plan utilizes a **MULTIFACETED COMMUNICATION APPROACH** to educate members regarding Open Enrollment (OE).

- 6 HBR Open Enrollment Trainings
- 16 Employing Unit Webinars
- 10 Active/Non-Medicare Webinars
- 10 Medicare Webinars
- 10 Medicare in-person meetings
- 3 Telephone Town Halls
- Direct Mail
- Email
- Social Media



2027 Open Enrollment Outreach

(as of 10/20/2026)

4,074 WEBINAR ATTENDEES

1,199 IN-PERSON ATTENDEES

32,889

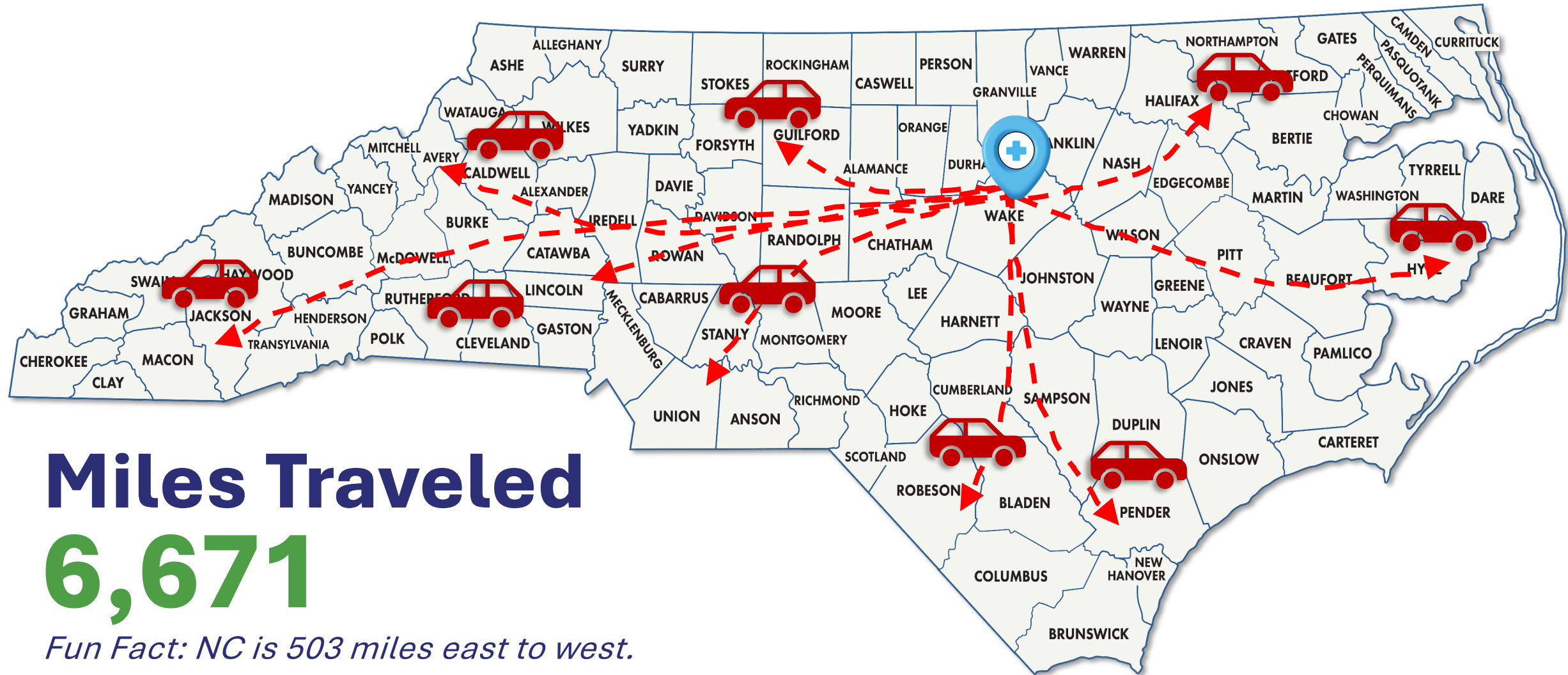
TELEPHONE TOWN HALL ATTENDEES

1,092,190

eNEWSLETTERS OPENED

1,053 / 5,338
GROWTH / INTERACTIONS
ON SOCIAL MEDIA

Open Enrollment Member Outreach



2027 Open Enrollment

In-person Outreach

Alexander Co. Schools
Becker's Healthcare Conference
Bethany CC
Cape Fear CC
Central Carolina Regional Education
Service Alliance
Cleveland Co. Legislative/State Employees
Davidson-Davie CC Benefit Fair
Davidson-Davie CC Overview
DPI Business Officers Conference
DST Benefits Fair
Emerging Issues in Medicine
Gaston Co.
GTCC Health & Wellness Fair
Lee Co. NCASBO Region 4/5
Lincoln Co. Legislative/State Employees
Millennium Charter Academy

NC Academy of Family Physicians
NC Assoc. Public Charter Schools
NC Assoc. of School Administrators
NC Assoc. of School Business Officials
NC DAC Benefit Fair
NC DHHS Black Mountain
NC DOT Benefit Fair Cabarrus Arena
NC DOT Benefit Fair Castle Hayne
NC Education Lottery Benefit Fair
NC Flex Benefit Fair
NC Medical Society
NC Society of Health Care Attorneys
NCASBO Hickory Chapter
Office of State Treasurer
Orange Co. Schools
Pender Co. Government
Pender Co. Schools
Physician Governance Meeting

Rutherford Co. Legislative/State
Employees
SEANC Annual Convention
SEANC Board Meeting
SEANC District Meeting
Superintendent Conference
Town of Goldsboro
UNC – Hillsboro Benefits Fair
Union County Public Schools
Washington Co. Schools



2027 Open Enrollment

Online Outreach

Ashe Co.

Charlotte-Mecklenburg Schools

Cumberland Co. Schools

Davidson-Davie CC

Durham Public Schools

Fayetteville Technical CC

Finance Officers

Guilford Co. Schools

Independent Pharmacists

Jackson Co. Schools

Legislative – District 31 (Durham)

Lincoln Co. Schools

Mooresville Graded School

Mountain Area Health Education Center

NC Assoc. of School Administrators

Legislative Lunch/Learn

NC DAC

NC DHHS

NC DOT

NC State

NC Wildlife

New Dimensions Charter School

Pender Co. Government

Pender Co. Schools

Town of Clayton Benefits Fair

UNC – Chapel Hill

UNC – Charlotte

UNC – Greensboro

UNC – Hillsborough

UNC System Benefits Network

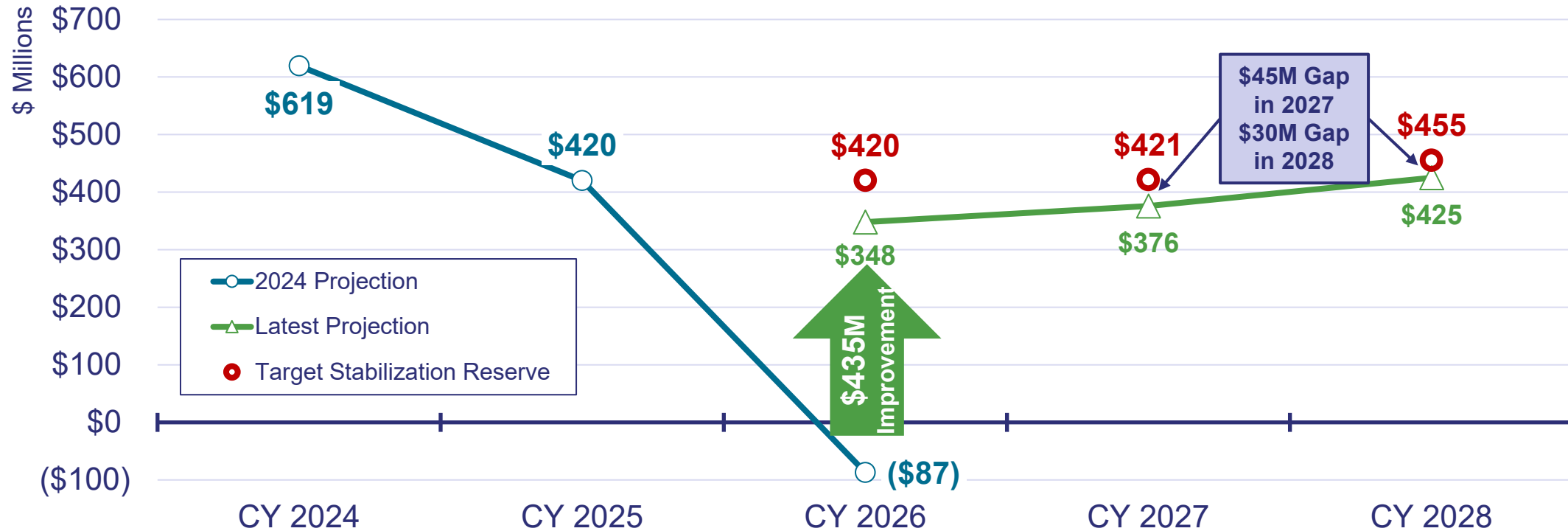
Wake Co. Schools

Wake Tech CC



We Began with a Significant Deficit that Will Continue to Grow

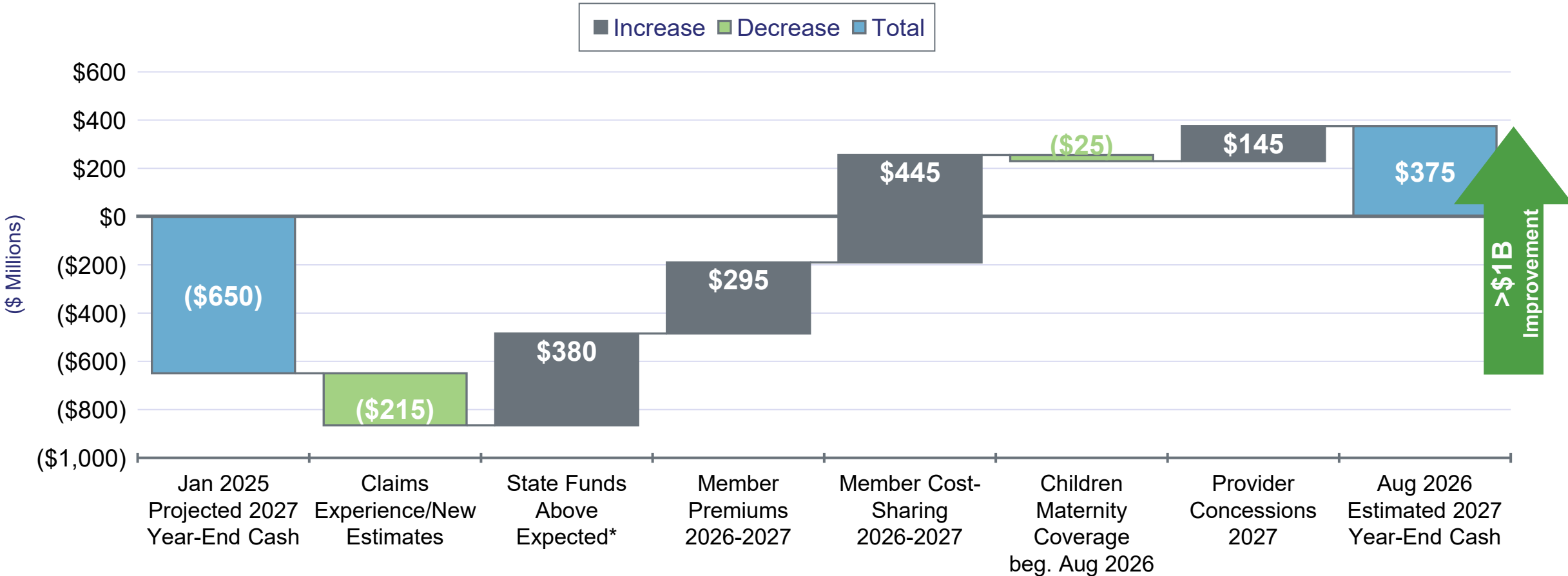
Projected Year-End Cash Balances



- In 2024, the Plan was facing a shortfall relative to its target stabilization reserve of more than \$500 million.
- The Treasurer and the SHP Board took action to maintain solvency, improving the outlook for 2026 through 2028.
- The most recent projections show the Plan on a more sustainable path for the next few years, but additional actions are needed to meet the Target Stabilization Reserve.

Resolving the State Health Plan Deficit

Projected 2027 Year-End Cash Balance

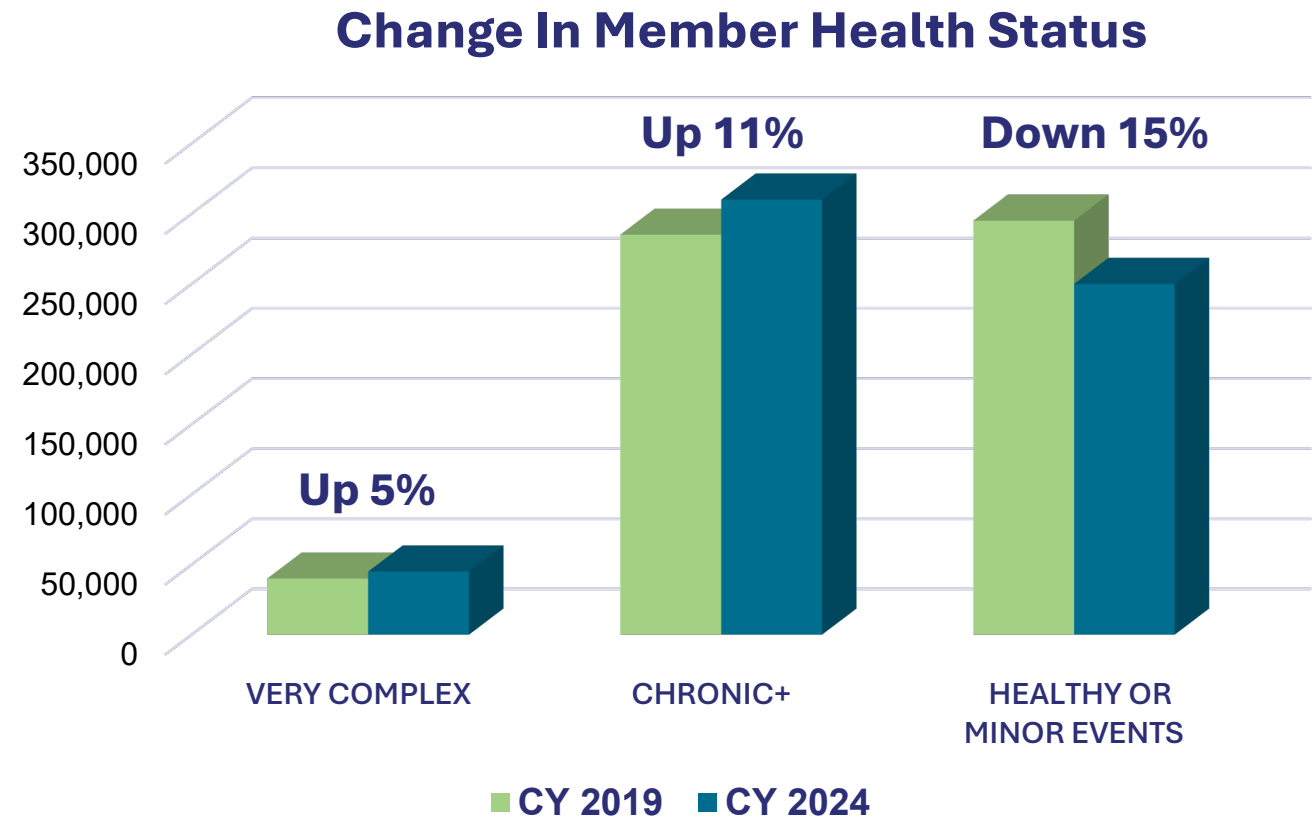


*The Jan 2025 projection assumed 4% annual increases in State funding; however, the State budgets for FY 2025-26 and FY 2026-27 provide 5% annual increases in employer contributions. The State also altered the funding structure for retirees by implementing a percent of salary funding model.

Meanwhile We Are Paying More and Getting Less Healthy

The status quo is getting us sicker.

- Over a five-year period, the overall health status of Plan members has declined 13%, with more members experiencing chronic conditions.
- This is despite continually paying more for care and members out of pocket costs projected to increase 20% from 2022-2026.



Because Costs Keep Rising

Medical cost trend is expected to hit 9%, highest in 17 years.

- PwC recently released their annual Behind the Numbers report, which estimates a 9% medical cost trend for the group market in 2027, the highest trend in over 15 years.
- Pointing to coding intensity (AI), inflation and provider consolidation, pharmacy costs, Behavioral Health use, and the No Surprises Act, many of which were inflators in 2026 and what the Plan is experiencing.

Behind the numbers 2027

Medical cost trend is expected to hit 9%, highest in 17 years.

We Needed a Different Path Forward

We Need to Address Cost by Focusing on Price and Investing in Health

- The situation we are in is no single health system or provider or member's fault; but it is the State Health Plan's **RESPONSIBILITY** to put us on a different path.
- Historically, the State Health Plan has focused on requiring more revenue from members and taxpayers
 - In turn, we've gotten a less rich benefit and a sicker population
- **WE CANNOT CONTINUE** to accept high prices; we need to be active purchasers of health so that we can sustain the Plan and invest in member health through:
 - Value-based care
 - Population health supports like remote monitoring
 - Incentives for healthy behavior

2027 Clinically Integrated Networks (CIN) & Lantern Partners



183

Aledade Accountable
Care 135, Inc.



276

Community Care
Physicians Network



57

UNC Health
Alliance



1,200+

Community
Health System



Dedicated Preferred Provider Websites



Novant Health

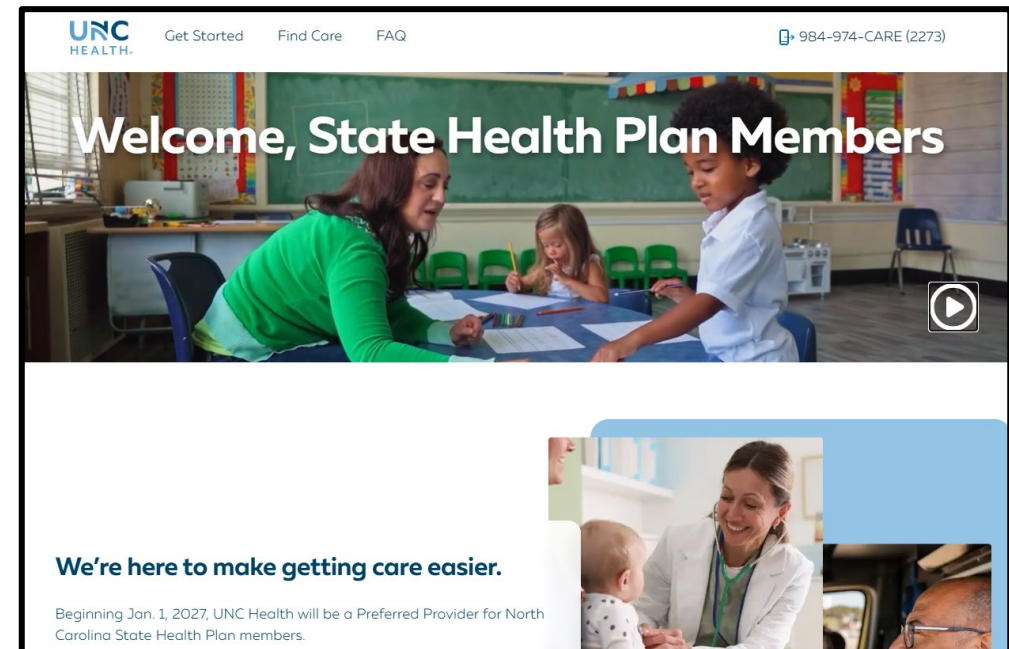
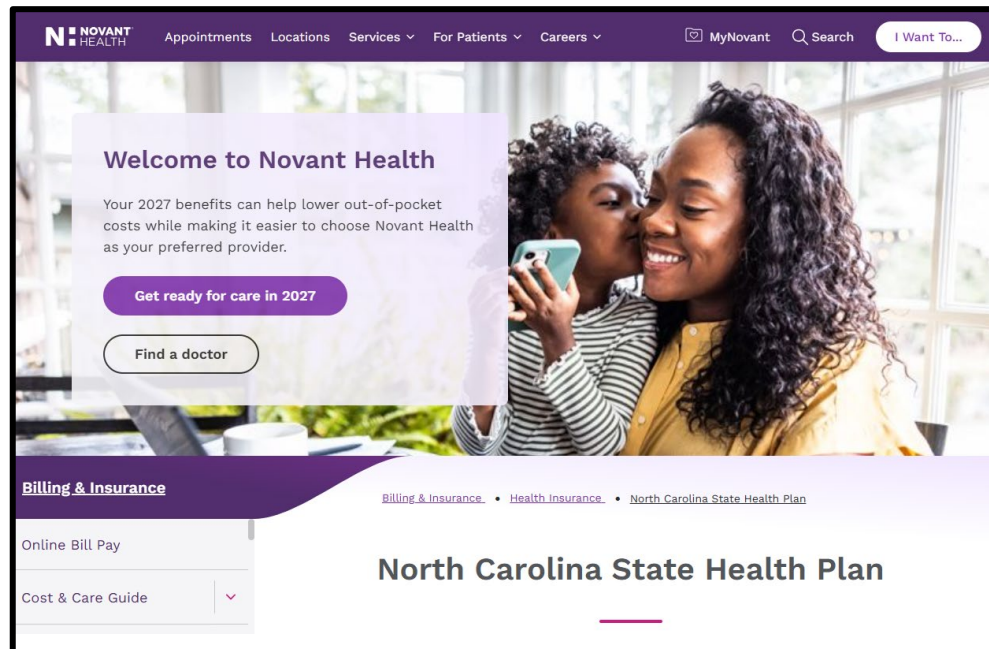
Dedicated website to learn more about
Novant Health as a Preferred Provider.



UNC Health

Dedicated website to learn more about
UNC Health as a Preferred Provider.

Access from www.SHPNC.gov



2027 Preferred Provider Priorities

The TOP PRIORITY is to continue aligning incentives around **ACCESS**, **QUALITY**, and **COST** for members, providers, and the Plan.

- Focus on existing access (independent providers) tier and differentiating where possible/appropriate
- Key ongoing discussions to bring to the Board in 2027:
 - Dermatology CIN
 - Rheumatology CIN
 - Capitated/Direct Primary Care Model

2028 Implementation Update

- Contracts awarded July 10, 2026
- Contract implementations kick-off July 23, 2026
- Requirements discovery concluded
- Vendor development underway
- Point to point testing targeted to begin in Mid-March
- End to end testing targeted to begin June 1
- 2028 Open Enrollment in October 2027

Implementation Workstreams		
	PBM	TPA
Account Management	X	X
Data Management	X	X
Network Management	NA	X
Financial Reporting & Banking	X	X
Group Set-Up, Enrollment & EDI	X	X
Member Experience	X	X
Operations & Claims Processing	X	X
Product, Plan Design, Formulary, Clinical & Medical Mgmt.	X	X
Pharmacy Services	X	NA
Part D Administration	X	NA
Appeals, Audit, Recoveries & Investigations	X	X



Financial Update

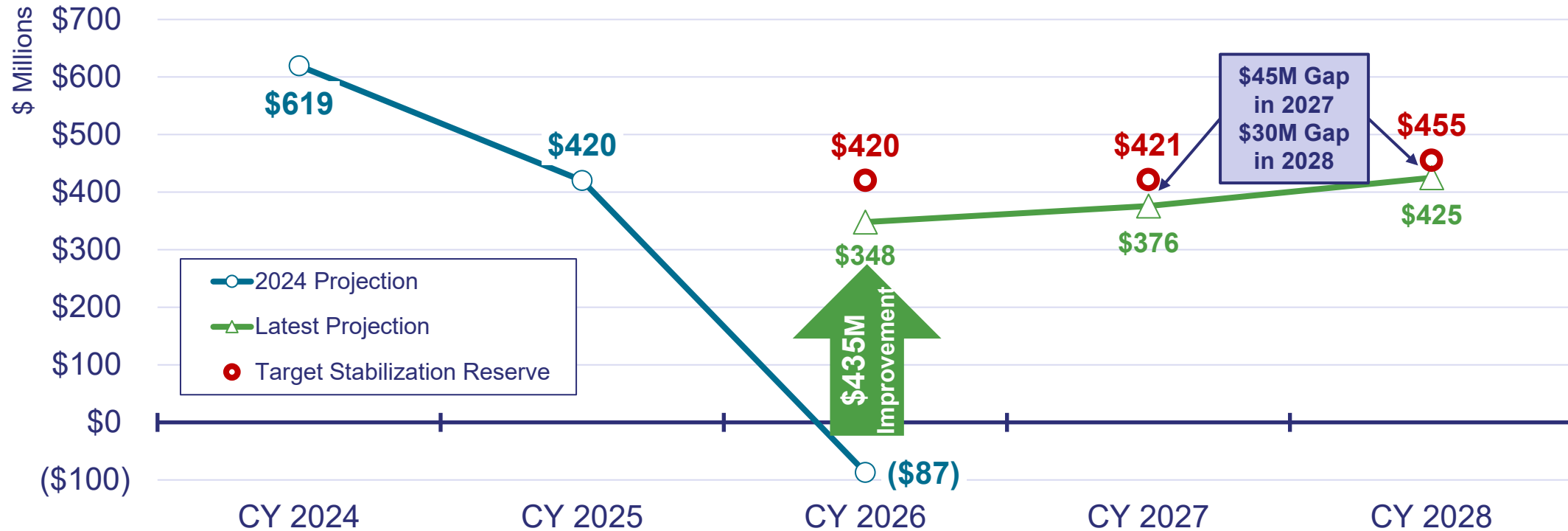
 *North Carolina*
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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Financial Report Outline

- Where We Started
- Financial Results through August 2026
 - Compared to 2025
 - Compared to Segal Projections
- Cash Balance
- Financial Strategy

We Began with a Significant Deficit that Will Continue to Grow

Projected Year-End Cash Balances



- In 2024, the Plan was facing a shortfall relative to its target stabilization reserve of more than \$500 million.
- The Treasurer and the SHP Board took action to maintain solvency, improving the outlook for 2026 through 2028.
- The most recent projections show the Plan on a more sustainable path for the next few years, but additional actions are needed to meet the Target Stabilization Reserve.

Finances through August 2026

CY 2026 Comparison to Prior Year

(\$ Millions)	Actual Jan-Aug 2026	Actual Jan-Aug 2025	Difference Better/(Worse)	% Change 2025 - 2026
Beginning Cash Balance	\$499	\$688	(\$189)	-27.5%
Plan Revenues	\$3,119	\$2,998	\$121	4.0%
Medical Expenses	2,497	2,388	(109)	
Pharmacy Expenses*	487	498	11	
Medicare Advantage Premiums	103	57	(46)	
Administrative Expenses	133	137	4	
Total Plan Expenses	\$3,220	\$3,080	(\$140)	4.5%
Net Gain/(Loss)	(101)	(82)	(19)	
Ending Cash Balance	\$398	\$606	(\$208)	-34.3%

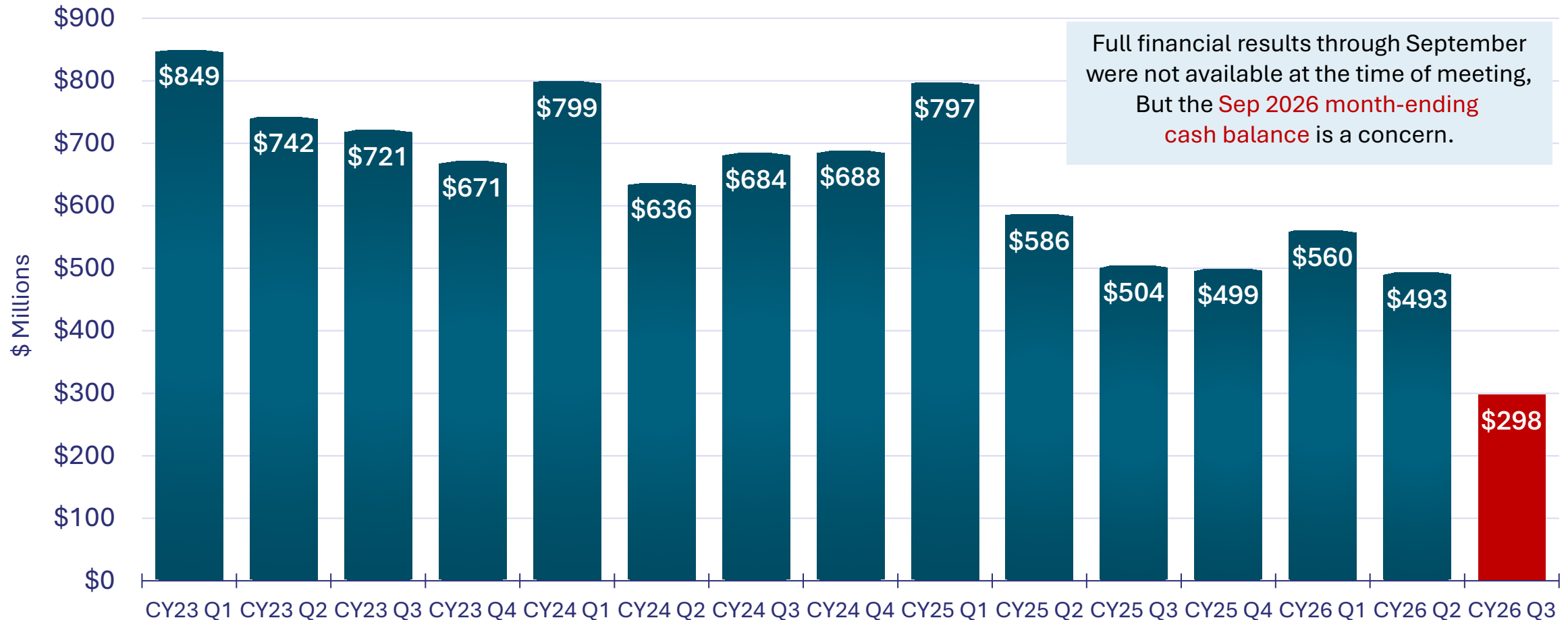
Finances through August 2026

Comparison to Segal's CY 2025 4th quarter projection

(\$ Millions)	Actual Jan-Aug 2026	Segal CY25 Q4 Projections Jan-Aug 2026	Difference from Projected Gain/(Loss)	% Difference
Beginning Cash Balance	\$499	\$499	-	0.0%
Plan Revenues	\$3,119	\$3,116	\$3	0.1%
Medical Expenses	2,497	2,366	(131)	
Pharmacy Expenses*	487	482	(5)	
Medicare Advantage Premiums	103	103	-	
Administrative Expenses	133	121	(12)	
Total Plan Expenses	\$3,220	\$3,072	(\$148)	4.8%
Net Gain/(Loss)	(101)	44	(145)	
Ending Cash Balance	\$398	\$543	(\$145)	-26.7%

Quarter Ending Cash Balance

CY 2023 through Present



Key Findings from Aetna Midyear Review

- **INPATIENT:** Inpatient trend increased, driven largely by higher admissions, with circulatory, nervous system, and digestive conditions among the key areas contributing to the increase.
- **HIGH-COST CLAIMS:** Claims exceeding \$100K in allowed spend continue to be concentrated in identifiable clinical conditions. Oncology, cardiac, and neurologic conditions represent the largest areas of concentration, with the overall trend primarily driven by an increase in the number of members requiring higher-cost care.
- **MEDICAL PHARMACY (MEDRX):** Continues to reflect higher oncology spend and utilization. Increased utilization and cost associated with outpatient oncology and specialty therapies remain the primary drivers.
- **EMERGENCY ROOM:** Overall utilization remained relatively stable, while cost per visit increased due to higher-acuity services. 66% of visits were classified as acuity levels 4–5.
- **AREAS OFFSETTING TREND:** Specialist costs declined due to lower cost/severity, while ambulatory facilities experienced lower utilization.

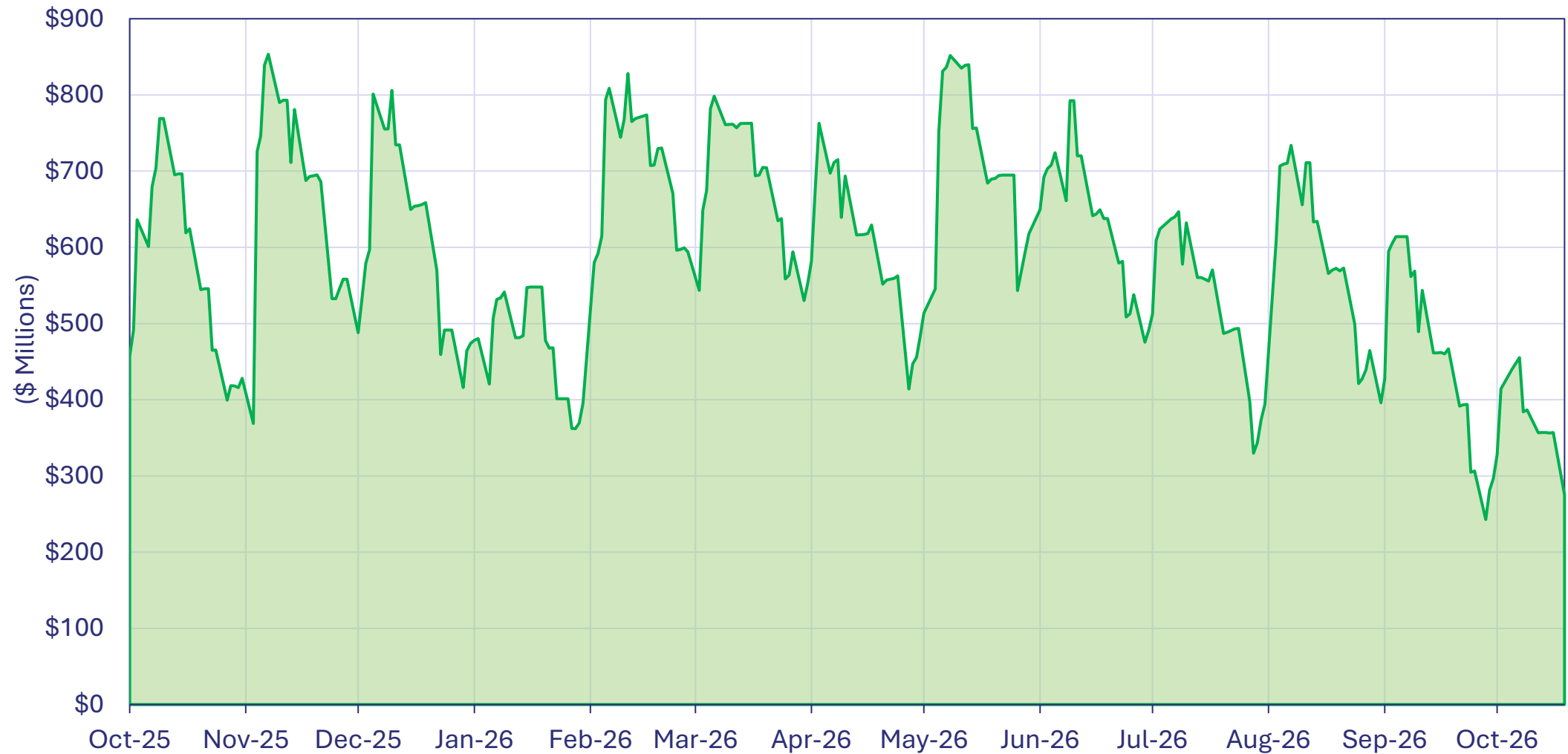
Plan Financial Flow

- The Plan is 100% receipt-supported, with more than 99% of its revenue derived from monthly employer contributions and retirement contributions, as well as member-paid premiums.
 - There are more than 400 employing units that send contributions to the Plan each month.
- The Plan pays medical claims weekly.
 - Aetna notifies the Plan Monday morning of the total cost for claims that were processed during the previous week.
 - By mid-day each Monday, the Plan initiates the transfer of funds to a bank account to enable the disbursement of claims payments to providers on Tuesday.
- CVS pays the Plan's share of pharmacy claims for Plan members and invoices the Plan twice per month for reimbursement.
- Medicare Advantage premiums are paid by the Plan once per month.
- With the exception of monthly payroll, the Plan is invoiced for administrative expenses and invoices are paid throughout the month.

Cash Balance

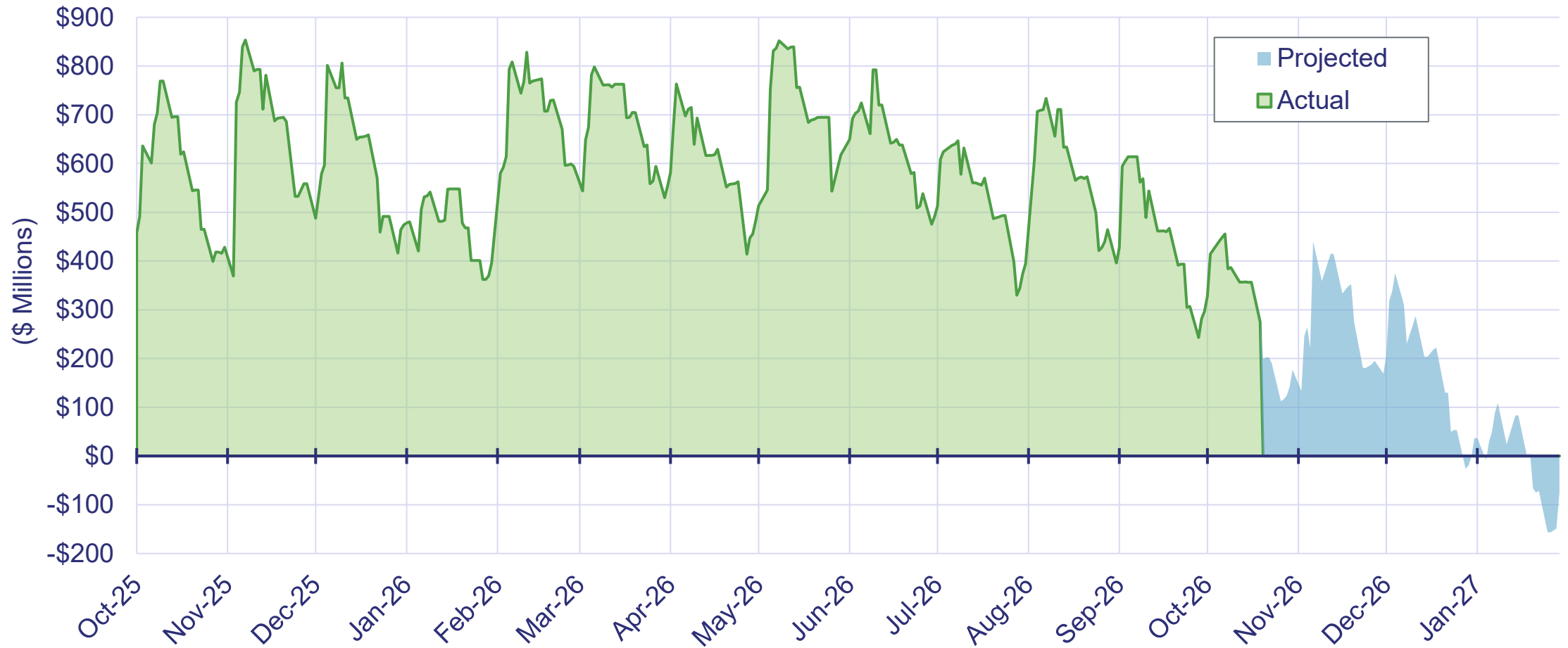
- The Plan is experiencing ongoing losses relative to projections, and these losses accelerated during the July to September quarter of 2026, depleting reserves beyond expectations.
- The Plan's Target Stabilization Reserve (TSR) is 9% of claims costs, approximately \$420 million for CY 2026
 - 9% represents just over one month of claims costs.
 - \$420 million is roughly equivalent to the incurred but unpaid claims estimate for FY 2025-26.
- If current trends continue into the final quarter of 2026, there is a possibility **THE PLAN WILL RUN OUT OF CASH** by the end of 2026 or the beginning of 2027.
- Approved benefits and premiums are expected to result in a slight gain in cash in CY 2027, providing some relief from the current cash crunch; however, it would take several months for any gains to result in a more sustainable cash position.

Daily Cash Balance



Daily Cash Balance with Projection

Actual and Projected Daily Cash Balance



Retiree Health Benefit Fund

- To avoid running out of cash, Plan staff recommends increasing the monthly contribution from the Retiree Health Benefit Fund (RHBF) to the Plan from \$300 to \$600 per retiree per month from July 2026 through December 2026.
- This would generate approximately \$415 million in additional funds before the end of the year.
- The increase in the RHBF monthly contribution would not affect premiums paid by members.
- In January 2027, RHBF contributions will revert to \$378 per retiree per month, as approved by the Board in July 2026.

VOTE: Increase the RHBF contribution to the Plan from \$300 per retiree per month, to \$600 per retiree per month, for the six-month period from July 2026 through December 2026.



REQUIRES VOTE

Financial Strategy

- **REBUILD** cash reserves using the transfer from RHBF and the increase in RHBF contributions
- **INCREASE PARTICIPATION** in Medicare Advantage plans while maintaining member choice
- **ENCOURAGE MEMBERS** to use preferred providers to maximize impact of direct contracts
- **BUILD ON** and **IMPROVE** shared savings and value-based programs with Lantern and other partners
- **CONTINUE PREPARATIONS** for new contracts set to launch January 2028
 - Improved guarantees in the new TPA contract
 - Formulary changes to maximize pharmacy rebates through the new PBM contract
- **CONTRACT** with a new PBM auditor
- **ENSURE** premium revenue from the State, RHBF, and members properly supports Plan costs
- Use data to **GUIDE INTERVENTIONS** for regions and services where they will have the greatest impact
- **INVEST IN** targeted population health efforts that demonstrate return on investment



KEY FINDINGS FROM THE 2026 POPULATION RISK REPORT

Actives and Non-Medicare Retirees

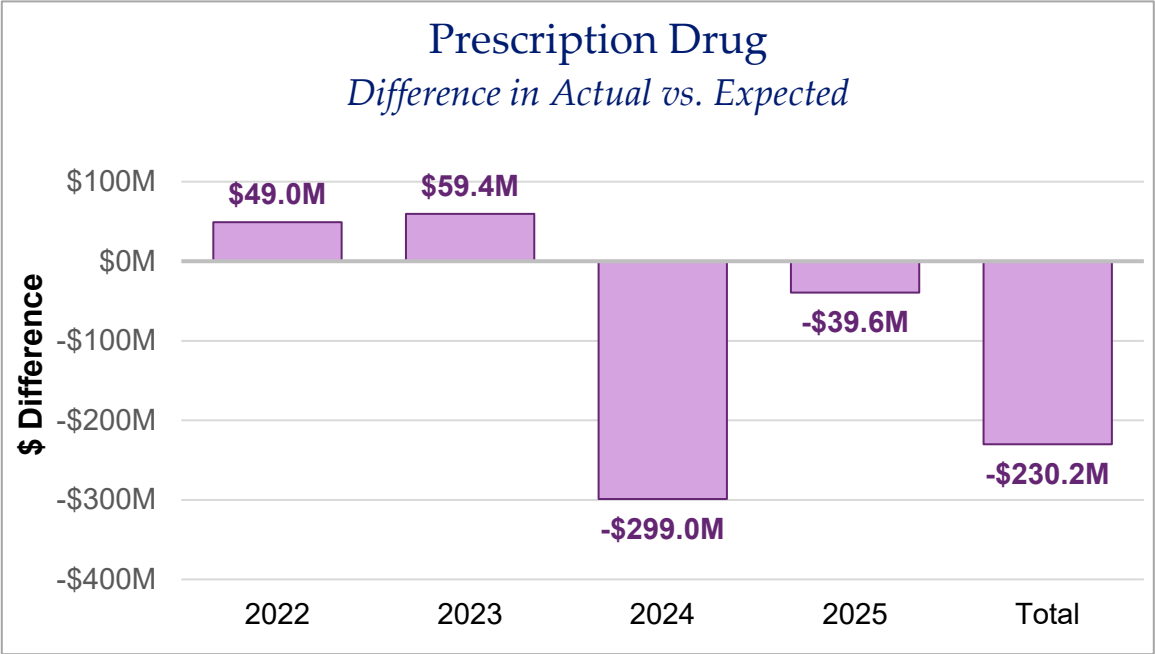
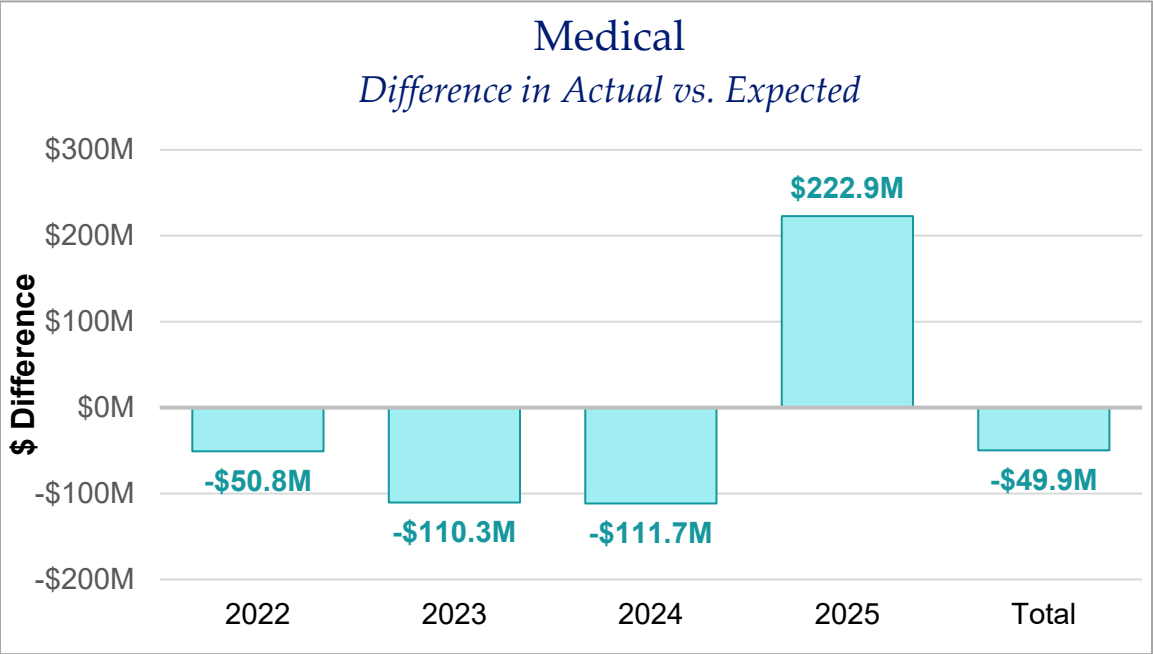
October 27, 2026

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Medical and Prescription Drug Summary

Actual vs. Expected Plan Paid

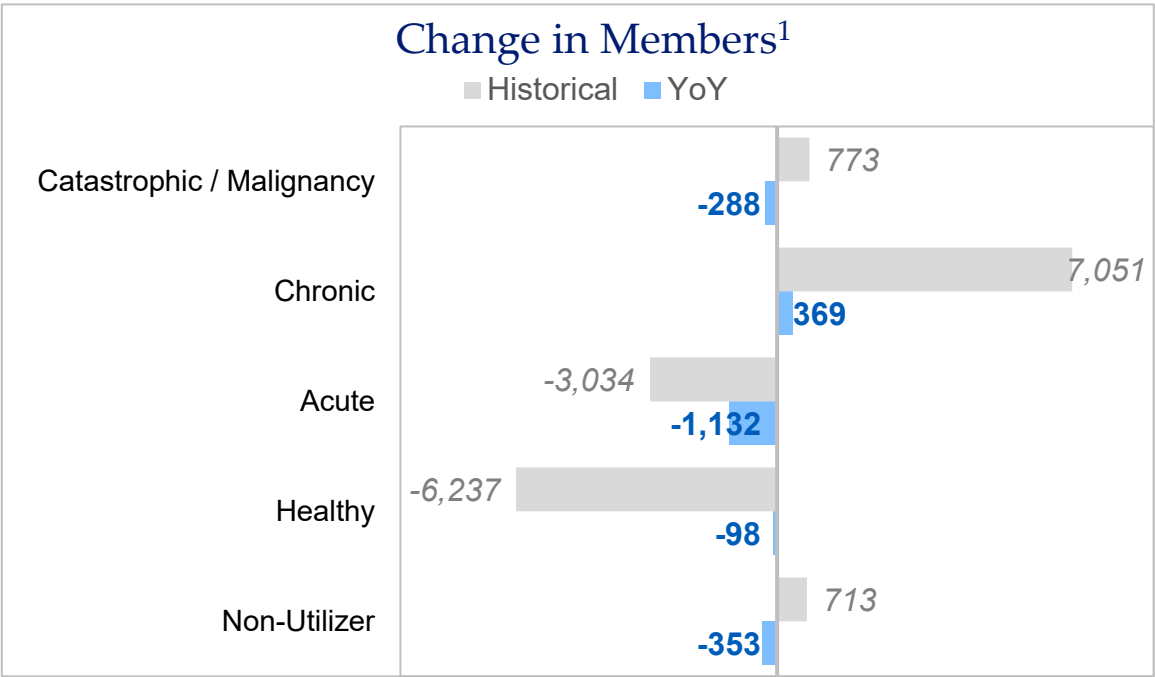
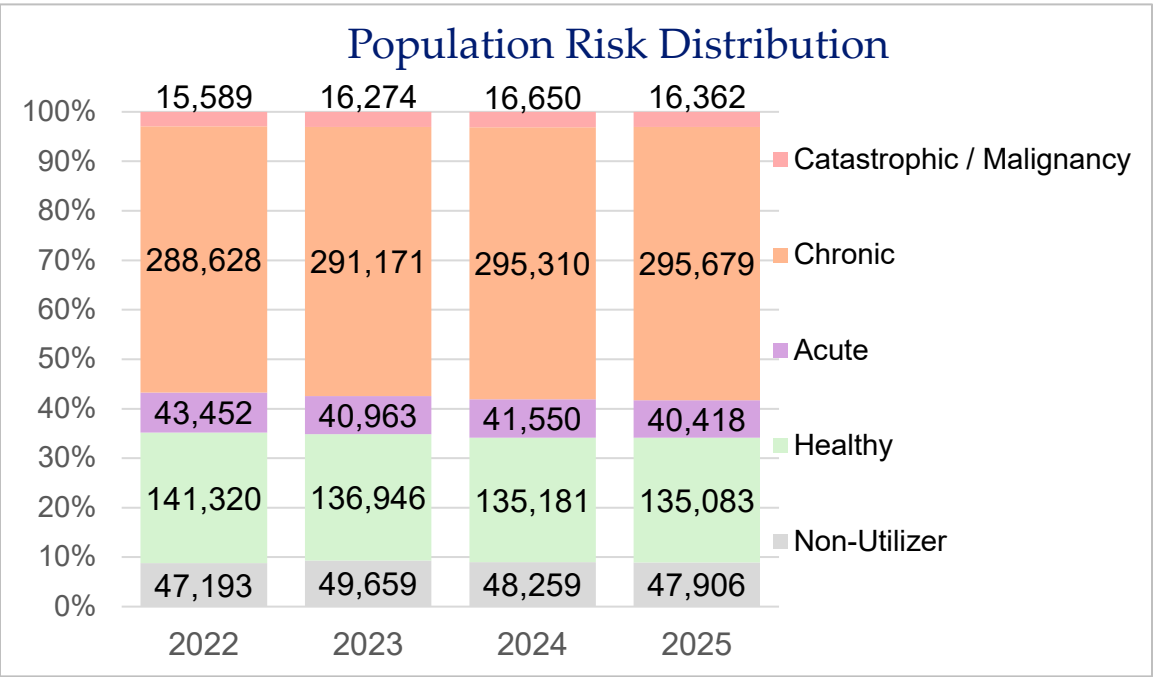


Observations

- The charts above quantify the difference between actual versus expected trends paid by the Plan.
 - Expected trends were determined based on Segal’s SHAPE benchmark plan paid trends for public sector groups.
- On the medical side, the Plan has paid approximately \$49.9 million less than expected during the last four years. However, in 2025 the Plan paid approximately \$222.9 million more than expected.
- On the prescription drug side, the Plan has paid approximately \$230.2 million less than expected during the last four years, mainly due to favorable experience in 2024 following the State’s decision to remove coverage for weight-loss drugs. Note that this figure is on a gross basis as we are unable to procure a benchmark that includes rebates for all public sector clients.

Population Risk Review

Historical Membership Risk Distribution

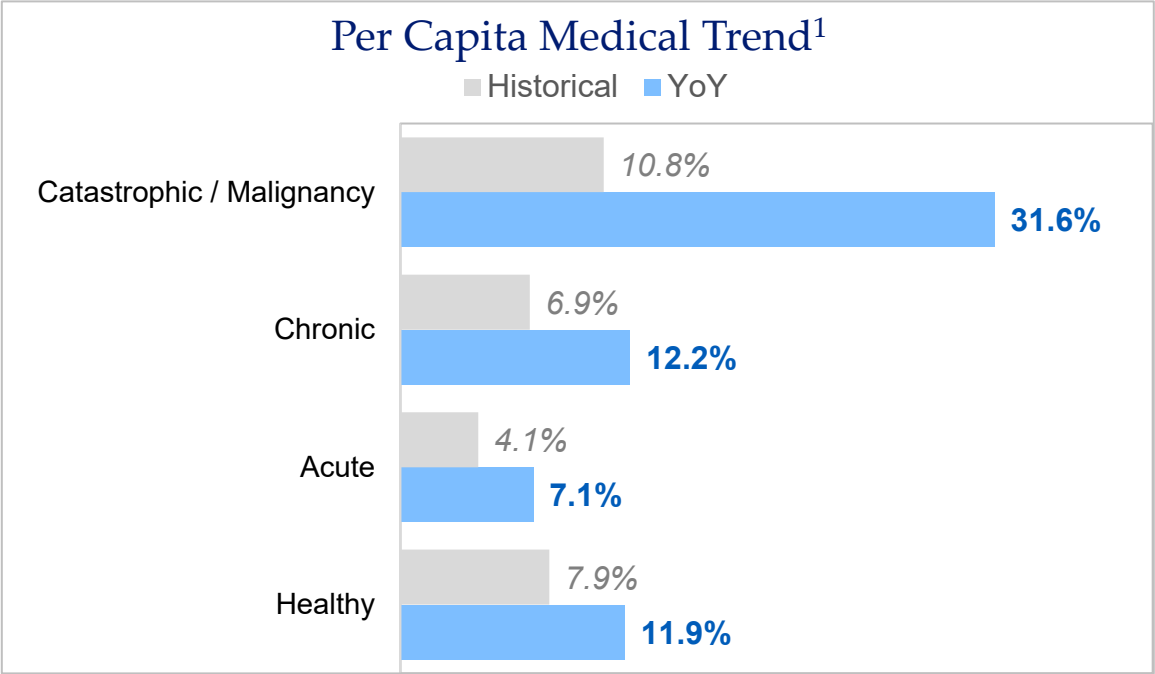
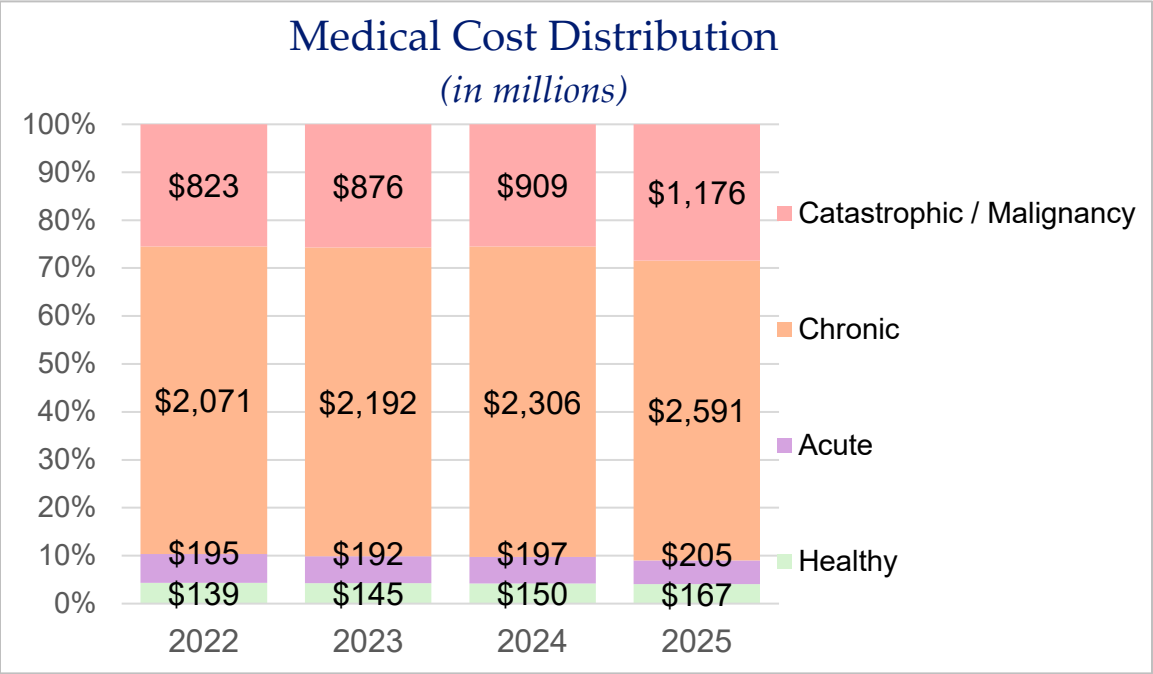


Observations

- The graphs above summarize trends in membership among the risk groups.
- Members with chronic conditions increased the most from 2022 to 2025 with an increase of 7,051 members (+2.4% increase). Note the majority of the increase happened in 2022-2024 as the chronic population was relatively stable in 2025.
 - Healthy members had the largest decrease in members from 2022 to 2025 of 6,237 (-4.4% decrease).
 - The number of non-utilizers increased by 713 members from 2022 to 2025 (+1.5%).
 - Then number of members grouped as catastrophic / malignancy increased by 773 members from 2022 to 2025 (+5.0%). However, the catastrophic / malignancy population experienced a decrease of 288 members in 2025.

Population Risk Review

Medical Cost Trend by Risk Group

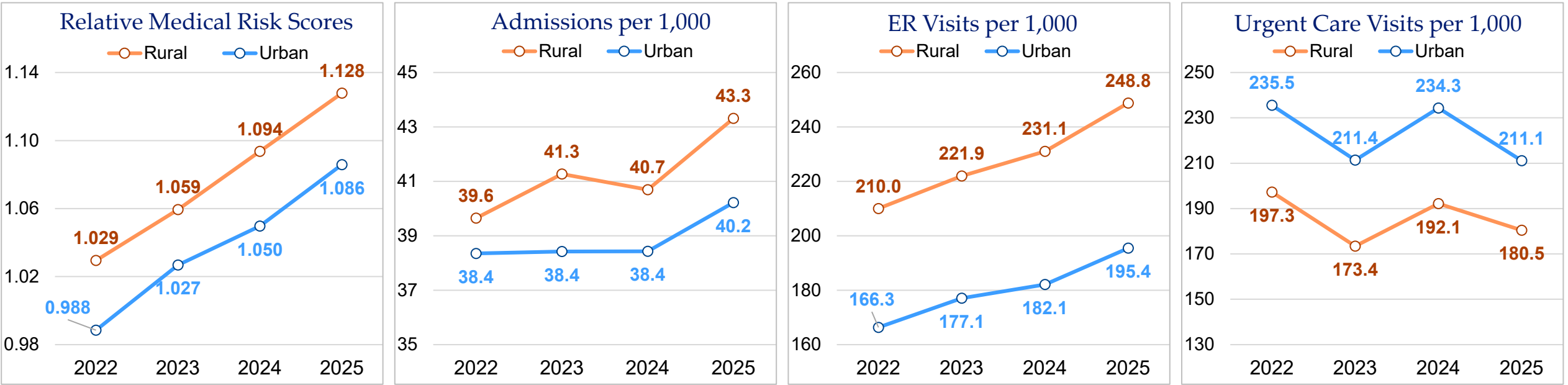


Observations

- The graphs above summarize trends in medical costs among the risk groups.
- \$2.6 billion was spent on members with chronic conditions in 2025, representing 63% of all medical costs. Medical costs per capita for this cohort have increased at an annual rate of 6.9% from 2022 through 2025.
 - The catastrophic / malignancy cohort has the highest per capita medical trend rate of 10.8% from 2022 through 2025, which was mainly driven by significantly higher costs in 2025, when medical costs increased 31.6%.
 - The main driver of medical trend is not necessarily increasing expenses within each risk group but instead due to members transitioning to riskier groups (e.g., from healthy to chronic).

Population Risk Review

Urban vs. Rural Comparison



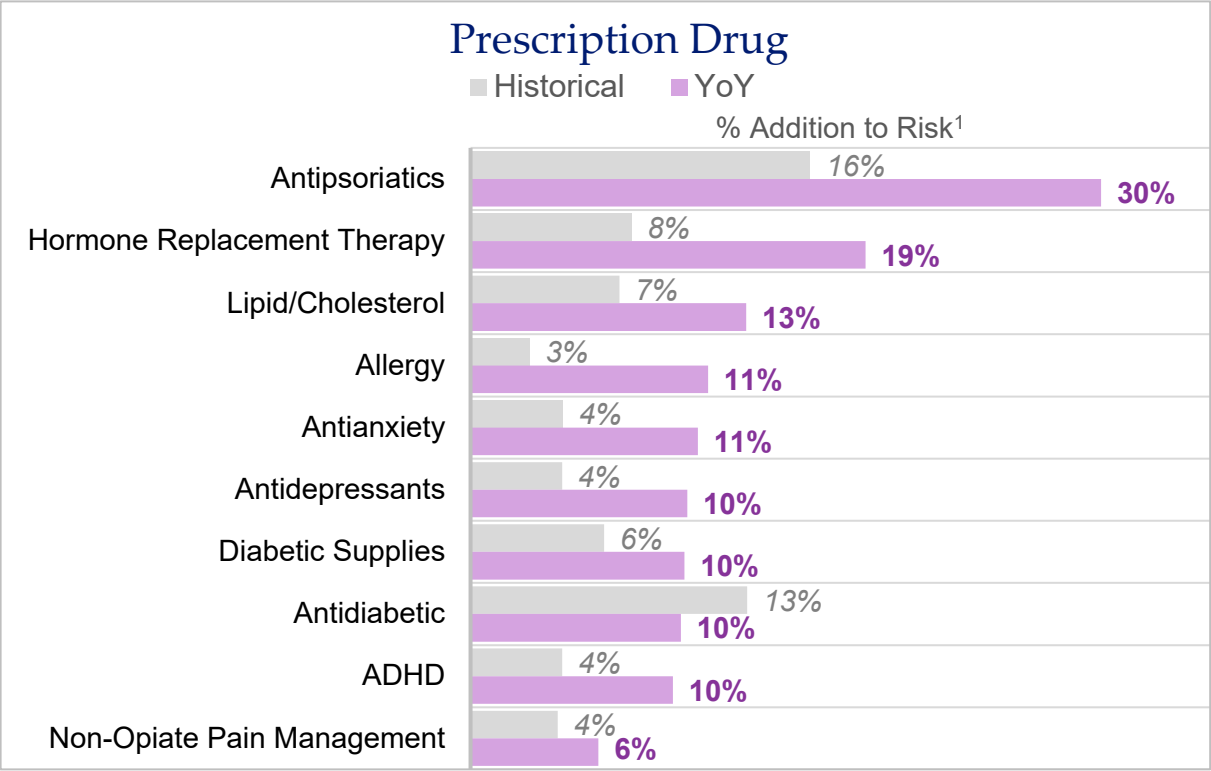
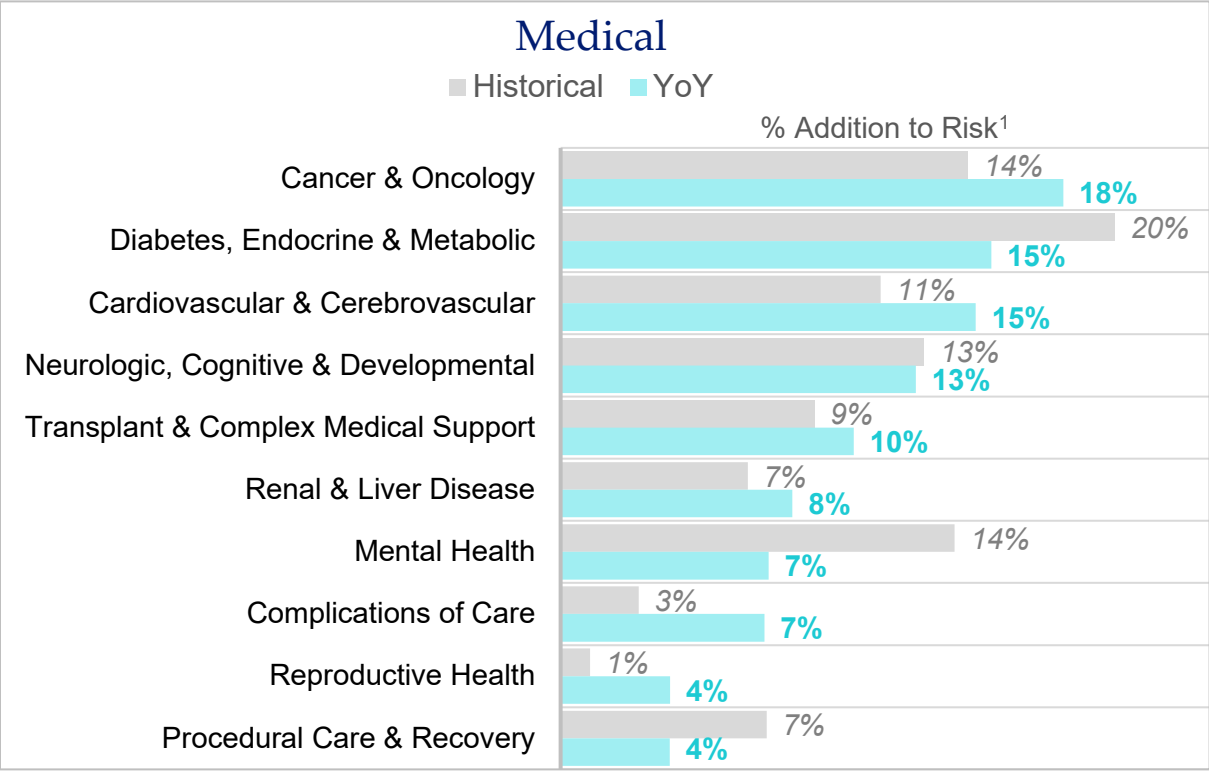
Observations

- The charts above summarize differences in risk and outcomes between members who reside in urban versus rural areas¹.
- Medical risk scores have increased slightly less over the experience period for members in rural areas (+9.6% versus +9.9%). However, risk scores for members in rural areas are about 4% higher.
 - Hospital admissions per 1,000 have historically been about 6% higher for members in rural areas. However, they were 8% higher in 2025, the largest differential during the experience period.
 - Emergency room (ER) visits per 1,000 have historically been about 26% higher for members in rural areas. However, ER visits were 27% higher for members in rural areas in 2025, the largest differential during the experience period.
 - The main reason for higher ER visits in rural areas appears to be lack of access to urgent care centers, where utilization is approximately 17% lower in rural areas.

¹ See Appendices for more information on the rural vs. urban classification.

Risk Drivers

Top Contributors to Risk



Observations

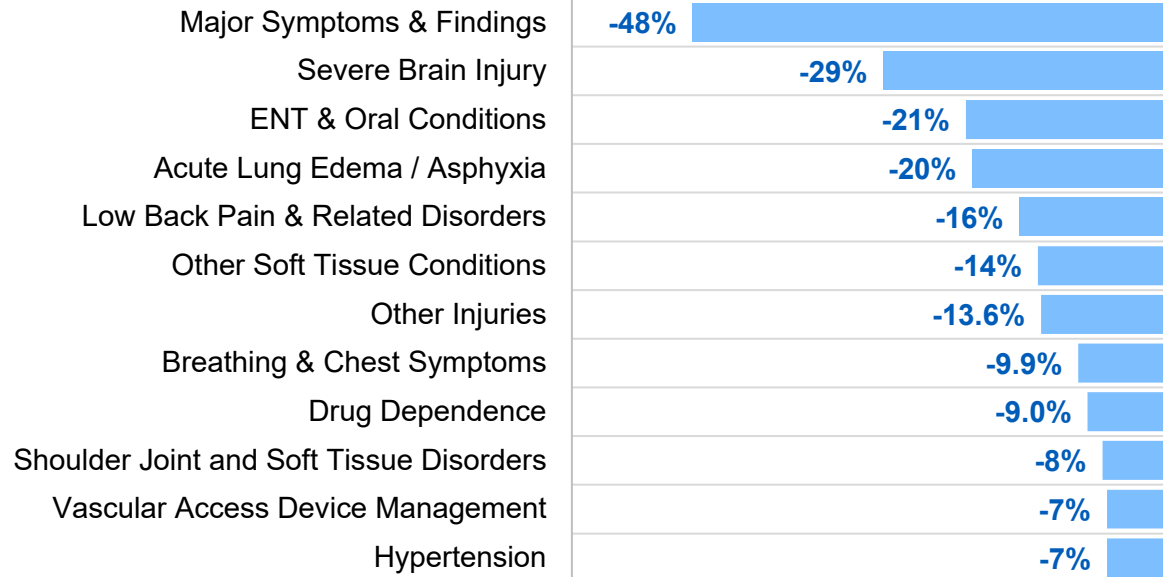
The graphs above summarize the conditions with the largest addition to risk from 2024 to 2025 along with the historical addition to risk.

- The main factors driving year-over-year (YoY) medical risk were cancer & oncology (18%), diabetes, endocrine, & metabolic (15%), and cardiovascular & cerebrovascular (15%).
- The main factors driving year-over-year (YoY) prescription drug risk were antipsoriatrics (30%), hormone replacement therapy (mainly women’s health and menopause management; 19%), and lipid/cholesterol (13%).

¹ Addition to risk represents the percent of the change in risk attributed to each risk category.

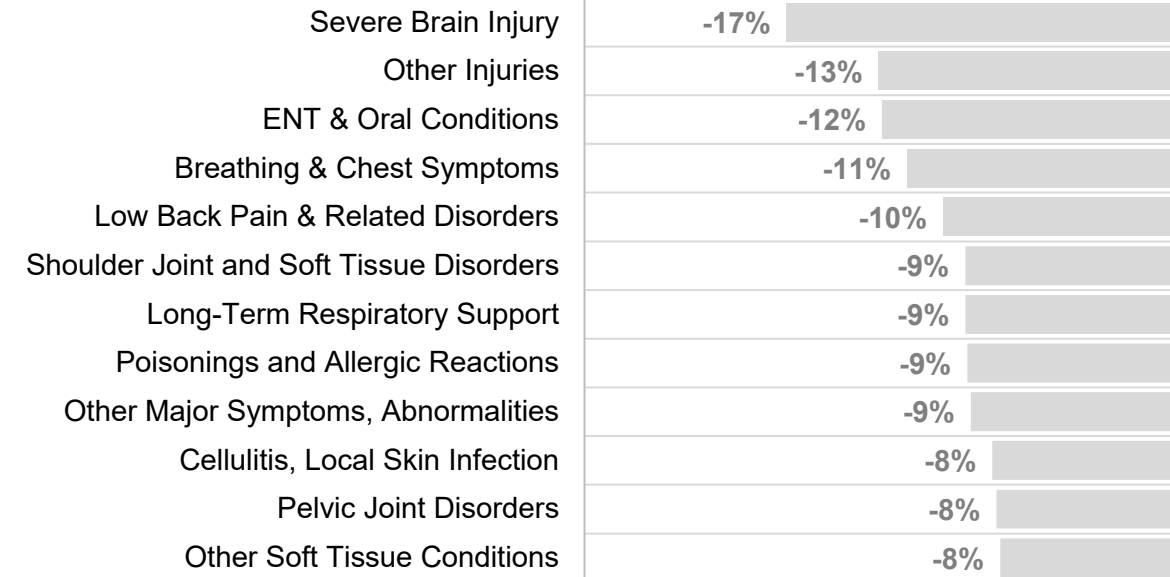
Year-Over-Year

% Change in Risk



Historical¹

% Change in Risk



Observations

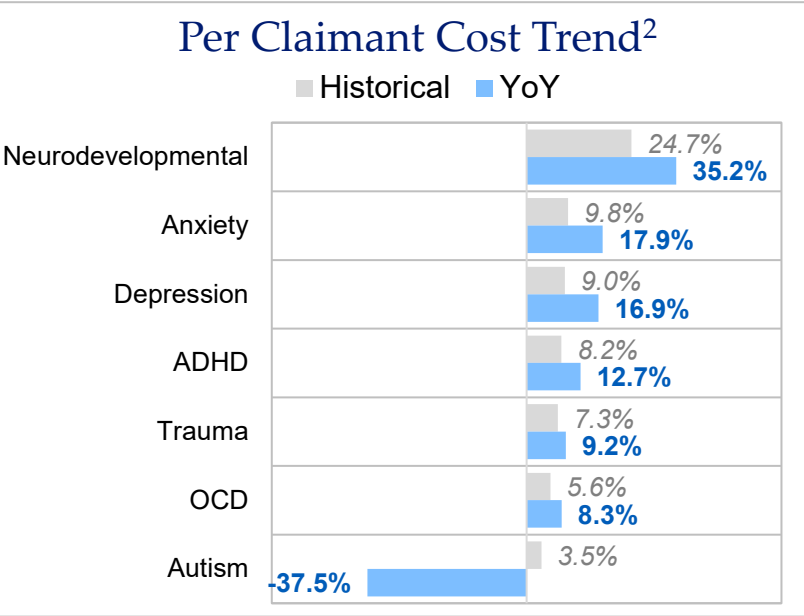
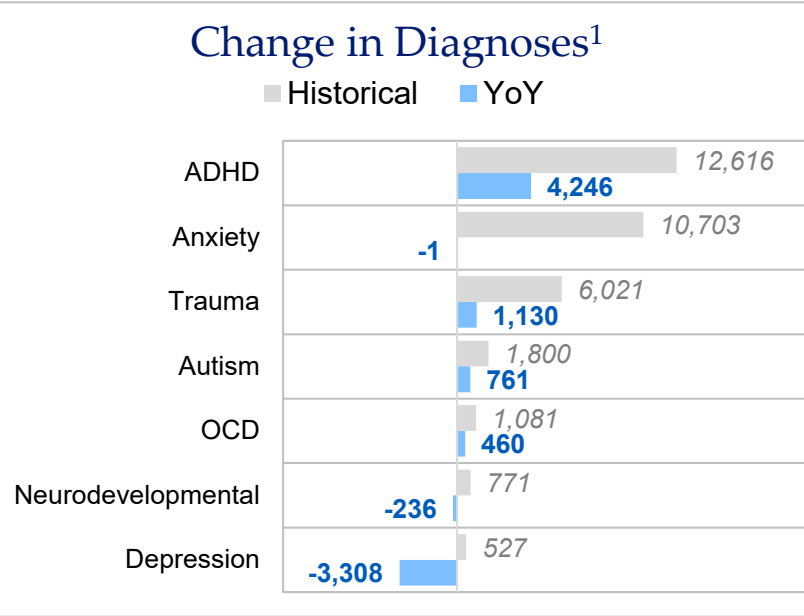
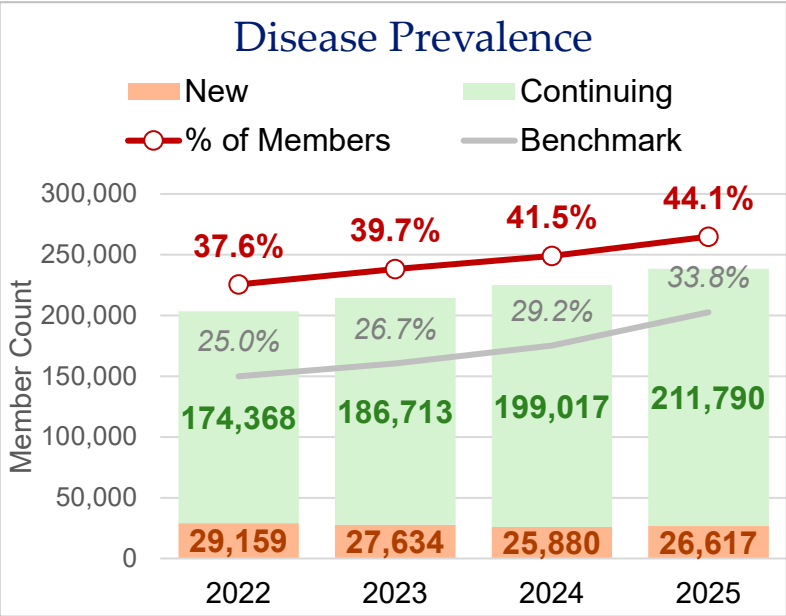
The graphs above summarize the conditions with the largest reductions in risk 2024 to 2025 (year-over-year) and 2022 to 2025 (historical).

- The Plan is seeing year-over-year health improvements for severe brain injuries, ear/nose/throat & oral conditions, and acute lung edema / asphyxia.
 - There has also been a 7% reduction in risk for hypertension, which is an encouraging sign as the State works to improve management of this population.
- From 2022 to 2025, the largest reductions in risk occurred for severe brain injuries, other injuries, and ear/nose/throat & oral conditions.

¹ Historical represents the % change in risk from 2022 to 2025.

Mental Health

Condition and Cost Trends



Observations

The graphs above summarize prevalence and cost trends for mental health conditions.

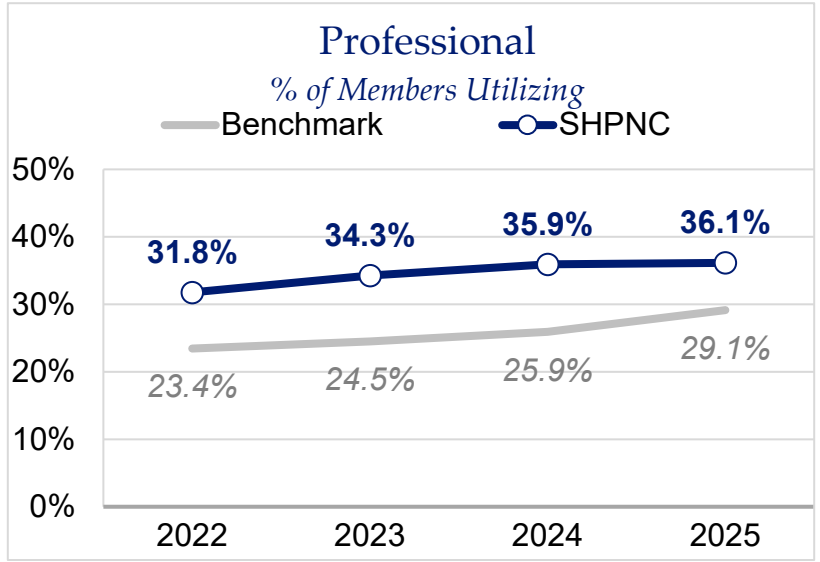
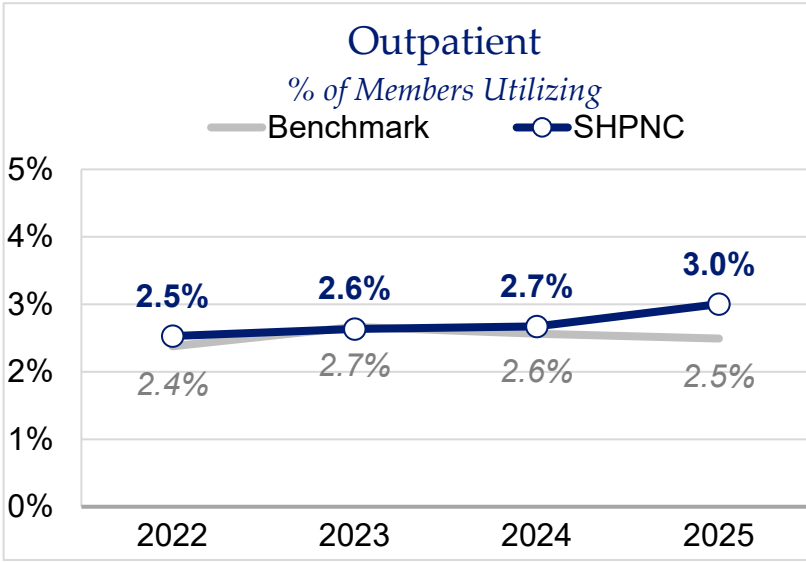
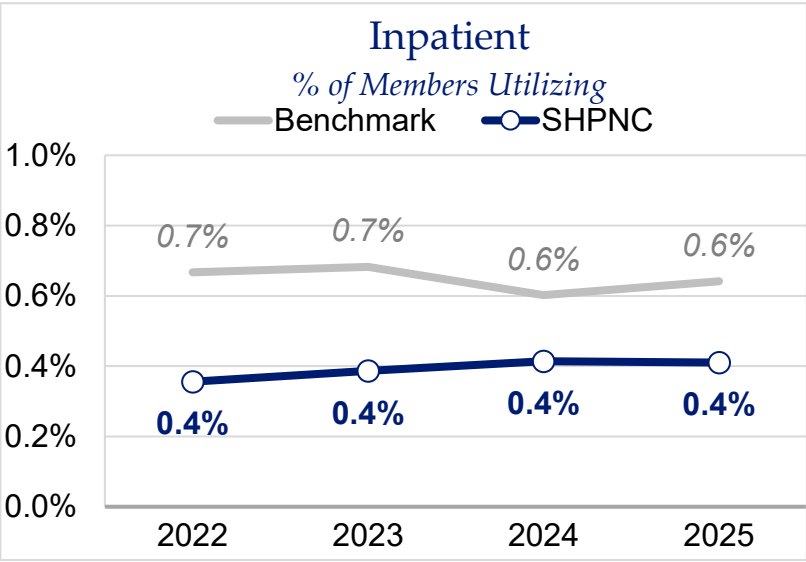
- Mental health prevalence has increased significantly over the experience period, from 37.6% of members in 2022 to 44.1% of members in 2025.
 - Mental health prevalence is over 10 percentage points higher in the State than our benchmark. However, this is partially due to have a greater share of females, who are typically higher utilizers of mental health care. Over 60% of the State's covered population is female.
- Anxiety and depression, two of the most prevalent conditions, saw reductions in members affected in 2025. However, costs for those treated increased significantly in 2025. Costs to treat anxiety increased 17.9% and costs to treat depression in increased 16.9%.
- Autism has been a significant cost driver over the last four years but experienced a 37.5% reduction in costs per member treated in 2025 due to more competitive provider pricing.

¹ Historical change in diagnoses reflects the total change in the number of members diagnosed with each mental health condition from 2022 to 2025.

² Historical change in cost reflects the annualized medical cost trend from 2022 to 2025.

Mental Health

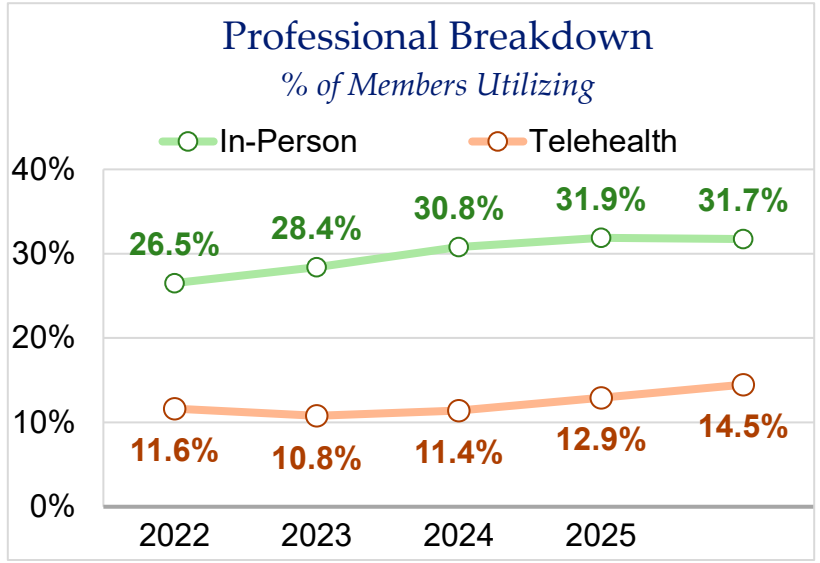
Utilization Trends by Place of Service



Observations

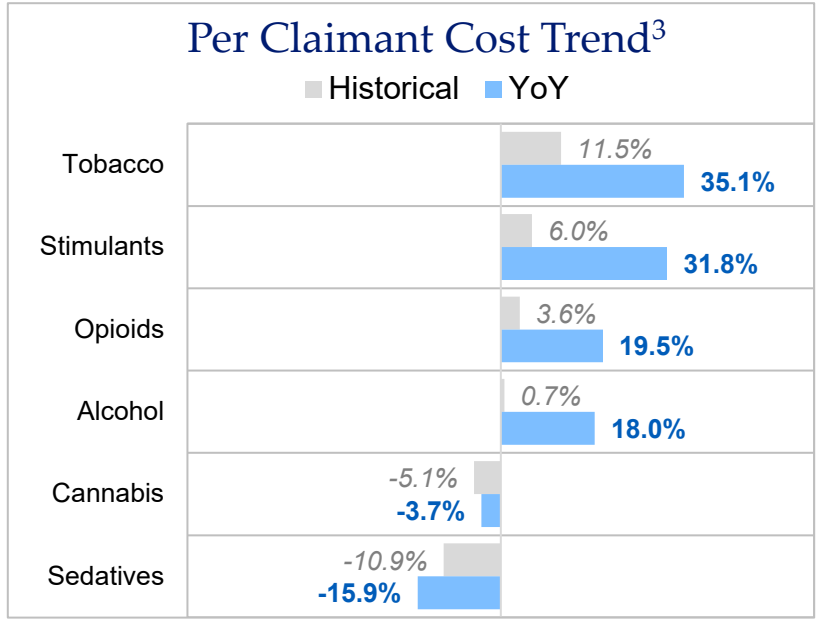
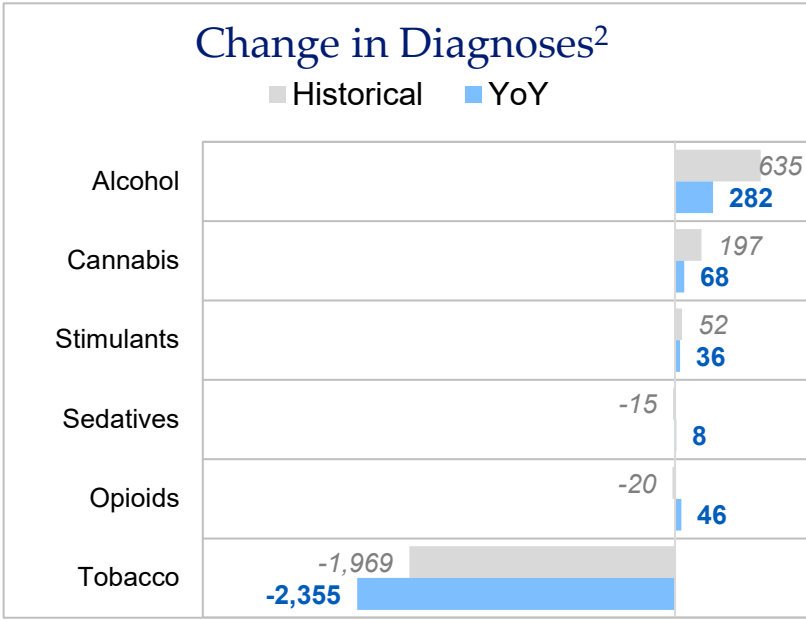
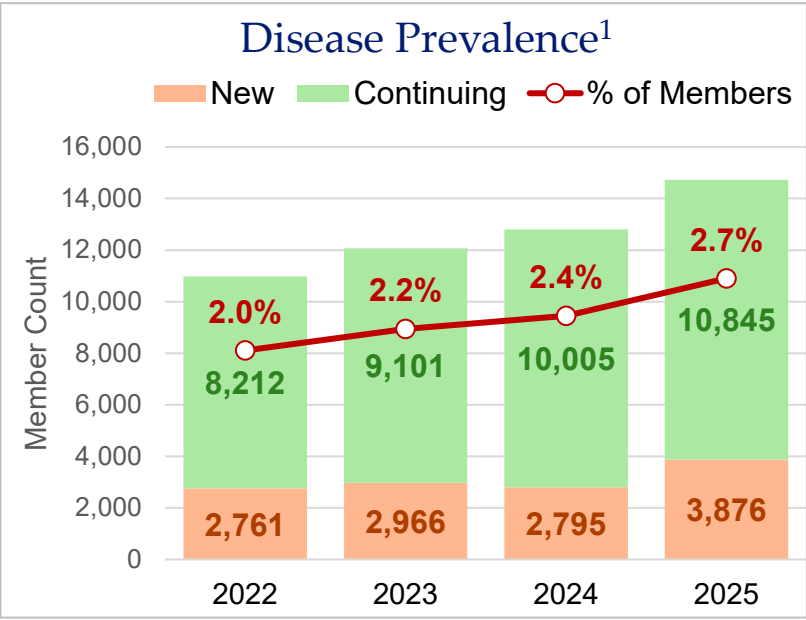
The graphs above summarize mental health-related utilization trends by place of service and compares it to Segal’s SHAPE public sector benchmark.

- Although there has been a slight increase in the percent of members ending up in the inpatient hospital for a mental health-related condition over the experience period, the State compares favorably to the benchmark with about 0.4% of members utilizing the inpatient hospital for mental health treatment.
- The State was consistent with the benchmark in terms of the percent of members utilizing the outpatient hospital for mental health treatment from 2022 – 2024 but diverged in 2025 due to anxiety, depression, and ADHD.
- The State has consistently had higher utilization of mental health treatment in the professional setting compared to Segal’s public sector benchmark, but the gap is narrowing.



Substance Use Disorder

Condition and Cost Trends



Observations

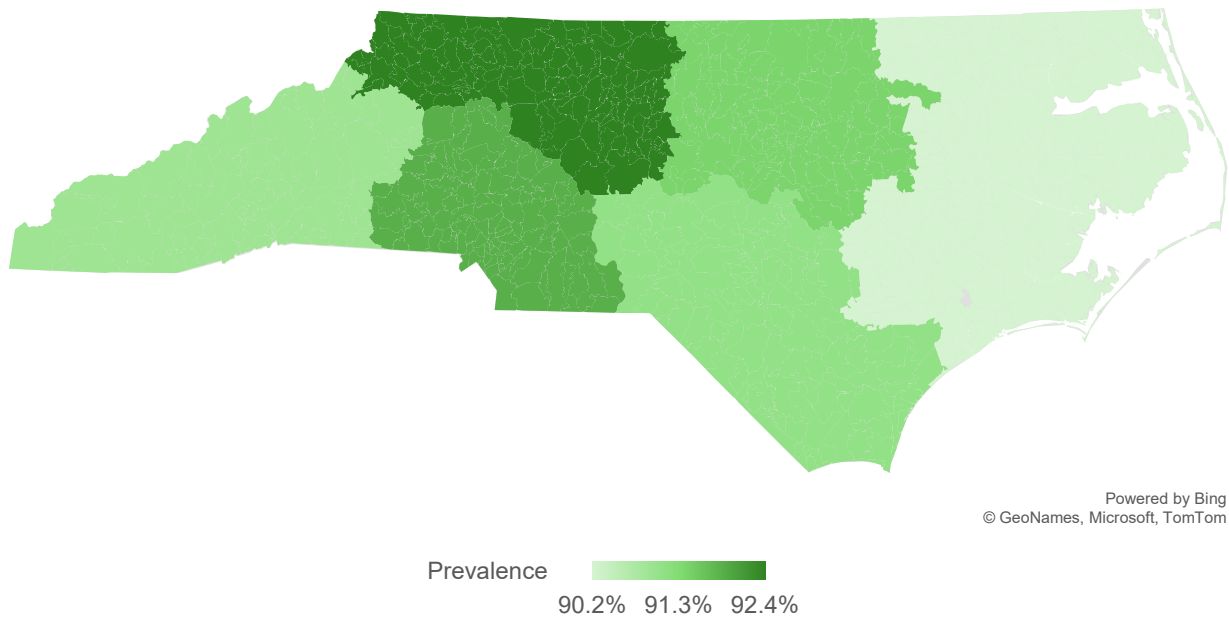
- The graphs above summarize prevalence and cost trends for Substance use disorder conditions.
- Substance use disorder prevalence has increased steadily over the experience period, from 2.0% of members in 2022 to 2.7% of members in 2025.
 - Prevalence has been driven by increases in alcohol, cannabis, and stimulant use disorder.
 - Sedatives, opioids, and tobacco have all experienced reductions in prevalence over the experience period.
 - Although there have been significant reductions in members treated for tobacco, the cost for treatment has increased significantly, rising 35.1% year-over-year and 11.5% per year from 2022 – 2025.
 - Due to its high prevalence, the main driver of costs for substance use disorder has been alcohol, which experienced an increase in costs per claimant of 18% in 2025.

¹ Disease prevalence excludes tobacco only.
² Historical change in diagnoses reflects the total change in the number of members diagnosed with each substance use disorder condition from 2022 to 2025.
³ Historical change in cost reflects the annualized medical cost trend from 2022 to 2025.

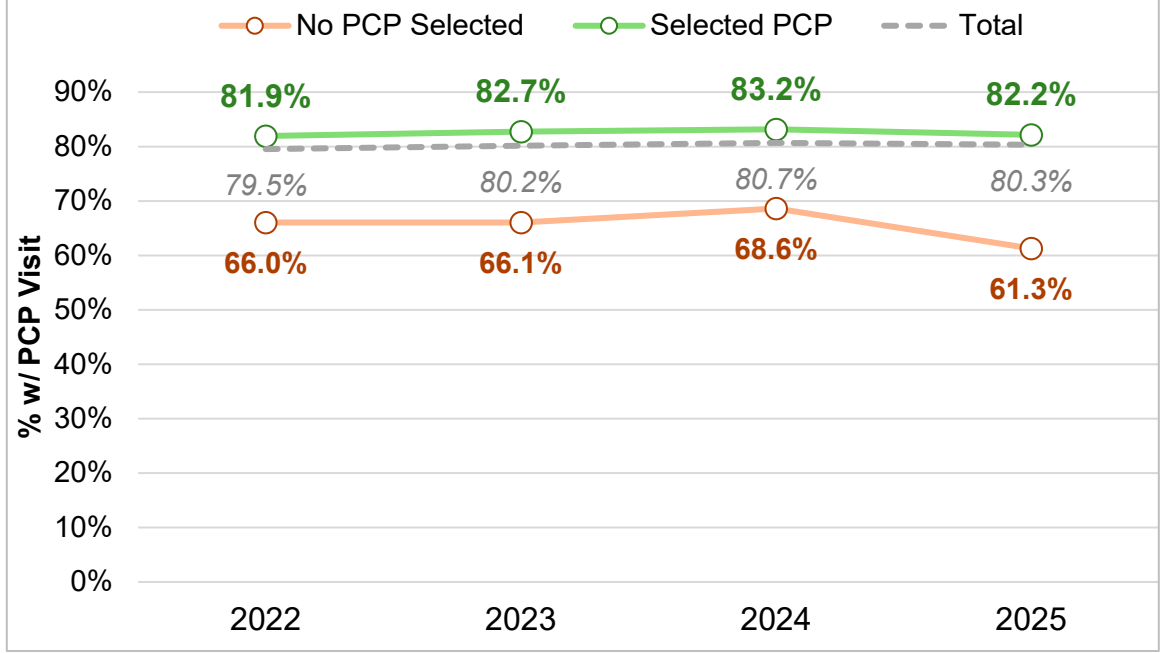
PCP Engagement

Overview

PCP Selection



PCP Selection and Engagement

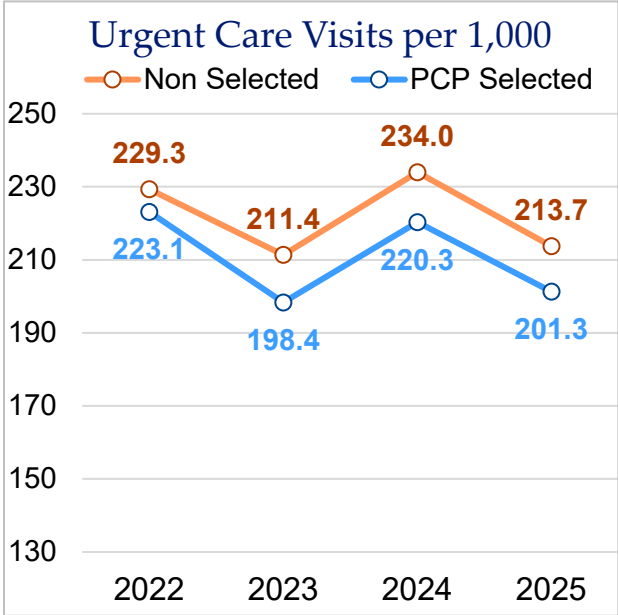
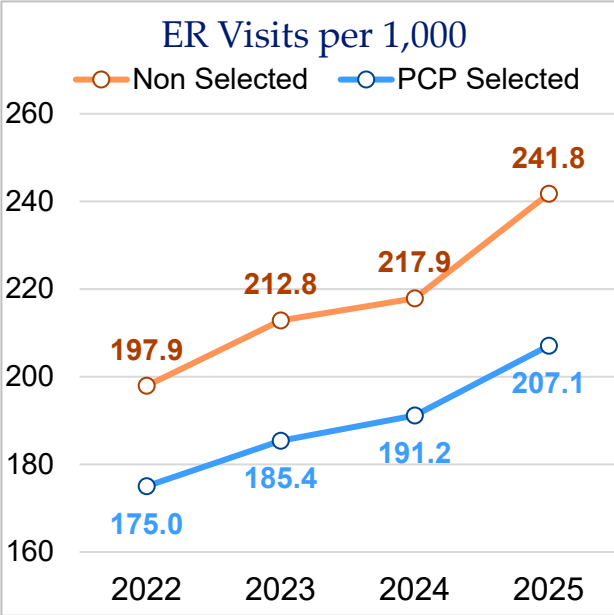
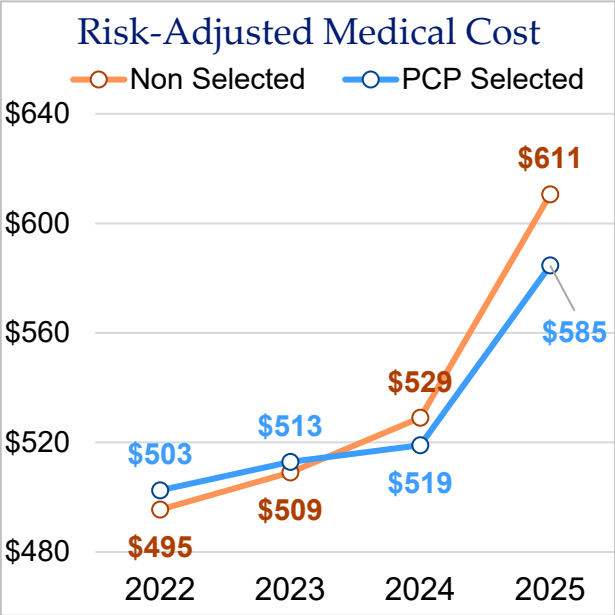
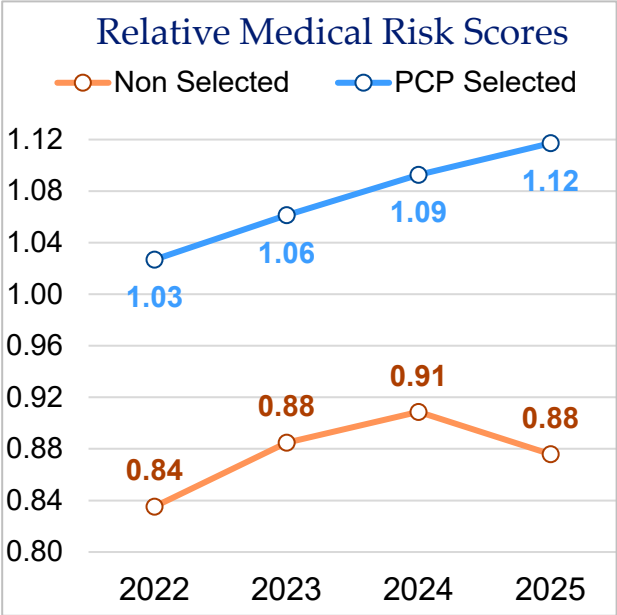


Observations

- The map and chart above show PCP selection and engagement. Members were determined to have selected a PCP if they had elected one on the enrollment file. Members were determined to be engaged if they had an evaluation and management visit.
- Overall PCP selection is high with about 91% of members selecting a PCP. Regions with the highest selection rates include Piedmont Triad and Metrolina (Charlotte).
 - The State saw increasing member engagement with evaluation & management visits, which include both PCP and specialist visits, from 2022 - 2024. However, there was a slight reduction in 2025, from 80.7% of members having an E&M visit in 2024 to 80.3% in 2025.

PCP Engagement

Outcomes



Observations

The charts above summarize differences in risk and outcomes between members who selected a PCP and members who did not.

- Medical risk scores have historically been over 20% higher for members who select a PCP.
- Risk-adjusted medical costs (shown above as per member per month) were slightly higher for members who selected in PCP in 2022 and 2023 but lower for members who selected a PCP in 2024 and 2025.
- Members who are not selecting a PCP appear more likely to use the emergency room or urgent care for treatment. Emergency room use for members not selecting a PCP has historically been about 40-50% higher than members who do select a PCP and urgent care use has historically been about 25-35% higher.

PCP Engagement

Urban vs. Rural Comparison

PCP Selection and Engagement By Region Urban vs. Rural						
Region	% Selecting a PCP		% Engaged		Change in Engagement ¹	
	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	91.8%	89.5%	81.4%	79.4%	0.2pp	-0.6pp
Region 2: Piedmont Triad	92.0%	93.1%	81.3%	82.1%	1.0pp	0.6pp
Region 3: Metrolina (Charlotte)	91.7%	92.8%	81.4%	82.4%	1.8pp	1.3pp
Region 4: Triangle	91.4%	91.4%	79.1%	79.7%	1.1pp	-0.1pp
Region 5: Cape Fear	90.6%	91.6%	80.0%	82.7%	0.2pp	1.0pp
Region 6: Eastern NC	90.5%	90.0%	79.6%	78.6%	0.2pp	0.6pp
Total	91.4%	91.3%	80.2%	80.8%	1.0pp	0.5pp

Observations

The chart above shows PCP engagement by region, separated by urban versus rural.

- PCP engagement is generally higher in rural areas but has also improved less than urban areas since 2022.

¹ Historical change represents the percentage point (pp) change from 2022 to 2025

Catastrophic Risk Group

Risk Categories

Category	Member Count				Change	
	2022	2023	2024	2025	YoY	Historical ¹
Cancer & Oncology	2,006	2,059	2,076	2,141	+65	+135
Transplant & Complex Medical Support	745	809	860	931	+71	+186
Pulmonary & Respiratory	433	451	414	461	+47	+28
Neurologic, Cognitive & Developmental	405	420	400	414	+14	+9
Cardiovascular & Cerebrovascular	302	382	389	446	+57	+144
Diabetes, Endocrine & Metabolic	236	255	281	308	+27	+72
Musculoskeletal	199	242	260	284	+24	+85
Renal & Liver Disease	223	246	238	267	+29	+44
Gastrointestinal	233	228	248	253	+5	+20
Hematologic, Immune & Infectious	208	228	217	223	+6	+15
Complications of Care	77	71	75	91	+16	+14
Newborn Care	76	78	62	69	+7	-7
Substance Abuse	42	61	64	58	-6	+16
All Other	79	108	112	128	+16	+49
Total	5,264	5,638	5,696	6,074	+378	+810

Observations

The table above summarizes the categories in the catastrophic risk group and members in each by year along with year-over-year and historical trends.

- 35.3% of the catastrophic risk group was due to cancer in 2025. There were 65 more members in the catastrophic risk group due to cancer in 2025 compared to 2024 and 135 more compared to 2022.
- The fastest growing categories in the catastrophic risk group over the historical period have been transplants and complex medical support (+186 members) and cardiovascular & cerebrovascular conditions (+144 members).
- There has been a reduction in newborns ending up in the catastrophic risk group over the historical period.

¹ Historical change reflects the change between 2022 and 2025.

Catastrophic Risk Group

Top Conditions and Modifiable Risk Factors

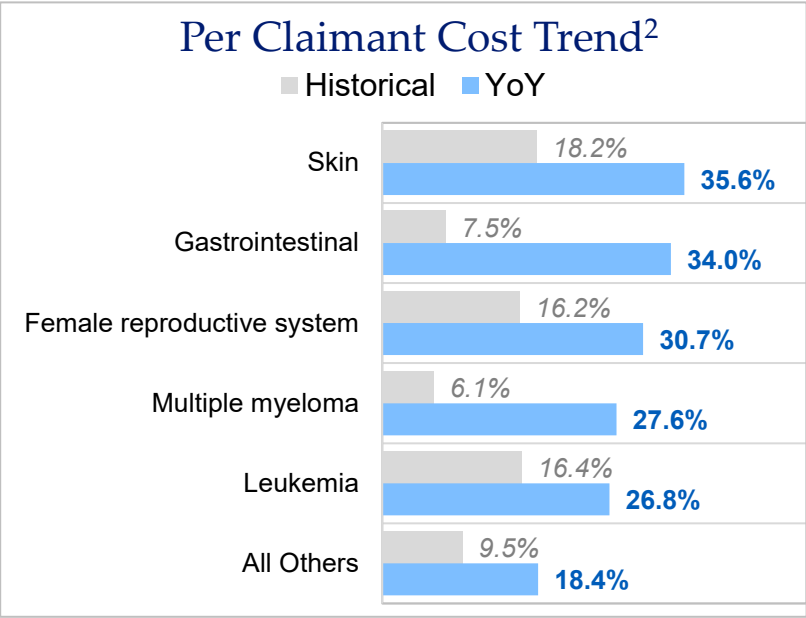
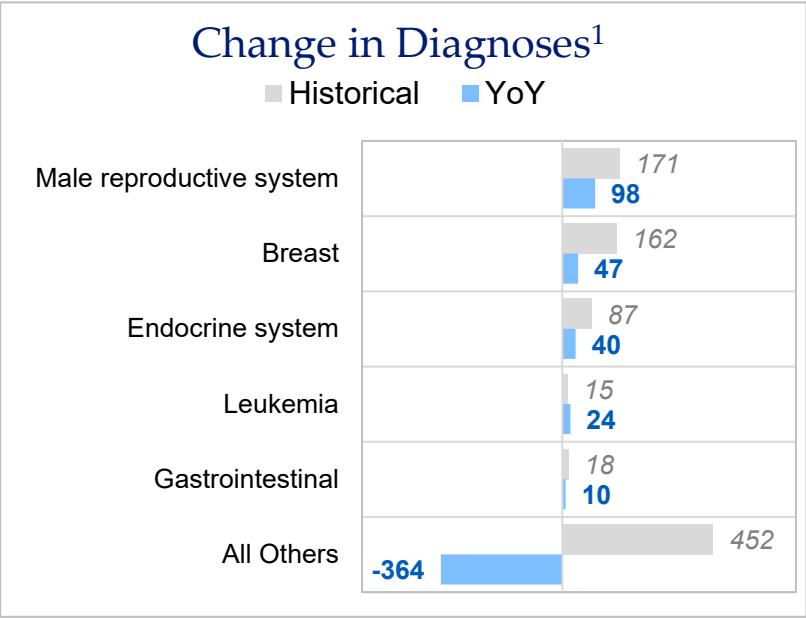
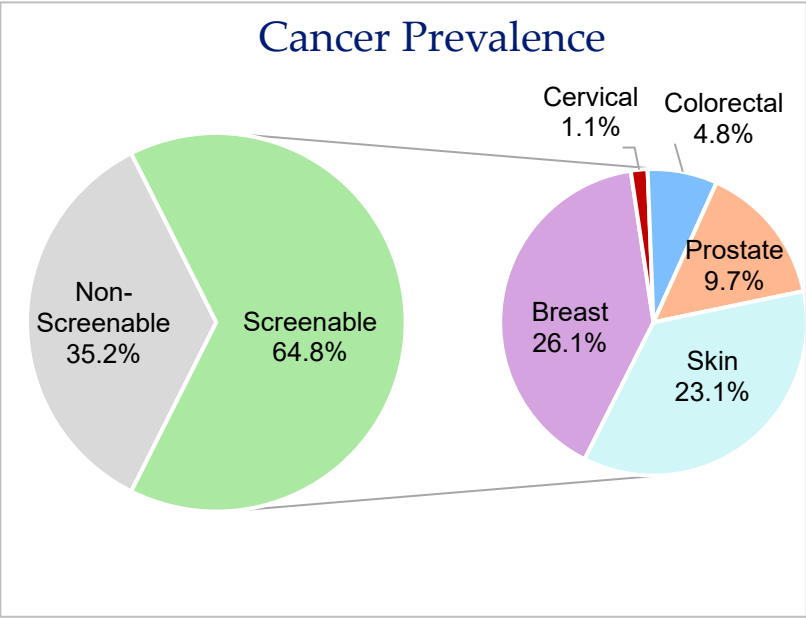
Condition	Potentially Modifiable Risk Factors	Member Count (CY 2025)
Chronic kidney disease	Diabetes, hypertension, obesity, cardiovascular disease, smoking, chronic NSAID use, certain autoimmune disorders.	527
Breast cancer	Obesity, alcohol use, physical inactivity, hormone replacement therapy.	382
Metastatic cancer	Delayed diagnosis, smoking, obesity.	326
Obesity	Excess caloric intake, sedentary lifestyle, poor diet, sleep deprivation, stress, socioeconomic factors, endocrine disorders.	234
Heart failure	Coronary artery disease, hypertension, diabetes, obesity, chronic kidney disease, valvular disease, smoking, excessive alcohol use, arrhythmias.	229
Diabetes	Obesity, physical inactivity, poor diet, hypertension, hyperlipidemia.	144
Fluid and electrolyte disorders	Chronic kidney disease, heart failure, liver disease, dehydration, diuretic use, endocrine disorders, gastrointestinal losses (vomiting/diarrhea), uncontrolled diabetes.	135
Heart disease	Hypertension, diabetes, obesity, hyperlipidemia, smoking, chronic kidney disease, physical inactivity, poor diet.	129
Spinal disorders	Autoimmune disease, inflammatory bowel disease, smoking, obesity, occupational strain.	105

Observations

- The table above summarizes the top conditions in the catastrophic risk group along with potentially modifiable risk factors for each.
- Approximately 9% of the catastrophic risk group is due to chronic kidney disease, 6% is due to breast cancer, and 5% is due to metastatic cancer.
 - Chronic kidney disease, which is mainly caused by unmanaged diabetes and/or hypertension, experienced an increase of 194 members in the catastrophic risk group in 2025.
 - The number of members in the catastrophic risk group increased by 378 members in 2025. However, there were some areas that did show improvement. Conditions with a reduction in catastrophic members include colorectal cancer (-42 members), regional enteritis and ulcerative colitis (-25 members), acute myocardial infarctions (-22 members) and renal failure (-22 members).

Cancer

Prevalence, Cost and Top Cancers



Observations

The graphs above summarize prevalence and cost trends by cancer type.

- 12,161 members were treated for cancer in 2025, 2,650 of which were newly diagnosed cancers. This represents a decrease from 2024 when 12,306 cancers were treated and 2,755 were new.
 - 64.8% of the cancers treated were for cancers with recommendations for routine screenings (i.e., screenable).
- There were 171 more male reproductive cancers (e.g., prostate) diagnosed in 2025 compared to 2022, representing the largest increase of all cancer types, followed by breast cancer. Both of these cancers are screenable.
- Costs for cancer treatment increased significantly in 2025, led by skin with a 35.6% increase in costs per claimant (mainly due to Keytruda, Yervoy, and Nplate) and followed by gastrointestinal (Imfinzi, Cyramza) and female reproductive system (Jemperli, Keytruda, Mvasi) with increases of 34.0% and 30.7%, respectively.

¹ Historical change in diagnoses reflects the total change in the number of members diagnosed with each cancer type from 2022 to 2025.

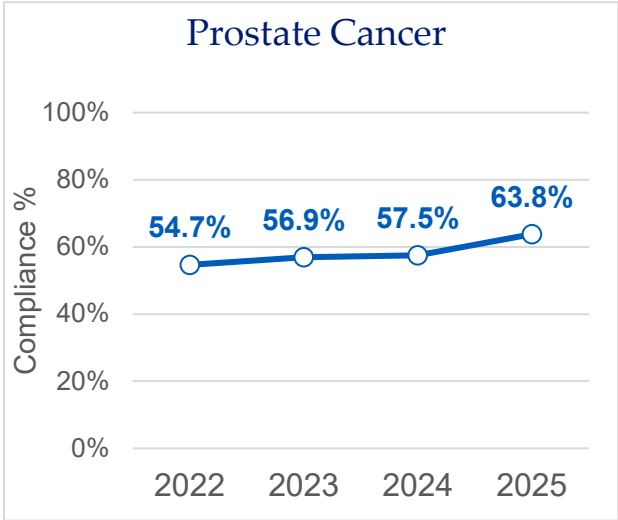
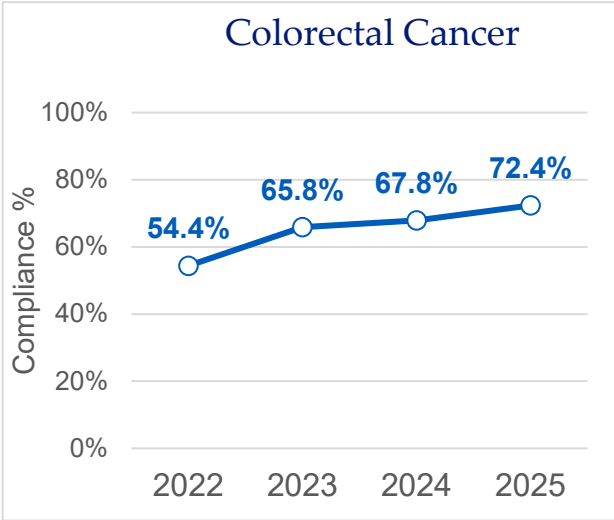
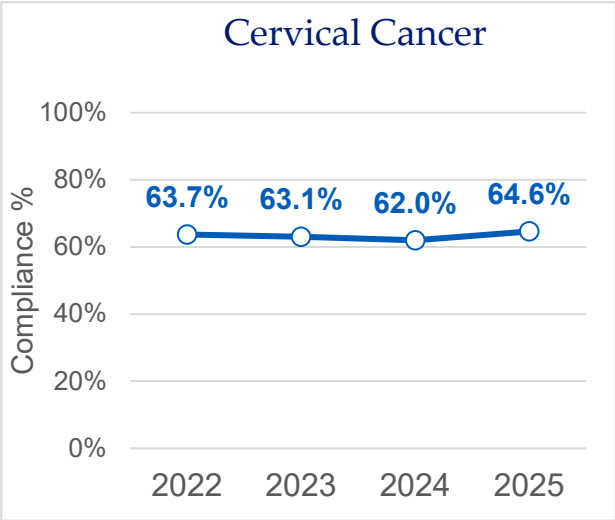
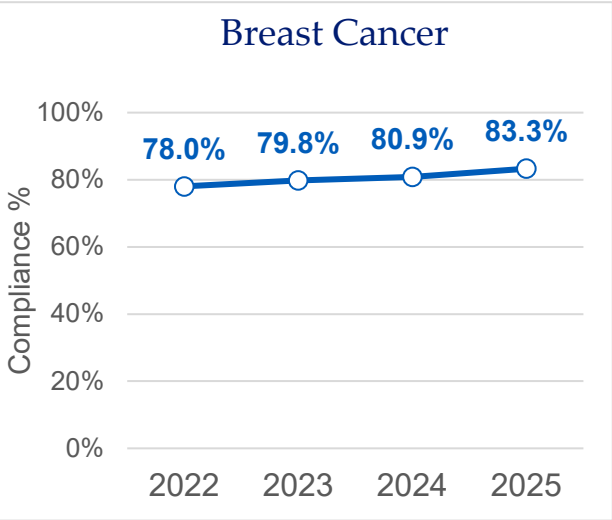
² Historical change in cost reflects the annualized medical and prescription drug cost trend from 2022 to 2025.



45

Screenable Cancer

Screening Compliance



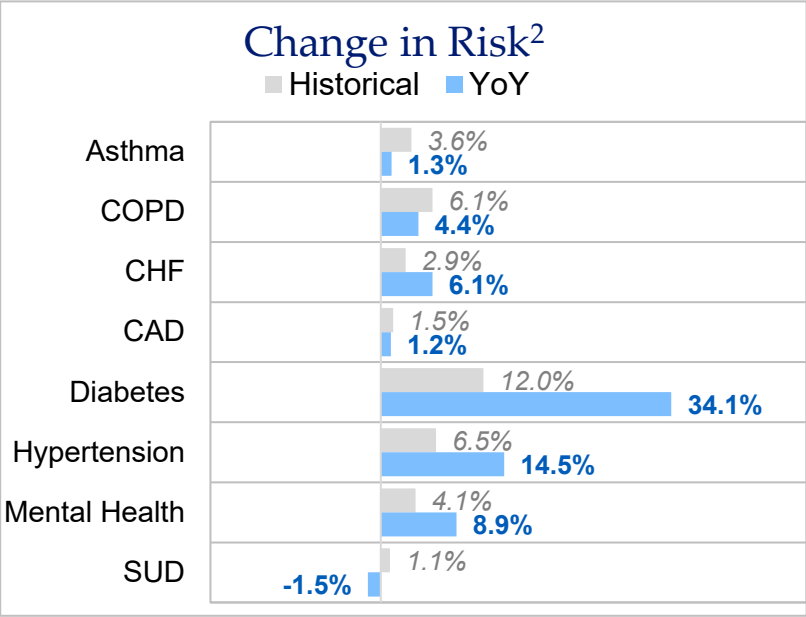
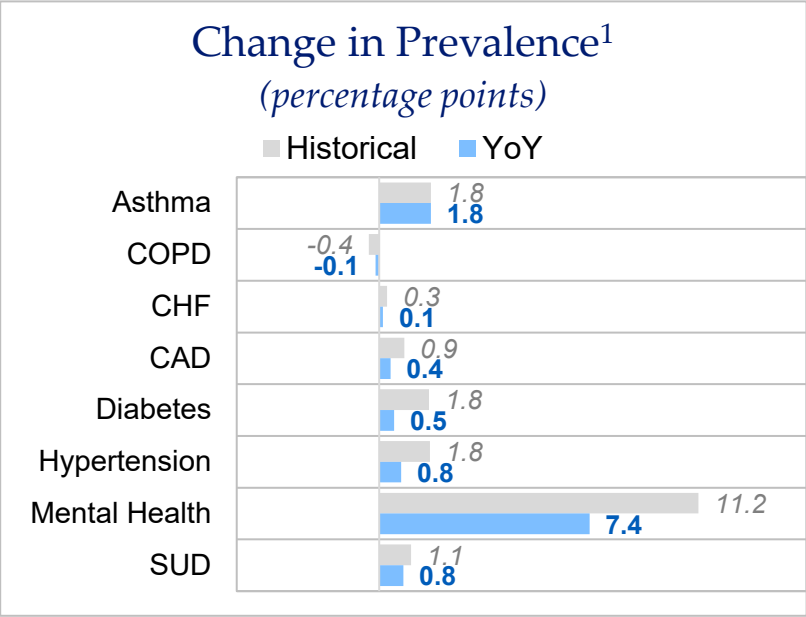
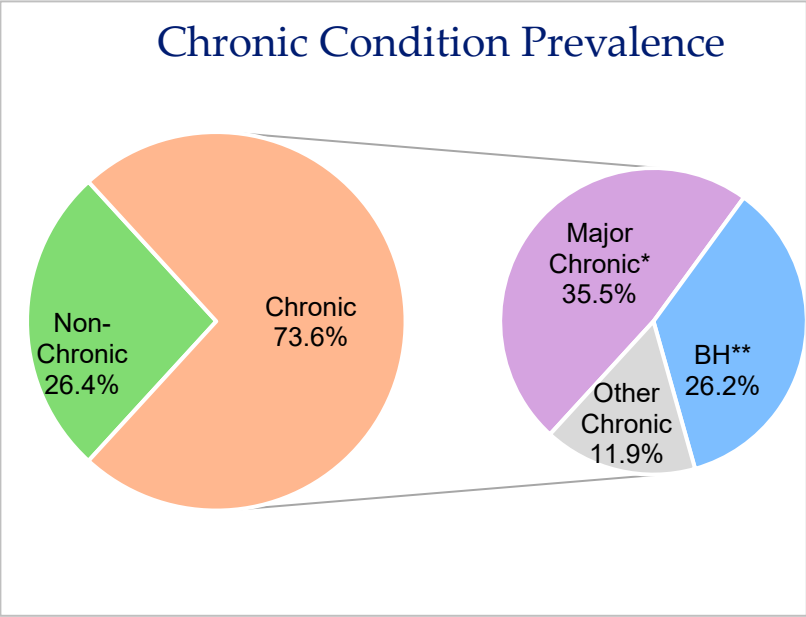
Observations

The graphs above summarize preventive screening rates for the four main screenable cancers.

- The State has made meaningful improvements in preventive cancer screening rates over the historical period. All four cancer screenings experienced an increase in compliance.
 - Colorectal cancer screening rates have increased the most and were over 72% in 2025.
 - Breast cancer screening rates have steadily increased over the last four years and were over 80% in 2025, the highest of all cancers.
 - There was a significant increase in compliance for prostate cancer screening year-over-year. 57.5% of males were compliant in 2024, which jumped to 63.8% in 2025.
 - Cervical cancer screenings have improved the least, which is a fairly common pattern across the general population. Females generally only require screening every 3-5 years, so improvements may take longer to show up in the data. Opportunities to improve compliance include targeted outreach to overdue members, education regarding current screening recommendations, and promoting newer screening options as they become available.

Chronic Conditions

Prevalence and Risk



Observations

The graphs above summarize prevalence and risk for chronic conditions.

- 73.6% of members had a chronic condition in 2025, which includes 35.5% with one or more of the six major physical chronic conditions*, 26.2% with a behavioral health (BH) condition**, and 11.9% of members with other chronic conditions (e.g., cystic fibrosis, epilepsy, glaucoma).
- All major chronic conditions aside COPD have seen an increase in prevalence over the historical period.
- Mental health prevalence has increased the most, with an increase of 11.2 percentage points from 2022 to 2025.
- Diabetics have experienced the largest increase in risk year-over-year (YoY) and over the historical period.
- Hypertension, which is the primary condition targeted by Hello Heart, experienced the second largest increase in risk YoY and over the historical period.

* Major Chronic = asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes, and hypertension.

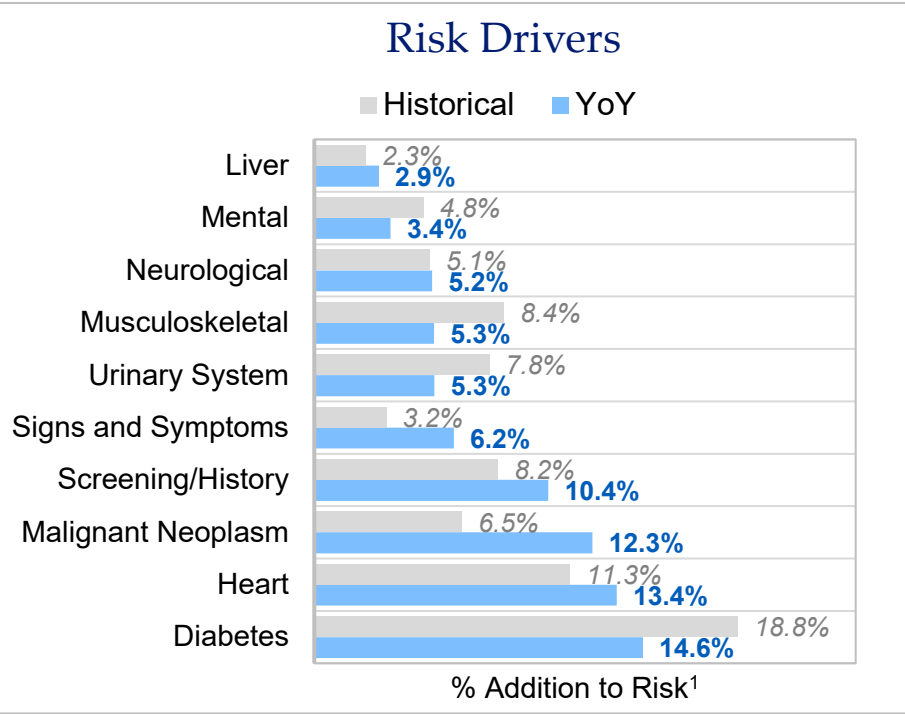
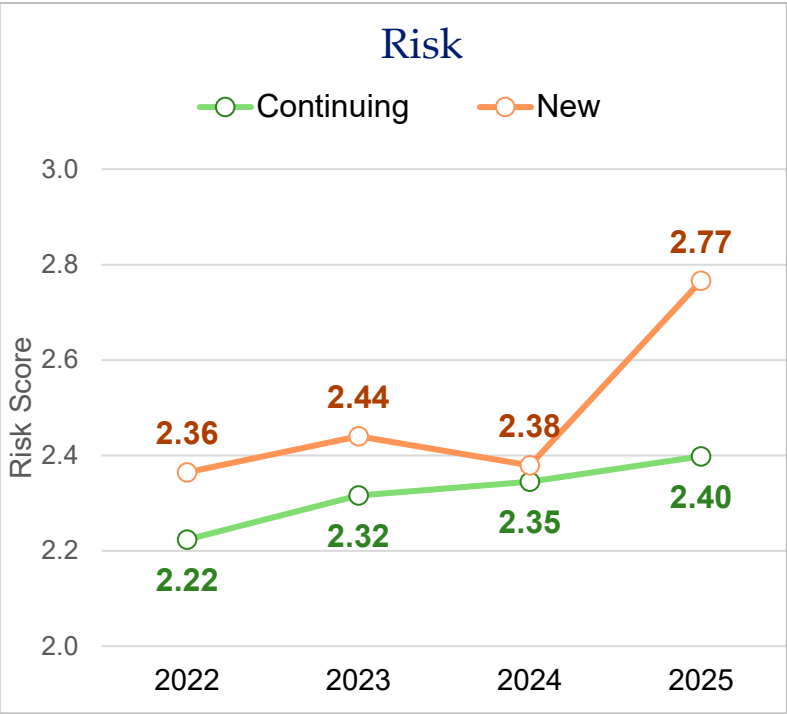
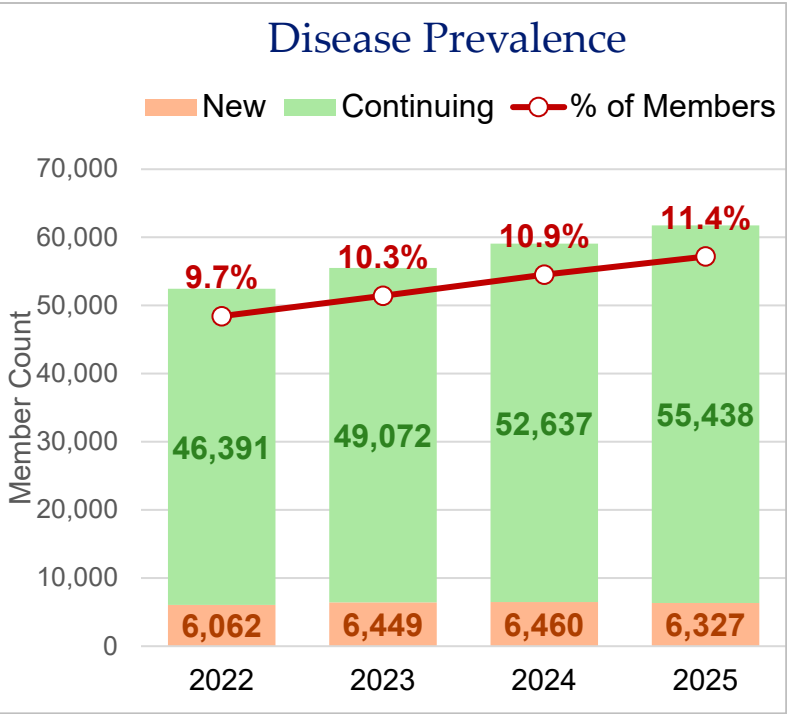
** BH = behavioral health, which includes both mental health and substance use disorders (SUD).

¹ Historical change in prevalence reflects the total change in percentage points from 2022 to 2025.

² Historical change in risk reflects the annualized trend in risk from 2022 to 2025.

Diabetes

Prevalence and Risk Trends



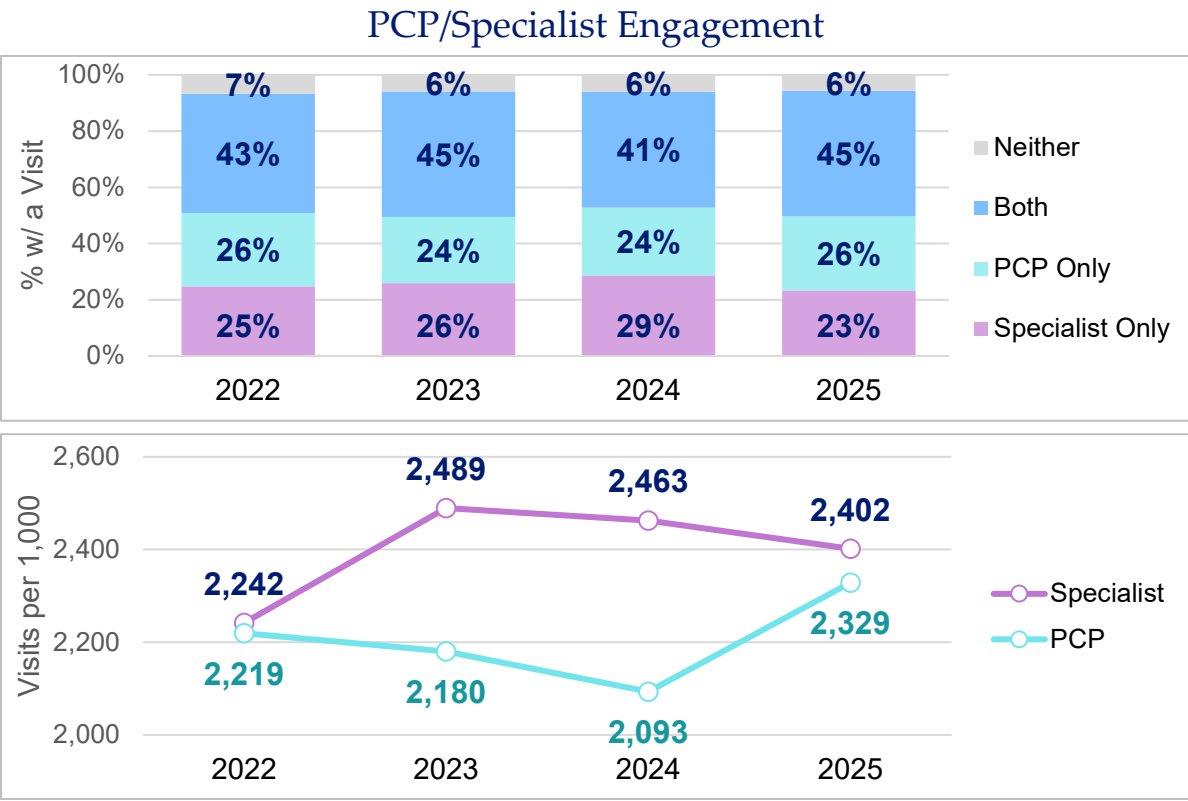
Observations

- The graphs above summarize prevalence, risk, and risk drivers for the diabetic population.
- The diabetic population has steadily increased over the experience period, from 9.7% of members in 2022 to 11.4% of members in 2025.
 - Despite the increase, the Plan is faring better than our public sector benchmark, which experienced an increase in prevalence from 8.7% to 12.0% over the same period.
 - There was a reduction in newly diagnosed members in 2025 for the first time in the experience period. However, the risk score for new diabetics increased significantly in 2025, mainly driven by cancer, screening/history, and heart disease.
 - Aside from diabetes, the largest drivers of risk for diabetics over the experience period have been heart disease and musculoskeletal conditions.

Diabetes

Condition Management

Diabetes Condition Management					
Metric	2022	2023	2024	2025	Change
Annual A1c Test	81.5%	78.9%	77.4%	83.9%	Increase YoY Increase Historical
Kidney Screening	89.7%	91.2%	91.5%	90.5%	Decrease YoY Increase Historical
% w/ Heart Disease	12.8%	13.9%	14.7%	16.3%	Increase YoY Increase Historical
Statin Use ¹	76.7%	75.3%	73.7%	72.9%	Decrease YoY Decrease Historical
GLP-1 Use	36.5%	46.6%	47.7%	45.5%	Decrease YoY Increase Historical
PCP Visit	68.6%	68.2%	65.4%	71.1%	Increase YoY Increase Historical
Specialist Visit	67.3%	70.5%	69.8%	68.0%	Decrease YoY Increase Historical
ER Visit	13.7%	14.3%	13.9%	14.9%	Increase YoY Increase Historical
Inpatient Visit	3.8%	4.0%	3.8%	3.9%	Increase YoY Increase Historical



Observations

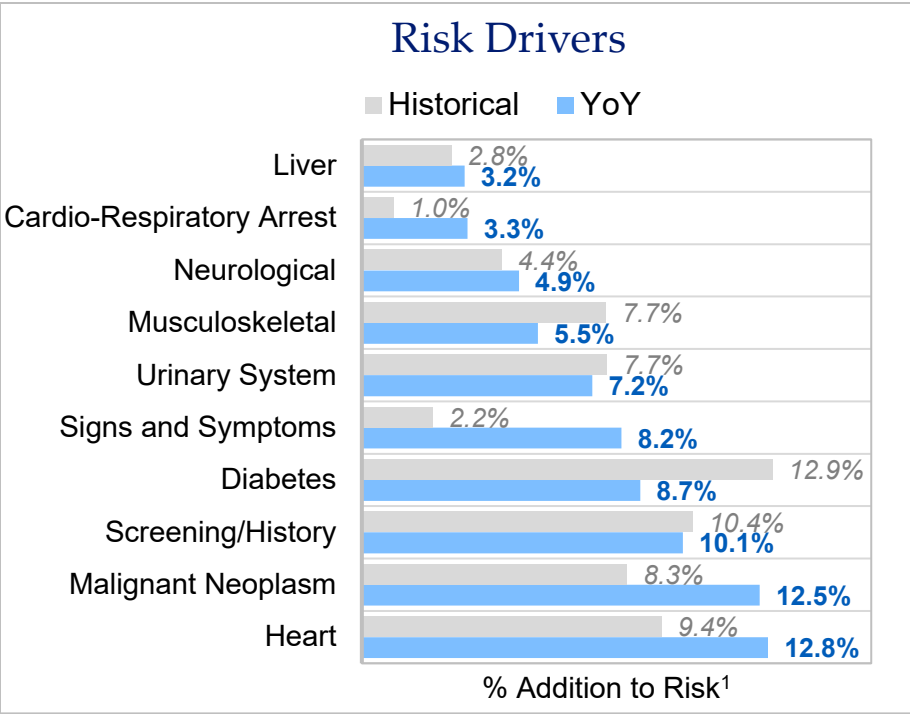
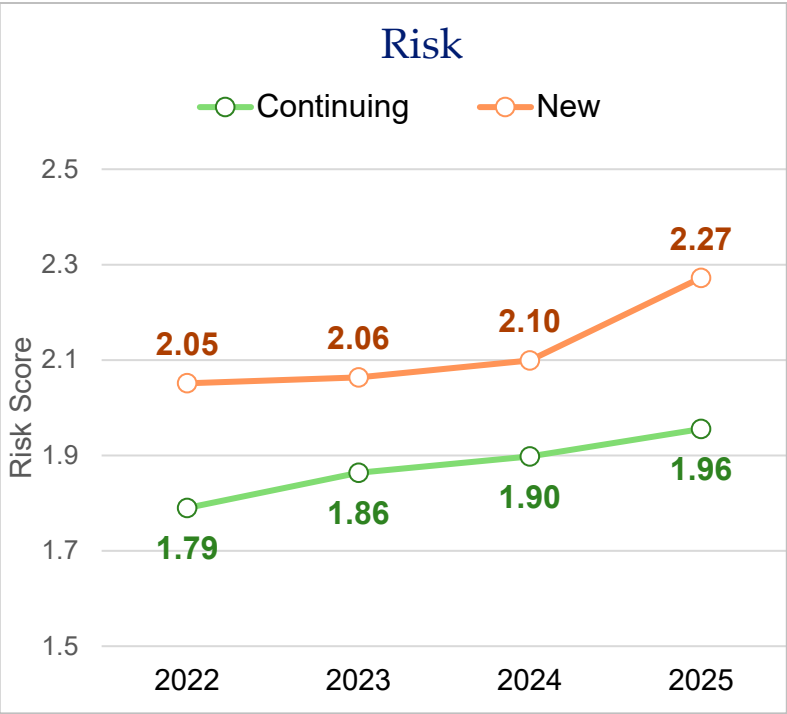
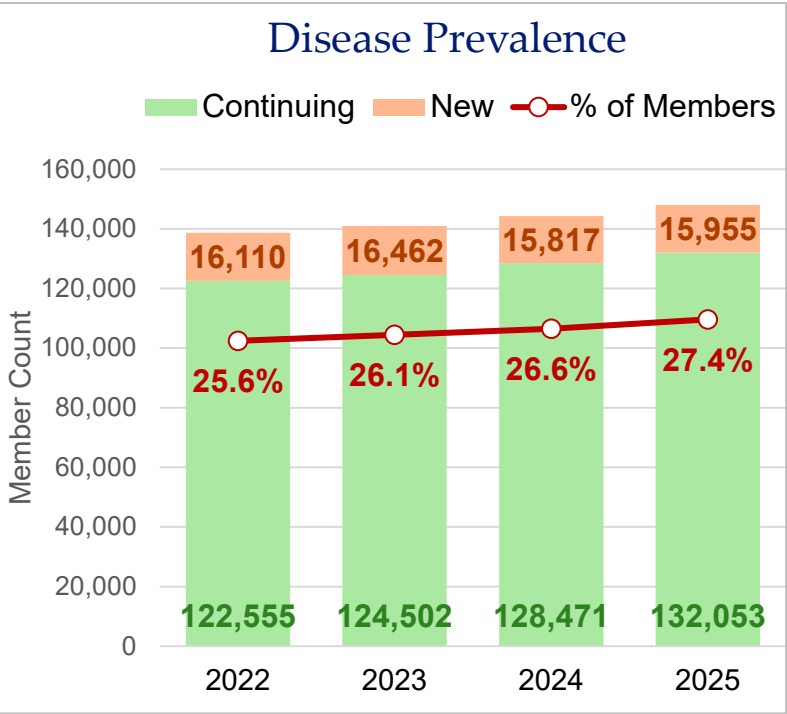
This page monitors trends in condition management for diabetics.

- Five out of the nine quality metrics improved over the historical period but only two out of nine improved year-over-year.
- 45.5% of diabetics were managing their condition with GLP-1s in 2025, which is slightly higher than the 44.4% in Segal’s public sector benchmark and represents a slight drop from 2024.
- Although PCP and specialist engagement has mostly been improving, diabetics are also ending up in the emergency room and inpatient hospital at higher rates.

¹ Only includes members age 40 and above with diabetes, hypertension, and heart disease.

Hypertension

Prevalence and Risk Trends



Observations

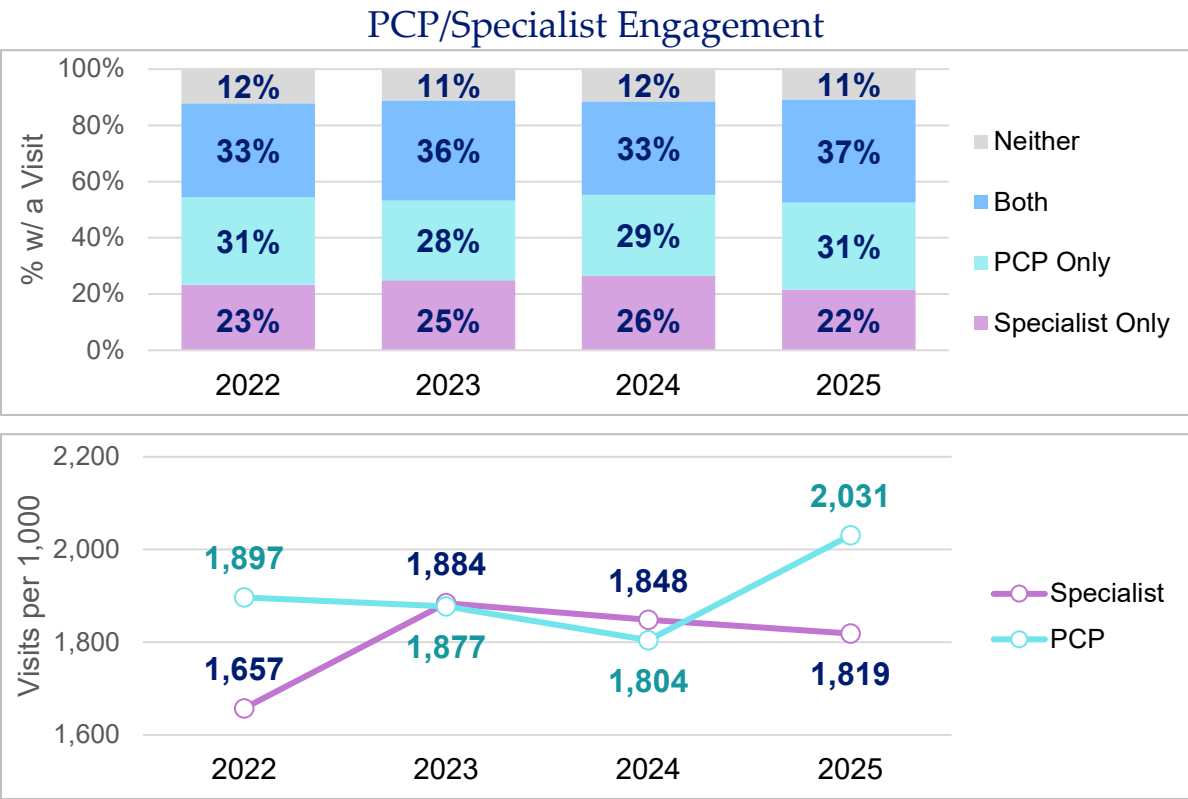
- The graphs above summarize prevalence, risk, and risk drivers for the hypertensive population.
- The hypertensive population has steadily increased over the experience period, from 25.6% of members in 2022 to 27.4% of members in 2025.
 - The risk of the hypertensive population increased 9.3% over the historical period, which is slightly higher than the increase for diabetics.
 - Similar to the diabetic population, newly diagnosed hypertensive members experienced a significant increase in risk in 2025 driven by heart disease and cancer.
 - The largest drivers of risk for hypertensive members over the experience period have been diabetes, screening/history, and heart disease.

¹ Addition to risk represents the percent of the increase in risk attributed to each risk category.

Hypertension

Condition Management

Hypertension Condition Management					
Metric	2022	2023	2024	2025	Change
Medication Adherence	59.4%	58.8%	56.4%	56.7%	Increase YoY Decrease Historical
Kidney Screening	84.2%	85.9%	86.4%	85.6%	Decrease YoY Increase Historical
% w/ Heart Disease	10.5%	11.5%	12.5%	13.6%	Increase YoY Increase Historical
Statin Use ¹	75.8%	74.4%	73.3%	72.3%	Decrease YoY Decrease Historical
PCP Visit	64.5%	64.0%	62.0%	67.6%	Increase YoY Increase Historical
Specialist Visit	56.5%	60.5%	59.7%	58.2%	Decrease YoY Increase Historical
ER Visit	11.8%	12.3%	12.1%	13.4%	Increase YoY Increase Historical
Inpatient Visit	2.8%	2.9%	2.9%	2.9%	Increase YoY Increase Historical



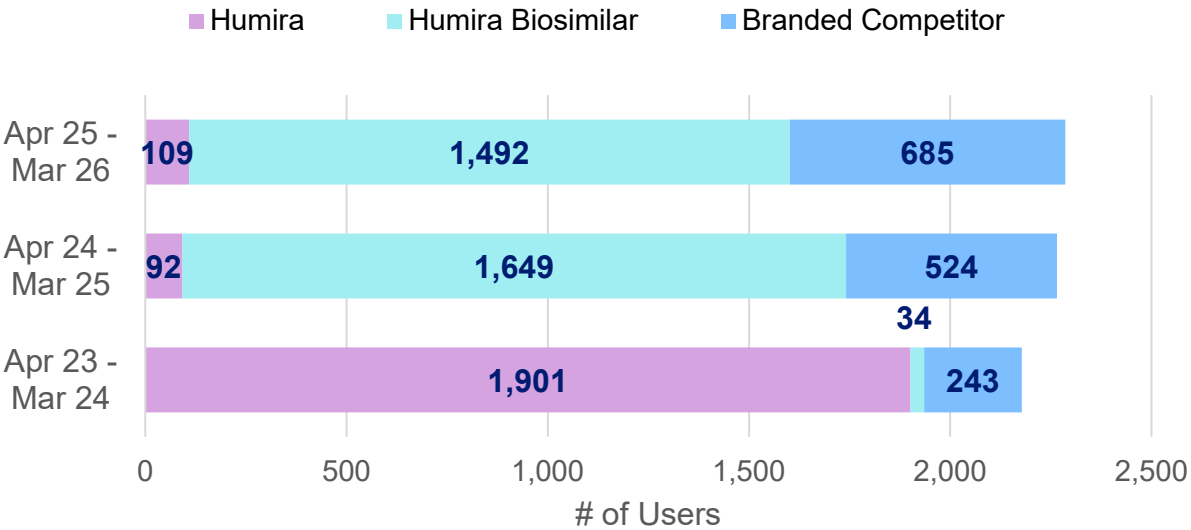
Observations

This page monitors trends in condition management for hypertension members.

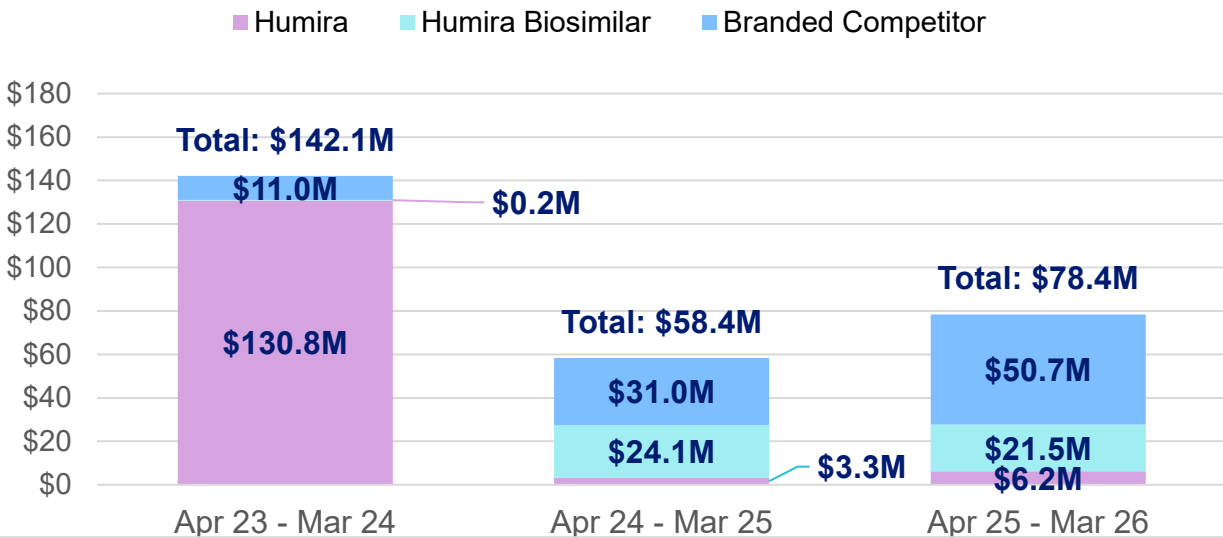
- Three out of the eight quality metrics improved over the historical period but only two out of nine improved year-over-year.
- PCP and specialist engagement have both improved over the historical period. However, there was a slight reduction in specialist engagement in each of the last two years.
- Although PCP and specialist engagement has mostly been improving, hypertensive members are also ending up in the emergency room and inpatient hospital at higher rates.

¹ Only includes members age 40 and above with diabetes, hypertension, and heart disease.

Unique Users by Category
Humira Users Pre-April 2024



Total Allowed by Category
Humira Users Pre-April 2024



Observations

- Humira biosimilars, which may be considered similar to generic medications, became preferred on April 1, 2024. Like generics, biosimilars may result in savings* around 80 to 90% when compared to their reference (i.e., brand) product. For members treated with Humira before this date, the majority switched to a Humira biosimilar in the year after (1,649). However, a growing number of members have subsequently used a competitor product, which carry a notably higher price than a biosimilar.
- While overall costs for Humira+biosimilar members dropped from \$142.1M in the year prior to the formulary change to \$58.4M in the year after, costs increased by \$20M in the second-year due utilization of these higher-cost competitor products. As more members change to a competitor product, initial savings from biosimilar usage is reduced (see next page).

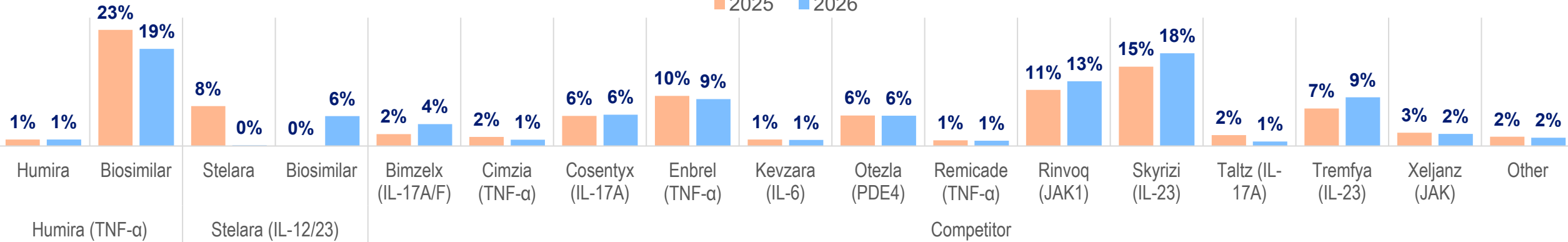
*Gross of rebates

Biosimilars

Market Share

% Total Therapy Days Dispensed

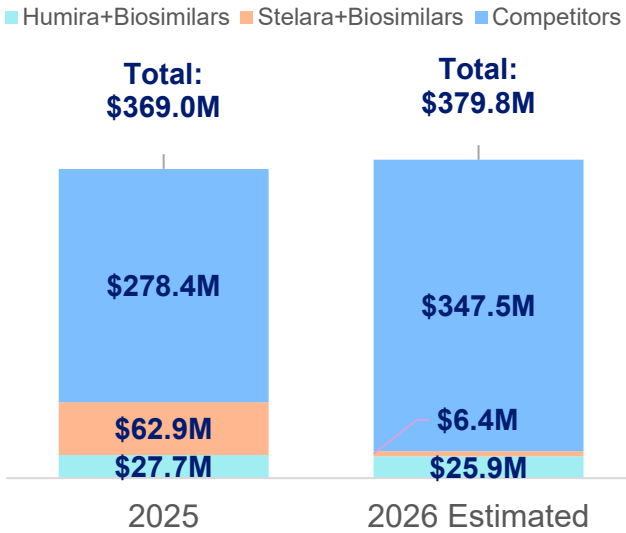
2025 2026



Observations

- The right chart displays the total costs by category for Humira, Stelara (which now has biosimilars) and their competitors (based on indications treatable with either Humira or Stelara: psoriasis, rheumatoid arthritis, Crohn’s disease, ulcerative colitis, psoriatic arthritis, axial spondyloarthritis, etc. [expanded list available in the appendix])
- Total costs for Humira and Stelara are estimated to decrease by 6.4% and 90% (\$58.3M combined) by the end of 2026, respectively. However, total spend on these groups of drugs will increase due to an estimated \$69M increase in spend for competitors, offsetting savings. While combined Humira and Stelara biosimilar adoption has improved from 2025 to 2026, notable shifts are being seen to higher-cost competitor products.
- Total utilization of Humira and its biosimilars dropped from a combined 24% to 20% with biosimilars specifically decreasing from 23% in 2025 to 19% in 2026.
- Similarly, while Stelara utilization shifted nearly entirely to biosimilars, total utilization for Stelara and its biosimilars dropped from 8% to 6% - essentially 2% of market share was not converted to lower-cost biosimilars and instead to higher cost competitors.
- Skyrizi, for example, accounted for 18% of total days’ supply dispensed in 2026, up from 15% in 2025.
- The average cost for Skyrizi in 2026 was \$9,358 per 30-days compared to approximately \$1,800 for Humira and Stelara biosimilars.
- The average cost of a competitor product rose from \$7,757 in 2025 to \$8,475 in 2026.

Total Allowed by Category
All Competitor Products



*Cost reported gross of rebates

Data Included

- This detailed risk study includes the following members of the SHPNC:
 - Actives: Any individual that is actively working, including Medicare-eligible members, and their eligible dependents
 - COBRA: Any individual receiving coverage through the Consolidated Omnibus Budget Reconciliation Act and their eligible dependents
 - Non-Medicare Retiree: Any individual enrolled in retiree coverage through the SHP and not yet eligible for Medicare and their non-Medicare-eligible dependents
- Note that individuals with any record of Medicare enrollment during a given year are excluded from this study.
- Medical and prescription drug claims incurred through 2025 and paid through July 2026.

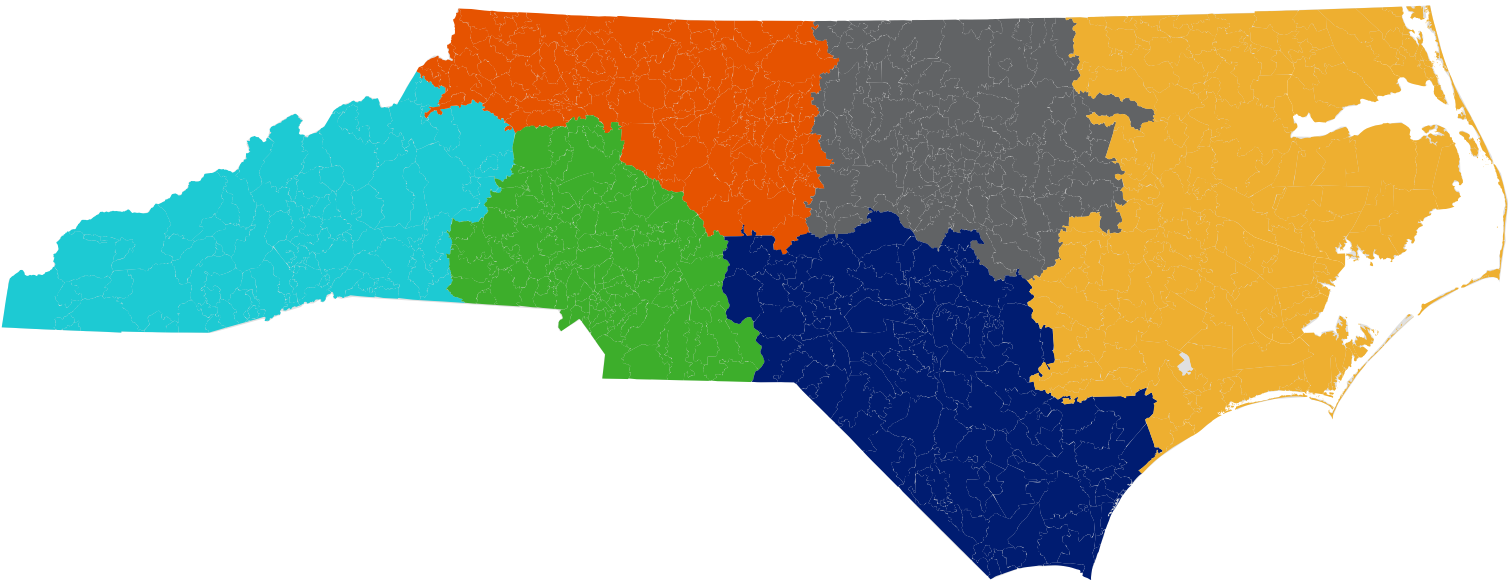
Member Profiles: Risk Group Definitions

- **Non-Utilizers:** Members who did not have any medical claims
- **Healthy:** Any member with a DxCG score below 28.7
- **Minor acute:** Members without a chronic condition identified who had a DxCG score between 28.7 and 82.6
- **Major acute:** Members without a chronic condition identified who had a DxCG score between 82.6 and 1,200
- **Chronic:** Members with exactly one identified chronic condition
- **Comorbidities:** Members with more than one identified chronic condition
- **Malignancies:** Any member having at least two encounters related to cancer treatment
- **Catastrophic:** Any member with a DxCG score greater than 1,200

Member Profiles: Risk Group Examples

Risk Group	Description/Example of DxCG Category
1. Non-Utilizers	n/a
2. Healthy	Non-Chronic Ear, Nose, Throat, and Mouth Disorders; Migraine and Tension Headache
3. Minor Acute	Gastrointestinal Disorders; Poisonings and Allergic Reactions
4. Major Acute	Psoriasis and Parapsoriasis without Arthropathy; Normal, Single Birth
5. Single Chronic	Major Depression; Asthma
6. Chronic w/ Comorbidities	Diabetes with Acute Complications and Morbid Obesity
7. Malignancies	Breast Cancer; Prostate Cancer
8. Catastrophic	Congestive Heart Failure, Respiratory Arrest / Shock Without Trauma / Sudden Death

PCP Selection



- Region 1: Western

■

Region 2: Piedmont Triad

■

Region 3: Metrolina (Charlotte)

■

Region 4: Triangle

■

Region 5: Cape Fear

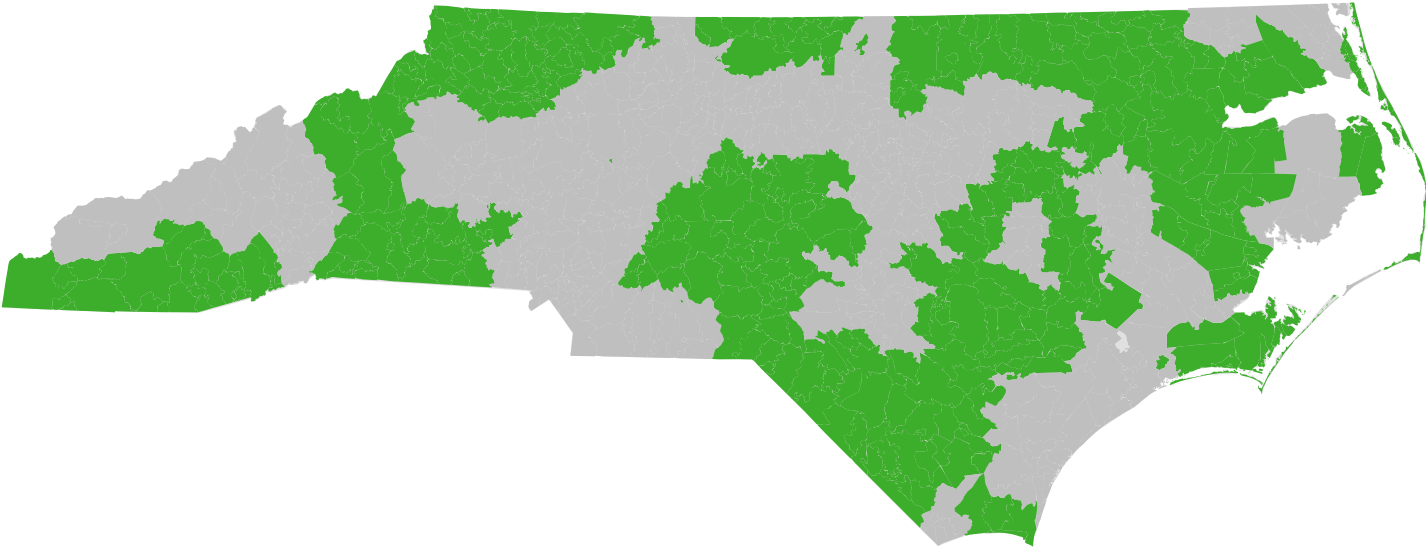
■

Region 6: Eastern NC

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Member Counts By Region		
Region	Member Count	% of Total
Region 1: Western	50,898	9.5%
Region 2: Piedmont Triad	77,852	14.5%
Region 3: Metrolina (Charlotte)	92,358	17.2%
Region 4: Triangle	164,967	30.8%
Region 5: Cape Fear	69,367	13.0%
Region 6: Eastern NC	69,105	12.9%
Out-of-State	10,875	2.0%
Unknown	26	0.0%
Total	535,448	100.0%

PCP Selection



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■ Rural ■ Urban

Member Counts By Region <i>Urban vs. Rural</i>			
Region	Member Count		% Rural
	Urban	Rural	
Region 1: Western	31,971	18,927	37%
Region 2: Piedmont Triad	53,415	24,437	31%
Region 3: Metrolina (Charlotte)	80,420	11,938	13%
Region 4: Triangle	142,433	22,534	14%
Region 5: Cape Fear	35,064	34,303	49%
Region 6: Eastern NC	37,325	31,780	46%
<i>Out-of-State</i>	7,492	3,383	31%
Total	388,120	147,302	28%

Source: Urban versus rural status is determined from the Centers for Medicare & Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) physician fee schedule.

Appendix

Biologic Mechanisms of Action and Indications

Branded Name	Non-Proprietary Name	Mechanism of Action	Major Indications
Humira	Adalimumab	TNF- α inhibitor	Rheumatoid arthritis (RA), Psoriatic arthritis (PsA), Plaque psoriasis (PsO), Ankylosing spondylitis (AS), Non-radiographic axial spondyloarthritis, Crohn's disease (CD), Ulcerative colitis (UC), Hidradenitis suppurativa (HS), Uveitis, Juvenile idiopathic arthritis (JIA)
Humira Biosimilars	Adalimumab biosimilars	TNF- α inhibitor	Same indications as Humira
Stelara	Ustekinumab	IL-12/23 inhibitor (binds p40 subunit shared by IL-12 and IL-23)	Psoriasis, PsA, Crohn's disease, Ulcerative colitis
Stelara Biosimilars	Various	IL-12/23 inhibitor	Same indications as Stelara
Bimzelx	Bimekizumab	Dual IL-17A and IL-17F inhibitor	Plaque psoriasis, PsA, Ankylosing spondylitis, Non-radiographic axial spondyloarthritis
Cimzia	Certolizumab pegol	TNF- α inhibitor	RA, PsA, Psoriasis, Crohn's disease, AS, Non-radiographic axial spondyloarthritis
Cosentyx	Secukinumab	IL-17A inhibitor	Psoriasis, PsA, AS, Non-radiographic axial spondyloarthritis, Hidradenitis suppurativa
Enbrel	Etanercept	Soluble TNF receptor fusion protein that binds TNF- α	RA, PsA, Psoriasis, AS, JIA
Kevzara	Sarilumab	IL-6 receptor antagonist	RA, Polymyalgia rheumatica (PMR)
Otezla	Apremilast	Phosphodiesterase-4 (PDE4) inhibitor, reducing inflammatory cytokine production	Psoriasis, PsA, Behçet's disease oral ulcers
Remicade	Infliximab	TNF- α inhibitor	RA, PsA, Psoriasis, Crohn's disease, UC, AS
Rinvoq	Upadacitinib	Selective JAK1 inhibitor	RA, PsA, AS, Non-radiographic axial spondyloarthritis, Atopic dermatitis, Crohn's disease, UC, Giant cell arteritis

Appendix

A Word About Privacy

- Data presented has been “de-identified,” which means it does not contain names or SSNs, etc.
- Specific medical conditions are identified.
- If the plan administrator knows the identity of individuals with a specific condition, that information is considered PHI.
- PHI is subject to the HIPAA Privacy Rule’s protections, which means it must be kept confidential and cannot be used for any reason other than health plan administration (e.g., using it for employment purposes, or by other benefit plans, is prohibited).

Appendix

Disclaimer

- This document has been prepared for the exclusive use and benefit of the State Health Plan of North Carolina, based on information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking information statements and does not guarantee any particular outcome or result. Except as may be required by law, this document should not be shared, copied or quoted, in whole or in part, without the consent of Segal. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax or other advisors before taking, or refraining from taking, any action.



Benefit Exclusion

Medical Policy Advisory Committee Update

Committee has had two meetings.

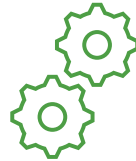
Completed task of reviewing the Plan's benefit exclusions.

Recommendations have been provided to Plan Leadership and analysis will begin soon.



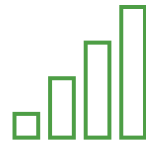
Initial Request:

Benefit changes can be proposed by Plan leadership, Plan members, Board of Trustees or legislative bodies, etc.



Initial Review:

The Plan reviews for strategic alignment and operational feasibility.



Actuarial & Fiscal Analysis:

Comprehensive cost-impact analysis is conducted.



Strategic Decision Making:

Leadership determines whether to proceed.



Formal Vote:

Presented to the Board of Trustees for vote.

2027 Benefit Exclusion Removal Vote

- The Medical Policy Advisory Committee (MPAC) recently reviewed the Plan's current limitations and exclusions.
- Upon review and analysis from Segal, Plan staff suggest to remove of such limitation.
- The Medical Policy Advisory Committee has recommended that the State Health Plan remove the "one procedure, per limb, per lifetime" limitation for varicose vein procedures.

See "What Is Not Covered" for a list of prosthetic appliance exclusions.

➤ ~~Varicose Veins~~

~~The treatment of varicose veins is covered when medically necessary and with the following limitations:~~

- ~~■ Endovenous Procedures — one procedure per limb per lifetime.~~
- ~~■ Sclerotherapy Procedures — three per limb per lifetime.~~



REQUIRES VOTE

2027 Benefit Exclusion Removal Vote

We're estimating a relatively small impact from removing the limitations below — approximately **\$500K**.

SHAPE data on these procedures:

Non-Medicare CY 2025 claims experience					
Service Type	Claimants	Visits	Allowed Amount	Plan Paid	Paid per Visit
Endovenous radiofrequency ablation (RFA)	429	661	\$1,400,317	\$1,327,914	\$2,009
Endovenous laser ablation (EVLA)	156	259	\$565,668	\$522,565	\$2,018
Sclerotherapy	795	2,190	\$2,670,964	\$2,590,638	\$1,183

From our research, removing the limitations would increase utilization by an estimated **10%-20%** or roughly **\$250K-\$500K**. We also pulled denials for these services. Had all of these previously denied claims been approved, it would have added approximately **\$500K** in claims.

Service Type	Claimants	Visits
Endovenous Procedures	87	89
Sclerotherapy Procedures	291	293



REQUIRES VOTE



 *North Carolina*
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

2028 Benefit Discussion

2028 Benefit Design

- 2028 Benefits Changes
- Consumer Directed Health Plan
 - Potential for Narrow Network to further lower costs

2028 Benefit Changes Under Consideration

- Given the transition to BCBSNC and giving the preferred provider structure needing time to evolve we want a more measured approach to benefit changes in 2028;
 - Adding a CDHP with HRA to address member feedback on wanting lower premium options and a savings vehicle for future healthcare costs
 - Includes rewards for health improvement activities
- No non-preferred IP behavioral healthcare; treat more like Emergency Department

Upcoming Provider Strategy

- Changes to non-preferred will be limited to 1/1 and 7/1 dates; this includes strategic changes and impacts of acquisitions.
- While practices can join the existing CIN partners and Lantern at anytime assuming they can come to contract terms (decision not owned by Plan); the Plan need to continually enhance our Preferred network by focusing on:
 - Quality,
 - Access, and
 - Total cost of care

Proposed Board Timeline for 2027

January 27	{	2028 Benefits Discussion
March 16	{	2028 Benefits Vote
May 25	{	Medicare Advantage
July 28	{	2028 Premiums
October 20	{	Implementation Update Open Enrollment Update 2029 Benefit Discussion



Appendix

Evolution of State Health Plan Tiering

2012-2017

- Reduced copay for selecting Primary Care Provider (PCP)
- Copay reduction for some inpatient and outpatient services based on quality

2018-2024

- Reduced copay for selecting PCP, deeper for Clear Pricing Project (CPP)
- Reduced copay for any CPP provider, across all specialties, no emphasis on quality or access but focused on transparency
- One value-based pilot
- **Key Learning:**
Members will utilize lower cost providers

CURRENT

PHASE 1

- Reduced copay for selecting PCP, deeper in preferred tier
- Reduced specialty copay for Multi-Disciplinary Specialty Clinically Integrated Network (CIN) in shared risk model
- \$0 for qualified surgery and procedures based on quality and access

PHASE 2

- Expand Preferred Provider model to three tiers to reflect differences in cost and access for high variance services
- Build out CIN with shared savings and reduced copays to drive down total cost of care and improve quality



Preferred Providers Tier Structure

Aligning COST, ACCESS and movement toward VALUE across all provider tiers.

PREFERRED PROVIDERS

- Focuses on reducing total cost of care and improving health outcomes
- Not all providers can be included in a given geography
- Provides lowest copay for members

ACCESS PROVIDERS

- Maintains essential access points in rural areas and outside of NC with limited provider options
- Cost neutral for members or in some cases may be lower out-of-pocket costs

NON-PREFERRED PROVIDERS

- These providers elected or were not selected to participate in PPP
- Members will see a significant cost increase when seeing these providers

OUT-OF-NETWORK PROVIDERS

- There is little member impact as the Plan's TPA, Aetna, has a broad, national network

2027 Benefit Changes

	STANDARD PPO Plan				PLUS PPO Plan			
	Preferred	Access	Non-Preferred	Out-of-Network	Preferred	Access	Non-Preferred	Out-of-Network
ANNUAL DEDUCTIBLE	\$1,500 Ind \$4,500 Fam	\$3,000 Ind \$9,000 Fam	\$5,000 Ind \$15,000 Fam	\$15,000 Ind \$45,000 Fam	\$1,000 Ind \$3,000 Fam	\$1,500 Ind \$4,500 Fam	\$4,000 Ind \$12,000 Fam	\$12,000 Ind \$36,000 Fam
OUT-OF-POCKET MAX (combined medical & pharmacy)	\$4,000 Ind \$12,000 Fam	\$6,500 Ind \$16,300 Fam	\$12,000 Ind \$24,000 Fam	\$36,000 Ind \$72,000 Fam	\$3,000 Ind \$9,000 Fam	\$5,000 Ind \$15,000 Fam	\$10,000 Ind \$20,000 Fam	\$30,000 Ind \$60,000 Fam
WALK-IN CLINIC	\$40 other PCP on ID card \$50 other PCP			50% after ded	\$30 other PCP on ID card \$40 other PCP			40% after ded
SPECIALISTS	\$40	\$65	30% after ded	50% after ded	\$25	\$50	20% after ded	40% after ded
HIGH-COST IMAGING	\$400	30% after ded	\$1,000, then 30% after ded	50% after ded	\$250	20% after ded	\$500, then 20% after ded	40% after ded
EMERGENCY ROOM	\$600, then 30% after deductible				\$500, then 20% after deductible			
INPATIENT HOSPITAL	\$750*	\$600, then 30% after ded	\$1,500, then 30% after ded	50% after ded	\$500*	\$500, then 20% after ded	\$1,000, then 20% after ded	40% after ded
OUTPATIENT SURGERY	\$600*	\$350, then 30% after ded	\$1,000, then 30% after ded	50% after ded	\$300*	\$300, then 20% after ded	\$500, then 20% after ded	40% after ded
AMBULATORY	\$400*	30% after ded	\$1,000, then 30% after ded	50% after ded	\$250*	20% after ded	\$500, then 20% after ded	40% after ded
LANTERN SURGICAL BENEFIT	Lantern Surgical Benefit \$0 Member Cost				Lantern Surgical Benefit \$0 Member Cost			



Preferred Provider



Access Provider
Same as 2026



Non-Preferred Provider

PCP=Primary Care Provider

In-Network (deductible & OOP max cross-accumulates)

*Facility copay only. Additional cost-share may apply.



Population Health Risk Full Report



2026 POPULATION RISK REPORT

Actives and Non-Medicare Retirees

October 27, 2026

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Background

- Aside from 2023, Segal has prepared a detailed risk study for the State Health Plan (SHP) for the past several years. The risk study originally utilized the Clinical Risk Groups (CRG) risk grouper but then transitioned to a combination of the Clinical Classifications Software Refined (CCSR) medical grouper and the SegalRx risk model. For this year and the year prior, the DxCG risk model has also been included in the report.
 - Medical risk scores are based off the DxCG model. Medical risk scores are provided both concurrently and prospectively.
 - The CCSR model was used to provide insights into trend drivers on the medical side.
 - The SegalRx model was used for prescription drug risk scores and to provide insights into trend drivers on the pharmacy side.
 - More information on key differences between the DxCG model and CCSR model can be found in the Appendix.
- The combined risk model provides the following benefits:
 - Provides customizable reports
 - Shows population morbidity changes over time.
 - Provides insights into medical and prescription drug trends
 - Provides a diagnostic tool to assist the SHP in understanding the health of Plan members and the impact of population health management and initiatives
- Four years of experience were utilized for the study: calendar year 2022 was used as the baseline period and calendar years 2023 through 2025 were used as the experience period. All experience in this study is shown in the year in which it incurred.
 - Unless stated otherwise, pharmacy rebates are not included in this study.
- Active and non-Medicare retirees and covered dependents are included. Medicare retirees are excluded from the report.

Objectives

- Identify the prevalent health risks within the plan's active and non-Medicare retiree population and predict the financial impact of those risks
- Identify emerging health risks
- Understanding the effect of comorbidities and how various chronic conditions interact with each other
- Measure the effectiveness of the wellness programs in improving member health risk over time
- Uncover opportunities for the plan to better control plan cost and improve the health of the covered population
- Measure clinical quality metrics and identify gaps in care
- Quantify health status and underlying drivers of trend
- To evaluate the impact of healthcare access challenges in rural areas on overall health outcomes, patient experience, and system efficiency
- Proactively identify aberrant utilization patterns
- Improve financial evaluation of program/vendor performance
- Risk stratification and target high risk groups for preventive interventions
- Forecast future medical expenses and support budgeting

Key Findings and Recommendations

Section	Key Findings	Recommendations
Medical and Prescription Drug Summary (pgs. 11-13)	• Medical trend increased to 14.6% in 2025, above Segal's public sector benchmark of 8.6%, after favorable results in 2022-2024. • Net prescription drug trend was -1.9% in 2025, the second consecutive year of negative net trend. • Medical risk increased 3.3%, substantially less than the growth in medical cost.	• Continue to monitor medical trend and consider a more detailed evaluation of the transition to Aetna. • Continue to monitor both gross drug trends and prescription drug rebates.
Population Risk Review (pgs. 14-21)	• Chronic members represented the largest cohort and 63% of 2025 medical costs. • Catastrophic/malignancy per-capita medical costs increased 31.6% in 2025, driven by higher cancer treatment costs. • Rural members had 4% higher risk, 8% higher hospital admissions, and 27% higher ER use than urban members. • Overall medical risk is projected to increase 2.7% in 2026.	• Continue to monitor emerging trend drivers to identify potential intervention strategies, particularly for diabetes, hypertension, mental health and cancer. • Continue to aggressively manage the PBM contract, including periodic PBM market checks, to ensure competitive pricing and maximized rebates. • Emergency room (ER) visits have increased significantly, led by members residing in rural areas. Expanding access and promoting awareness of alternatives to the ER can help reduce unnecessary emergency room visits. • Use prospective risk scores to support targeted outreach and care management.

Key Findings and Recommendations

Section	Key Findings	Recommendations
Risk Drivers (pgs. 22-23)	• Cancer & oncology accounted for 18% of the year-over-year increase in medical risk, diabetes, endocrine & metabolic contributed 15% and cardiovascular & cerebrovascular also added 15%. • Antipsoriaties were the largest pharmacy risk driver, followed by hormone replacement therapy (e.g., women's health and menopause management), and lipid/cholesterol drugs. • Risk improved for severe brain injuries, ear/nose/throat & oral conditions, and acute lung edema / asphyxia.	• Focus clinical and vendor strategies on cancer, cardiovascular disease, and diabetes. • Monitor antipsoriatric utilization, biosimilar adoption, and movement to higher-cost competitors. • Complications of care was a top risk driver in 2025. The State should conduct targeted reviews of high-cost procedures and implanted medical devices, monitor readmissions and infection-related complications, and strengthen care management for members with complex conditions to reduce avoidable downstream costs.
Mental Health (pgs. 24-26)	• Mental health prevalence increased from 37.6% in 2022 to 44.1% in 2025, although new diagnoses are beginning to moderate. • Anxiety and depression prevalence declined in 2025, but cost per treated member increased 17.9% and 16.9%, respectively. • Inpatient hospital utilization remained below the benchmark and professional utilization remained above benchmark. • Outpatient hospital costs increased sharply in 2025. • Autism cost per treated member declined 37.5% in 2025.	• Offering clinical navigation services can help ensure members get the right care from the start, reducing unnecessary tests and visits. Navigation services should be able to identify highest-quality providers to reduce the number of counseling sessions used. • Ensure that the Aetna network strategy has adequate coverage for mental health and is accessible to members. • Investigate 2025 outpatient cost growth for anxiety and depression. • Continue monitoring autism utilization, unit cost, family support, and care coordination.

Key Findings and Recommendations

Section	Key Findings	Recommendations
Substance Use Disorder (pg. 27)	• SUD prevalence (excluding tobacco) increased from 2.0% in 2022 to 2.7% in 2025. • Growth was driven by alcohol, cannabis, and stimulant use disorders. • Sedative, opioid, and tobacco prevalence declined over the experience period (2022 – 2025). • Alcohol was the largest cost driver, with cost per claimant increasing 18% in 2025.	• Review the substance use disorder treatment network to ensure timely access to evidence-based care across all levels of treatment, including medication-assisted treatment, intensive outpatient, residential, and recovery support services. • Monitor wait times, treatment engagement, and outcomes, and consider clinical navigation programs to improve access, and care coordination.
PCP Engagement (pgs. 28-30)	• About 91% of members selected a PCP in 2025. • Overall evaluation and management (E&M) engagement remains strong but declined slightly from 80.7% in 2024 to 80.3% in 2025. • Members who select a PCP have higher risk scores, but lower risk-adjusted medical costs, few ER visits, and fewer urgent care visits. • Engagement was slightly higher in rural areas than urban areas, but engagement improved more in urban areas since 2022.	• Use panel-level reporting to compare PCP performance on engagement, care gaps, and avoidable utilization. • Consider value-based incentives for closing care gaps and improving chronic-condition outcomes. • Target members without a PCP or recent E&M visit who have chronic conditions or multiple emergency room visits. • Integrate PCP engagement in broader wellness programs and/or consider reduced physician copays for members compliant with wellness initiatives.

Key Findings and Recommendations

Section	Key Findings	Recommendations
Catastrophic Risk Group (pg. 31-33)	- The catastrophic/malignancy population declined by 288 members in 2025, the first decrease in the experience period. - Chronic kidney disease was the leading condition, representing about 9% of the risk group and adding 190 members in 2025. - Breast and metastatic cancer were also leading conditions. - Only about 12% of members in the catastrophic risk group went through case management in 2025.	- Intervention strategies used to prevent catastrophic claims for individuals with chronic conditions often involve promoting maintenance and preventive care, medication adherence, lifestyle modifications, care coordination, and health education. - Discuss with Aetna how high-risk members are identified and managed and consider implementing clinical high-cost claim reviews. These reviews involve in-depth assessments of high-cost claims to identify opportunities to improve care management interventions and coordination of care.
Cancer (pgs. 34-37)	12,161 members were treated for cancer in 2025, including 2,650 newly diagnosed members, both were reductions from 2024. 64.8% of cancers treated had routine screening recommendations. - The State has made meaningful improvements in preventive cancer screening rates. All four screenable cancers experienced an increase in screening compliance over the experience period. - Breast and prostate prevalence increased, and all four screenable cancers had double-digit cost increases in 2025.	- Increasing awareness and providing comprehensive information about the availability and importance of cancer screenings is key to improving compliance rates. - Review Aetna navigation, second-opinion, centers-of-excellence, and treatment-guidance programs. - Consider offering financial incentives (e.g., gift card, premium discount) to employees who complete all recommended screenings to improve screening compliance and earlier detection.

Key Findings and Recommendations

Section	Key Findings	Recommendations
Chronic Conditions (pg. 38)	• 73.6% of members had a chronic condition in 2025, including 35.5% with a major physical chronic condition¹ and 26.2% with a behavioral health condition². • Mental health prevalence increased 11.2 percentage points from 2022 to 2025. • Diabetes had the largest increase in risk and hypertension had the second largest increase.	• Review availability and appropriateness of disease management programs through Aetna. • Consider implementing a point solution for diabetes and developing a comprehensive wellness program that incentivizes healthy activities and nutrition. • Monitor effectiveness of Hello Heart for managing hypertensive members. • Add chronic condition-specific communications to website, including testimonials from employees on how they are staying healthy, recipes (e.g., keto-friendly recipes for diabetics), and other wellness information (e.g., important benefits of exercise and spending time outdoors). • Disease management programs that aim to address the main chronic conditions should take a holistic approach to managing members’ health as opposed to treating the condition in a silo, including integrating management of mental health conditions.

¹ Major Chronic = asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes, and hypertension.

² Behavioral health = mental health (MH) and/or substance use disorders (SUD).

Key Findings and Recommendations

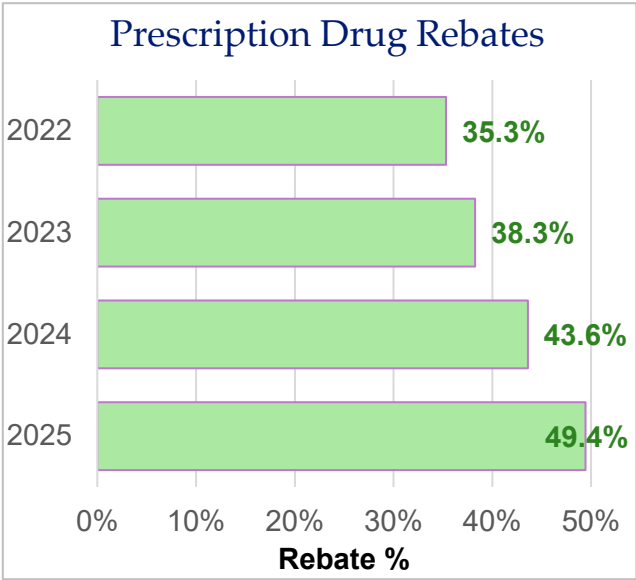
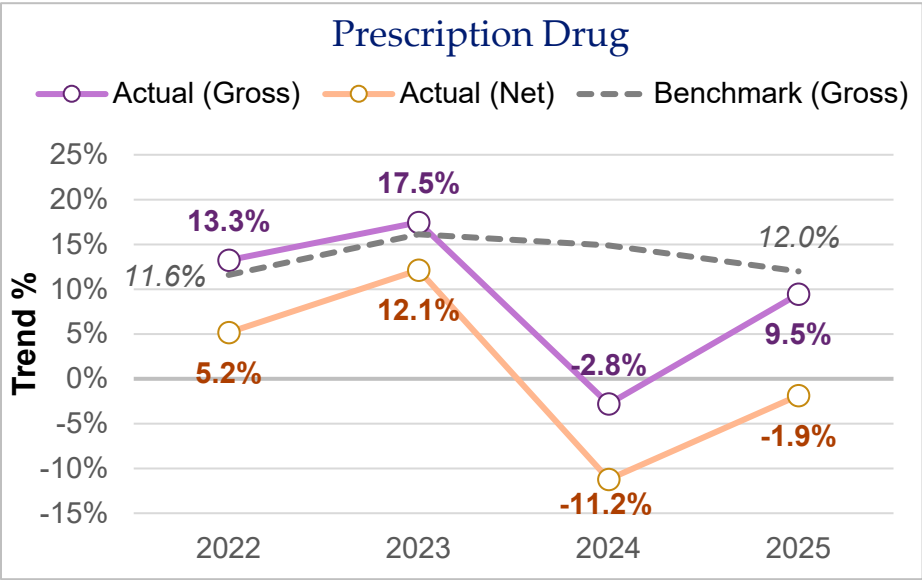
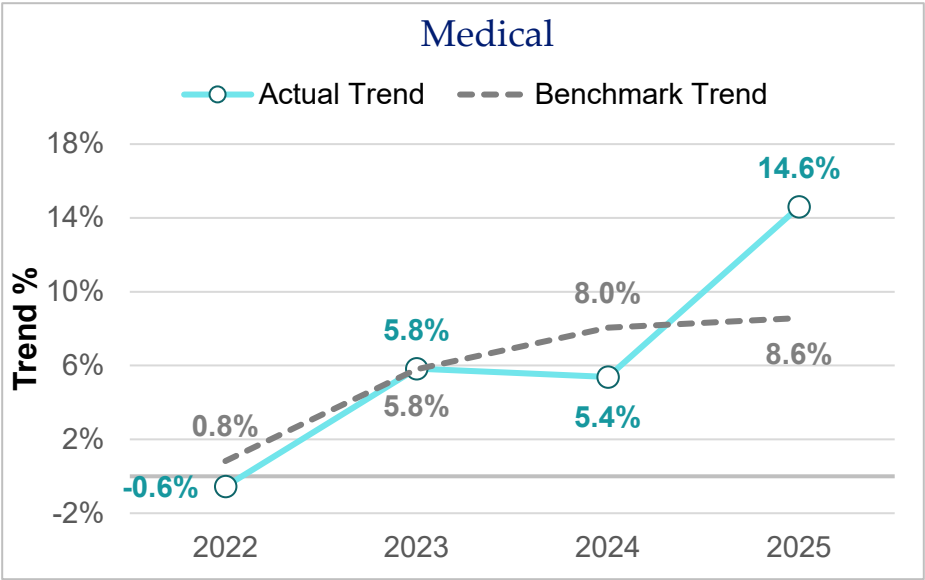
Section	Key Findings	Recommendations
Diabetes (pgs. 39-44)	• Diabetes prevalence increased from 9.7% in 2022 to 11.4% in 2025, although new diagnoses declined in 2025. • Cardiometabolic costs increased 8.5% annually, including a 25% increase in medical costs in 2025. • More diabetics are developing multiple comorbidities. 16.3% had heart disease in 2025, up from 12.8% in 2022. • A1C testing and PCP visits improved in 2025. However, hospital admissions and ER use also increased. • Eastern NC had the highest prevalence and greatest increase in risk.	• Consider adding a point solution that specializes in diabetes management and/or health coaching. Coaches can work one-on-one with members to help them learn more about their condition and how to manage it. • Consider adding digital tools that allow for syncing of personal fitness devices. Members using such tools can join group challenges and explore virtual courses that make managing the condition more engaging for members. • Consider implementing a quantity limit on the first fill and then a reauthorization criteria for diabetic GLP-1 medications to confirm a positive response to current therapy and/or continued need. • Address dialysis, outpatient hospital, and ICU cost growth through care management and site-of-care review.

Key Findings and Recommendations

Section	Key Findings	Recommendations
Hypertension (pgs. 45-50)	• Hypertension prevalence increased from 25.6% in 2022 to 27.4% in 2025, while overall risk increased 9.3%. • Cardiometabolic medical costs increased 29.9% in 2025, led by inpatient, outpatient, dialysis, and pharmacy costs. • The hypertensive population experienced higher rates of PCP and specialist engagement. However, emergency room visits and inpatient admissions continue to increase as well. • Eastern NC had the highest prevalence and greatest increase in risk.	• Monitor effectiveness of Hello Heart, including who's enrolling, who the program is not reaching, program persistency, and outcomes. Outcomes should be compared to a statistically similar matched comparison group. • Promote regular blood pressure screenings and consider integrating blood pressure monitoring into a broader wellness program. • Support lifestyle interventions and promote physical activity programs (e.g., walking challenges, gym discounts). • Offer and promote nutritional counseling. • Continue to monitor prevalence and risk of hypertensive population.
Biosimilars (pgs. 51-52)	• Humira and Stelara biosimilar adoption increased after formulary changes, initially reducing average 30-day cost. • Although the State has realized savings from utilization of Humira and Stelara biosimilars, utilization has shifted toward higher-cost competitors. • Skyrizi, Rinvoq, and Tremfya were prominent higher-cost competitors.	• Tighten formulary and utilization-management rules to limit non-clinical switching to higher-cost competitors. • Monitor net cost, persistence, and competitor migration after biosimilar conversion. • Evaluate step therapy and preferred-product strategies with the PBM.

Medical and Prescription Drug Summary

Trends

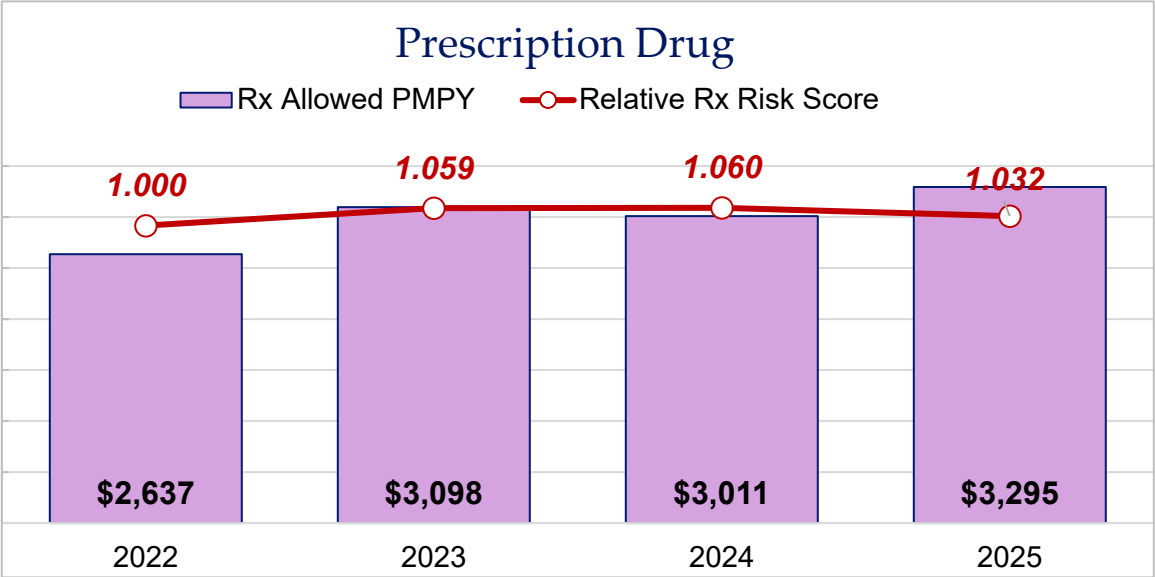
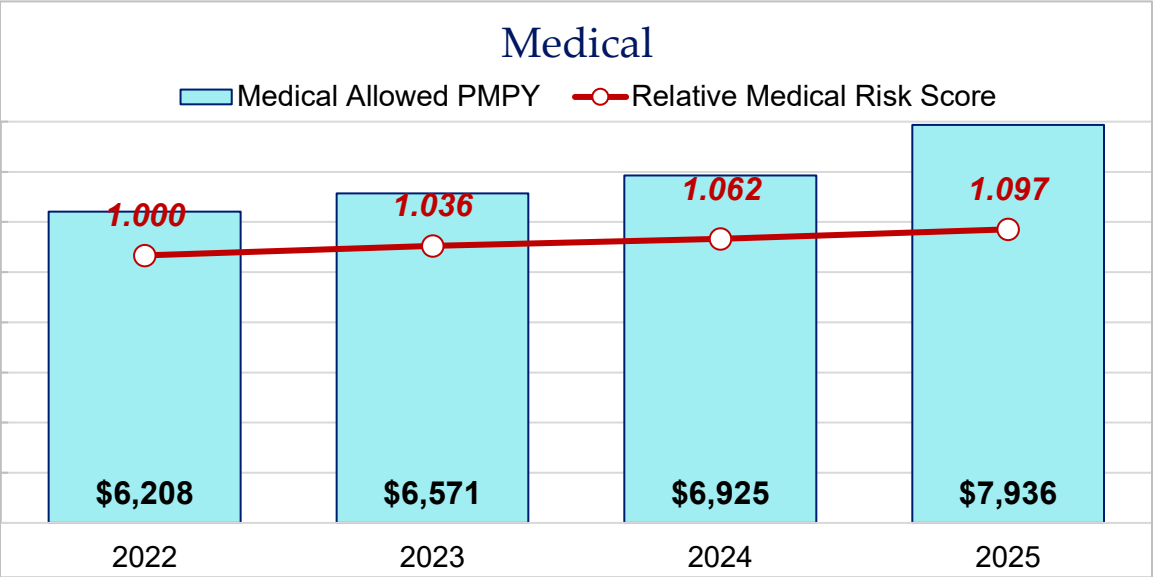


Observations

- The charts above summarize year-over-year (YoY) medical and prescription drug per member per month (PMPM) trends.
 - Trends are based on allowed amounts, which include both the plan paid and member paid amounts.
 - Prescription drug trend is shown on a gross and net (i.e., including rebates) basis.
- Benchmark trend represents the trend from Segal’s SHAPE public sector book-of-business. Benchmark trend for prescription drugs is gross of rebates.
- Overall, the Plan was doing well at managing medical expenses until 2025. Medical trend for the plan was favorable compared to the benchmark in 2022 through 2024 but significantly higher in 2025.
- The Plan experienced higher prescription drug trend than the benchmark in 2022 and 2023 but lower trend in 2024 and 2025 following the decision to remove weight-loss drugs and Humira from coverage. Once rebates are factored in, prescription drug trend in 2025 was -1.9%, marking two consecutive years of negative trend.

Medical and Prescription Drug Summary

Cost and Risk

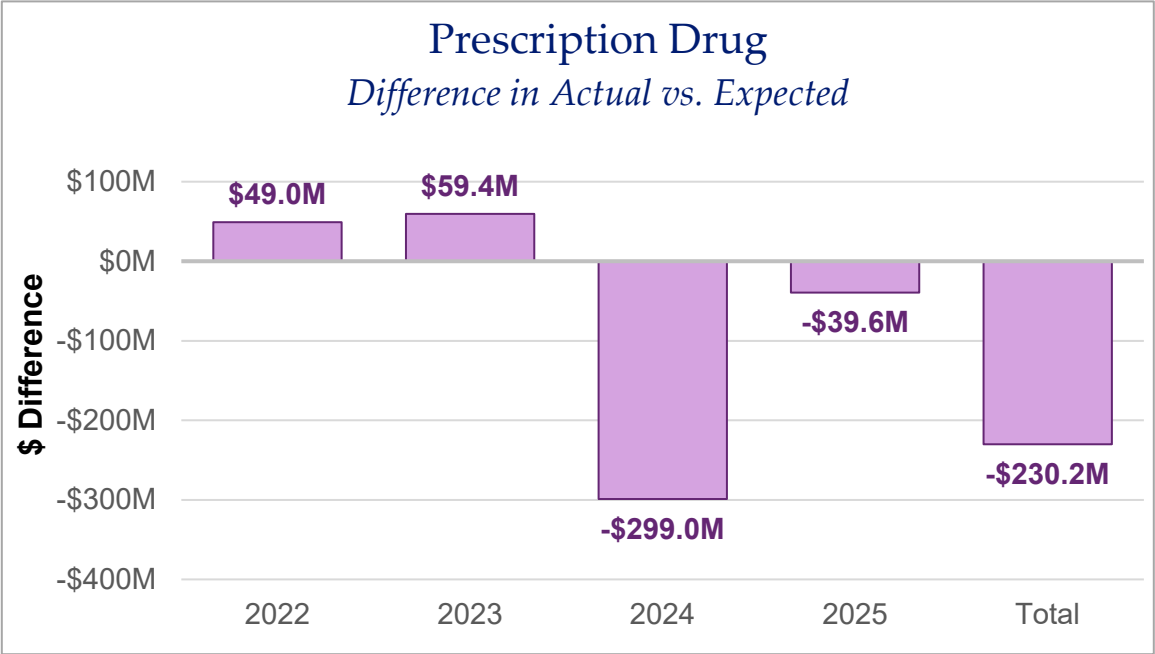
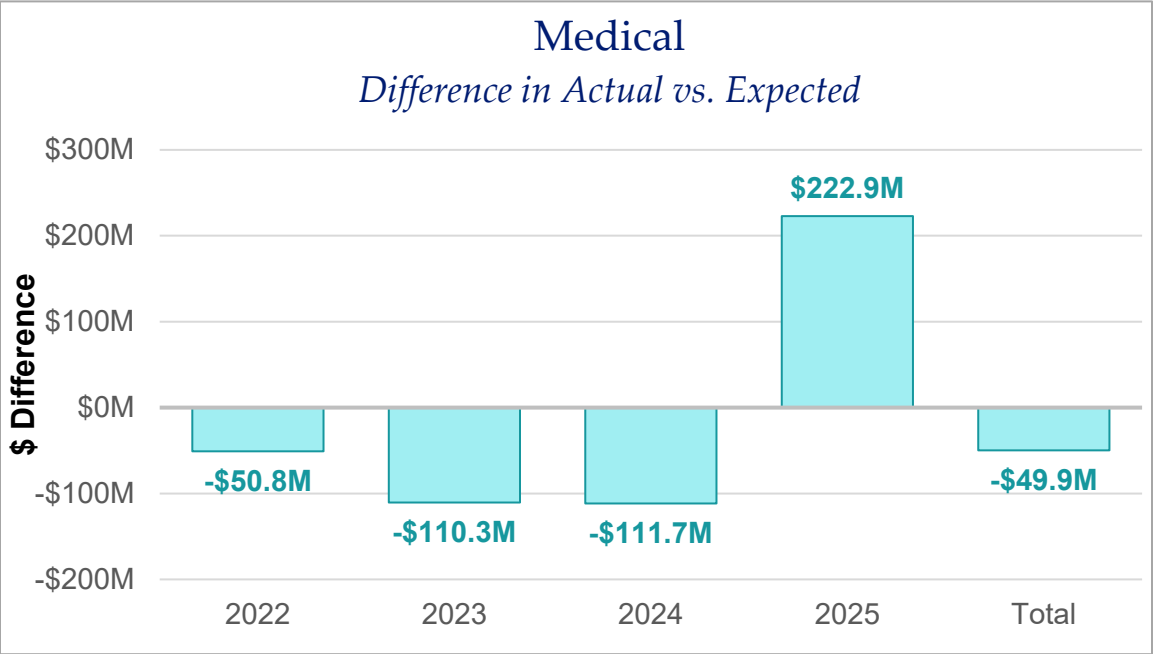


Observations

- Medical risk scores have increased about 3% per year since 2022 and have been driven by cancer & oncology, diabetes, endocrine & metabolic, as well as cardiovascular & cerebrovascular.
 - While medical risk increased 3.3% in 2025, per capita medical costs increased 14.6%, the highest of any year in the experience period.
- Prescription drug risk scores have been stable over the last four years. Although the Plan has experienced a rise in risk due to psoriasis, diabetes, hormone replacement therapy (primarily women’s health and menopause management), and cholesterol disorders, it has mostly been offset by a reduction in risk driven by less utilization of opiates, anti-obesity agents, insulin, and sedatives.
- Summaries of cost and risk by region (e.g., Piedmont Triad, Metrolina, Triangle) are provided in the appendices.

Medical and Prescription Drug Summary

Actual vs. Expected Plan Paid

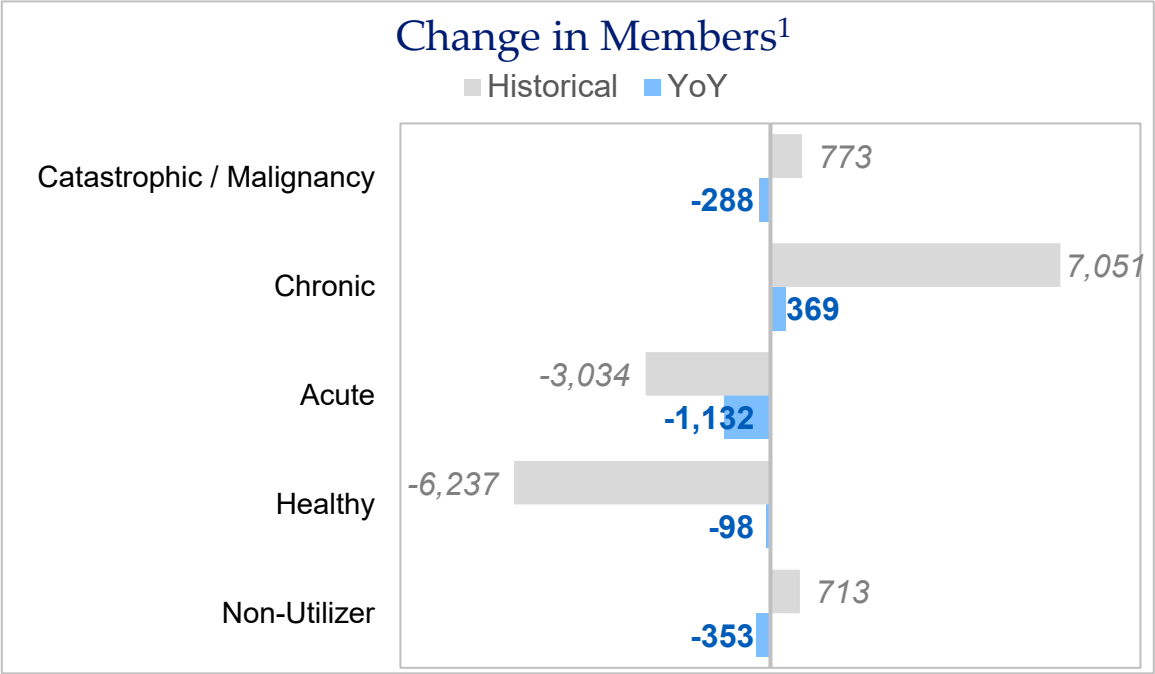
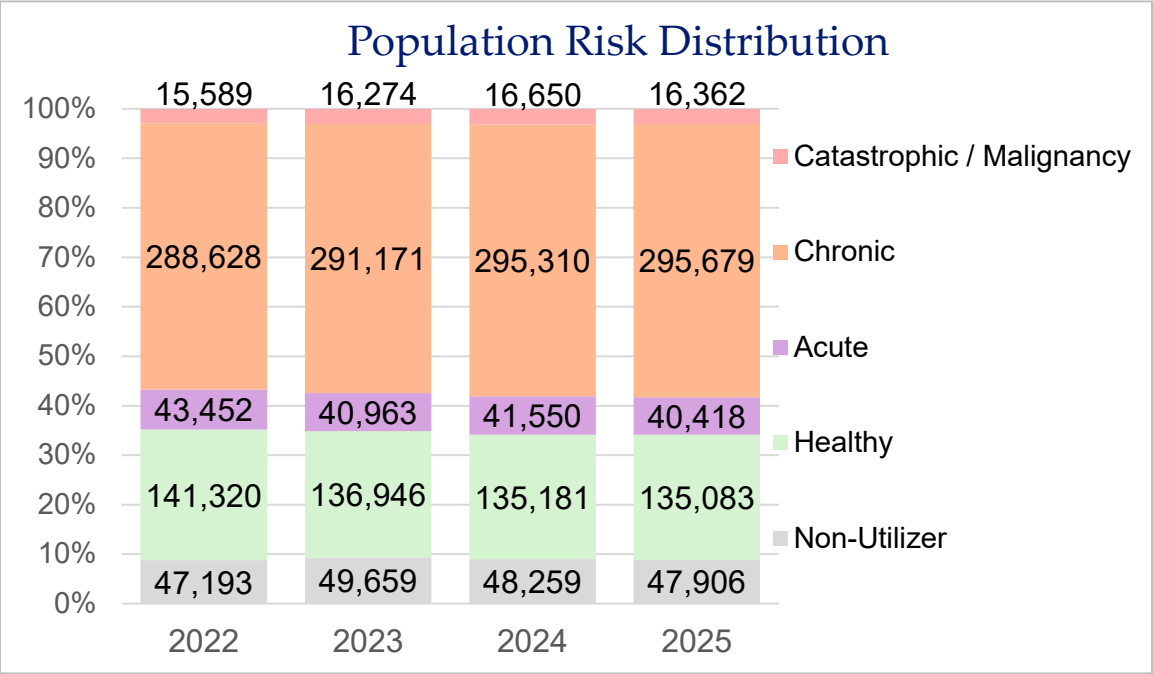


Observations

- The charts above quantify the difference between actual versus expected trends paid by the Plan.
 - Expected trends were determined based on Segal’s SHAPE benchmark plan paid trends for public sector groups.
- On the medical side, the Plan has paid approximately \$49.9 million less than expected during the last four years. However, in 2025 the Plan paid approximately \$222.9 million more than expected.
- On the prescription drug side, the Plan has paid approximately \$230.2 million less than expected during the last four years, mainly due to favorable experience in 2024 following the State’s decision to remove coverage for weight-loss drugs. Note that this figure is on a gross basis as we are unable to procure a benchmark that includes rebates for all public sector clients.

Population Risk Review

Historical Membership Risk Distribution

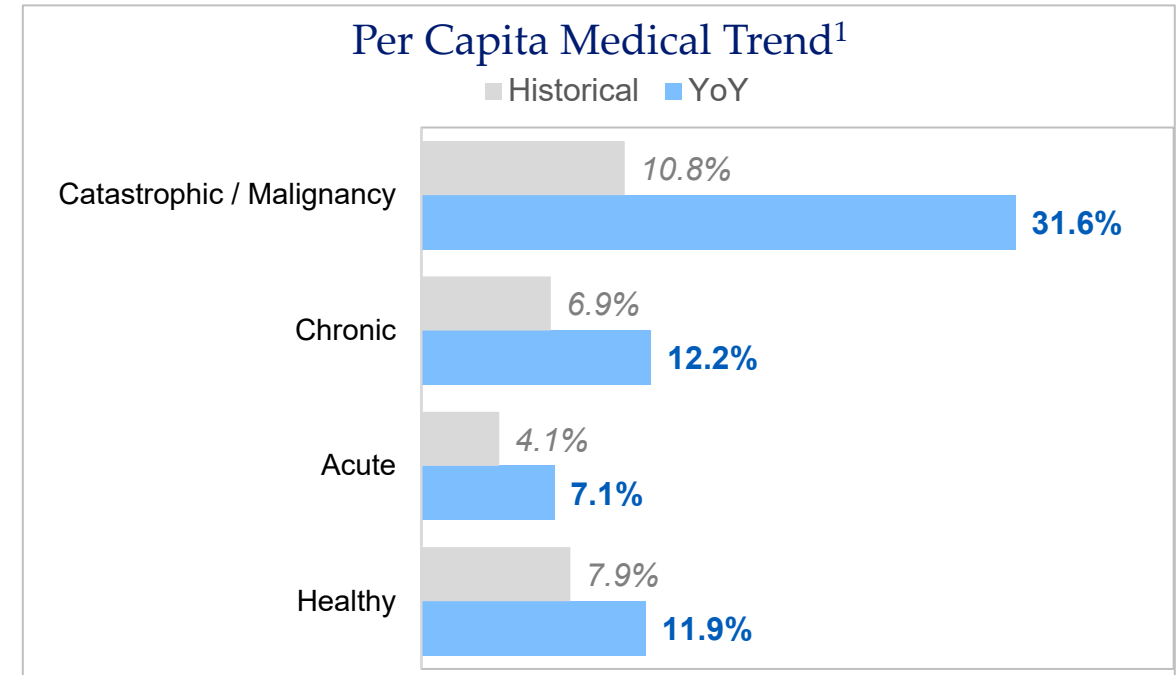
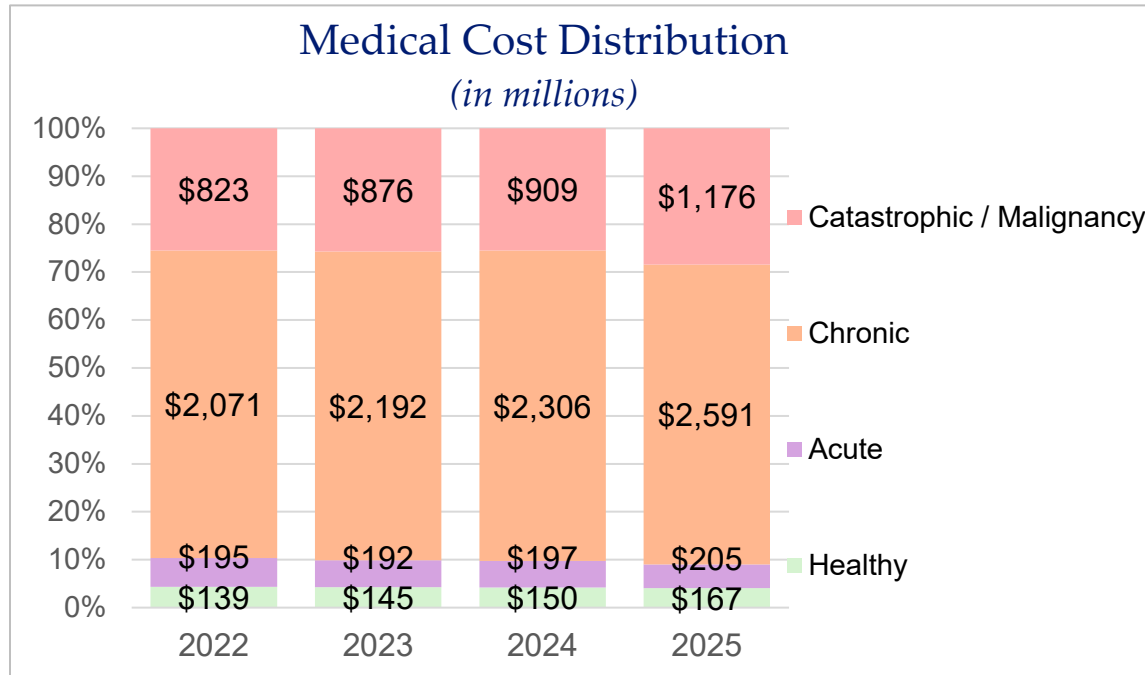


Observations

- The graphs above summarize trends in membership among the risk groups.
- Members with chronic conditions increased the most from 2022 to 2025 with an increase of 7,051 members (+2.4% increase). Note the majority of the increase happened in 2022-2024 as the chronic population was relatively stable in 2025.
 - Healthy members had the largest decrease in members from 2022 to 2025 of 6,237 (-4.4% decrease).
 - The number of non-utilizers increased by 713 members from 2022 to 2025 (+1.5%).
 - Then number of members grouped as catastrophic / malignancy increased by 773 members from 2022 to 2025 (+5.0%). However, the catastrophic / malignancy population experienced a decrease of 288 members in 2025.

Population Risk Review

Medical Cost Trend by Risk Group



Observations

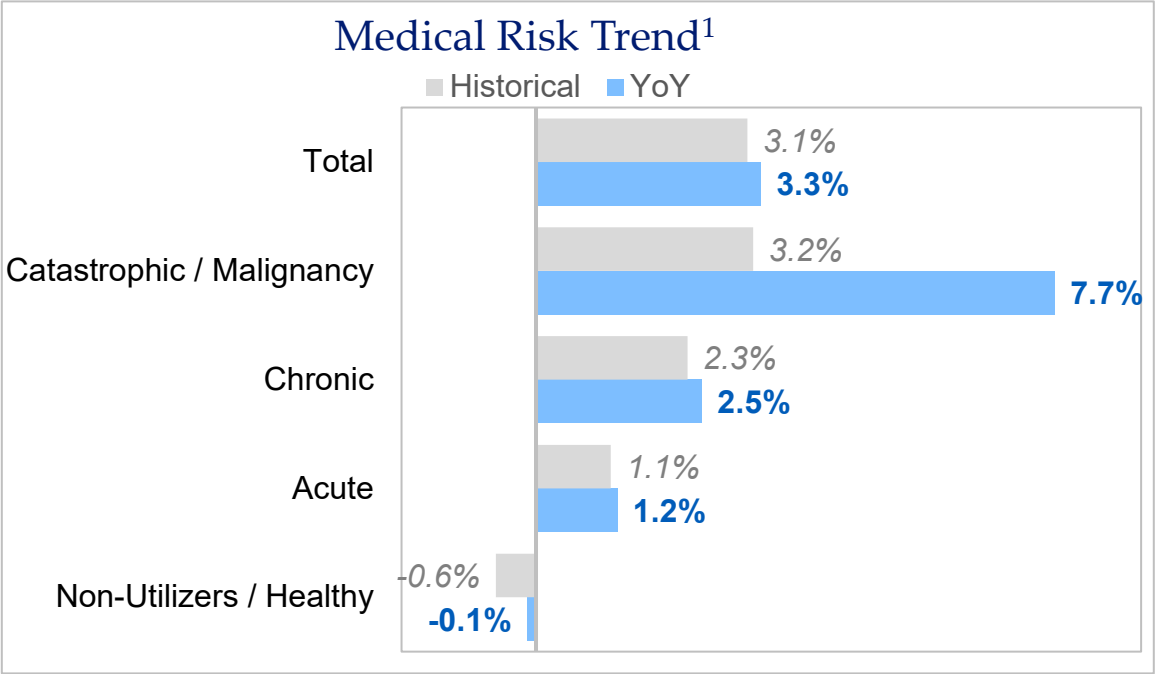
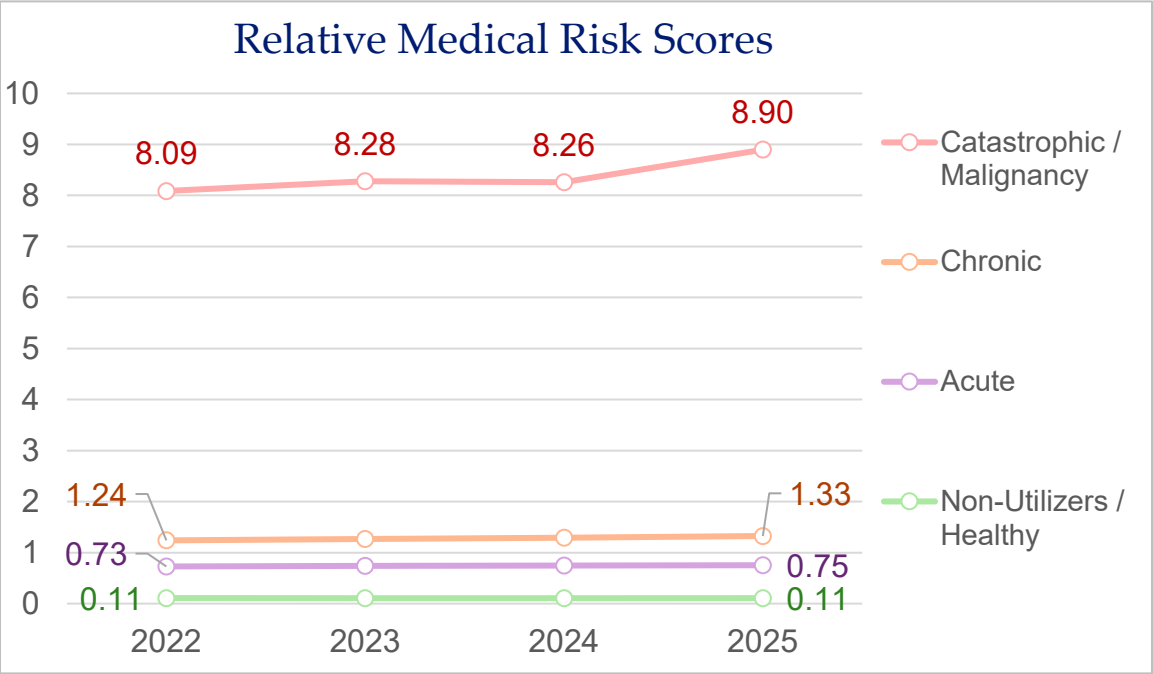
The graphs above summarize trends in medical costs among the risk groups.

- \$2.6 billion was spent on members with chronic conditions in 2025, representing 63% of all medical costs. Medical costs per capita for this cohort have increased at an annual rate of 6.9% from 2022 through 2025.
- The catastrophic / malignancy cohort has the highest per capita medical trend rate of 10.8% from 2022 through 2025, which was mainly driven by significantly higher costs in 2025, when medical costs increased 31.6%.
- The main driver of medical trend is not necessarily increasing expenses within each risk group but instead due to members transitioning to riskier groups (e.g., from healthy to chronic).

¹ Historical trend reflects the annualized trend between 2022 and 2025.

Population Risk Review

Medical Risk Scores by Risk Group



Observations

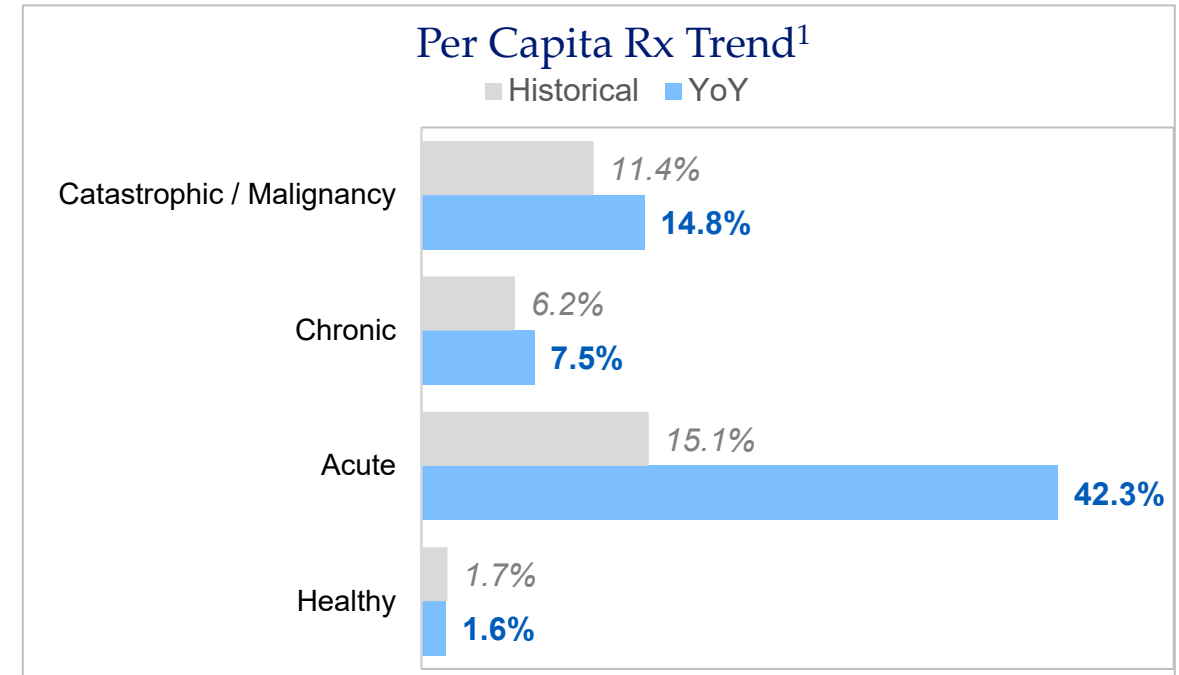
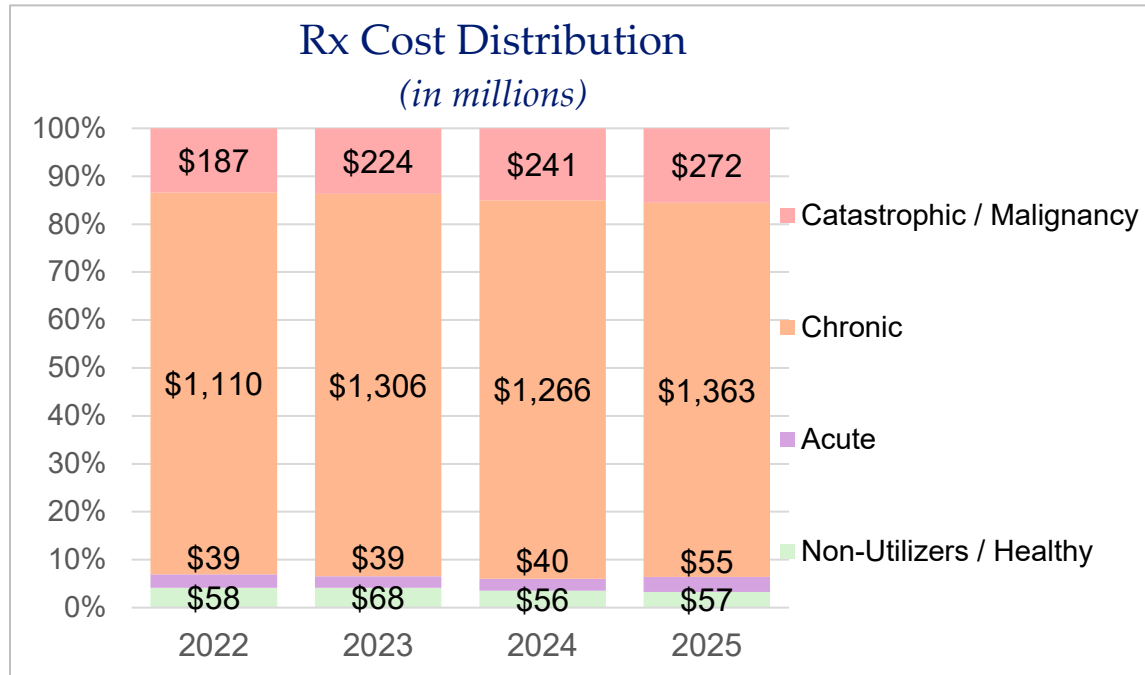
The graphs above summarize trends in medical risk scores among the risk groups.

- The healthy and acute cohorts have had relatively stable risk scores over the experience period.
- Risk scores for the catastrophic / malignancy risk group have increased the most over the experience period at an annualized rate of 3.2%, mainly due to a 7.7% increase in 2025. The risk score for this group increase in 2025 from metastatic cancers, kidney failure requiring dialysis, organ transplants, and congestive heart failure.
- Overall medical risk scores have increased 3.1% per year since 2022, which is higher than all individual risk groups aside from catastrophic / malignancy. This is due to members transitioning to higher risk groups.

¹ Historical trend reflects the annualized trend between 2022 and 2025.

Population Risk Review

Rx Cost Trend by Risk Group



Observations

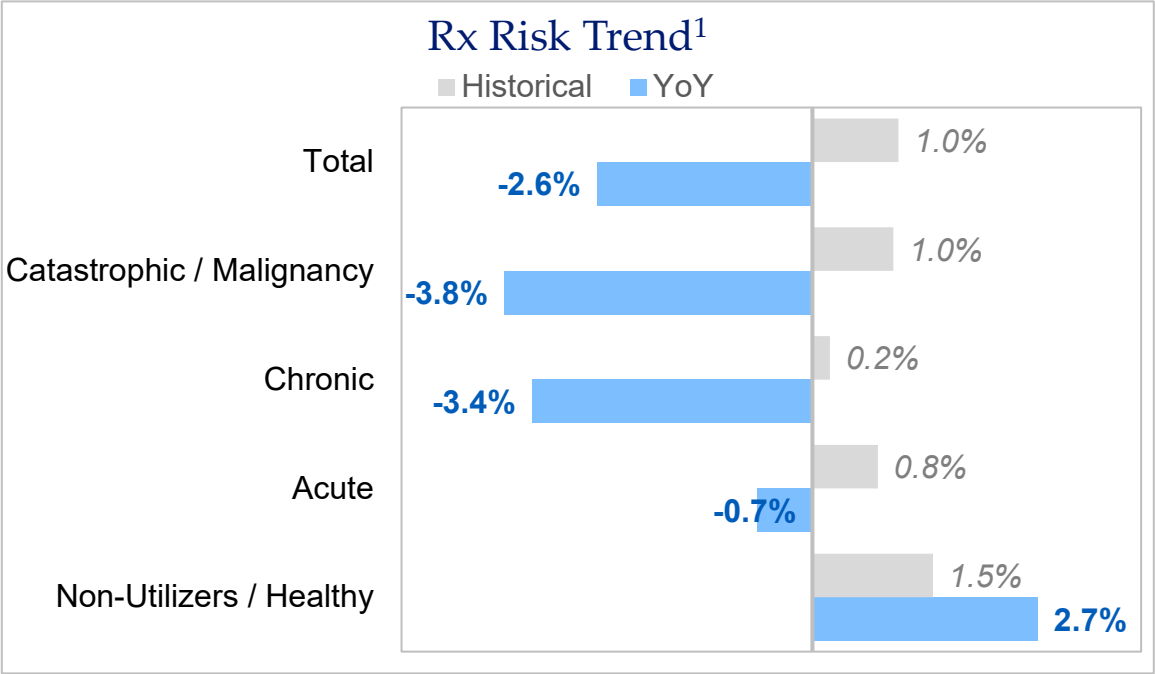
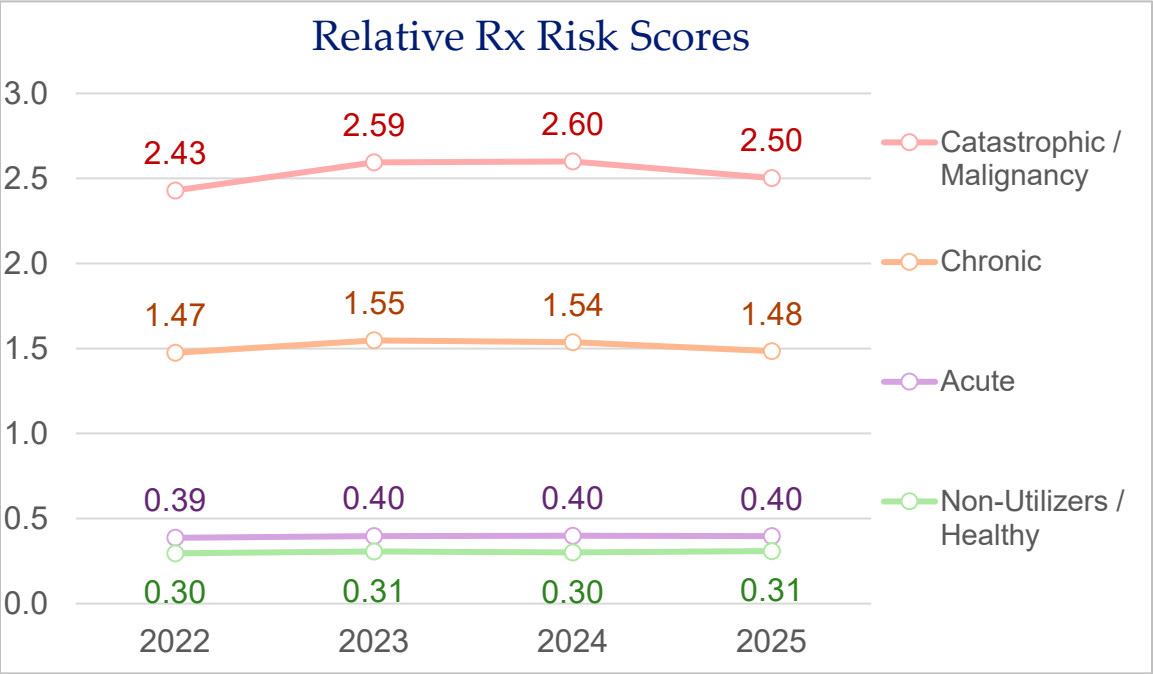
The graphs above summarize trends in prescription drug costs among the risk groups.

- \$1.4 billion was spent on members with chronic conditions in 2025, representing 78% of all drug costs. Drug costs per capita for this cohort have increased at an annual rate of 6.2% from 2022 through 2025, 2nd lowest of all risk groups.
- The acute cohort has the highest drug cost per capita trend rate of 15.1% from 2022 through 2025, driven by a 42.3% increase in 2025. 2025 drug costs were primarily driven by psoriasis (Skyrizi, Tremfya, Bimzelx) and skin disorders (Dupixent).

¹ Historical trend reflects the annualized trend between 2022 and 2025.

Population Risk Review

Rx Risk Scores by Risk Group



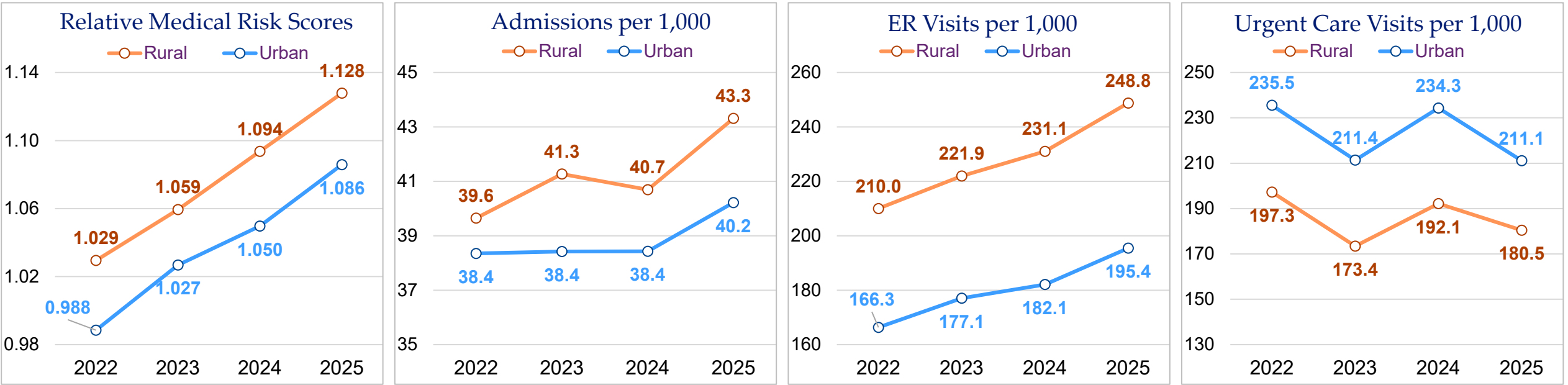
Observations

- The graphs above summarize trends in prescription drug risk scores among the risk groups.
- All cohorts experienced a reduction in Rx risk in 2025 aside from non-utilizers / healthy but are up slightly over the experience period.
 - Risk scores for the non-utilizers / healthy risk group have increased the most over the experience period at an annualized rate of 1.5%. Note that risk for this cohort is low and a small increase in risk can amount to a large percentage increase
 - Overall drug risk scores have increased 1.0% per year since 2022, which is higher than all individual risk groups aside from non-utilizers / healthy. This is due to members transitioning to higher risk groups.

¹ Historical trend reflects the annualized trend between 2022 and 2025.

Population Risk Review

Urban vs. Rural Comparison



Observations

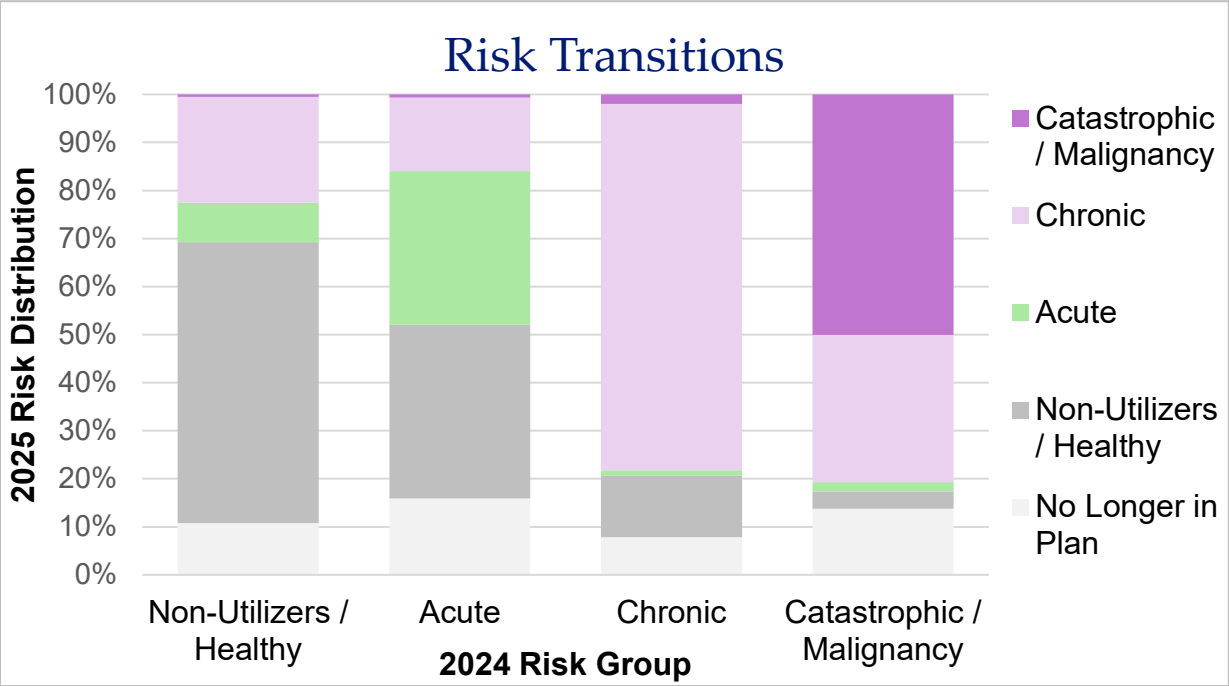
The charts above summarize differences in risk and outcomes between members who reside in urban versus rural areas¹.

- Medical risk scores have increased slightly less over the experience period for members in rural areas (+9.6% versus +9.9%). However, risk scores for members in rural areas are about 4% higher.
- Hospital admissions per 1,000 have historically been about 6% higher for members in rural areas. However, they were 8% higher in 2025, the largest differential during the experience period.
- Emergency room (ER) visits per 1,000 have historically been about 26% higher for members in rural areas. However, ER visits were 27% higher for members in rural areas in 2025, the largest differential during the experience period.
 - The main reason for higher ER visits in rural areas appears to be lack of access to urgent care centers, where utilization is approximately 17% lower in rural areas.

¹ See Appendices for more information on the rural vs. urban classification.

Population Risk Review

Membership Migration



Observations

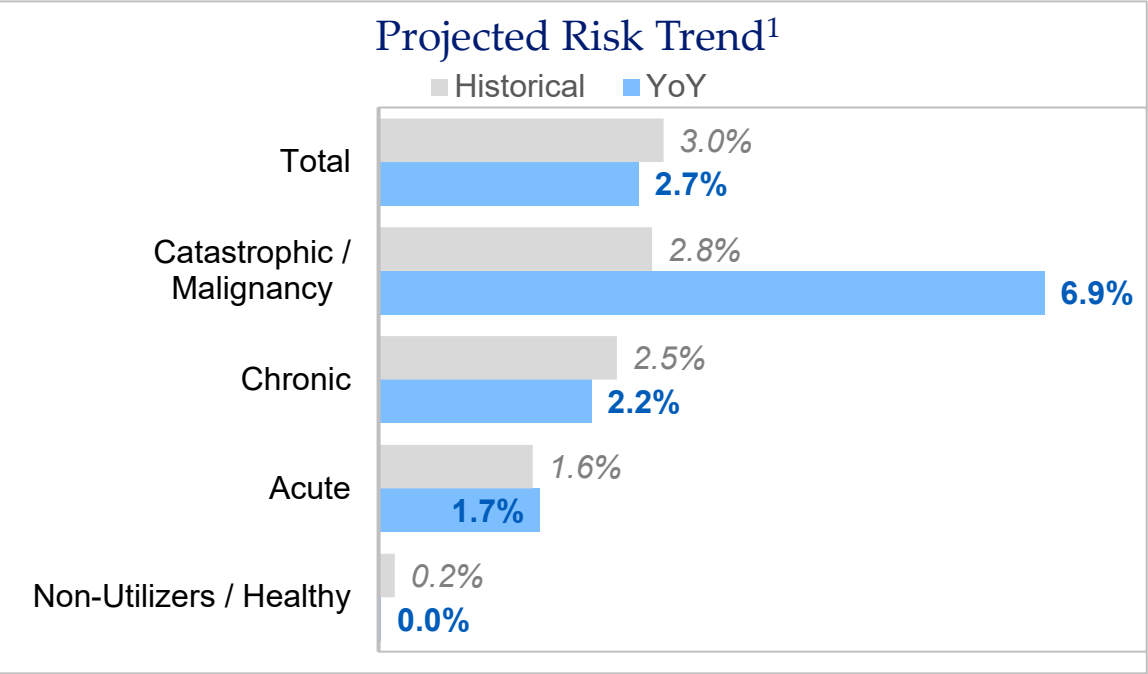
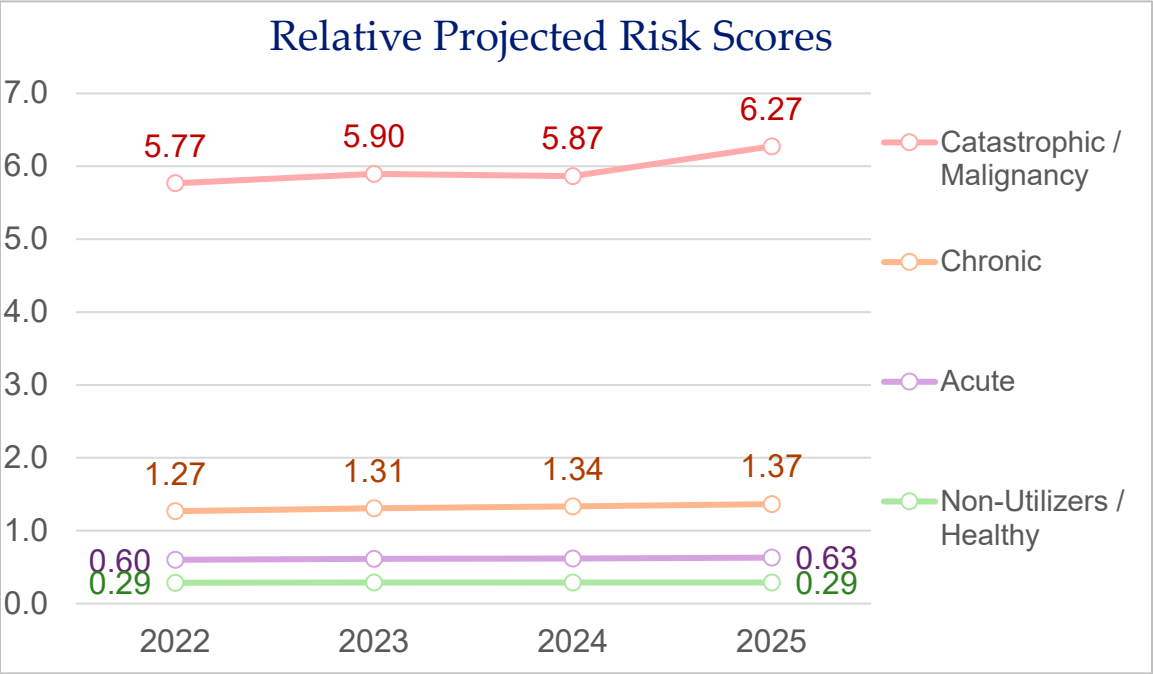
This page summarizes the risk group transitions that took place from 2024 to 2025 and key drivers of each.

- Approximately 36% of new members and 25% of members that were non-utilizers / healthy in 2024 fell into the chronic category in 2025, driven by mental health, musculoskeletal, diabetes, and gastrointestinal.
- 2.1% of chronic members in 2024 were in the catastrophic / malignancy risk group in 2025, drive by cancer, musculoskeletal, and heart disease.
 - 2.2% of chronic members transitioned to the catastrophic / malignancy risk group in 2023 and 2024, thus 2025 was a slight improvement.

Risk Transitions 2024 -> 2025		
Risk Transition	% of Risk Group	Top Drivers
New -> Chronic	36.3%	1. Mental
		2. Musculoskeletal and Connective Tissue
		3. Diabetes
New -> Catastrophic / Malignancies	2.0%	1. Malignant Neoplasm
		2. Urinary System
		3. Neonates
Non-Utilizer / Healthy -> Chronic	25.0%	1. Mental
		2. Musculoskeletal and Connective Tissue
		3. Gastrointestinal
Non-Utilizer / Healthy -> Catastrophic / Malignancies	0.6%	1. Malignant Neoplasm
		2. Benign/In Situ/Uncertain Neoplasm
		3. Cardio-Respiratory Arrest
Acute -> Chronic	15.5%	1. Mental
		2. Developmental Disability
		3. Musculoskeletal and Connective Tissue
Acute -> Catastrophic / Malignancies	0.7%	1. Malignant Neoplasm
		2. Benign/In Situ/Uncertain Neoplasm
		3. Musculoskeletal and Connective Tissue
Chronic -> Catastrophic / Malignancies	2.1%	1. Malignant Neoplasm
		2. Musculoskeletal and Connective Tissue
		3. Heart

Population Risk Review

Medical Risk Projection



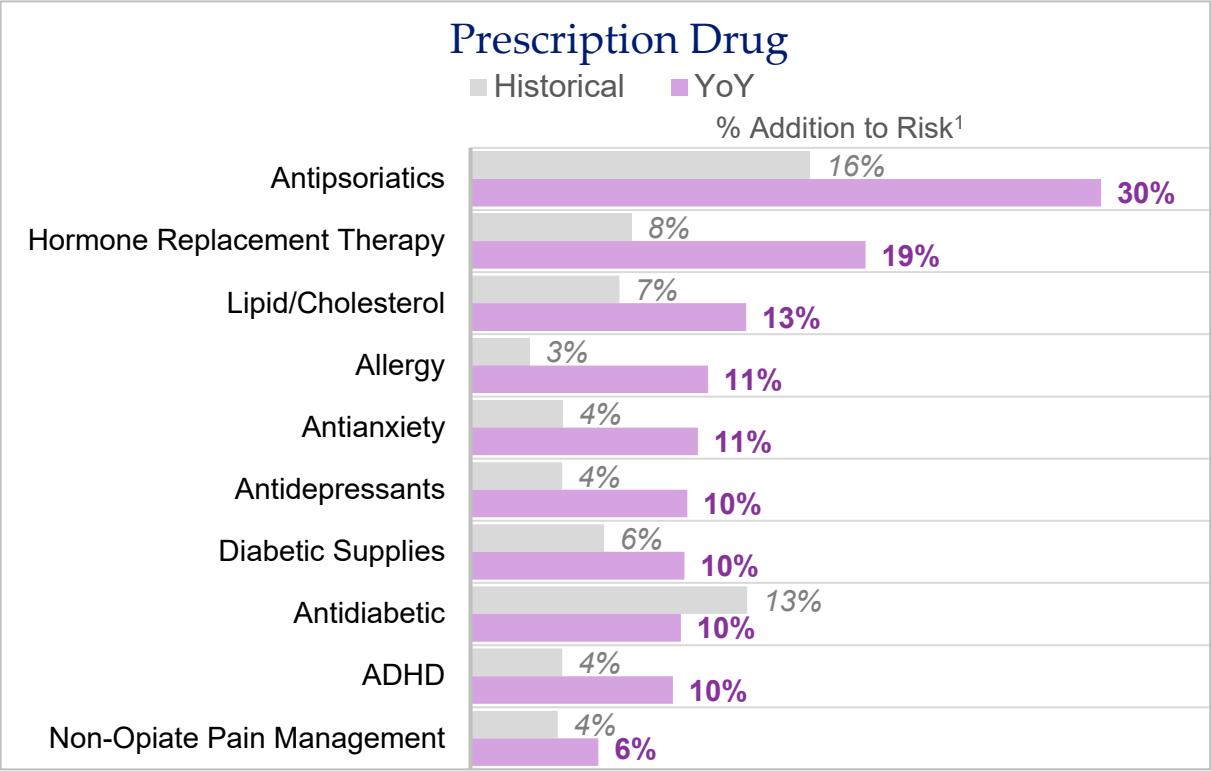
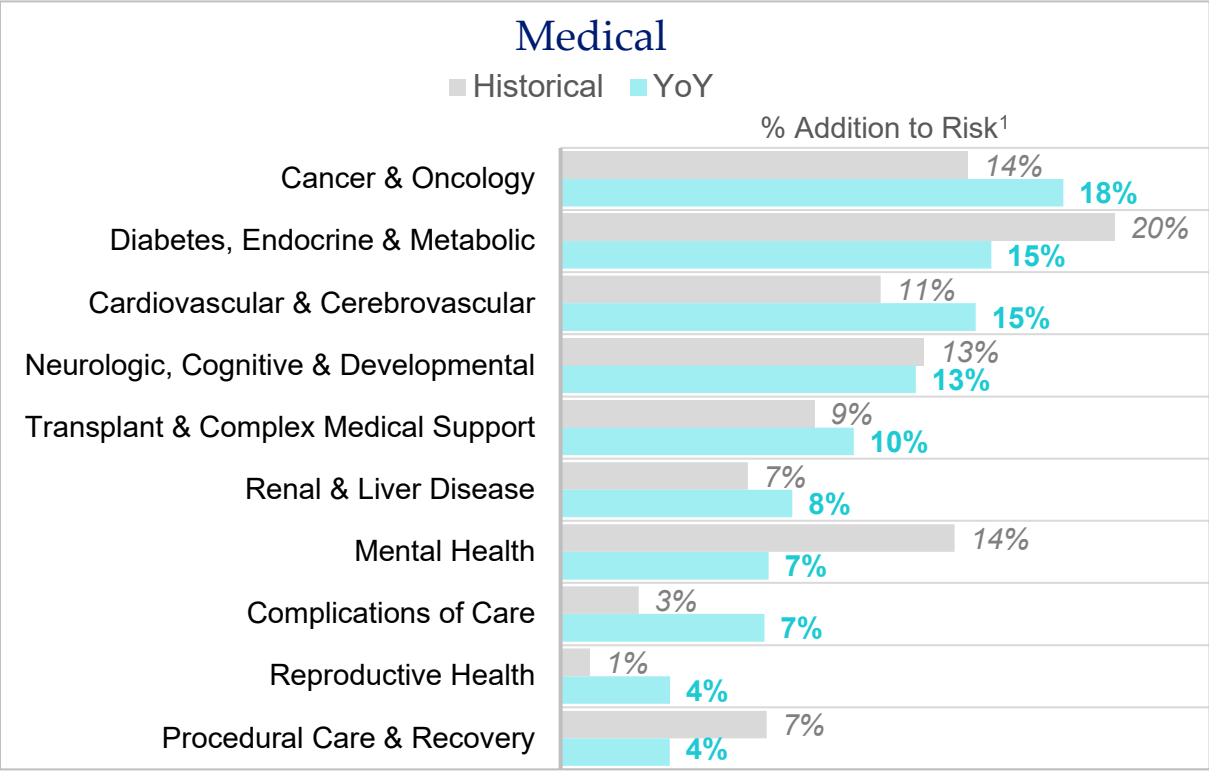
Observations

- The charts above summarize trends in projected medical risk scores among the risk groups. The projected scores are calculated through the DxCG model and focus more on ongoing chronic conditions compared with the concurrent scores used elsewhere in this report.
- The catastrophic / malignancy cohorts are expected to experience a 6.9% increase in risk in 2026, significantly higher than the 2.8% historical increase.
 - Risk scores for the chronic condition risk group are expected to increase 2.2% in 2026, which is below the 2.5% historical increase.
 - Overall medical risk scores are projected to increase 2.7% in 2026, which is lower than the 3.0% annual increase the Plan has experienced over the historical period

¹ Historical trend reflects the annualized trend between 2022 and 2025.

Risk Drivers

Top Contributors to Risk



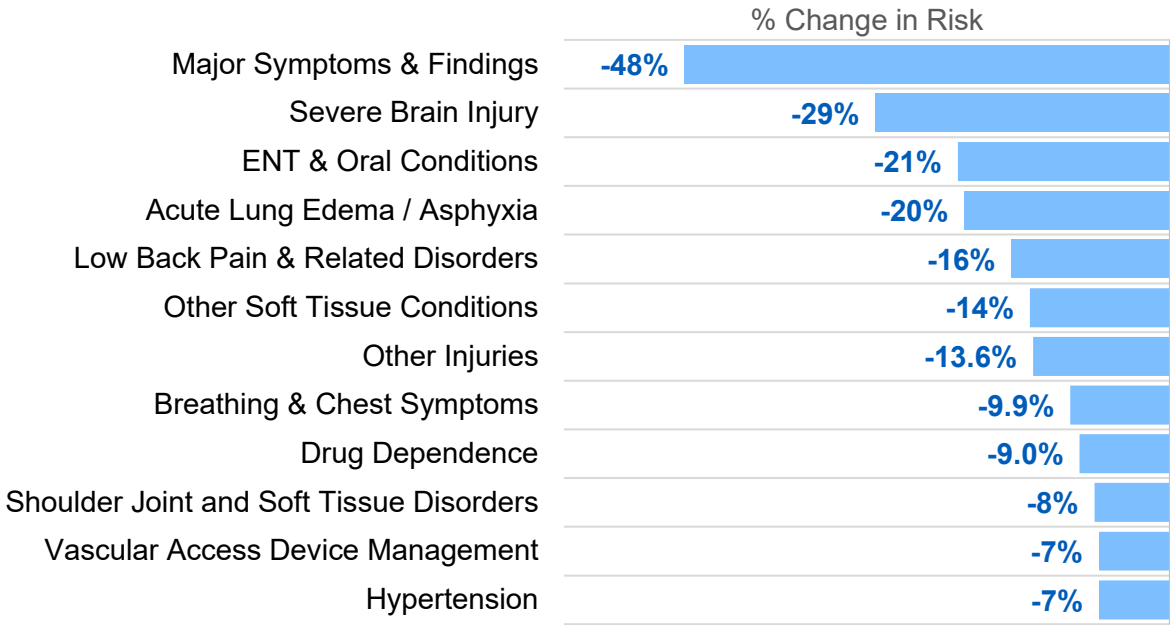
Observations

The graphs above summarize the conditions with the largest addition to risk from 2024 to 2025 along with the historical addition to risk.

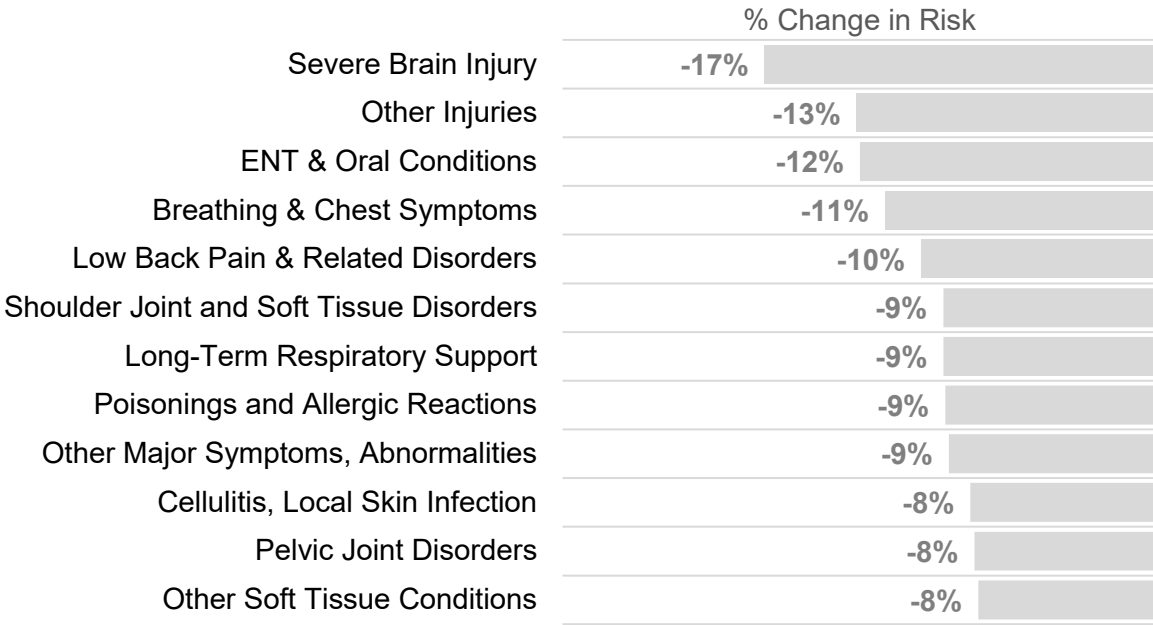
- The main factors driving year-over-year (YoY) medical risk were cancer & oncology (18%), diabetes, endocrine, & metabolic (15%), and cardiovascular & cerebrovascular (15%).
- The main factors driving year-over-year (YoY) prescription drug risk were antipsoriatrics (30%), hormone replacement therapy (mainly women’s health and menopause management; 19%), and lipid/cholesterol (13%).

¹ Addition to risk represents the percent of the change in risk attributed to each risk category.

Year-Over-Year



Historical¹



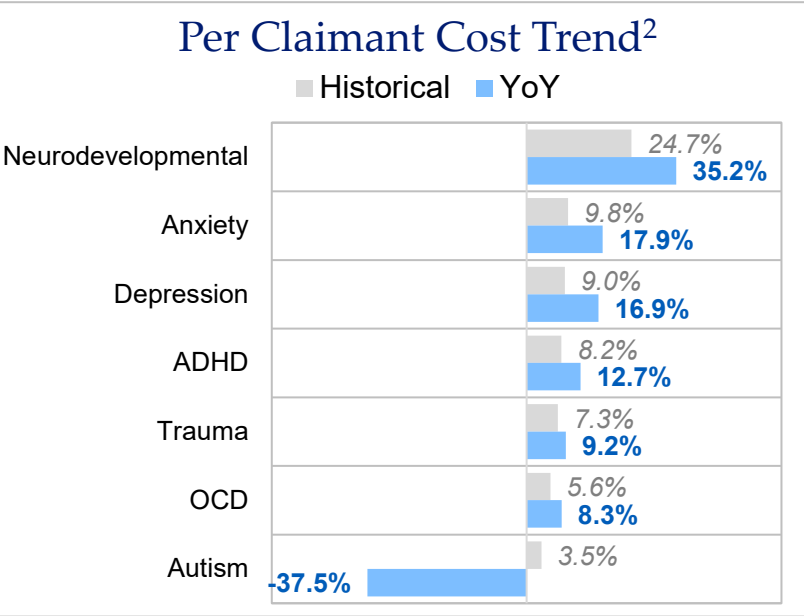
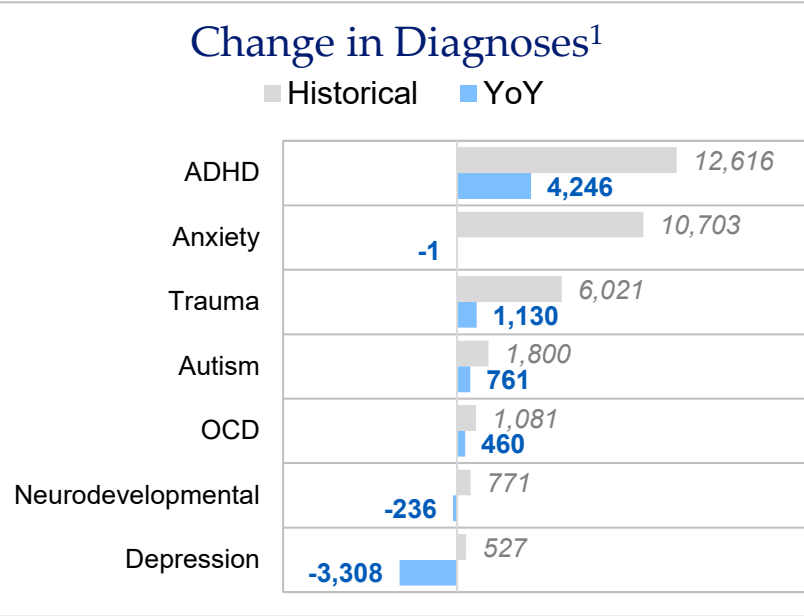
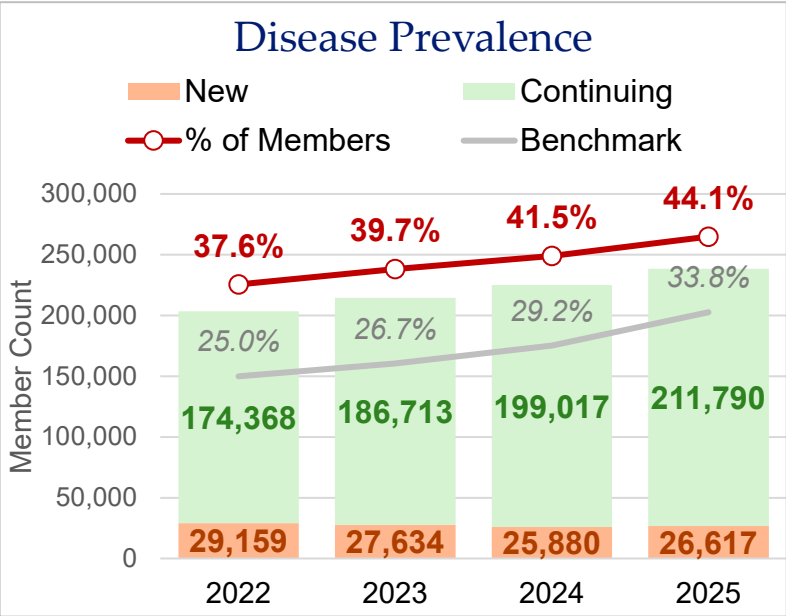
Observations

- The graphs above summarize the conditions with the largest reductions in risk 2024 to 2025 (year-over-year) and 2022 to 2025 (historical).
- The Plan is seeing year-over-year health improvements for severe brain injuries, ear/nose/throat & oral conditions, and acute lung edema / asphyxia.
 - There has also been a 7% reduction in risk for hypertension, which is an encouraging sign as the State works to improve management of this population.
 - From 2022 to 2025, the largest reductions in risk occurred for sever brain injuries, other injuries, and ear/nose/throat & oral conditions.

¹ Historical represents the % change in risk from 2022 to 2025.

Mental Health

Condition and Cost Trends



Observations

The graphs above summarize prevalence and cost trends for mental health conditions.

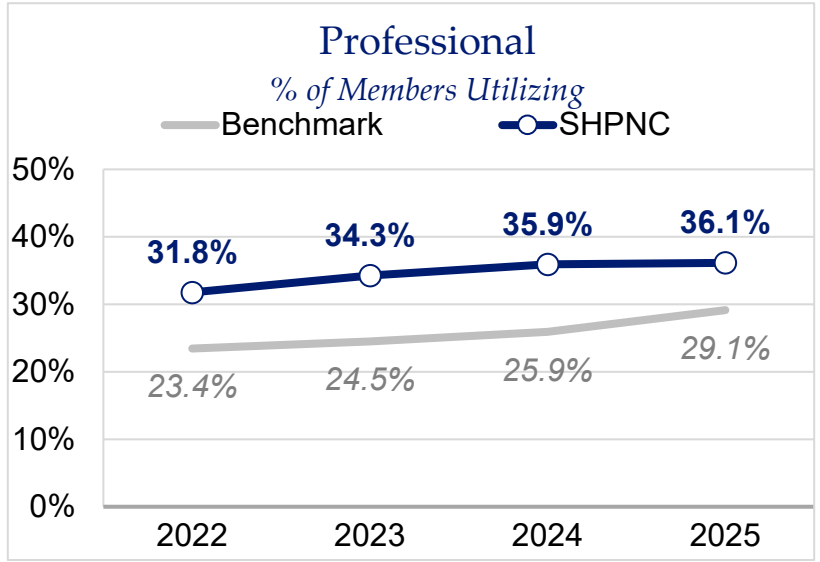
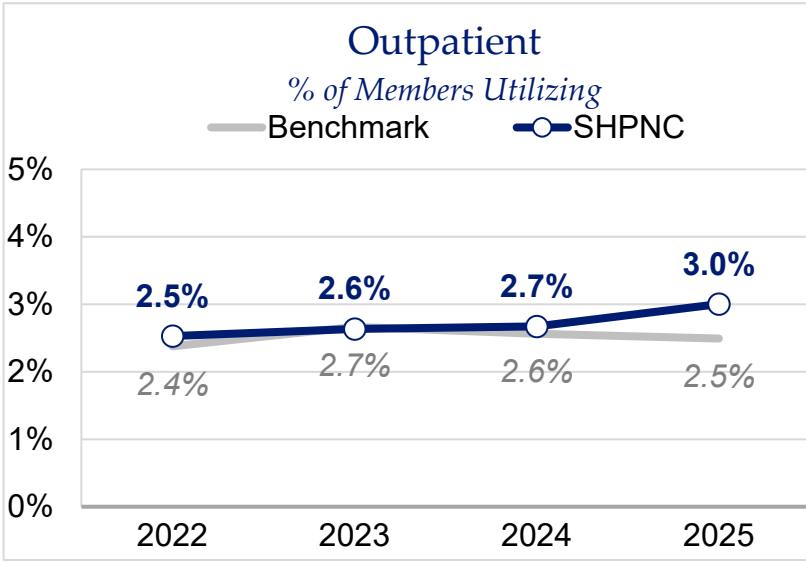
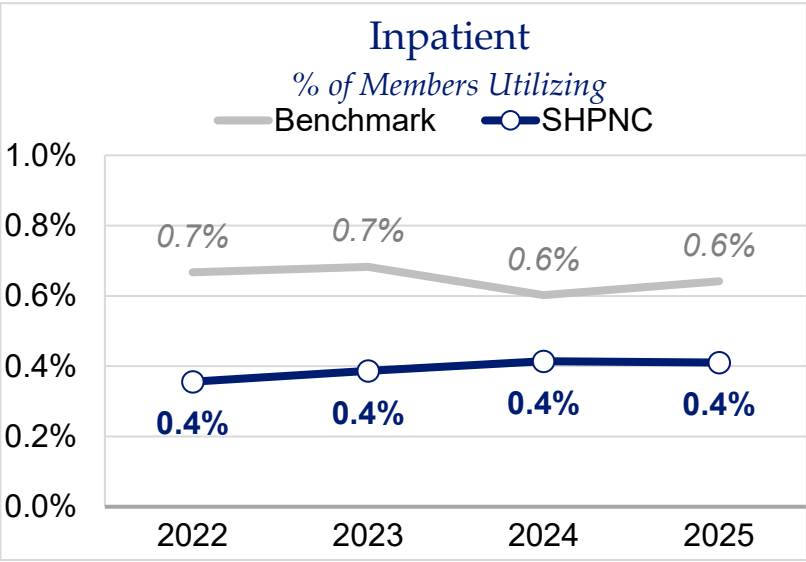
- Mental health prevalence has increased significantly over the experience period, from 37.6% of members in 2022 to 44.1% of members in 2025.
 - Mental health prevalence is over 10 percentage points higher in the State than our benchmark. However, this is partially due to have a greater share of females, who are typically higher utilizers of mental health care. Over 60% of the State's covered population is female.
- Anxiety and depression, two of the most prevalent conditions, saw reductions in members affected in 2025. However, costs for those treated increased significantly in 2025. Costs to treat anxiety increased 17.9% and costs to treat depression in increased 16.9%.
- Autism has been a significant cost driver over the last four years but experienced a 37.5% reduction in costs per member treated in 2025 due to more competitive provider pricing.

¹ Historical change in diagnoses reflects the total change in the number of members diagnosed with each mental health condition from 2022 to 2025.

² Historical change in cost reflects the annualized medical cost trend from 2022 to 2025.

Mental Health

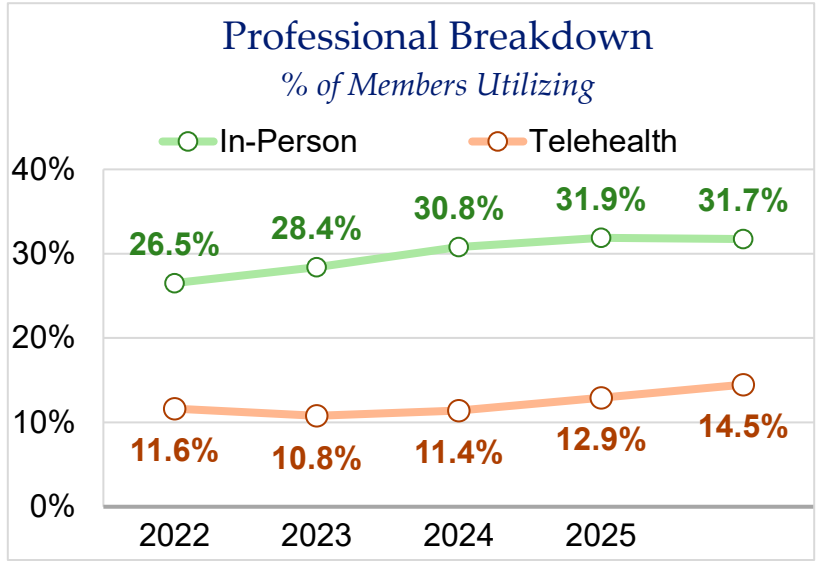
Utilization Trends by Place of Service



Observations

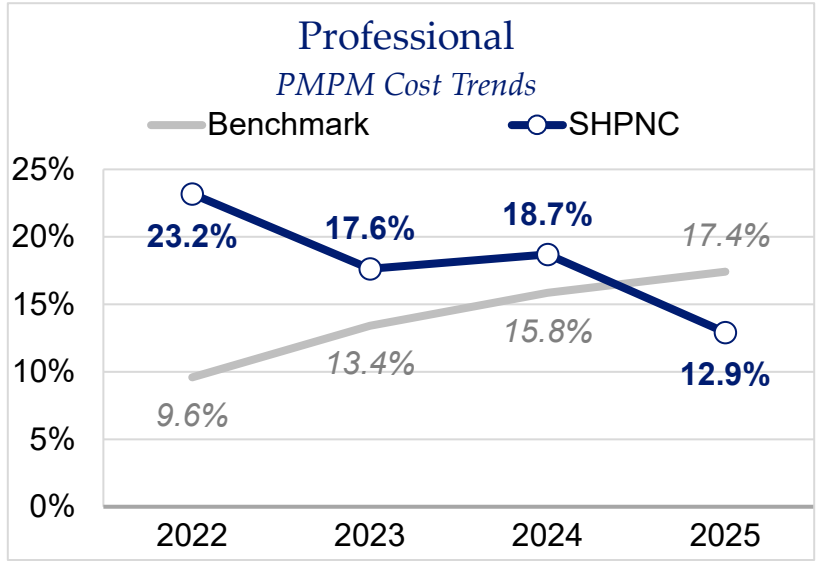
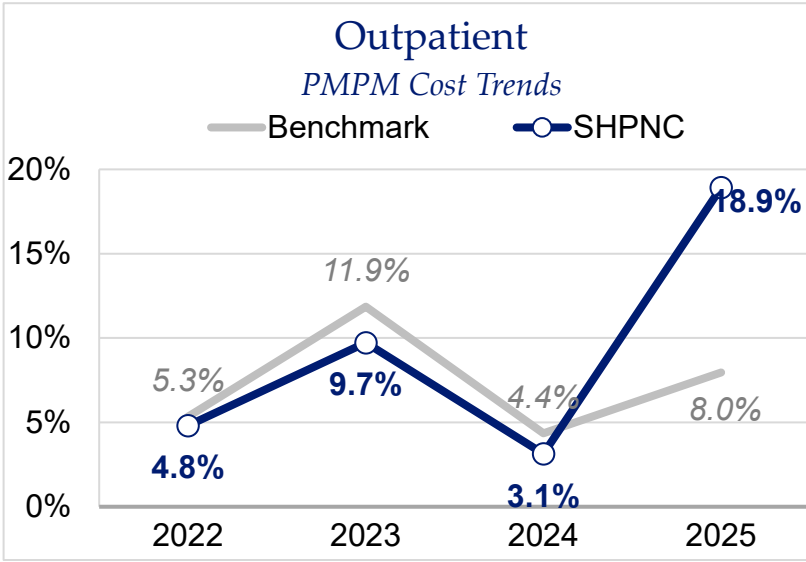
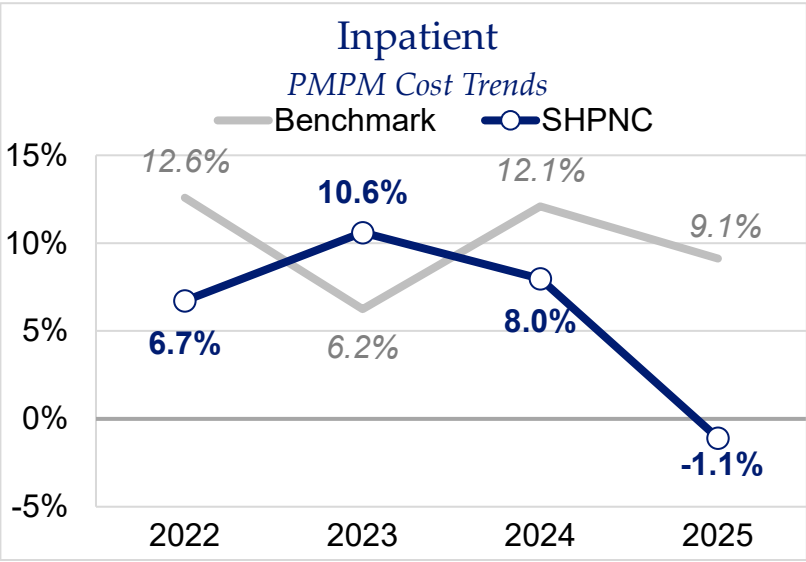
The graphs above summarize mental health-related utilization trends by place of service and compares it to Segal’s SHAPE public sector benchmark.

- Although there has been a slight increase in the percent of members ending up in the inpatient hospital for a mental health-related condition over the experience period, the State compares favorably to the benchmark with about 0.4% of members utilizing the inpatient hospital for mental health treatment.
- The State was consistent with the benchmark in terms of the percent of members utilizing the outpatient hospital for mental health treatment from 2022 – 2024 but diverged in 2025 due to anxiety, depression, and ADHD.
- The State has consistently had higher utilization of mental health treatment in the professional setting compared to Segal’s public sector benchmark, but the gap is narrowing.



Mental Health

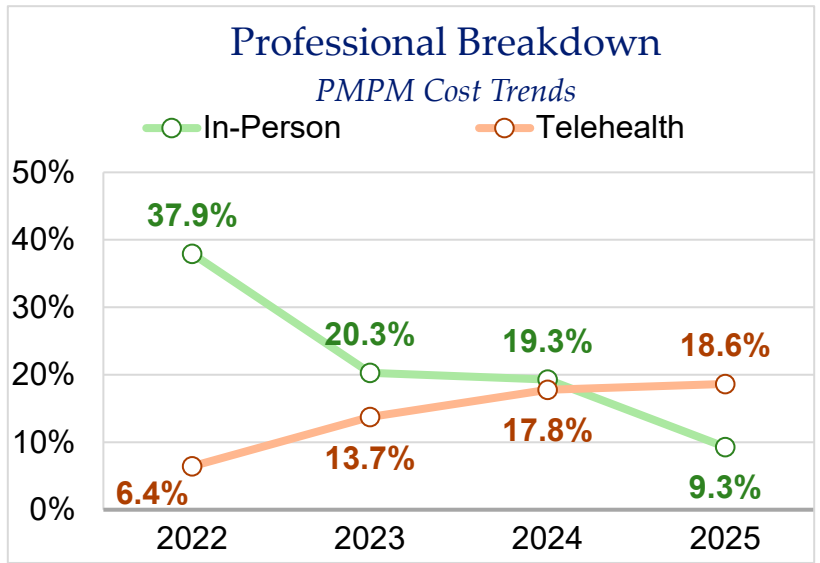
Cost Trends by Place of Service



Observations

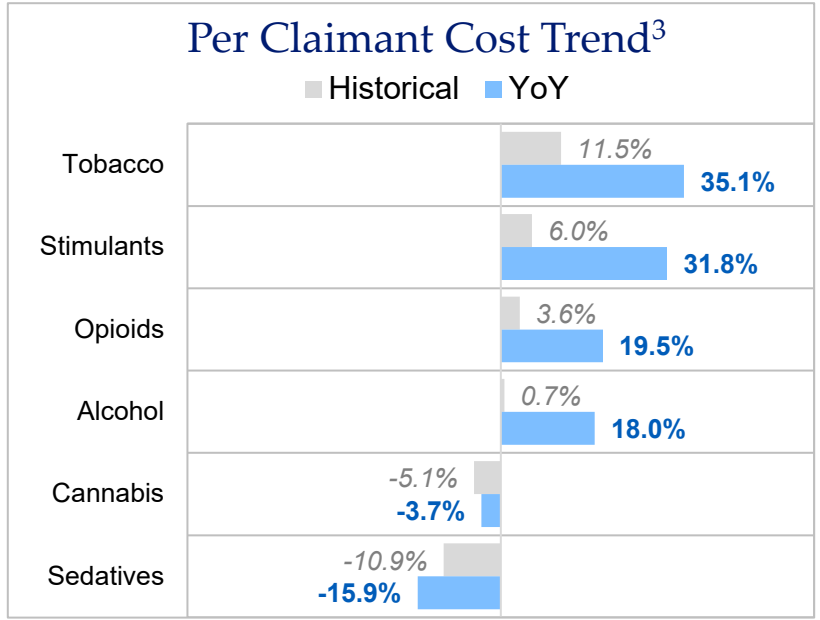
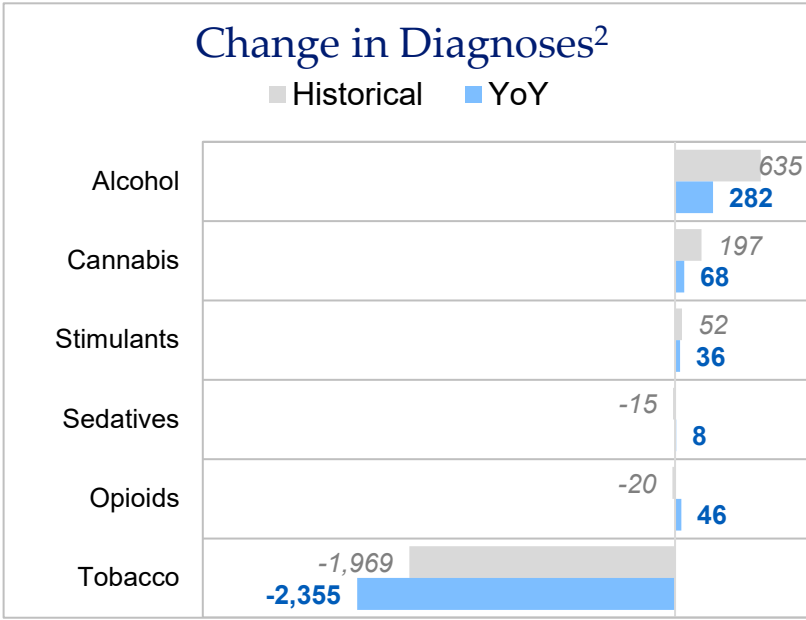
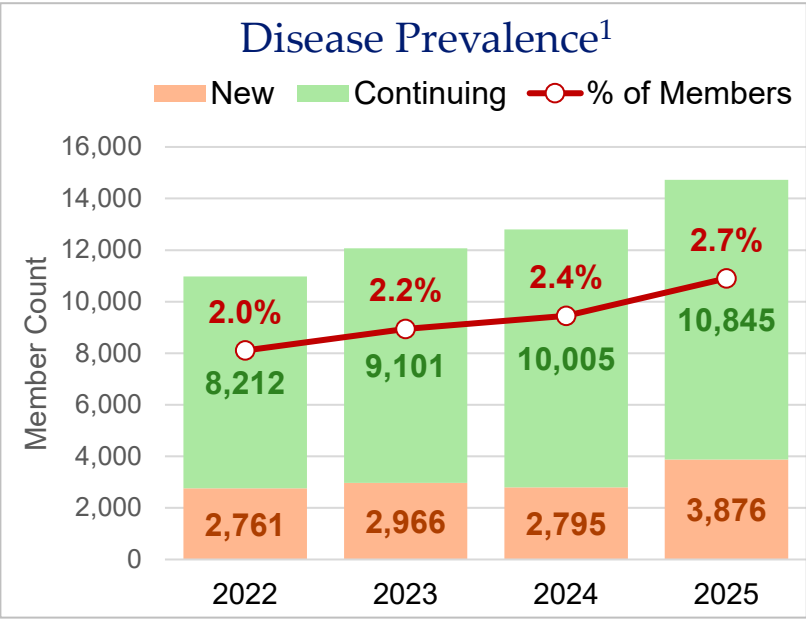
The graphs above summarize mental health-related cost trends by place of service and compares it to Segal’s SHAPE public sector benchmark.

- Inpatient cost trends were lower for the State compared to the benchmark in 2024 and 2025.
- Mental-health related outpatient hospital trends were favorable for the State when compared to the benchmark in 2023 and 2024 but significantly higher in 2025 due to a large increase in costs to treat anxiety and depression.
- Professional trends were higher for the State compared to the benchmark in 2023 and 2024 but lower in 2025, driven by a large reduction in costs to treat autism.
- Cost trends for in-person professional treatment has steadily decreased from a high of 37.9% in 2022. However, telehealth trends are been increasing.



Substance Use Disorder

Condition and Cost Trends



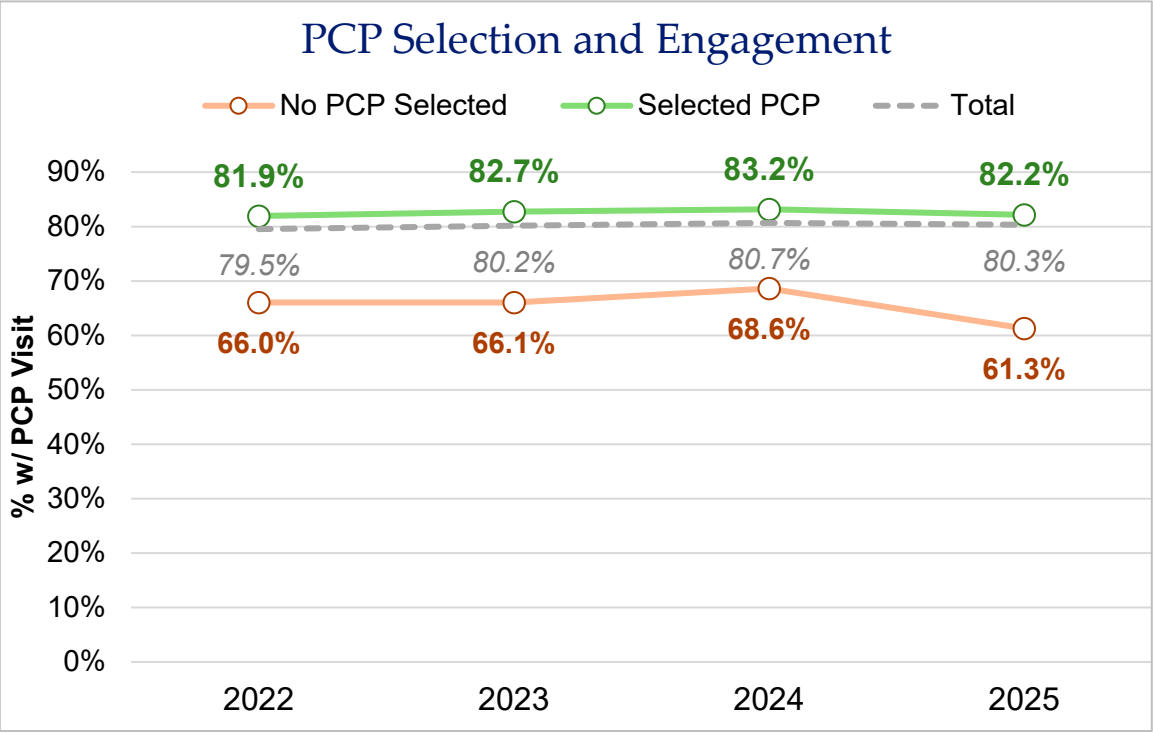
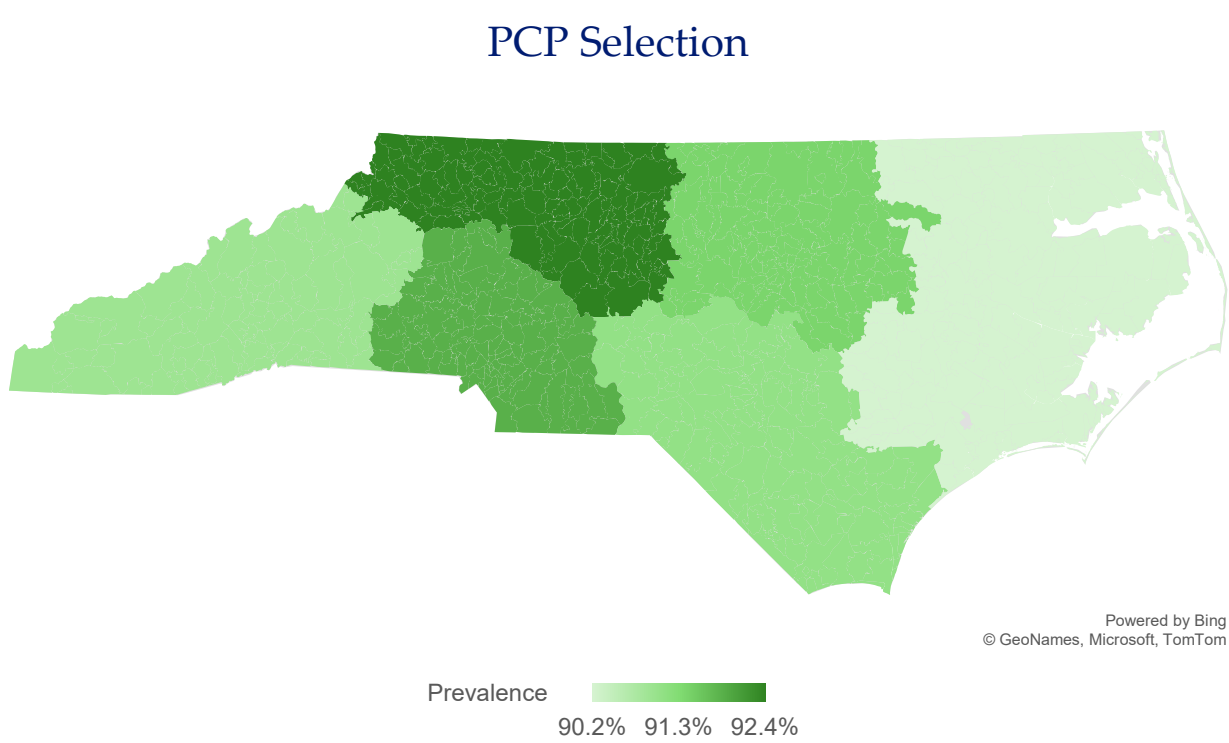
Observations

- The graphs above summarize prevalence and cost trends for Substance use disorder conditions.
- Substance use disorder prevalence has increased steadily over the experience period, from 2.0% of members in 2022 to 2.7% of members in 2025.
 - Prevalence has been driven by increases in alcohol, cannabis, and stimulant use disorder.
 - Sedatives, opioids, and tobacco have all experienced reductions in prevalence over the experience period.
 - Although there have been significant reductions in members treated for tobacco, the cost for treatment has increased significantly, rising 35.1% year-over-year and 11.5% per year from 2022 – 2025.
 - Due to its high prevalence, the main driver of costs for substance use disorder has been alcohol, which experienced an increase in costs per claimant of 18% in 2025.

¹ Disease prevalence excludes tobacco only.
² Historical change in diagnoses reflects the total change in the number of members diagnosed with each substance use disorder condition from 2022 to 2025.
³ Historical change in cost reflects the annualized medical cost trend from 2022 to 2025.

PCP Engagement

Overview

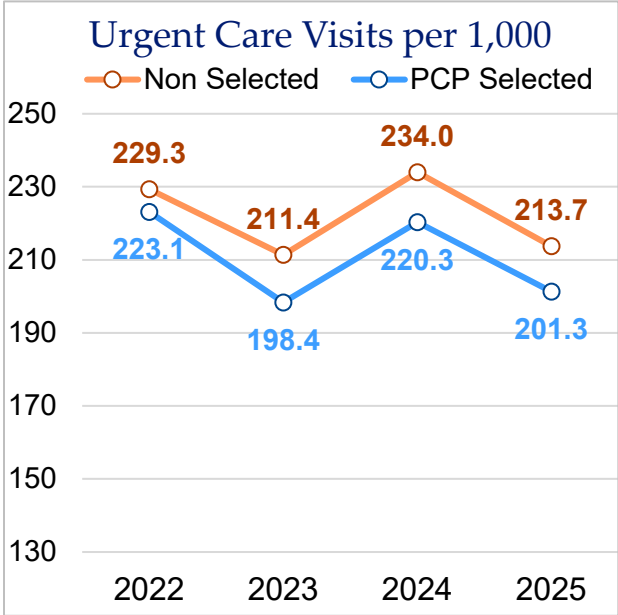
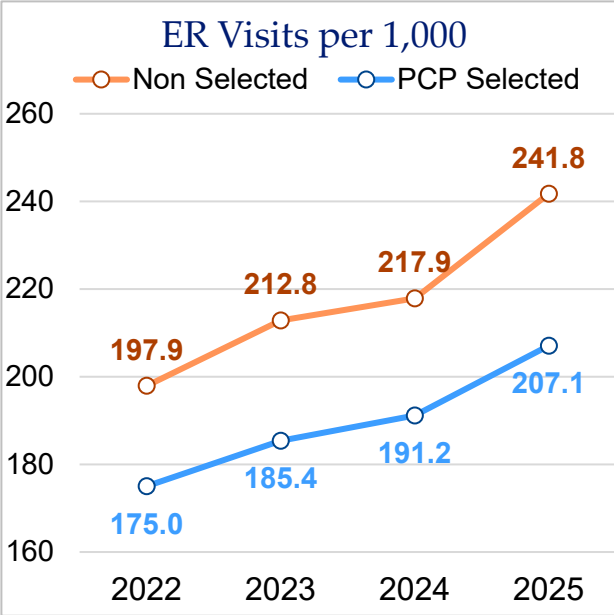
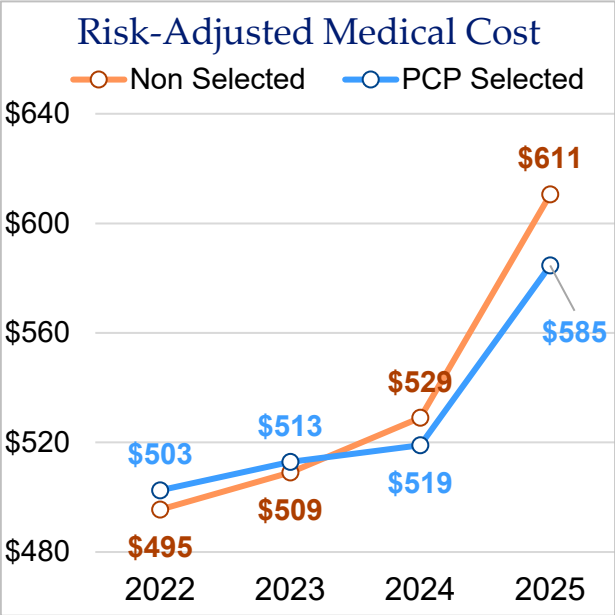
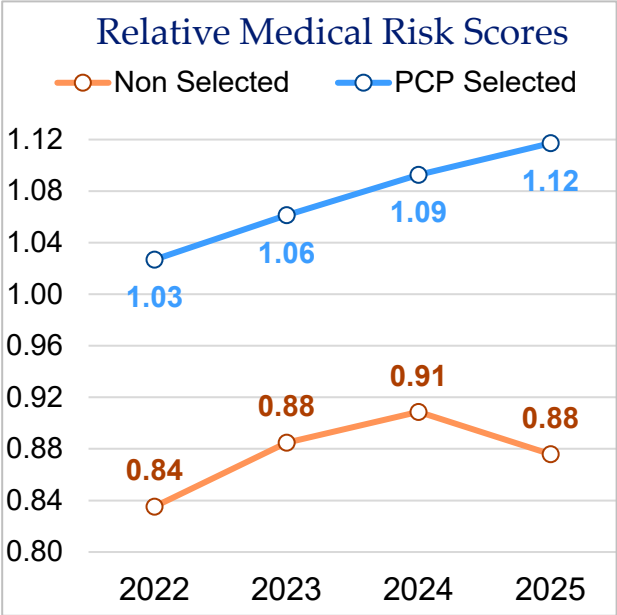


Observations

- The map and chart above show PCP selection and engagement. Members were determined to have selected a PCP if they had elected one on the enrollment file. Members were determined to be engaged if they had an evaluation and management visit.
- Overall PCP selection is high with about 91% of members selecting a PCP. Regions with the highest selection rates include Piedmont Triad and Metrolina (Charlotte).
 - The State saw increasing member engagement with evaluation & management visits, which include both PCP and specialist visits, from 2022 - 2024. However, there was a slight reduction in 2025, from 80.7% of members having an E&M visit in 2024 to 80.3% in 2025.

PCP Engagement

Outcomes



Observations

- The charts above summarize differences in risk and outcomes between members who selected a PCP and members who did not.
- Medical risk scores have historically been over 20% higher for members who select a PCP.
 - Risk-adjusted medical costs (shown above as per member per month) were slightly higher for members who selected in PCP in 2022 and 2023 but lower for members who selected a PCP in 2024 and 2025.
 - Members who are not selecting a PCP appear more likely to use the emergency room or urgent care for treatment. Emergency room use for members not selecting a PCP has historically been about 40-50% higher than members who do select a PCP and urgent care use has historically been about 25-35% higher.

PCP Engagement

Urban vs. Rural Comparison

PCP Selection and Engagement By Region Urban vs. Rural						
Region	% Selecting a PCP		% Engaged		Change in Engagement ¹	
	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	91.8%	89.5%	81.4%	79.4%	0.2pp	-0.6pp
Region 2: Piedmont Triad	92.0%	93.1%	81.3%	82.1%	1.0pp	0.6pp
Region 3: Metrolina (Charlotte)	91.7%	92.8%	81.4%	82.4%	1.8pp	1.3pp
Region 4: Triangle	91.4%	91.4%	79.1%	79.7%	1.1pp	-0.1pp
Region 5: Cape Fear	90.6%	91.6%	80.0%	82.7%	0.2pp	1.0pp
Region 6: Eastern NC	90.5%	90.0%	79.6%	78.6%	0.2pp	0.6pp
Total	91.4%	91.3%	80.2%	80.8%	1.0pp	0.5pp

Observations

The chart above shows PCP engagement by region, separated by urban versus rural.

- PCP engagement is generally higher in rural areas but has also improved less than urban areas since 2022.

¹ Historical change represents the percentage point (pp) change from 2022 to 2025

Catastrophic Risk Group

Risk Categories

Category	Member Count				Change	
	2022	2023	2024	2025	YoY	Historical ¹
Cancer & Oncology	2,006	2,059	2,076	2,141	+65	+135
Transplant & Complex Medical Support	745	809	860	931	+71	+186
Pulmonary & Respiratory	433	451	414	461	+47	+28
Neurologic, Cognitive & Developmental	405	420	400	414	+14	+9
Cardiovascular & Cerebrovascular	302	382	389	446	+57	+144
Diabetes, Endocrine & Metabolic	236	255	281	308	+27	+72
Musculoskeletal	199	242	260	284	+24	+85
Renal & Liver Disease	223	246	238	267	+29	+44
Gastrointestinal	233	228	248	253	+5	+20
Hematologic, Immune & Infectious	208	228	217	223	+6	+15
Complications of Care	77	71	75	91	+16	+14
Newborn Care	76	78	62	69	+7	-7
Substance Abuse	42	61	64	58	-6	+16
All Other	79	108	112	128	+16	+49
Total	5,264	5,638	5,696	6,074	+378	+810

Observations

The table above summarizes the categories in the catastrophic risk group and members in each by year along with year-over-year and historical trends.

- 35.3% of the catastrophic risk group was due to cancer in 2025. There were 65 more members in the catastrophic risk group due to cancer in 2025 compared to 2024 and 135 more compared to 2022.
- The fastest growing categories in the catastrophic risk group over the historical period have been transplants and complex medical support (+186 members) and cardiovascular & cerebrovascular conditions (+144 members).
- There has been a reduction in newborns ending up in the catastrophic risk group over the historical period.

¹ Historical change reflects the change between 2022 and 2025.

Catastrophic Risk Group

Case Management

Category	% w/ CM	Avg. Medical & Rx Cost		Risk Score		Risk-Adjusted Medical Cost	
		No Case Management	Case Management	No Case Management	Case Management	No Case Management	Case Management
Cancer & Oncology	11.7%	\$226,742	\$329,465	21.8	27.4	\$9,077	\$10,785
Transplant & Complex Medical Support	13.7%	\$223,154	\$330,276	27.5	34.7	\$7,206	\$8,441
Pulmonary & Respiratory	11.5%	\$182,221	\$317,000	21.3	36.0	\$6,078	\$8,135
Neurologic, Cognitive & Developmental	9.2%	\$141,063	\$222,089	15.8	22.3	\$7,649	\$9,205
Cardiovascular & Cerebrovascular	13.5%	\$123,286	\$196,955	13.6	18.1	\$7,977	\$10,048
Diabetes, Endocrine & Metabolic	14.3%	\$137,406	\$179,898	14.7	19.1	\$7,772	\$8,814
Musculoskeletal	15.1%	\$130,690	\$162,437	12.7	14.4	\$6,356	\$8,668
Renal & Liver Disease	13.1%	\$122,700	\$219,781	15.1	20.7	\$6,985	\$10,032
Gastrointestinal	10.7%	\$119,737	\$149,623	13.3	17.2	\$6,062	\$7,499
Hematologic, Immune & Infectious	9.0%	\$164,150	\$282,657	16.6	21.4	\$5,359	\$9,963
Complications of Care	12.1%	\$113,771	\$225,774	12.7	18.7	\$8,594	\$11,747
Newborn Care	10.1%	\$133,011	\$265,465	15.4	24.3	\$8,654	\$10,912
Substance Abuse	10.3%	\$146,521	\$207,360	13.9	17.3	\$9,958	\$11,210
All Other	8.6%	\$101,302	\$200,468	11.9	16.5	\$7,204	\$10,848
Total	12.1%	\$183,442	\$275,246	19.5	25.8	\$7,892	\$9,585

Observations

- The table above summarizes the differences in catastrophic members who go through case management versus those who do not.
- Only about 12.1% of the catastrophic risk group went through case management in 2025, suggesting an opportunity for improved risk identification and outreach.
 - Case management is reaching the higher risk members. The average risk score for those going through case management was 25.8 compared to 19.5.
 - We are showing that even after adjusting for risk, medical costs are approximately 21% higher for members who go through case management. However, risk score accuracy tends to degrade the higher risk a member is so this may not be indicative of case management not working as intended.

Catastrophic Risk Group

Top Conditions and Modifiable Risk Factors

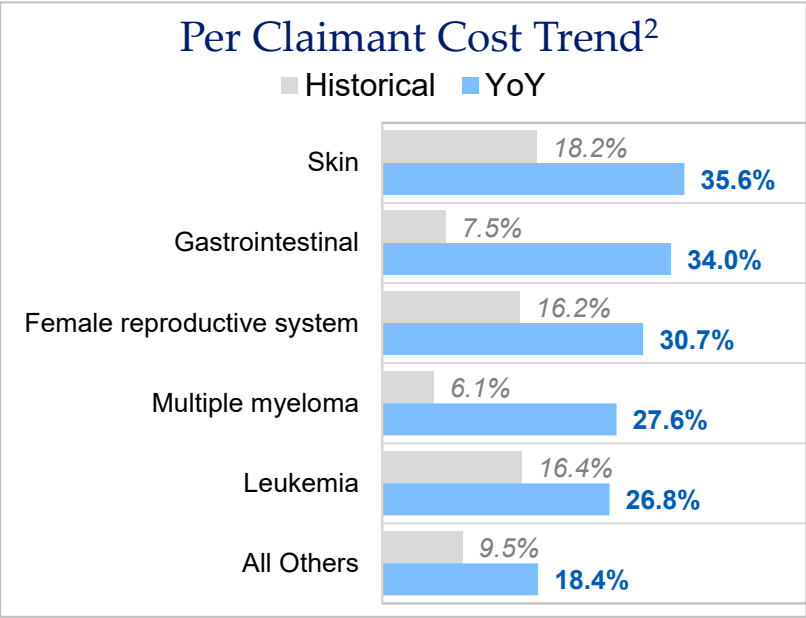
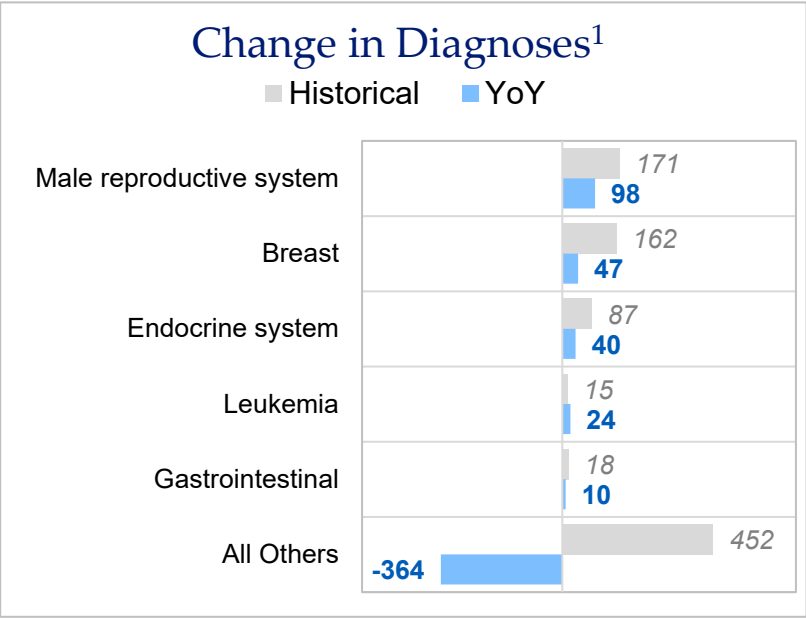
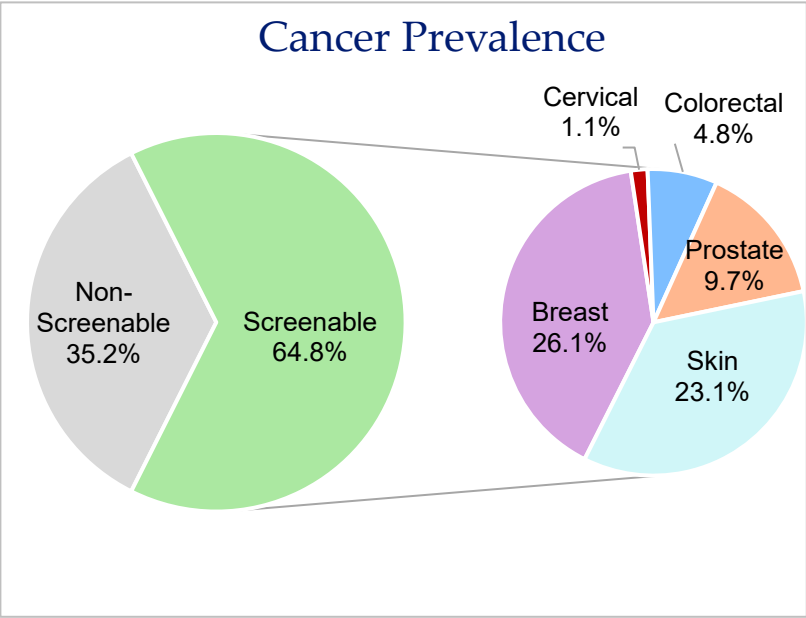
Condition	Potentially Modifiable Risk Factors	Member Count (CY 2025)
Chronic kidney disease	Diabetes, hypertension, obesity, cardiovascular disease, smoking, chronic NSAID use, certain autoimmune disorders.	527
Breast cancer	Obesity, alcohol use, physical inactivity, hormone replacement therapy.	382
Metastatic cancer	Delayed diagnosis, smoking, obesity.	326
Obesity	Excess caloric intake, sedentary lifestyle, poor diet, sleep deprivation, stress, socioeconomic factors, endocrine disorders.	234
Heart failure	Coronary artery disease, hypertension, diabetes, obesity, chronic kidney disease, valvular disease, smoking, excessive alcohol use, arrhythmias.	229
Diabetes	Obesity, physical inactivity, poor diet, hypertension, hyperlipidemia.	144
Fluid and electrolyte disorders	Chronic kidney disease, heart failure, liver disease, dehydration, diuretic use, endocrine disorders, gastrointestinal losses (vomiting/diarrhea), uncontrolled diabetes.	135
Heart disease	Hypertension, diabetes, obesity, hyperlipidemia, smoking, chronic kidney disease, physical inactivity, poor diet.	129
Spinal disorders	Autoimmune disease, inflammatory bowel disease, smoking, obesity, occupational strain.	105

Observations

- The table above summarizes the top conditions in the catastrophic risk group along with potentially modifiable risk factors for each.
- Approximately 9% of the catastrophic risk group is due to chronic kidney disease, 6% is due to breast cancer, and 5% is due to metastatic cancer.
 - Chronic kidney disease, which is mainly caused by unmanaged diabetes and/or hypertension, experienced an increase of 194 members in the catastrophic risk group in 2025.
 - The number of members in the catastrophic risk group increased by 378 members in 2025. However, there were some areas that did show improvement. Conditions with a reduction in catastrophic members include colorectal cancer (-42 members), regional enteritis and ulcerative colitis (-25 members), acute myocardial infarctions (-22 members) and renal failure (-22 members).

Cancer

Prevalence, Cost and Top Cancers



Observations

The graphs above summarize prevalence and cost trends by cancer type.

- 12,161 members were treated for cancer in 2025, 2,650 of which were newly diagnosed cancers. This represents a decrease from 2024 when 12,306 cancers were treated and 2,755 were new.
 - 64.8% of the cancers treated were for cancers with recommendations for routine screenings (i.e., screenable).
- There were 171 more male reproductive cancers (e.g., prostate) diagnosed in 2025 compared to 2022, representing the largest increase of all cancer types, followed by breast cancer. Both of these cancers are screenable.
- Costs for cancer treatment increased significantly in 2025, led by skin with a 35.6% increase in costs per claimant (mainly due to Keytruda, Yervoy, and Nplate) and followed by gastrointestinal (Imfinzi, Cyramza) and female reproductive system (Jemperli, Keytruda, Mvasi) with increases of 34.0% and 30.7%, respectively.

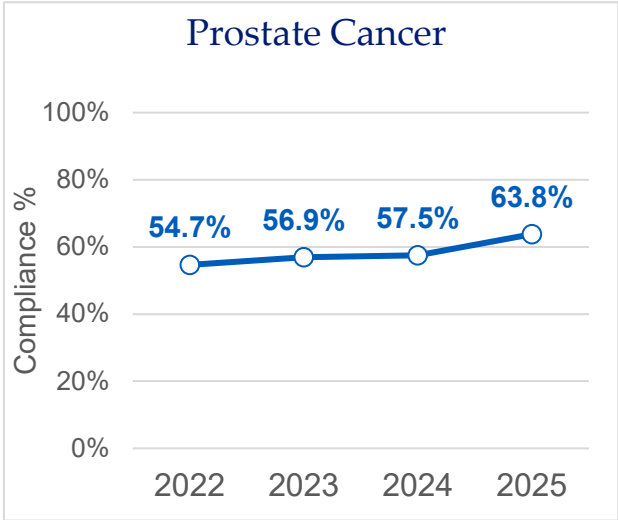
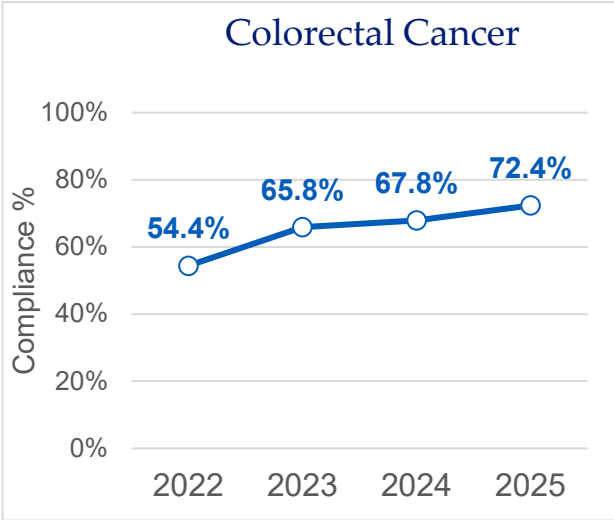
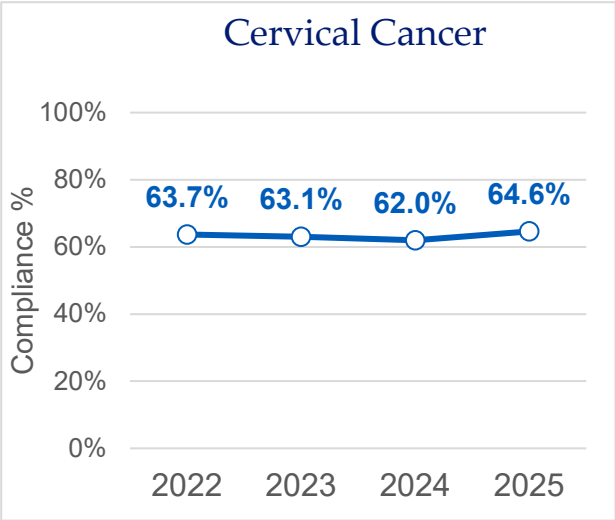
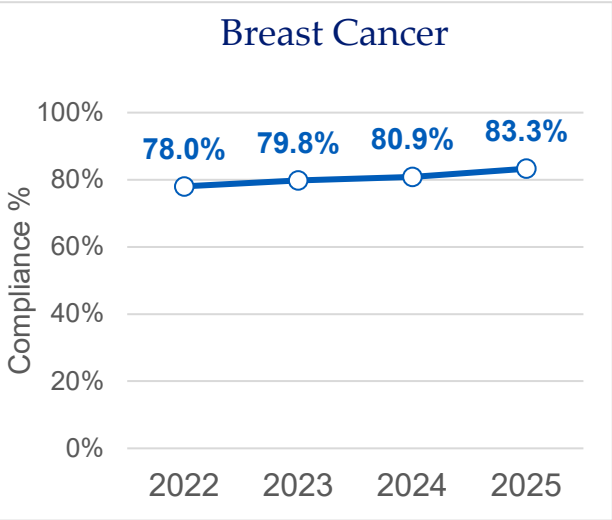
¹ Historical change in diagnoses reflects the total change in the number of members diagnosed with each cancer type from 2022 to 2025.

² Historical change in cost reflects the annualized medical and prescription drug cost trend from 2022 to 2025.

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Screenable Cancer

Screening Compliance



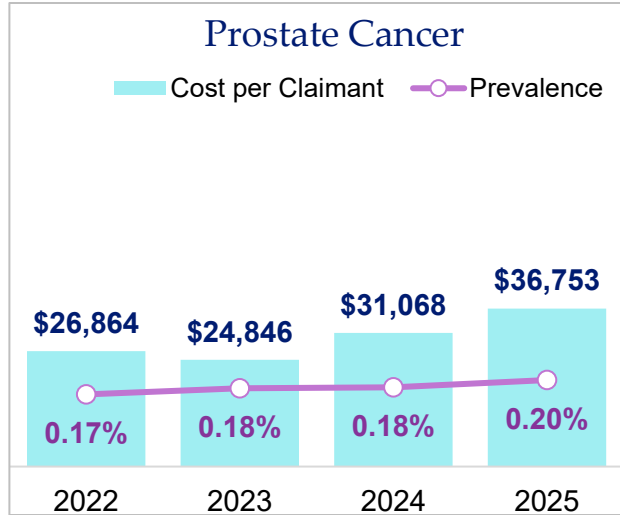
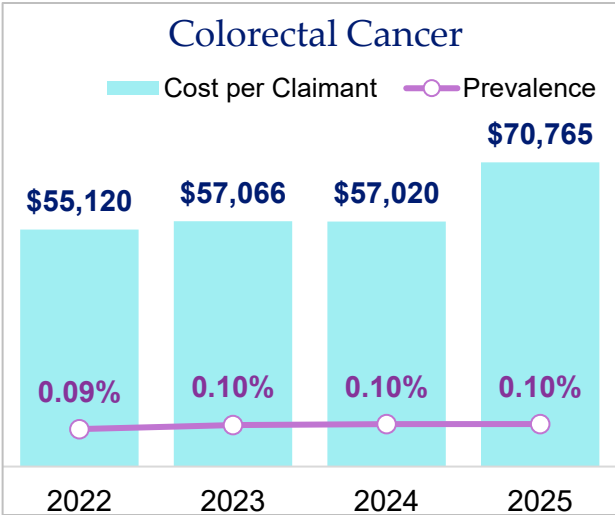
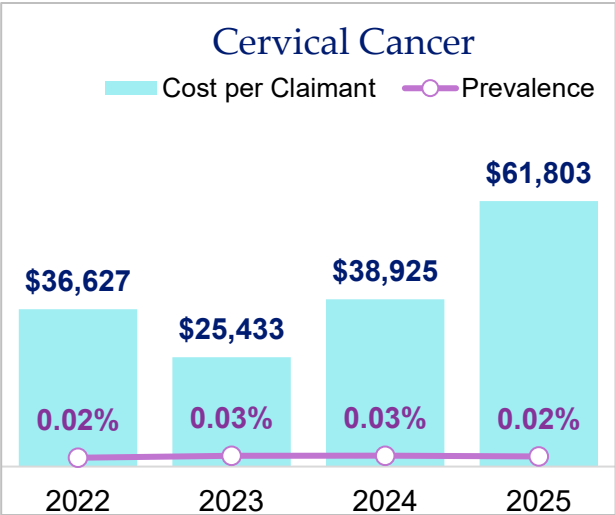
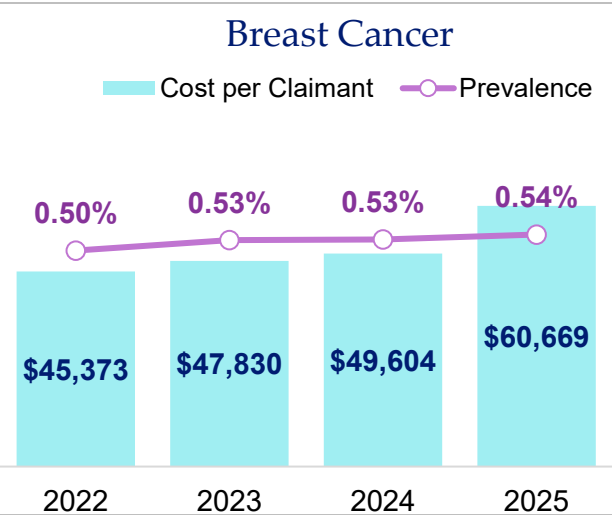
Observations

The graphs above summarize preventive screening rates for the four main screenable cancers.

- The State has made meaningful improvements in preventive cancer screening rates over the historical period. All four cancer screenings experienced an increase in compliance.
 - Colorectal cancer screening rates have increased the most and were over 72% in 2025.
 - Breast cancer screening rates have steadily increased over the last four years and were over 80% in 2025, the highest of all cancers.
 - There was a significant increase in compliance for prostate cancer screening year-over-year. 57.5% of males were compliant in 2024, which jumped to 63.8% in 2025.
 - Cervical cancer screenings have improved the least, which is a fairly common pattern across the general population. Females generally only require screening every 3-5 years, so improvements may take longer to show up in the data. Opportunities to improve compliance include targeted outreach to overdue members, education regarding current screening recommendations, and promoting newer screening options as they become available.

Screenable Cancer

Prevalence & Cost



Observations

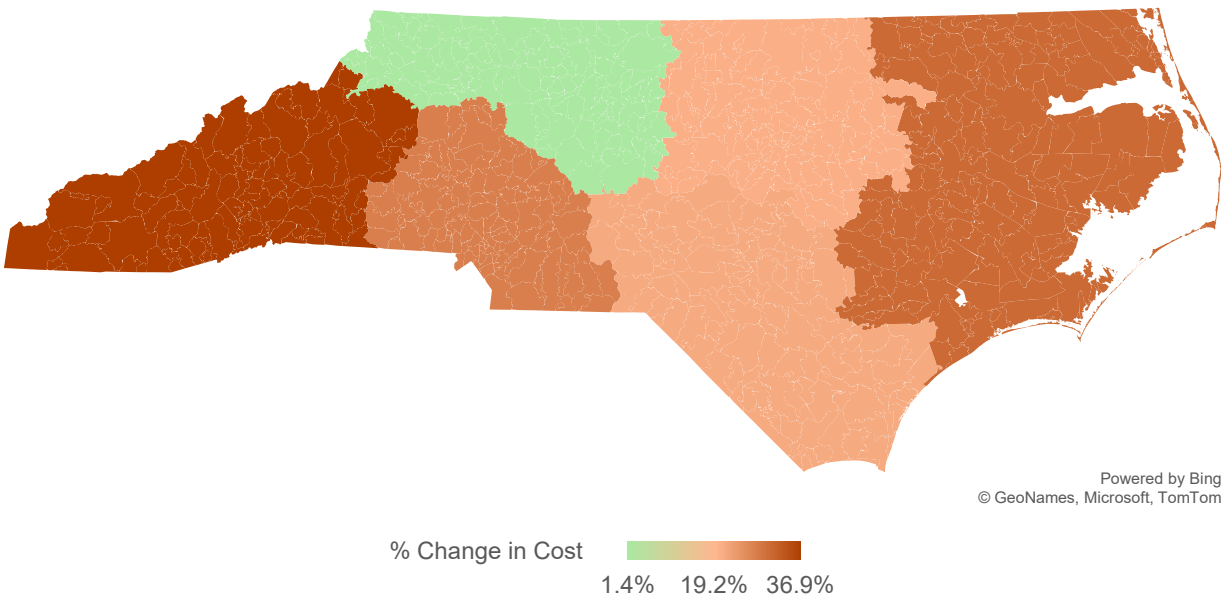
The graphs above summarize prevalence and cost trends for the four main screenable cancers.

- Cervical cancer and colorectal cancer rates were stable in 2025 but both breast and prostate cancers experienced an increased in prevalence.
- All four screenable cancers had relatively stable costs between 2022 and 2024. However, all experienced a double digit increase in costs in 2025.
 - Cervical cancer experienced the largest increase in treatment costs of 59%. However, this is also the least prevalence cancer of the screenable cancers and costs can be volatile. Costs have primarily been driven by Keytruda, Sandostatin Lar Depot, Trodelvy, and Enhertu.
 - The other three screenable cancers experienced increases in costs of around 20% and were a primary driver of overall medical trend in 2025. Costs for breast cancer were primarily driven by Phesgo, Neulasta, and Ogivri. Costs for colorectal cancer have primarily driven by Vectibix, Fulphila, Zirabev, Opdualag, and Neulasta. Costs for prostate cancer have primarily been driven by Provenge.

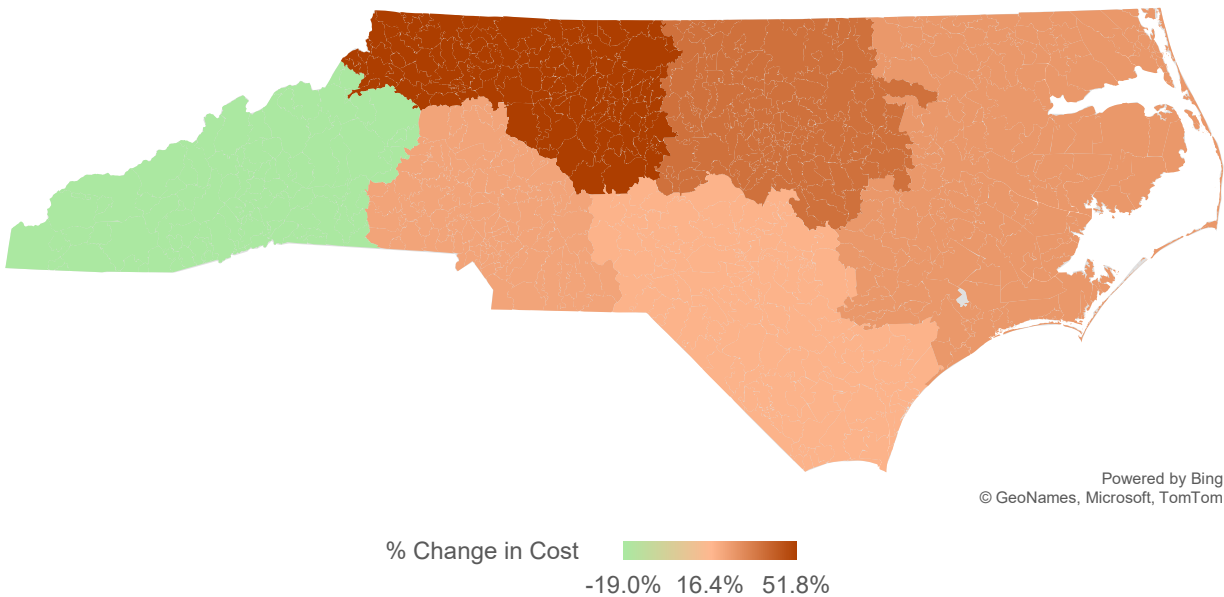
Screenable Cancer

Cost Trends by Region

Change in Cost to Treat Breast Cancer
2024 to 2025



Change in Cost to Treat Colorectal Cancer
2024 to 2025



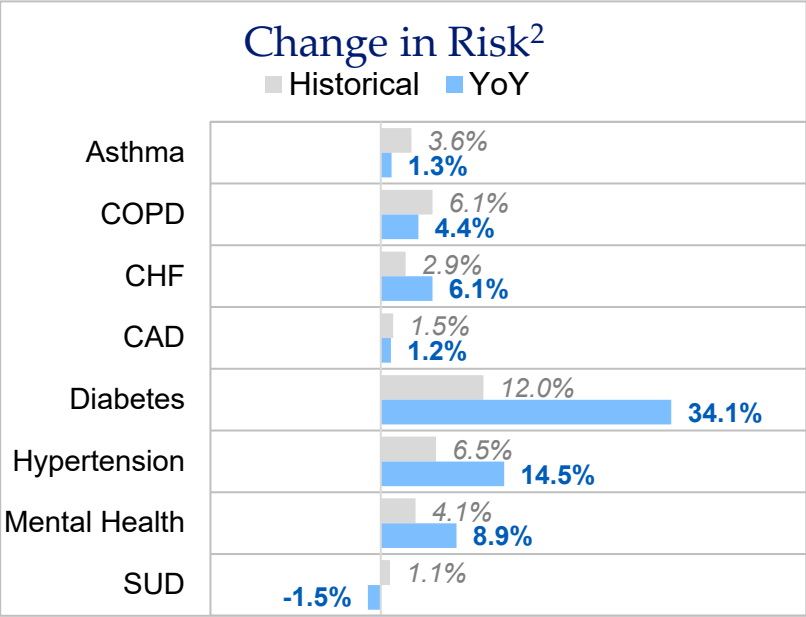
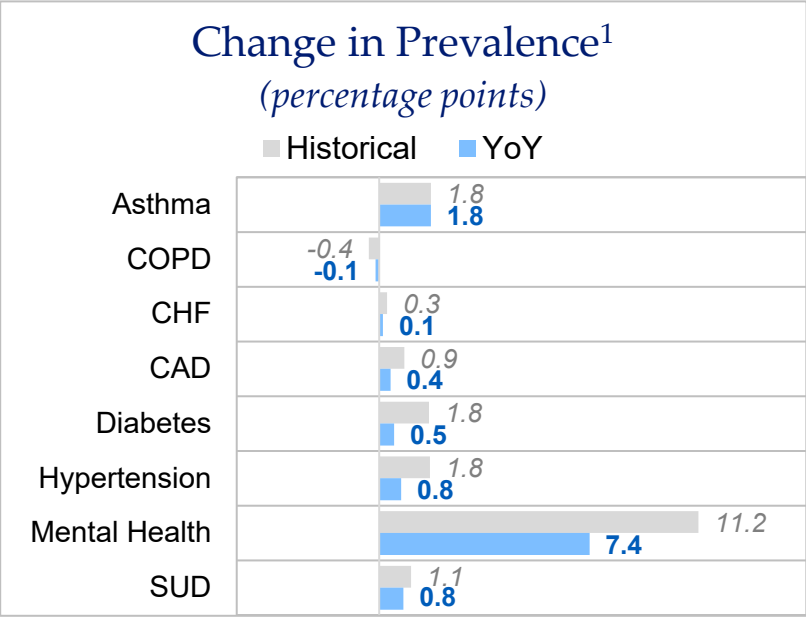
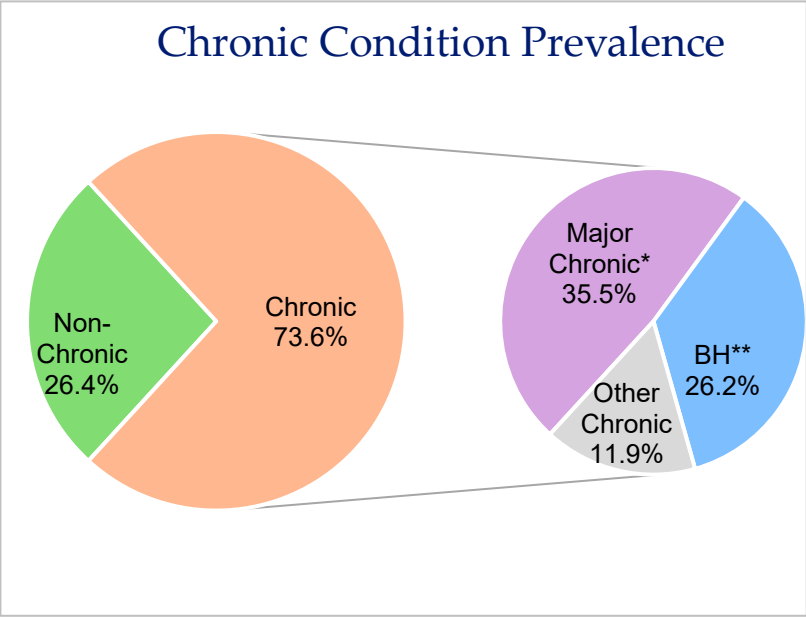
Observations

The maps above show the change in cost to treat two different cancers that have been a primary driver of medical trend: breast and colorectal.

- Interestingly, Region 1: Western had the highest increase in costs to treat breast cancer from 2024 to 2025 but the smallest increase in costs to treat colorectal cancer. Conversely, Region 2: Piedmont Triad had the smallest increase in costs to treat breast cancer but the largest increase in cost to treat colorectal cancer.

Chronic Conditions

Prevalence and Risk



Observations

The graphs above summarize prevalence and risk for chronic conditions.

- 73.6% of members had a chronic condition in 2025, which includes 35.5% with one or more of the six major physical chronic conditions*, 26.2% with a behavioral health (BH) condition**, and 11.9% of members with other chronic conditions (e.g., cystic fibrosis, epilepsy, glaucoma).
- All major chronic conditions aside COPD have seen an increase in prevalence over the historical period.
- Mental health prevalence has increased the most, with an increase of 11.2 percentage points from 2022 to 2025.
- Diabetics have experienced the largest increase in risk year-over-year (YoY) and over the historical period.
- Hypertension, which is the primary condition targeted by Hello Heart, experienced the second largest increase in risk YoY and over the historical period.

* Major Chronic = asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes, and hypertension.

** BH = behavioral health, which includes both mental health and substance use disorders (SUD).

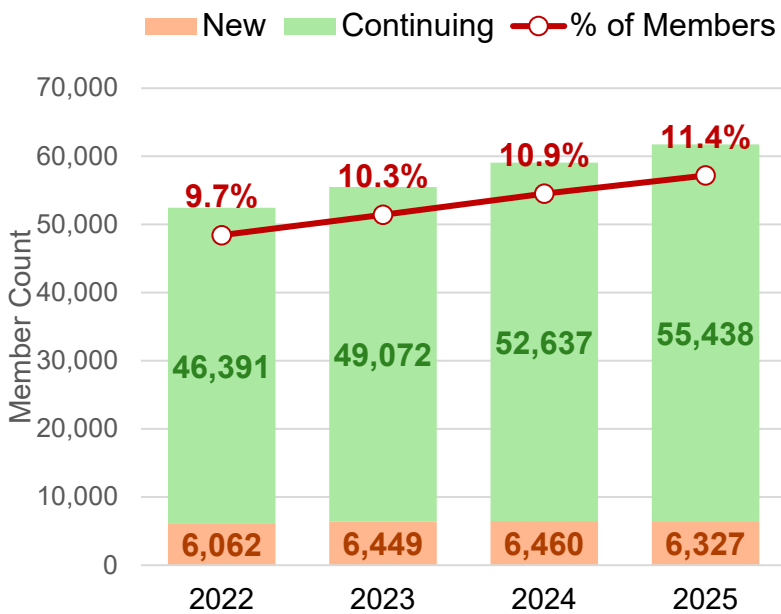
¹ Historical change in prevalence reflects the total change in percentage points from 2022 to 2025.

² Historical change in risk reflects the annualized trend in risk from 2022 to 2025.

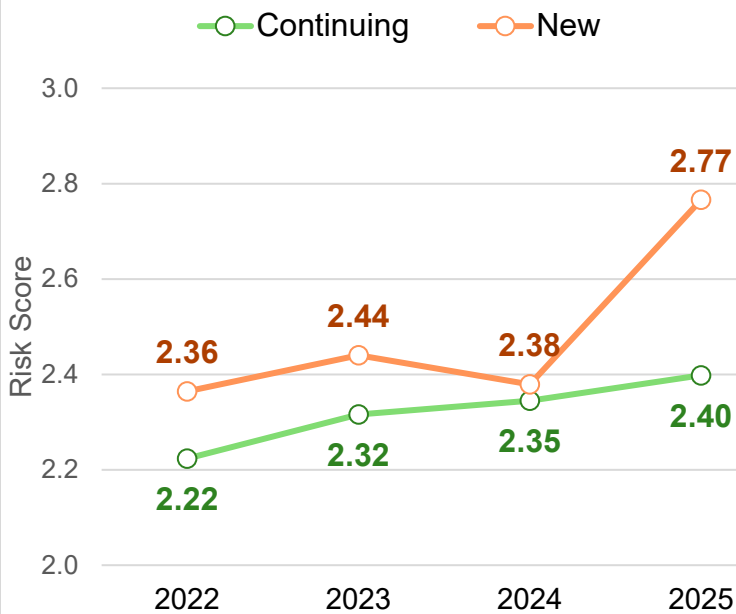
Diabetes

Prevalence and Risk Trends

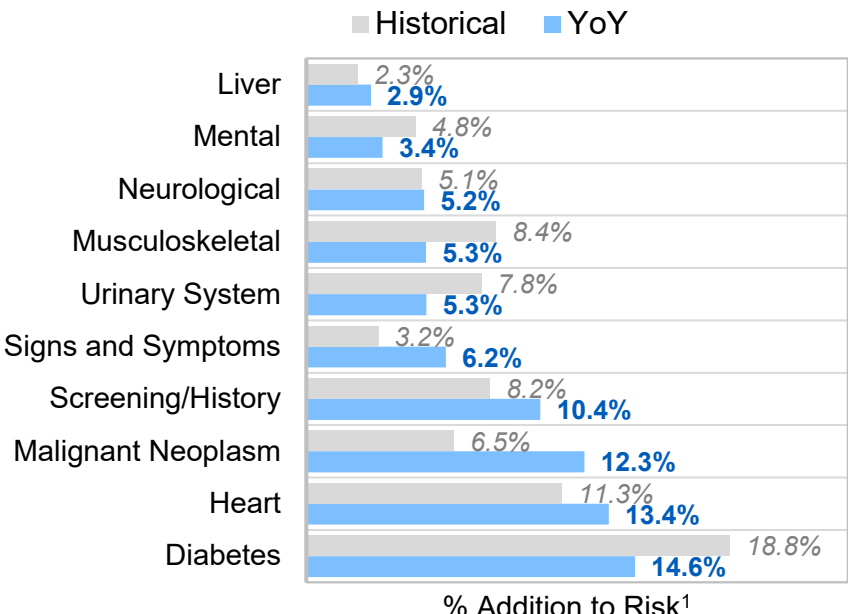
Disease Prevalence



Risk



Risk Drivers



Observations

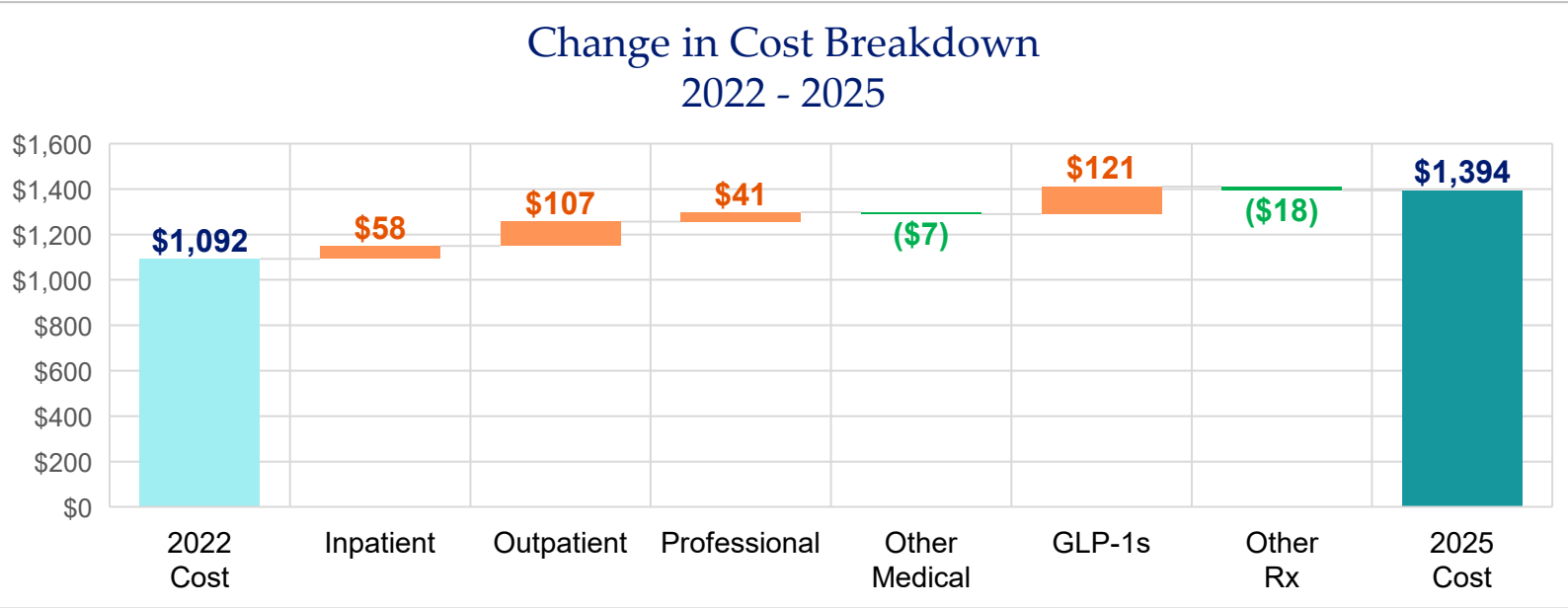
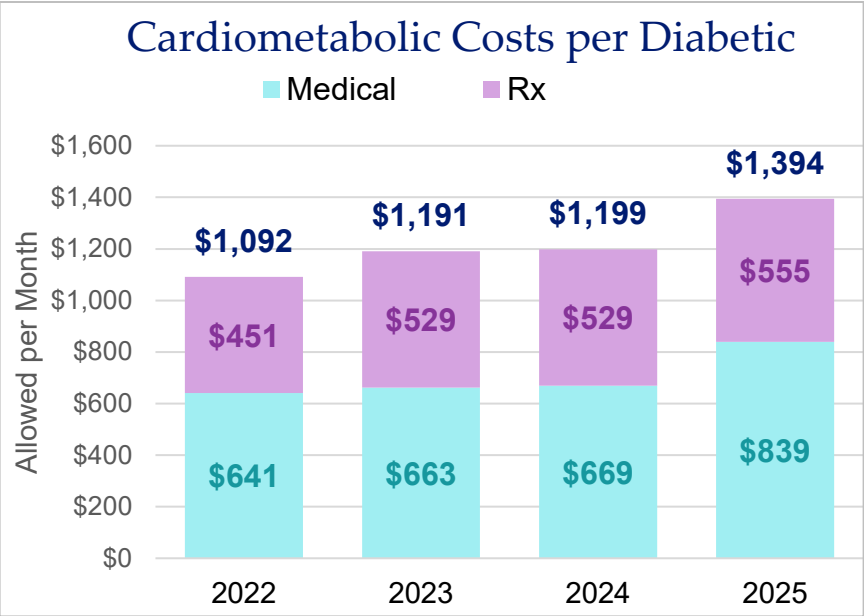
The graphs above summarize prevalence, risk, and risk drivers for the diabetic population.

- The diabetic population has steadily increased over the experience period, from 9.7% of members in 2022 to 11.4% of members in 2025.
 - Despite the increase, the Plan is faring better than our public sector benchmark, which experienced an increase in prevalence from 8.7% to 12.0% over the same period.
- There was a reduction in newly diagnosed members in 2025 for the first time in the experience period. However, the risk score for new diabetics increased significantly in 2025, mainly driven by cancer, screening/history, and heart disease.
- Aside from diabetes, the largest drivers of risk for diabetics over the experience period have been heart disease and musculoskeletal conditions.

¹ Addition to risk represents the percent of the increase in risk attributed to each risk category.

Diabetes

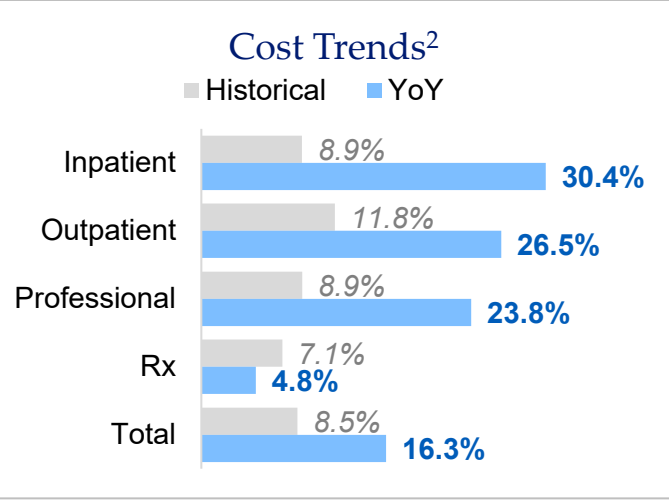
Cost Trends



Observations

The graphs on this page summarize cardiometabolic¹ costs for diabetics, cost drivers, and trends by place of service.

- Cardiometabolic medical costs for diabetics were relatively steady from 2022 – 2024 but increased 25% in 2025.
- From 2022 – 2025, total cardiometabolic costs (medical + Rx) increased 8.5% per year and was driven by GLP-1s and outpatient hospital expenses.
 - Outpatient hospital expenses have increased 11.8% per year over the experience period, inpatient hospital and professional costs have increased 8.9% per year, and prescription drug costs have increased 7.1% per year.



¹ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea).
² Historical reflects the annualized trend in cost from 2022 to 2025.

Diabetes

Cost Trends by Service Category

Cardiometabolic ¹ Medical Cost Detail Diabetic Members Only						
Service Category	2022	2023	2024	2025	% Change	
					YoY	Historical ²
Inpatient	\$199	\$201	\$197	\$257	30.6%	8.9%
Surgery	\$125	\$119	\$114	\$134	16.8%	2.4%
ICU	\$23	\$28	\$25	\$51	105.2%	30.3%
Other	\$51	\$54	\$58	\$73	26.1%	12.4%
Outpatient	\$271	\$285	\$299	\$378	26.5%	11.8%
Surgery	\$123	\$126	\$132	\$147	11.0%	6.0%
Emergency Room	\$53	\$59	\$57	\$73	28.4%	11.1%
Cardiovascular	\$8	\$9	\$10	\$12	20.0%	17.2%
Radiology	\$12	\$14	\$15	\$18	22.5%	13.4%
Labs/Pathology	\$11	\$12	\$12	\$15	23.9%	11.0%
Dialysis	\$19	\$21	\$27	\$41	49.8%	29.3%
Preventive	\$3	\$4	\$4	\$7	73.8%	26.8%
Pharmacy	\$22	\$21	\$23	\$40	77.6%	22.7%
Other	\$19	\$20	\$19	\$25	33.2%	9.9%
Professional	\$140	\$145	\$146	\$181	24.0%	8.9%
Surgery	\$13	\$13	\$13	\$13	4.1%	1.2%
Radiology	\$4	\$5	\$5	\$6	13.6%	8.0%
Labs/Pathology	\$10	\$10	\$11	\$17	55.1%	18.0%
Evaluation & Management	\$60	\$62	\$62	\$68	9.9%	4.0%
Preventive	\$12	\$13	\$13	\$16	25.7%	10.3%
Pharmacy	\$9	\$10	\$10	\$15	47.5%	16.4%
Other	\$31	\$32	\$33	\$47	41.5%	14.6%
Ancillary	\$31	\$31	\$28	\$24	-12.6%	-8.5%
DME	\$22	\$21	\$18	\$16	-10.1%	-9.0%
Other	\$10	\$10	\$10	\$8	-17.5%	-7.4%
Total	\$641	\$663	\$669	\$840	25.6%	9.4%

Observations

The table to the left provides detail on trends in cardiometabolic medical costs for diabetics over the experience period.

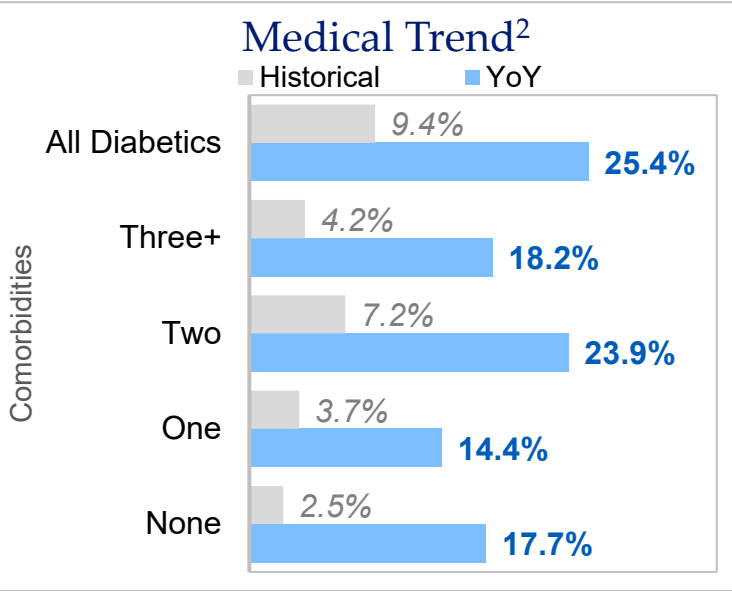
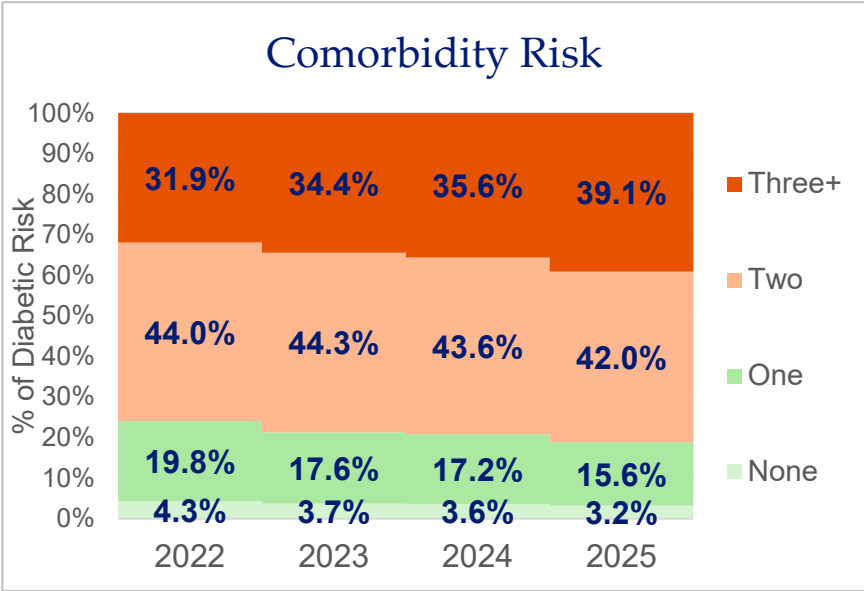
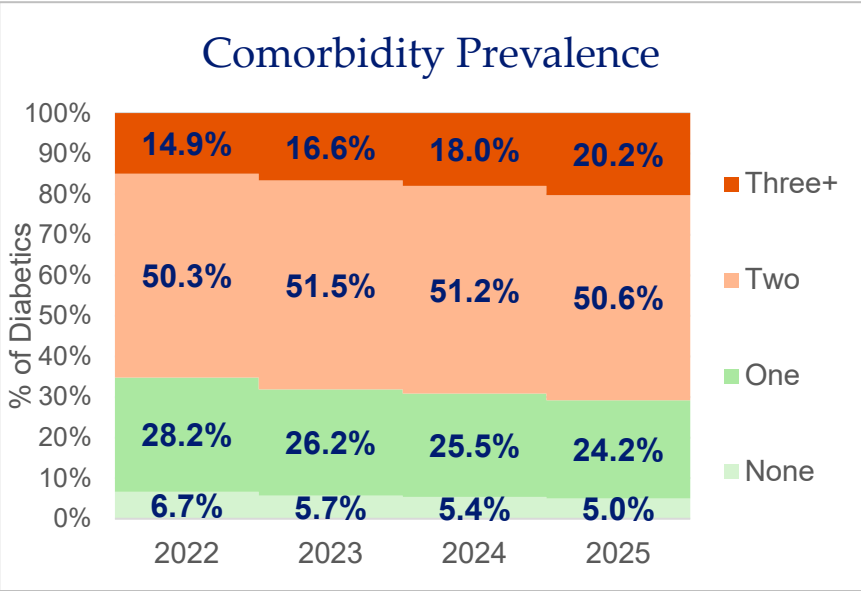
- In terms of cost, inpatient claims related to surgery and the ICU increased the most in 2025.
- The emergency room was the third largest driver of medical costs in 2025, increasing by \$16 per member per month, or 28%.
- Costs for dialysis have also been a significant contributor to trend, increasing 49.8% in 2025 and 29.3% per year from 2022 – 2025.
- There are encouraging trends for preventive care, which increased 73.8% in the outpatient hospital setting and 25.7% in the professional setting in 2025.
- Although preventive trends are encouraging, evaluation and management-related claims had the smallest increase in costs in the professional setting aside from surgeries. This category includes PCP and specialist visits, that are critical for ongoing condition management and detecting problems early.

¹ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea). 

² Historical reflects the annualized trend in cost from 2022 to 2025.

Diabetes

Comorbidities¹



Observations

The graphs on this page summarize comorbidity prevalence among diabetics, as well as risk and cost trends.

- The diabetic population continues to develop more comorbidities. 34.8% of diabetics had one or fewer comorbidities in 2022 versus only 29.2% in 2025. Conversely, 14.9% of diabetics had three or more comorbidities in 2022 versus 20.2% in 2025.
- 39.1% of all diabetic risk in 2025 was associated with diabetics with three or more comorbidities, up from 31.9% in 2022.
- The medical trend shown in the chart on the right only includes cardiometabolic-related³ medical expenses. Cardiometabolic-related medical costs increased 25.4% for diabetics in 2025, well above the historical rate of 9.4% per year from 2022 through 2025.

¹ Comorbidities include hypertension, obesity, cardiovascular disease, and chronic kidney disease.

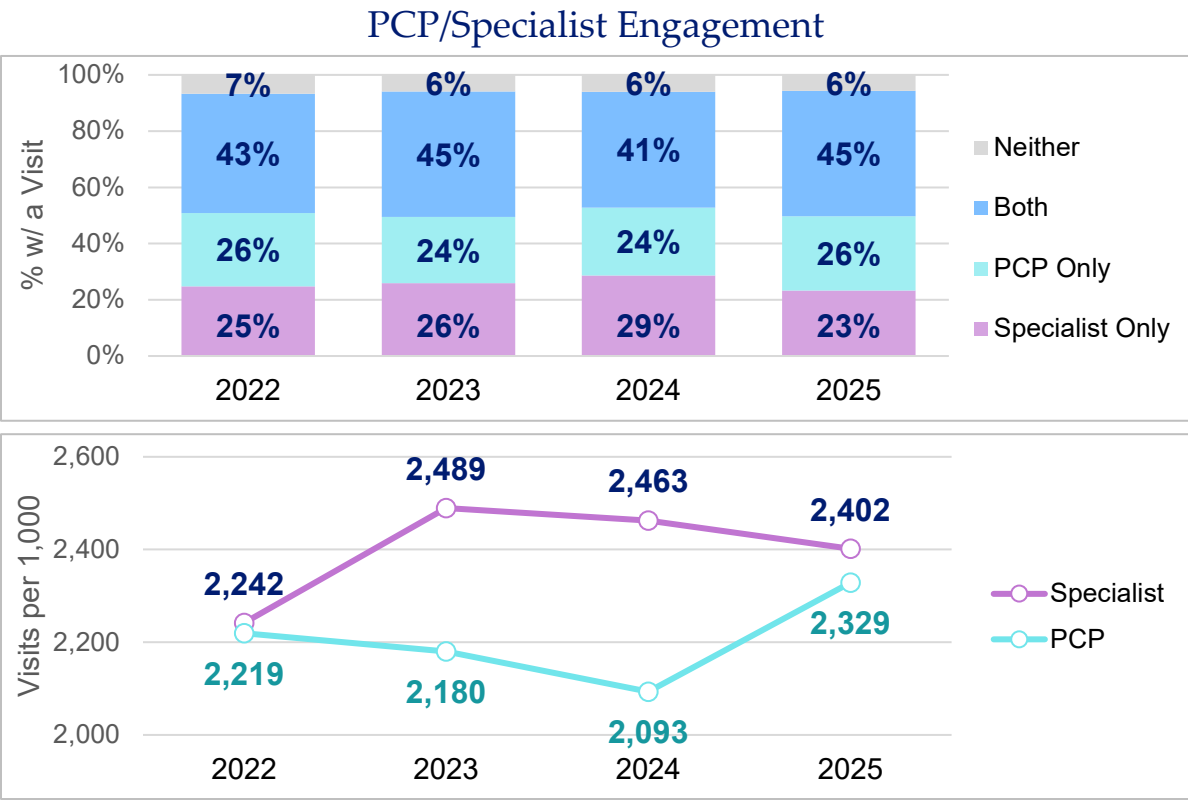
² Historical reflects the annualized trend in cost from 2022 to 2025.

³ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea)

Diabetes

Condition Management

Diabetes Condition Management					
Metric	2022	2023	2024	2025	Change
Annual A1c Test	81.5%	78.9%	77.4%	83.9%	Increase YoY Increase Historical
Kidney Screening	89.7%	91.2%	91.5%	90.5%	Decrease YoY Increase Historical
% w/ Heart Disease	12.8%	13.9%	14.7%	16.3%	Increase YoY Increase Historical
Statin Use ¹	76.7%	75.3%	73.7%	72.9%	Decrease YoY Decrease Historical
GLP-1 Use	36.5%	46.6%	47.7%	45.5%	Decrease YoY Increase Historical
PCP Visit	68.6%	68.2%	65.4%	71.1%	Increase YoY Increase Historical
Specialist Visit	67.3%	70.5%	69.8%	68.0%	Decrease YoY Increase Historical
ER Visit	13.7%	14.3%	13.9%	14.9%	Increase YoY Increase Historical
Inpatient Visit	3.8%	4.0%	3.8%	3.9%	Increase YoY Increase Historical



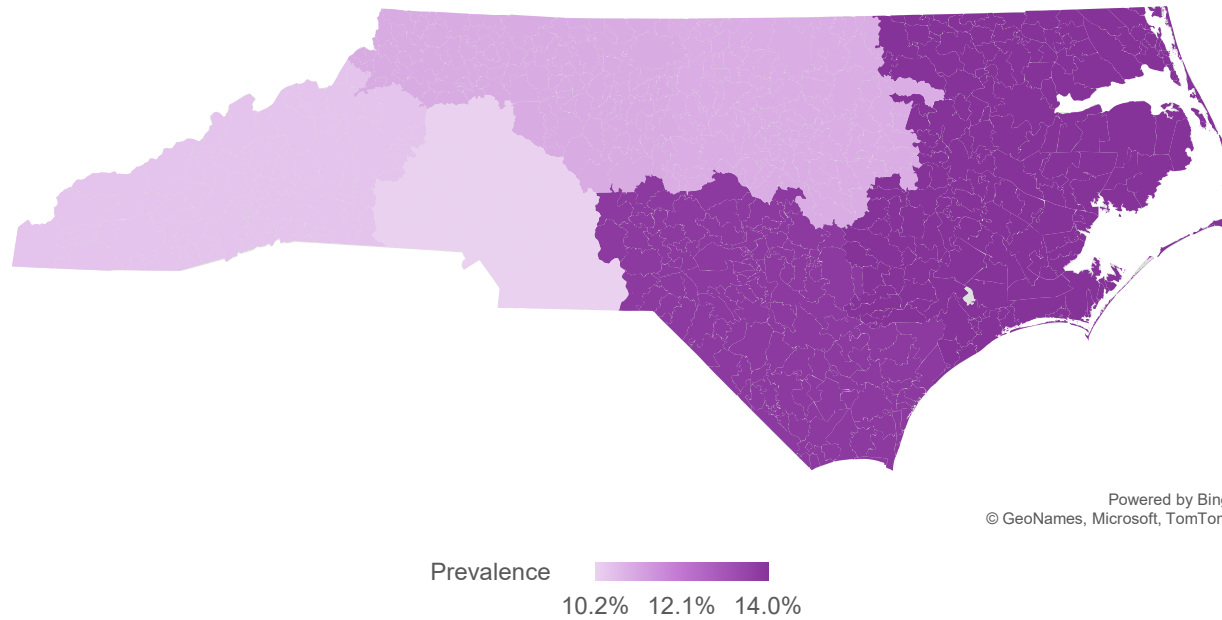
Observations

This page monitors trends in condition management for diabetics.

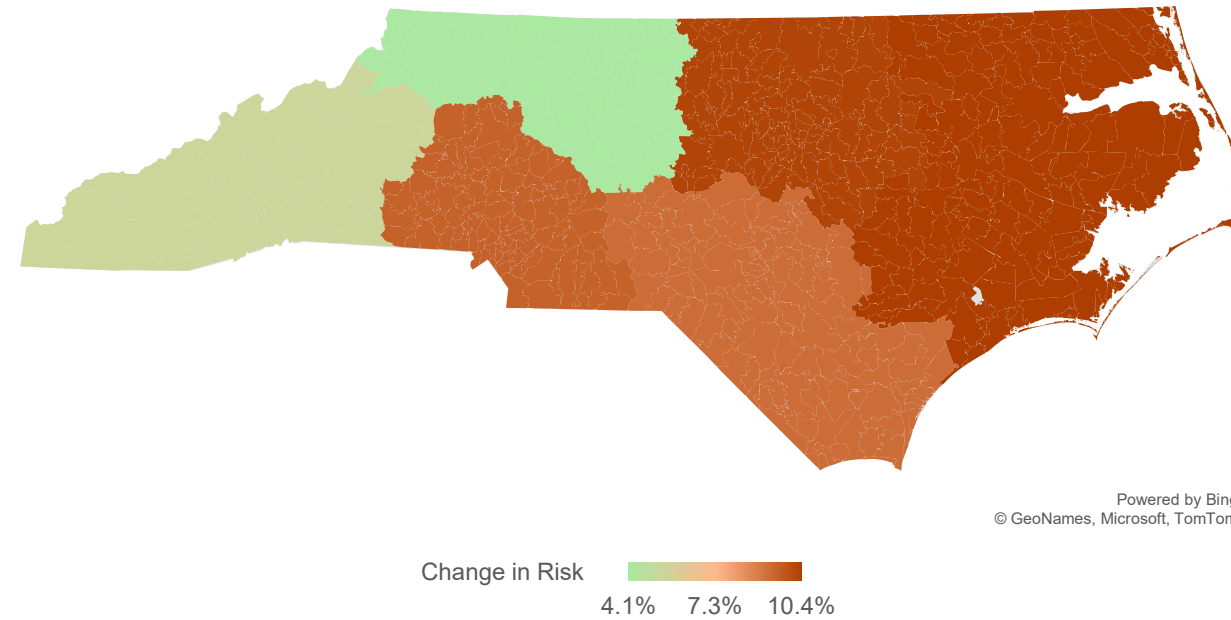
- Five out of the nine quality metrics improved over the historical period but only two out of nine improved year-over-year.
- 45.5% of diabetics were managing their condition with GLP-1s in 2025, which is slightly higher than the 44.4% in Segal’s public sector benchmark and represents a slight drop from 2024.
- Although PCP and specialist engagement has mostly been improving, diabetics are also ending up in the emergency room and inpatient hospital at higher rates.

¹ Only includes members age 40 and above with diabetes, hypertension, and heart disease.

Diabetes Prevalence



Diabetes Risk



Observations

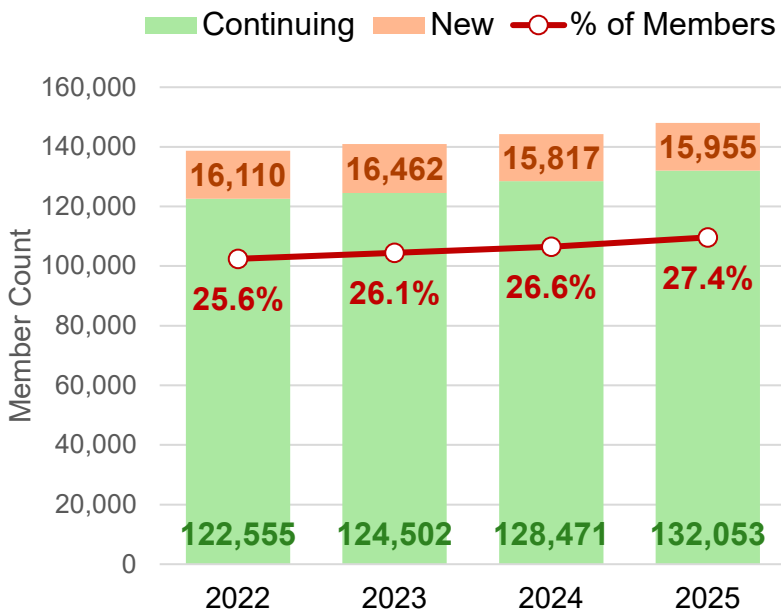
The maps above show diabetes prevalence and change in risk for diabetics from 2022 to 2025 by region.

- The eastern part of the State (i.e., Region 6: Eastern NC) represents the greatest opportunity to improve outcomes for diabetics as it has the greatest prevalence of diabetes and the greatest increase in risk from 2022 – 2025.

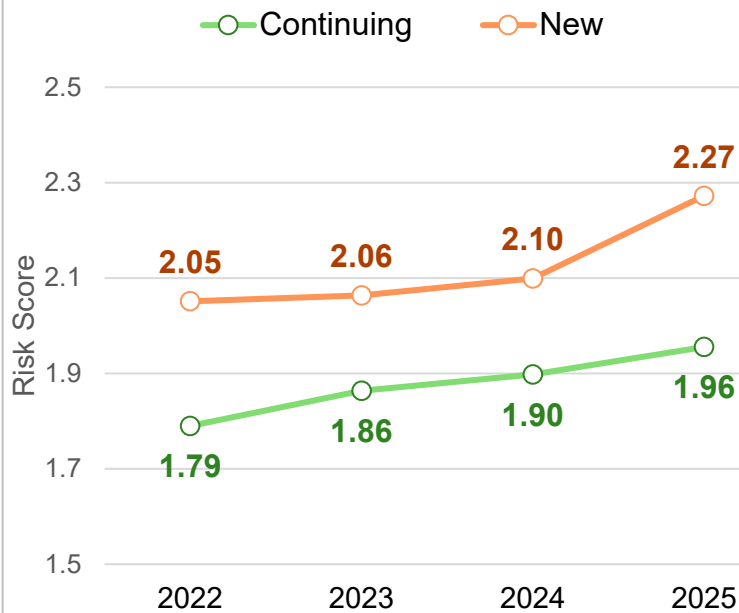
Hypertension

Prevalence and Risk Trends

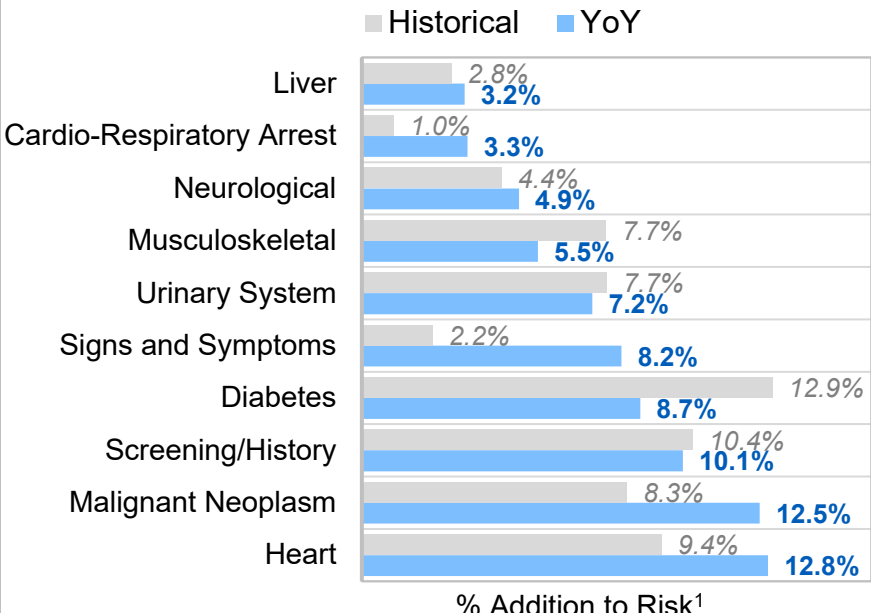
Disease Prevalence



Risk



Risk Drivers



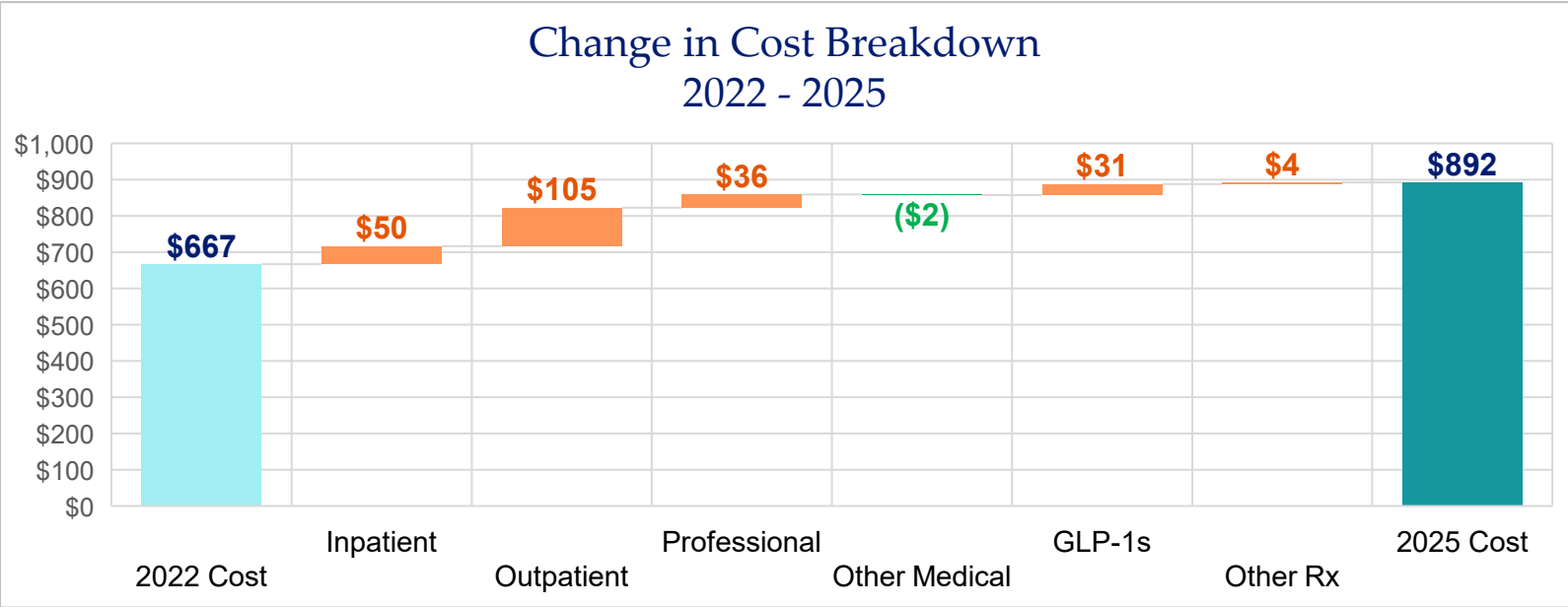
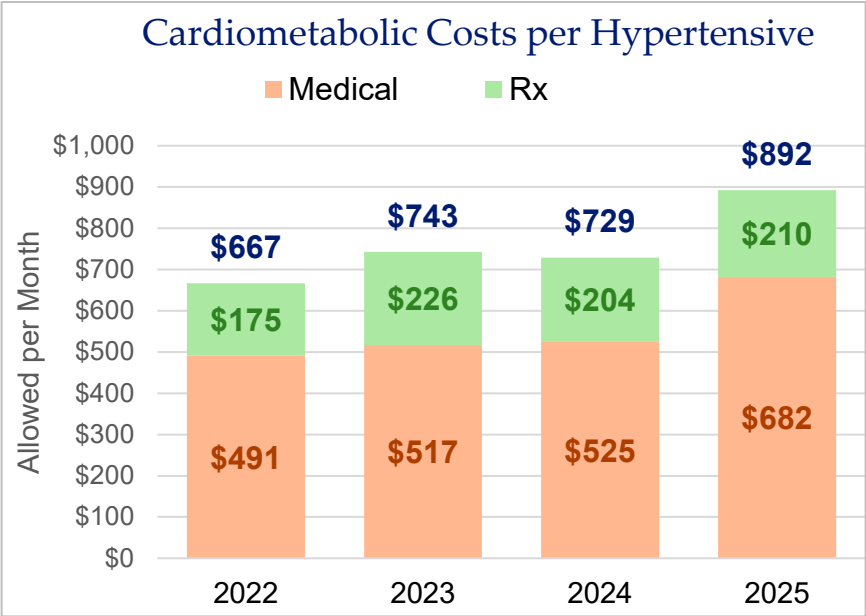
Observations

- The graphs above summarize prevalence, risk, and risk drivers for the hypertensive population.
- The hypertensive population has steadily increased over the experience period, from 25.6% of members in 2022 to 27.4% of members in 2025.
 - The risk of the hypertensive population increased 9.3% over the historical period, which is slightly higher than the increase for diabetics.
 - Similar to the diabetic population, newly diagnosed hypertensive members experienced a significant increase in risk in 2025 driven by heart disease and cancer.
 - The largest drivers of risk for hypertensive members over the experience period have been diabetes, screening/history, and heart disease.

¹ Addition to risk represents the percent of the increase in risk attributed to each risk category.

Hypertension

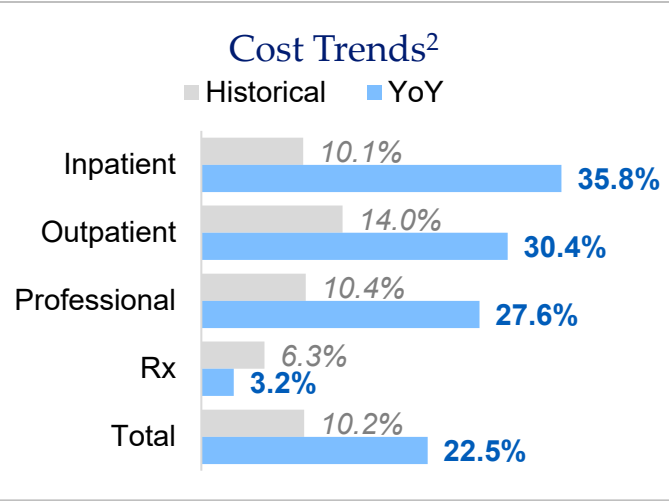
Cost Trends



Observations

The graphs on this page summarize cardiometabolic¹ costs for members with hypertension, cost drivers, and trends by place of service.

- Cardiometabolic medical costs for hypertensive members increased 3.3% per year from 2022 – 2024 but then increased 29.9% in 2025.
- From 2022 – 2025, total cardiometabolic costs (medical + Rx) increased 10.2% per year and was driven by inpatient and outpatient hospital expenses.
 - Outpatient hospital expenses increased 14.0% per year over the experience period, professional costs increased 10.4% per year, inpatient hospital costs increased 10.1% per year, and prescription drug costs increased 6.3% per year.



¹ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea).
² Historical reflects the annualized trend in cost from 2022 to 2025.

Hypertension

Cost Trends by Service Category

**Cardiometabolic¹ Medical Cost Detail
Hypertensive Members Only**

Service Category	2022	2023	2024	2025	% Change	
					YoY	Historical ²
Inpatient	\$150	\$150	\$147	\$200	35.8%	10.1%
Surgery	\$96	\$93	\$86	\$103	19.3%	2.3%
ICU	\$16	\$18	\$18	\$40	116.8%	35.1%
Other	\$38	\$39	\$43	\$58	33.8%	14.9%
Outpatient	\$219	\$240	\$249	\$324	30.4%	14.0%
Surgery	\$105	\$112	\$114	\$130	14.0%	7.7%
Emergency Room	\$43	\$48	\$47	\$63	32.6%	13.5%
Cardiovascular	\$7	\$7	\$9	\$10	19.8%	16.2%
Radiology	\$10	\$12	\$13	\$16	21.9%	15.6%
Labs/Pathology	\$8	\$9	\$10	\$12	25.5%	13.0%
Dialysis	\$11	\$11	\$14	\$23	64.9%	28.4%
Preventive	\$3	\$4	\$4	\$6	76.8%	28.5%
Pharmacy	\$18	\$21	\$24	\$43	82.4%	33.2%
Other	\$14	\$15	\$15	\$21	41.2%	13.4%
Professional	\$106	\$109	\$112	\$142	27.6%	10.4%
Surgery	\$9	\$9	\$9	\$10	5.6%	2.9%
Radiology	\$4	\$4	\$4	\$5	16.4%	9.8%
Labs/Pathology	\$8	\$8	\$8	\$13	63.4%	20.1%
Evaluation & Management	\$45	\$47	\$47	\$52	12.6%	5.1%
Preventive	\$13	\$13	\$13	\$17	24.3%	9.6%
Pharmacy	\$5	\$5	\$6	\$11	76.5%	25.5%
Other	\$23	\$23	\$24	\$35	44.3%	15.6%
Ancillary	\$17	\$18	\$17	\$15	-12.3%	-3.6%
DME	\$9	\$11	\$10	\$9	-5.9%	-0.6%
Other	\$7	\$8	\$7	\$6	-20.9%	-7.8%
Total	\$491	\$517	\$525	\$682	29.9%	11.5%

Observations

The table to the left provides detail on trends in cardiometabolic medical costs for hypertensive members over the experience period.

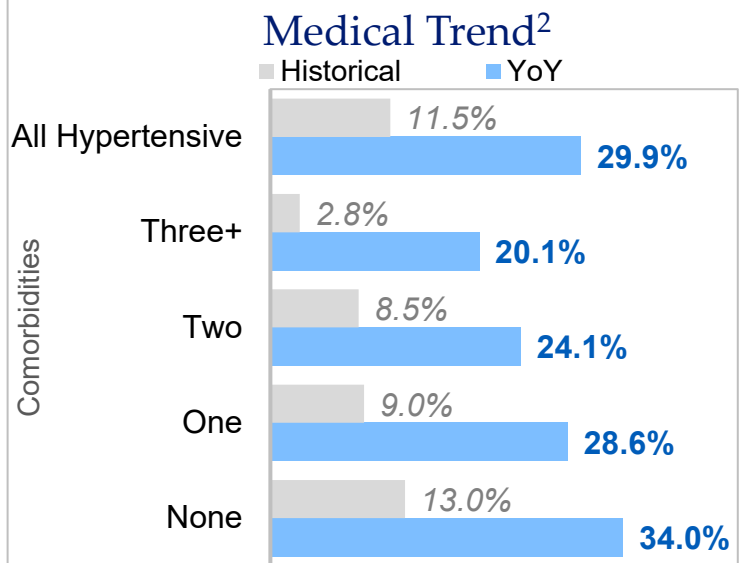
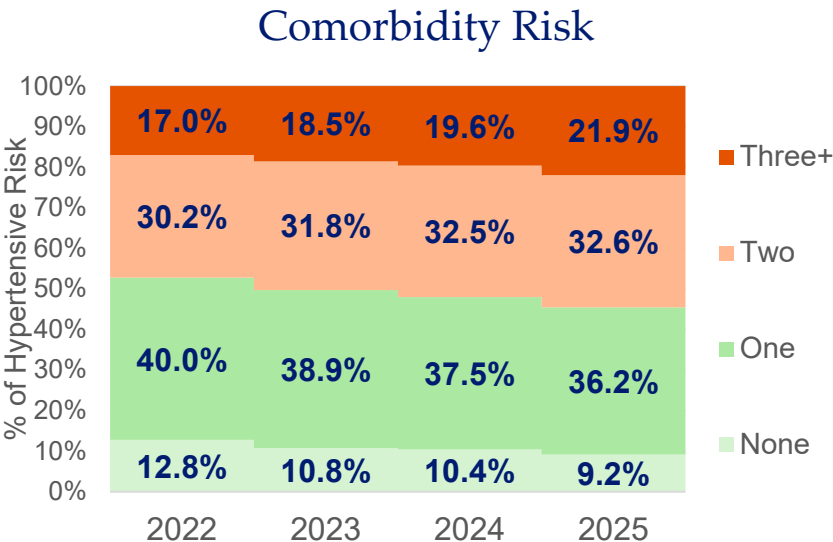
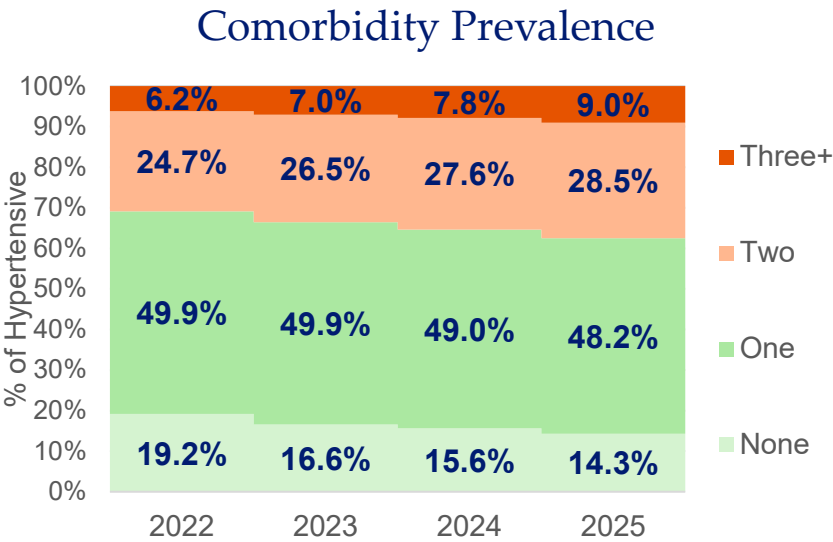
- In terms of cost, inpatient claims in the ICU and outpatient pharmacy increased the most in 2025.
- Costs in the emergency room increased 32.6% in 2025 and have increased 13.5% over the historical period.
- There have also been significant increases in costs for dialysis, where costs increased 64.9% in 2025 and have increased 28.4% per year over the historical period.
- Lab/pathology costs in the professional setting were stable from 2022 - 2024 but increased 63.4% in 2025.
- Aside from ancillary costs, all other service categories experienced higher trend in 2025 when compared to the annualized trend from 2022 – 2025.

¹ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea). 

² Historical reflects the annualized trend in cost from 2022 to 2025.

Hypertension

Comorbidities¹



Observations

The graphs on this page summarize comorbidity prevalence among hypertensive members, as well as risk and cost trends.

- The hypertensive population continues to develop more comorbidities. 69.2% of hypertensive members had one or fewer comorbidities in 2022 versus only 62.5% in 2025. Conversely, 6.2% of hypertensive members had three or more comorbidities in 2022 versus 9.0% in 2025.
- 21.9% of all hypertensive risk in 2025 was associated with hypertensive members with three or more comorbidities, up from 17.0% in 2022.
- The medical trend shown in the chart on the right only includes cardiometabolic-related³ medical expenses. Cardiometabolic-related medical costs increased 29.9% for hypertensive members in 2025, well above the historical rate of 11.5% per year from 2022 through 2025.

¹ Comorbidities include hypertension, obesity, cardiovascular disease, and chronic kidney disease.

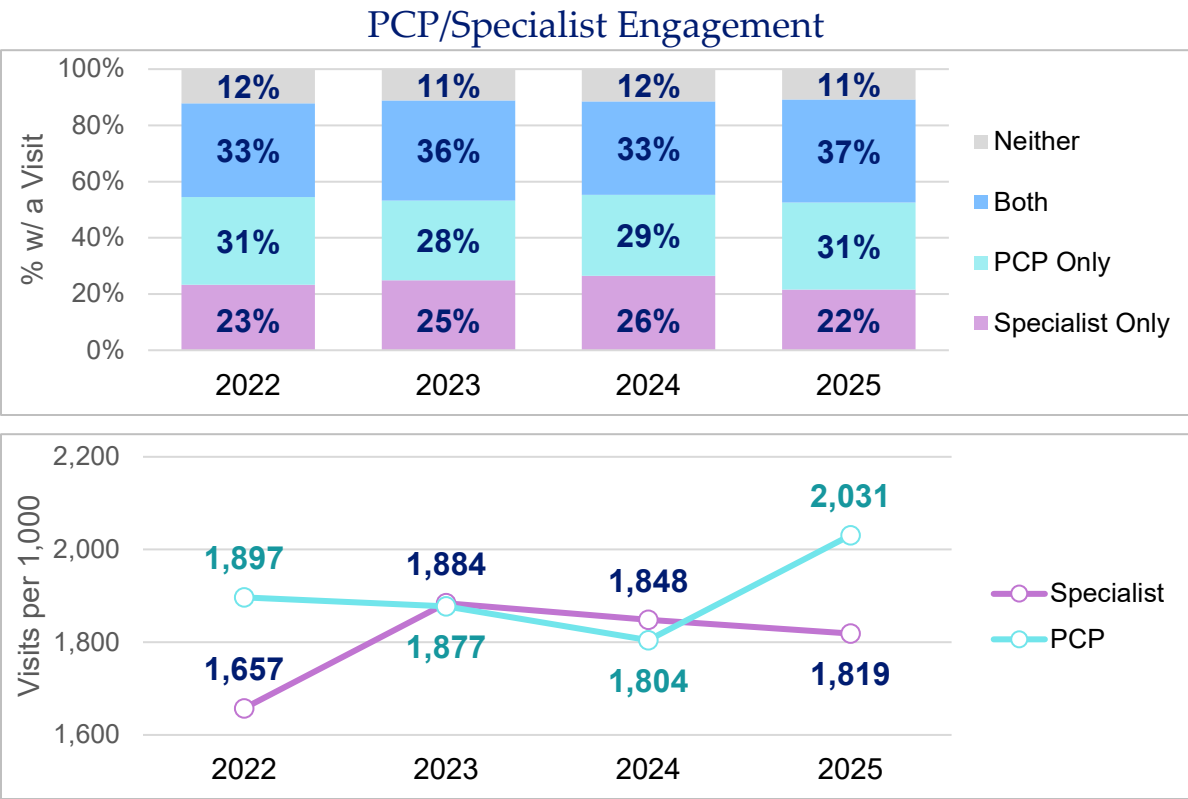
² Historical reflects the annualized trend in cost from 2022 to 2025.

³ Cardiometabolic includes costs associated with conditions that affect both the cardiovascular and metabolic systems (e.g., heart disease, hypertension, diabetes, obesity, and sleep apnea)

Hypertension

Condition Management

Hypertension Condition Management					
Metric	2022	2023	2024	2025	Change
Medication Adherence	59.4%	58.8%	56.4%	56.7%	Increase YoY Decrease Historical
Kidney Screening	84.2%	85.9%	86.4%	85.6%	Decrease YoY Increase Historical
% w/ Heart Disease	10.5%	11.5%	12.5%	13.6%	Increase YoY Increase Historical
Statin Use ¹	75.8%	74.4%	73.3%	72.3%	Decrease YoY Decrease Historical
PCP Visit	64.5%	64.0%	62.0%	67.6%	Increase YoY Increase Historical
Specialist Visit	56.5%	60.5%	59.7%	58.2%	Decrease YoY Increase Historical
ER Visit	11.8%	12.3%	12.1%	13.4%	Increase YoY Increase Historical
Inpatient Visit	2.8%	2.9%	2.9%	2.9%	Increase YoY Increase Historical



Observations

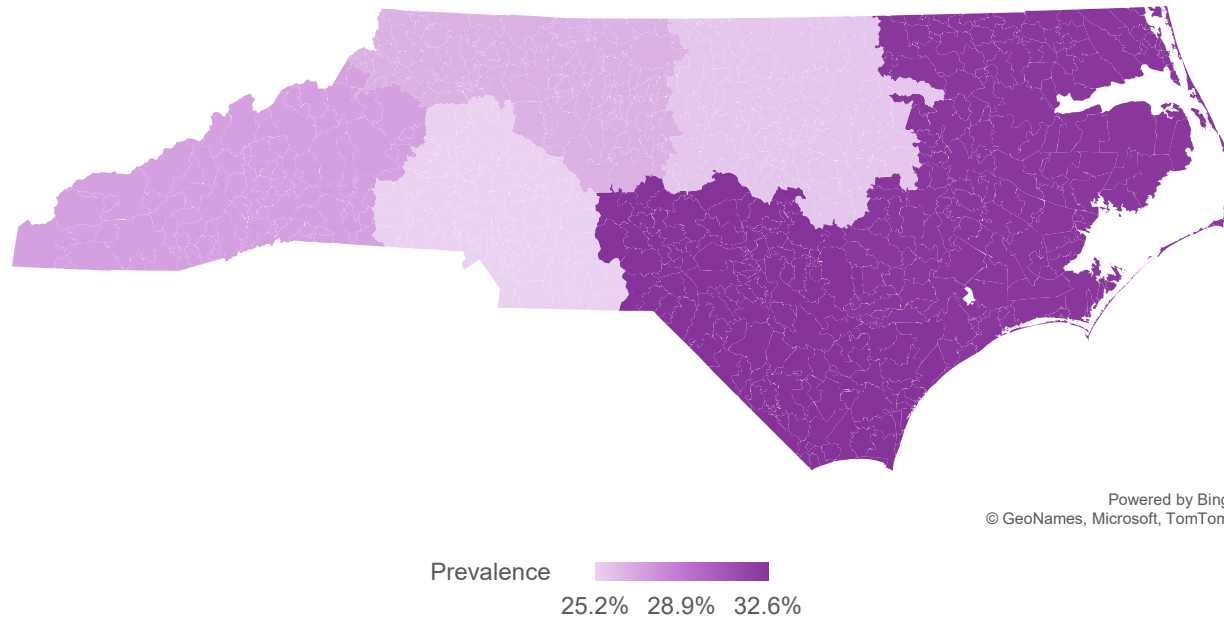
This page monitors trends in condition management for hypertension members.

- Three out of the eight quality metrics improved over the historical period but only two out of nine improved year-over-year.
- PCP and specialist engagement have both improved over the historical period. However, there was a slight reduction in specialist engagement in each of the last two years.
- Although PCP and specialist engagement has mostly been improving, hypertensive members are also ending up in the emergency room and inpatient hospital at higher rates.

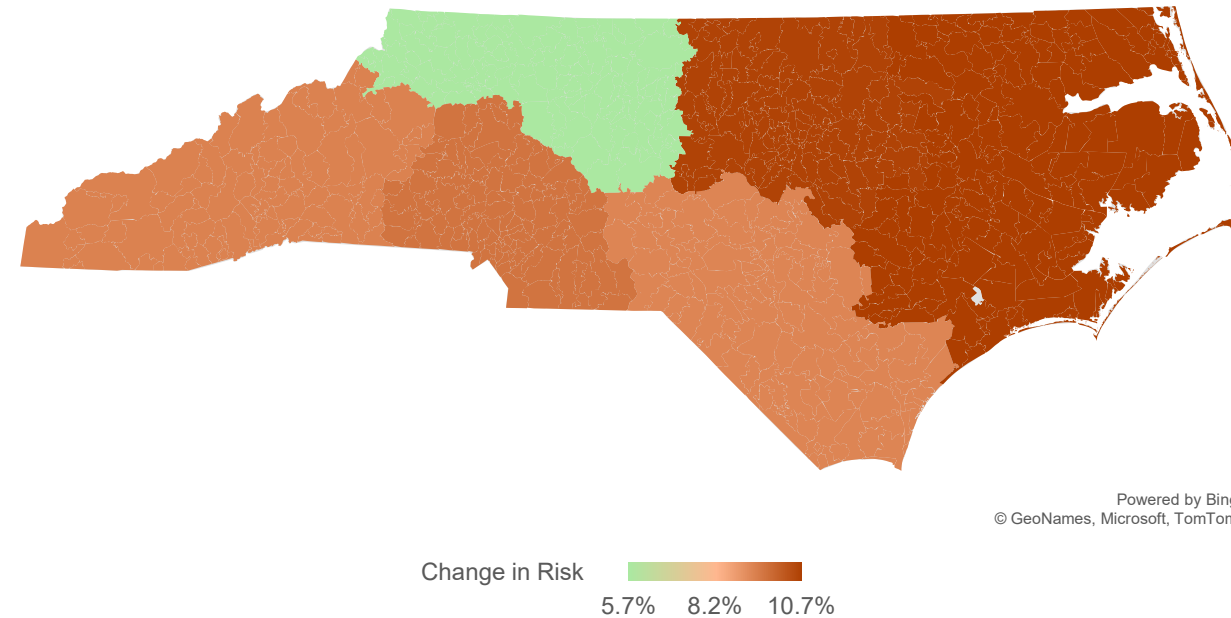
¹ Only includes members age 40 and above with diabetes, hypertension, and heart disease.

Hypertension Risk Map

Hypertension Prevalence



Hypertension Risk

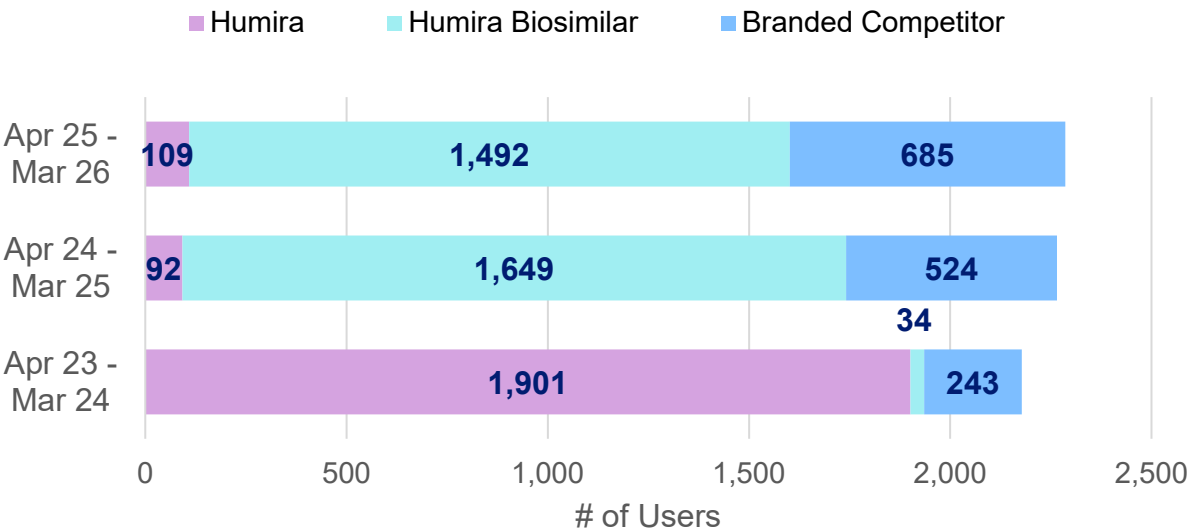


Observations

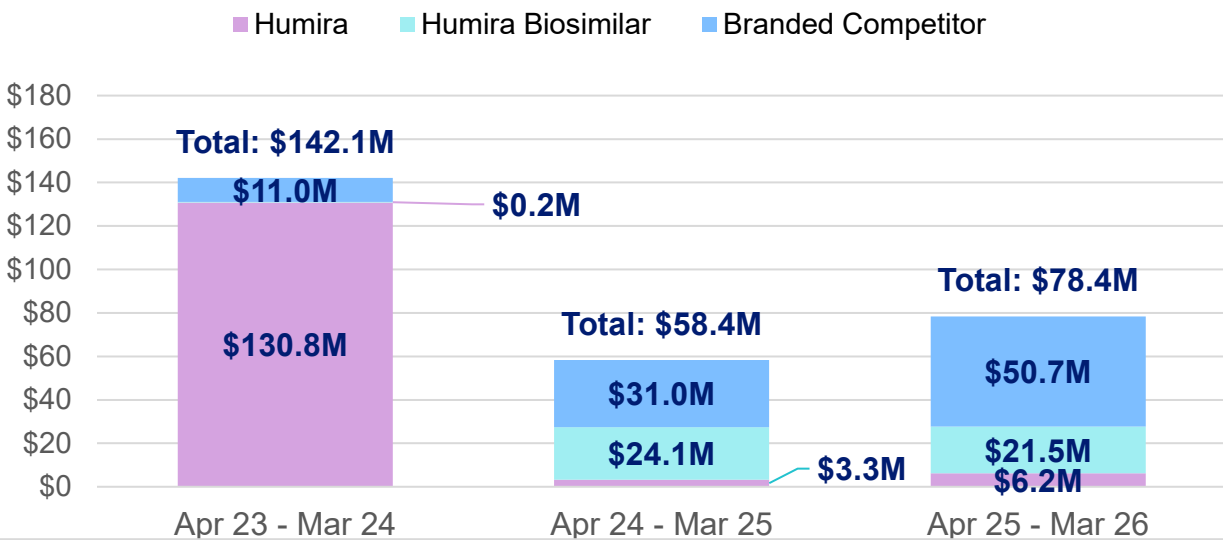
The maps above show hypertension prevalence and change in risk for hypertension members from 2022 to 2025 by region.

- The eastern part of the State (i.e., Region 6: Eastern NC) represents the greatest opportunity to improve outcomes for hypertensive members as it has the greatest prevalence of hypertension and the greatest increase in risk from 2022 – 2025.

Unique Users by Category
Humira Users Pre-April 2024



Total Allowed by Category
Humira Users Pre-April 2024



Observations

- Humira biosimilars, which may be considered similar to generic medications, became preferred on April 1, 2024. Like generics, biosimilars may result in savings* around 80 to 90% when compared to their reference (i.e., brand) product. For members treated with Humira before this date, the majority switched to a Humira biosimilar in the year after (1,649). However, a growing number of members have subsequently used a competitor product, which carry a notably higher price than a biosimilar.
- While overall costs for Humira+biosimilar members dropped from \$142.1M in the year prior to the formulary change to \$58.4M in the year after, costs increased by \$20M in the second-year due utilization of these higher-cost competitor products. As more members change to a competitor product, initial savings from biosimilar usage is reduced (see next page).

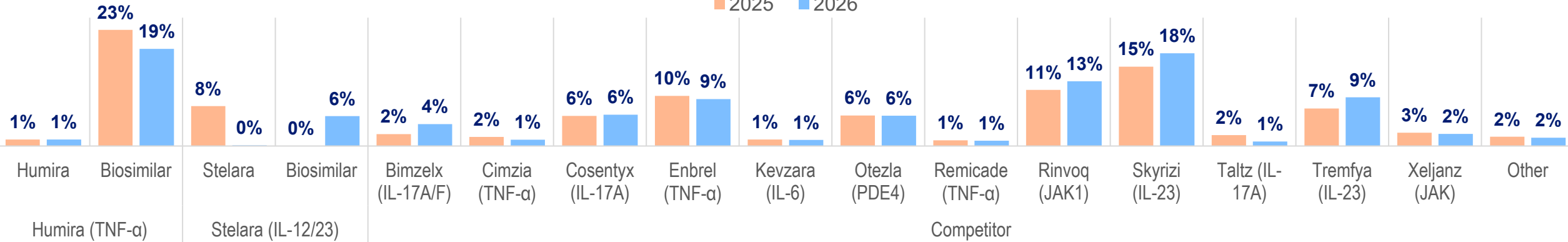
*Gross of rebates

Biosimilars

Market Share

% Total Therapy Days Dispensed

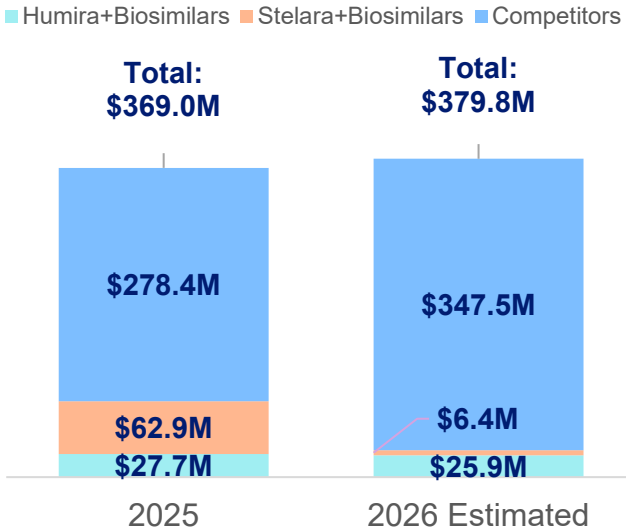
2025 2026



Observations

- The right chart displays the total costs by category for Humira, Stelara (which now has biosimilars) and their competitors (based on indications treatable with either Humira or Stelara: psoriasis, rheumatoid arthritis, Crohn’s disease, ulcerative colitis, psoriatic arthritis, axial spondyloarthritis, etc. [expanded list available in the appendix])
- Total costs for Humira and Stelara are estimated to decrease by 6.4% and 90% (\$58.3M combined) by the end of 2026, respectively. However, total spend on these groups of drugs will increase due to an estimated \$69M increase in spend for competitors, offsetting savings. While combined Humira and Stelara biosimilar adoption has improved from 2025 to 2026, notable shifts are being seen to higher-cost competitor products.
- Total utilization of Humira and its biosimilars dropped from a combined 24% to 20% with biosimilars specifically decreasing from 23% in 2025 to 19% in 2026.
- Similarly, while Stelara utilization shifted nearly entirely to biosimilars, total utilization for Stelara and its biosimilars dropped from 8% to 6% - essentially 2% of market share was not converted to lower-cost biosimilars and instead to higher cost competitors.
- Skyrizi, for example, accounted for 18% of total days’ supply dispensed in 2026, up from 15% in 2025.
- The average cost for Skyrizi in 2026 was \$9,358 per 30-days compared to approximately \$1,800 for Humira and Stelara biosimilars.
- The average cost of a competitor product rose from \$7,757 in 2025 to \$8,475 in 2026.

Total Allowed by Category
All Competitor Products



*Cost reported gross of rebates

Data Included

- This detailed risk study includes the following members of the SHPNC:
 - Actives: Any individual that is actively working, including Medicare-eligible members, and their eligible dependents
 - COBRA: Any individual receiving coverage through the Consolidated Omnibus Budget Reconciliation Act and their eligible dependents
 - Non-Medicare Retiree: Any individual enrolled in retiree coverage through the SHP and not yet eligible for Medicare and their non-Medicare-eligible dependents
- Note that individuals with any record of Medicare enrollment during a given year are excluded from this study.
- Medical and prescription drug claims incurred through 2025 and paid through July 2026.

Member Profiles: Risk Group Definitions

- **Non-Utilizers:** Members who did not have any medical claims
- **Healthy:** Any member with a DxCG score below 28.7
- **Minor acute:** Members without a chronic condition identified who had a DxCG score between 28.7 and 82.6
- **Major acute:** Members without a chronic condition identified who had a DxCG score between 82.6 and 1,200
- **Chronic:** Members with exactly one identified chronic condition
- **Comorbidities:** Members with more than one identified chronic condition
- **Malignancies:** Any member having at least two encounters related to cancer treatment
- **Catastrophic:** Any member with a DxCG score greater than 1,200

Member Profiles: Risk Group Examples

Risk Group	Description/Example of DxCG Category
1. Non-Utilizers	n/a
2. Healthy	Non-Chronic Ear, Nose, Throat, and Mouth Disorders; Migraine and Tension Headache
3. Minor Acute	Gastrointestinal Disorders; Poisonings and Allergic Reactions
4. Major Acute	Psoriasis and Parapsoriasis without Arthropathy; Normal, Single Birth
5. Single Chronic	Major Depression; Asthma
6. Chronic w/ Comorbidities	Diabetes with Acute Complications and Morbid Obesity
7. Malignancies	Breast Cancer; Prostate Cancer
8. Catastrophic	Congestive Heart Failure, Respiratory Arrest / Shock Without Trauma / Sudden Death

- This study utilizes the DxCG model for medical risk scoring, the CCSR risk adjustment model for grouping medical claims, and the SegalRx risk adjustment model for prescription drug risk scores and grouping prescription drug claims. More information regarding all models can be found in the appendices of this presentation.
- All models provide risk scores that are to be used as a measure of population health.
 - The DxCG model uses diagnosis, procedure, pharmacy, and demographic data to estimate current and forecast future medical expenses.
 - Although risk scores from the CCSR model were not used directly in this report, the model can provide risk scores which are developed as follows: when an individual has an encounter with the healthcare system and is coded with a primary diagnosis code, that code is then mapped to a CCSR category, and a risk score is assigned for that encounter. For a given experience period, all the risk scores for a given individual are added up to produce an overall risk score for that individual's health for that period. Risk scores are only counted once within a given category.
 - For the SegalRx risk adjustment model, when an individual has a drug prescription filled, the National Drug Code (NDC) for that drug is mapped to a SegalRx category and severity level, and a risk score is assigned for that fill. Similar to the CCSR model, all risk scores for that individual during the experience period are added up to provide an overall risk score for that individual. Risk scores are only counted once within a given condition based on the highest severity level.
- Risk scores are shown relative to 2022 for both medical and prescription drugs in order to make it easier to understand morbidity changes over time. Relative risk scores can be read as follows:
 - A risk score of 1.097 in 2025 means that population morbidity has increased by 9.7% since 2022. Said another way, costs are expected to be 9.7% higher in 2025 compared to 2022 before taking into account medical cost inflation.
- It's possible for risk scores to decrease and costs to increase. Risk scores reflect relative morbidity within a population. For example, if overall medical inflation increases by 7% but population morbidity decreases by 3%, costs may still increase by 4%. Additionally, a risk score is just an estimate of healthcare resource utilization and does not factor in changes in physician coding practices over time.

Why Use Risk Scores?

- Risk scoring is a way to provide a meaningful, on-level measure of a population's utilization or expenditures, whether at the patient level, provider level, hospital level, or for particular diseases.
- Population-based risk grouper models can be used for a number of business applications, including:
 - Determine the escalation of health status over time
 - Identify and stratify (prioritize) members for outreach strategies
 - Enable member outreach to improve care compliance
 - Evaluate the saving of case management and wellness program that are “true savings” and not simply a regression to the mean
 - Accurately profile providers for utilization review and quality of care
 - Support risk-based contracts and gain sharing

What is DxCG?

- The DxCG model was developed by Cotiviti in partnership with the U.S. Centers for Medicare & Medicaid Services (CMS) and served as the foundation for the Hierarchical Condition Category (HCC) model that CMS still uses as the foundation for risk-adjusted healthcare payments today. It is also a predictive, financial risk adjustment tool used by many payers and providers to manage cost and care.
- Predictive Risk Modeling: DxCG uses diagnosis and claims data to estimate future healthcare costs and utilization for individuals and populations.
- Hierarchical Condition Categories (HCCs): It organizes diagnoses into clinically coherent categories that reflect disease burden and severity.
- Relative Risk Scoring: Each individual receives a risk score that quantifies expected healthcare costs relative to a benchmark population.
- Supports Financial Planning: Used by health plans and providers for budgeting, underwriting, and setting capitation rates.
- Care Management Targeting: Helps identify high-risk patients for proactive care coordination and disease management programs.
- Population Health Analytics: Enables segmentation of populations based on risk to inform strategic planning and resource allocation.
- Incorporates Social Determinants of Health (SDoH)
- Members can fall into up to five categories, each with a different weight that adds up to 100%. The risk score for a member is a weighted average of the five categories. Below are some examples of DxCG diagnosis categories:
 - Mental: Major Depression
 - Diabetes: Diabetes with No or Unspecified Complications
 - Lung: Asthma
 - Developmental Disability: Attention Deficit Disorder
 - Musculoskeletal and Connective Tissue: Osteoarthritis of Knees

What is CCSR?

- Clinical Classifications Software Refined (CCSR) is a database developed as part of the Healthcare Cost and Utilization Project (HCUP), a Federal –State-Industry partnership sponsored by the Agency of Healthcare Research and Quality (AHRQ).
- The CCSR grouper uses medical diagnosis codes to identify one of 543 clinical categories to which members can be grouped and risk adjusted.
 - All valid ICD-10 codes are mapped to a clinical category.
- The CCS software is open-source, allowing greater flexibility in using its grouping methodology.
- Separate demographic and condition scores are provided:
 - Demographic score based on age, sex, and enrollment duration
 - Condition score based on ICD-10 diagnoses and procedure codes
- Starting data set used was the IBM Watson Marketscan Commercial data (26 million members nationwide).
 - Random forest modeling was used to develop demographic and condition-specific values by eligibility band (e.g., 1-3 months, 4-6 month, 7-9 months, 10-11 months, 12 months).
- Members can fall into multiple different condition categories. Below are some examples of CCSR diagnosis categories:
 - CIR007 Essential hypertension
 - CIR008 Hypertension with complications and secondary hypertension
 - CIR009 Acute myocardial infarction
 - CIR011 Coronary atherosclerosis and other heart disease

What is SegalRx?

- SegalRx was developed by health actuaries at Segal and utilizes the Medi-Span Generic Product Identifier grouper to allocate 63,169 different prescription drugs to one of 69 different conditions, based on National Drug Codes (NDCs).
- Up to four severity levels are established within each condition. Each condition category is hierarchical, meaning if a member utilizes drugs within multiple severity levels of the same condition, only the highest severity will be used for risk adjustment.
- In total, there are 135 different condition and severity levels in which prescription drugs are grouped.
- Risk scores were developed utilizing multiple regression modeling from 2025 pharmacy data in Segal's Data Warehouse (2.5 million members in the calibration sample).
 - Members with less than 12 months of enrollment or with any record of Medicare enrollment were excluded from the calibration sample.
- Risk scores were developed for both demographic and condition-specific values.
 - Risk scores are adjusted depending on how many months of enrollment an individual has during the experience period.
 - The total risk score for an individual is a sum of the demographic and condition values.
- Members can fall into multiple different condition categories. Below are some examples of SegalRx condition categories:
 - Disease modifying anti-rheumatic agents
 - Anti-hepatitis C (HCV) agents
 - Immunosuppressive agents
 - Anti-arrhythmic agents

Appendix

Clinical Classification Software Refined (CCSR) versus DxCG

Risk Model Comparison		
	DxCG	CCSR
Purpose and Use		
Primary Goal	Predict healthcare costs and assess risk for individuals and populations	Group ICD-10-CM diagnosis codes into clinically meaningful categories for analysis. Designed for transparency and ease of use.
Use Case	Financial risk adjustment, budgeting, underwriting, care management	Clinical data analysis, utilization tracking, outcomes research, and basic risk stratification
Data and Classification Approach		
Data Input	Claims data including diagnoses, procedures, pharmacy, demographics	ICD-10-CM diagnosis codes and demographics
Classification System	Proprietary Hierarchical Condition Categories (HCCs) and predictive algorithms	Aggregates ~70,000 ICD-10-CM codes into ~530 clinical categories across 22 body systems
Granularity	High – includes detailed risk scores and predictive modeling	Moderate – focused on clinical grouping, not predictive scoring
Output and Interpretation		
Output	Relative Risk Scores (RRS), stratification by cost/utilization risk. Supports prospective and concurrent risk scoring.	Clinical categories for diagnoses, used for ranking and analysis. Concurrent only: not intended for financial risk prediction.
Interpretation	Quantifies expected healthcare costs and identifies high-risk individuals	Helps understand disease prevalence, utilization patterns, and outcomes
Technical		
Developer	Cotiviti	Agency for Healthcare Research and Quality
Availability	Proprietary and commercial tool	Free, publicly available tool

Appendix

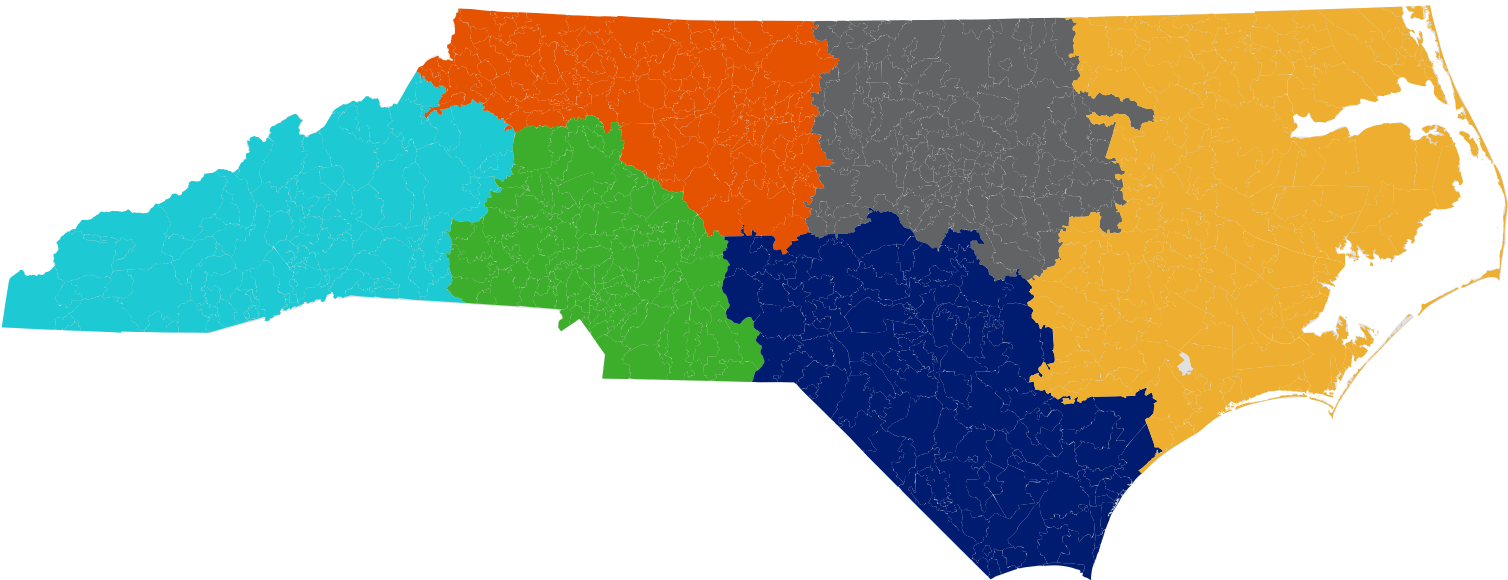
Impact of Coding Practices on Risk Score Comparisons Over Time

- As available treatments, cost of care, and standards of practice evolve over time, risk scores become increasingly challenging to compare across years. Although we are showing a relatively large increase in risk since 2022, some of this may be due to improved coding practices. An example of this is type II diabetics. In 2022, type II diabetics were mostly coded with the generic diabetes ICD-10 code indicating no or unspecified complications. Since then, we are seeing more diabetics being coded with ICD-10 codes indicating specific complications alongside diabetics. The following table summarizes trends in medical coding for diabetics:

Diabetes Risk Groups				
DxCG Group	Member Count			
	2022	2023	2024	2025
Diabetes with No or Unspecified Complications	18,792	19,193	19,479	20,206
Diabetes with Acute Complications	11,617	12,458	13,189	13,966
Diabetes with Neurologic or Peripheral Circulatory Manifestation	6,535	6,973	7,350	8,132
Diabetes with Ophthalmologic Manifestation	4,101	4,439	4,701	5,144
Diabetes with Renal Manifestation	2,666	3,022	3,322	3,691
% w/ Complications	57.0%	58.4%	59.5%	60.5%

- Complications increase the risk score assigned to a participant. However, it's unclear if diabetic members actually have more complications and are thus higher risk or if coding patterns have improved and physicians are being more specific in the codes they use for patients.

PCP Selection



- Region 1: Western

■ Region 2: Piedmont Triad

■ Region 3: Metrolina (Charlotte)

■ Region 4: Triangle

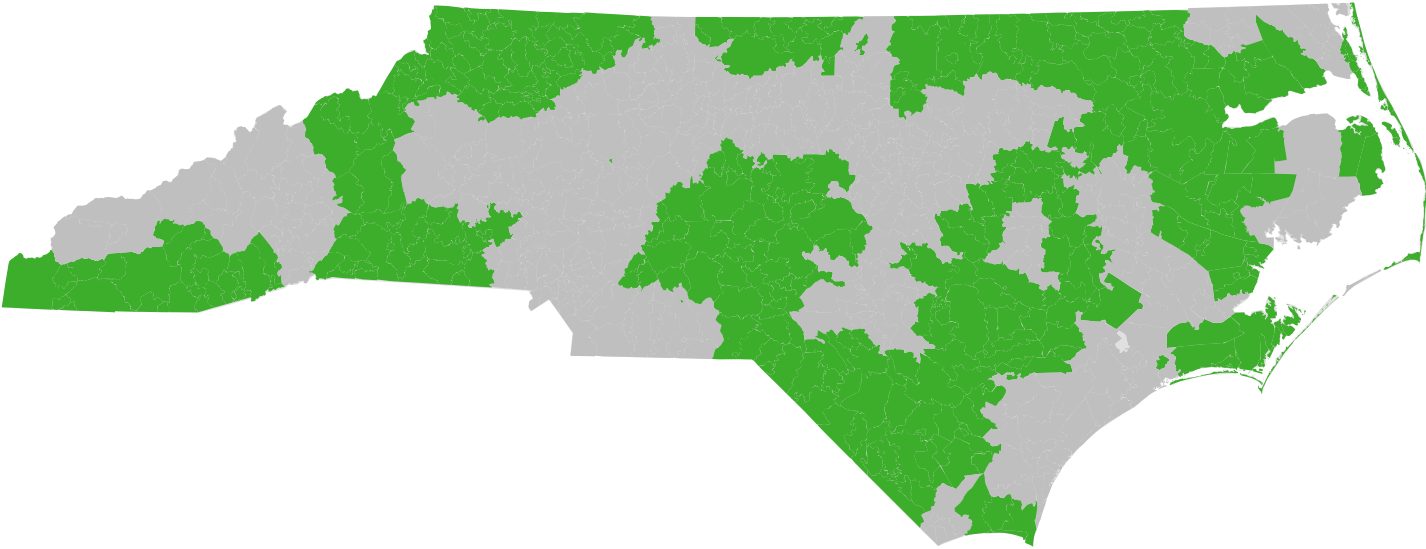
■ Region 5: Cape Fear

■ Region 6: Eastern NC

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Member Counts By Region		
Region	Member Count	% of Total
Region 1: Western	50,898	9.5%
Region 2: Piedmont Triad	77,852	14.5%
Region 3: Metrolina (Charlotte)	92,358	17.2%
Region 4: Triangle	164,967	30.8%
Region 5: Cape Fear	69,367	13.0%
Region 6: Eastern NC	69,105	12.9%
Out-of-State	10,875	2.0%
Unknown	26	0.0%
Total	535,448	100.0%

PCP Selection



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■ Rural ■ Urban

Member Counts By Region <i>Urban vs. Rural</i>			
Region	Member Count		% Rural
	Urban	Rural	
Region 1: Western	31,971	18,927	37%
Region 2: Piedmont Triad	53,415	24,437	31%
Region 3: Metrolina (Charlotte)	80,420	11,938	13%
Region 4: Triangle	142,433	22,534	14%
Region 5: Cape Fear	35,064	34,303	49%
Region 6: Eastern NC	37,325	31,780	46%
<i>Out-of-State</i>	7,492	3,383	31%
Total	388,120	147,302	28%

Source: Urban versus rural status is determined from the Centers for Medicare & Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) physician fee schedule.

Appendix

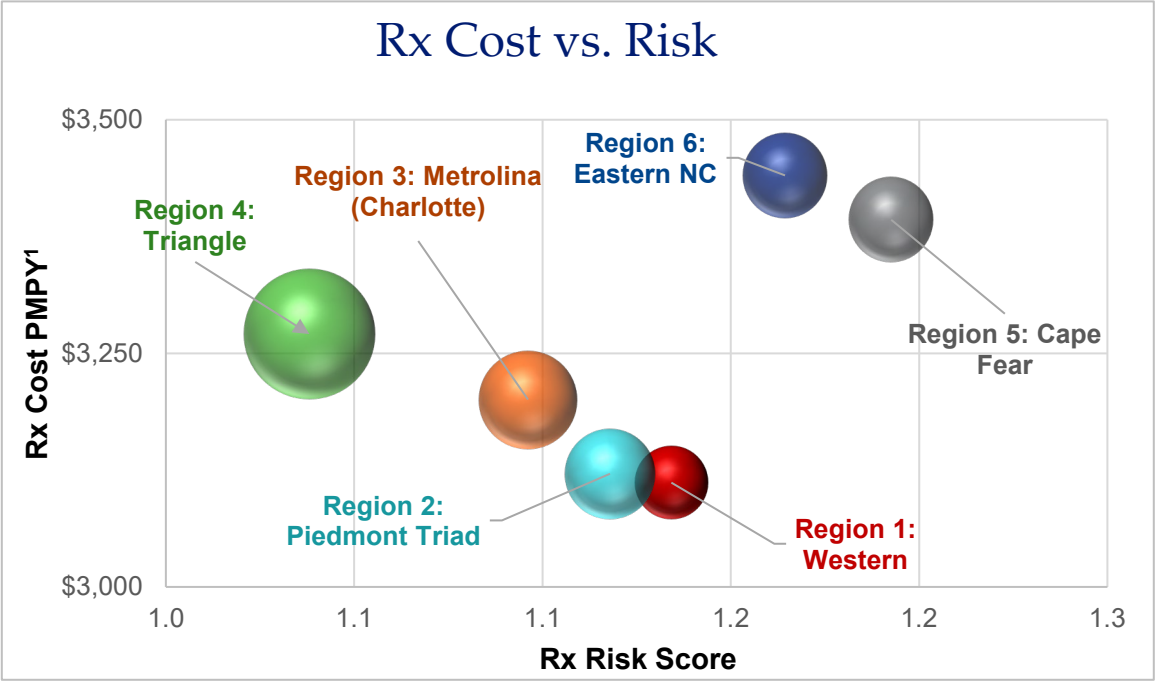
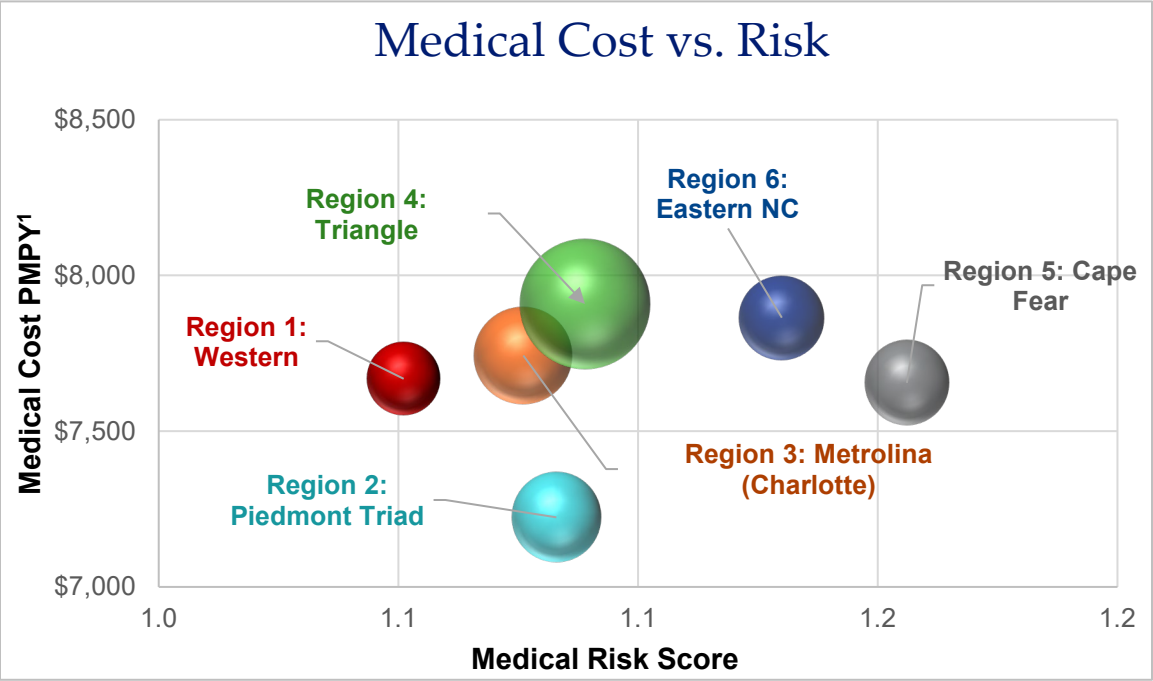
Cost, Risk, and Utilization by Region

Cost, Risk, and Utilization By Region											
Region	Medical PMPY ¹	Medical Risk Score	Rx PMPY ¹	Rx Risk Score	% Chronic	Utilization per 1,000					
						Hospital Admissions	Emergency Room	Urgent Care	Telehealth	Physicals	Rx Scripts
Region 1: Western	\$7,668	1.05	\$3,112	1.13	72.9%	40.9	197.0	189.4	1,430.4	661.7	13,582.5
Region 2: Piedmont Triad	\$7,223	1.08	\$3,121	1.12	72.6%	41.2	196.7	190.7	1,551.9	753.3	12,915.0
Region 3: Metrolina (Charlotte)	\$7,743	1.08	\$3,200	1.10	71.8%	41.4	211.1	153.3	1,631.7	735.1	12,482.8
Region 4: Triangle	\$7,909	1.09	\$3,271	1.04	73.1%	39.5	186.6	261.7	2,667.9	747.1	11,835.1
Region 5: Cape Fear	\$7,655	1.16	\$3,393	1.19	75.7%	42.2	244.0	171.8	1,344.3	684.6	13,730.6
Region 6: Eastern NC	\$7,864	1.13	\$3,440	1.16	74.8%	42.5	255.5	180.2	1,156.5	598.5	13,451.3
Out-of-State	\$8,470	1.15	\$3,440	1.16	71.4%	46.3	212.0	216.5	1,392.0	624.7	13,065.8
Total	\$7,731	1.10	\$3,263	1.11	73.3%	41.1	210.1	202.7	1,816.8	708.1	12,748.9

¹ PMPY = per member per year

Appendix

Cost and Risk by Region



¹ PMPY = per member per year

Appendix

Top-20 DxCG Level 1 Categories

DxCG Category	CY2023			CY2024			CY2025			Change			
	Members	% of Members	% of Risk	Members	% of Members	% of Risk	Members	% of Members	% of Risk	Members ¹	% of Members ²	Risk ³	% of Risk ²
Symptoms, Signs and Ill-Defined Conditions	265,044	44.7%	6.6%	260,772	44.1%	6.4%	259,876	44.3%	6.3%	-34,315	-4.9pp	-3.2%	-1.6pp
Musculoskeletal and Connective Tissue	242,005	40.8%	12.3%	244,134	41.3%	12.3%	240,135	40.9%	12.1%	-389	0.7pp	0.5%	-0.4pp
Mental	142,921	24.1%	6.9%	148,814	25.2%	7.1%	153,426	26.1%	7.1%	19,365	3.7pp	2.5%	0.4pp
Nutritional and Metabolic	109,712	18.5%	3.8%	110,420	18.7%	3.8%	115,656	19.7%	3.8%	14,017	2.7pp	1.8%	0.1pp
Skin and Subcutaneous	98,750	16.6%	3.2%	103,076	17.4%	3.3%	106,311	18.1%	3.3%	12,674	2.5pp	2.6%	0.2pp
Screening/History	93,643	15.8%	10.0%	98,109	16.6%	10.1%	101,359	17.3%	10.2%	11,900	2.3pp	1.8%	0.3pp
Ears, Nose, and Throat	115,698	19.5%	1.4%	109,592	18.6%	1.3%	99,563	17.0%	1.2%	-11,863	-1.7pp	-3.4%	-0.3pp
Gastrointestinal	92,536	15.6%	5.6%	91,324	15.5%	5.5%	90,146	15.4%	5.4%	1,977	0.6pp	0.7%	-0.1pp
Heart	68,717	11.6%	4.8%	69,873	11.8%	4.8%	74,323	12.7%	5.0%	6,630	1.3pp	2.7%	0.4pp
Lung	64,055	10.8%	3.0%	70,277	11.9%	3.1%	73,450	12.5%	3.0%	8,363	1.6pp	1.3%	0.0pp
Genital System	55,792	9.4%	1.5%	57,454	9.7%	1.5%	62,856	10.7%	1.5%	8,342	1.6pp	0.8%	0.0pp
Diabetes	53,798	9.1%	6.5%	56,095	9.5%	6.7%	59,865	10.2%	6.8%	8,847	1.7pp	2.7%	0.5pp
Neurological	56,086	9.5%	4.8%	57,207	9.7%	4.8%	57,114	9.7%	4.7%	1,243	0.4pp	0.9%	-0.1pp
Benign/In Situ/Uncertain Neoplasm	47,139	7.9%	0.9%	48,857	8.3%	0.9%	50,354	8.6%	0.9%	4,214	0.9pp	0.5%	0.0pp
Eyes	59,578	10.0%	1.2%	55,354	9.4%	1.1%	49,533	8.4%	1.0%	-2,830	-0.3pp	-1.6%	-0.2pp
Developmental Disability	40,117	6.8%	1.6%	44,481	7.5%	1.7%	49,047	8.4%	1.9%	13,668	2.4pp	6.6%	0.4pp
Infectious and Parasitic	48,931	8.2%	2.1%	47,495	8.0%	2.1%	42,571	7.3%	2.0%	6,105	1.2pp	1.5%	0.0pp
Urinary System	39,442	6.6%	4.1%	39,856	6.7%	4.0%	41,391	7.1%	4.0%	3,662	0.7pp	2.0%	0.2pp
Injury, Poisoning	44,072	7.4%	1.3%	45,887	7.8%	1.4%	40,452	6.9%	1.2%	-1,569	-0.1pp	-0.9%	-0.1pp
Hematological	28,926	4.9%	2.6%	30,539	5.2%	2.6%	33,314	5.7%	2.7%	6,479	1.2pp	2.8%	0.2pp

¹ Reflects the change in members from 2022 to 2025.

² Reflects the percentage point (pp) change between 2022 to 2025.

³ Reflects the annualized trend in risk between 2022 and 2025.

Appendix

Top-20 DxCG Level 2 Categories

DxCG Category	CY2023			CY2024			CY2025			Change			
	Members	% of Members	% of Risk	Members	% of Members	% of Risk	Members	% of Members	% of Risk	Members ¹	% of Members ²	Risk ³	% of Risk ²
Other Non-Chronic Ear, Nose, Throat, and Mouth Disorders	107,744	18.2%	1.1%	101,739	17.2%	1.0%	91,303	15.6%	0.8%	-12,470	-1.8pp	-4.6%	-0.3pp
Other Major Symptoms, Abnormalities	103,485	17.4%	2.3%	92,717	15.7%	1.9%	86,554	14.7%	1.7%	-60,502	-9.8pp	-12.3%	-1.8pp
Symptoms, Signs, and Findings NEC	80,201	13.5%	0.4%	83,229	14.1%	0.4%	84,675	14.4%	0.3%	13,382	2.5pp	0.8%	0.0pp
Other Dermatological Disorders	62,867	10.6%	0.8%	65,084	11.0%	0.8%	66,754	11.4%	0.8%	5,796	1.2pp	0.7%	0.0pp
Other Aftercare	57,761	9.7%	3.5%	61,152	10.4%	3.7%	61,300	10.4%	3.6%	8,309	1.6pp	2.2%	0.2pp
Other Gastrointestinal Disorders	60,534	10.2%	1.7%	59,652	10.1%	1.7%	57,658	9.8%	1.5%	208	0.2pp	-0.9%	-0.2pp
Thyroid/Testicular/Ovarian and Metabolic/Nutritional Disorders	49,390	8.3%	0.8%	51,231	8.7%	0.8%	54,407	9.3%	0.9%	6,616	1.3pp	1.1%	0.0pp
Major Depression	44,538	7.5%	2.8%	46,668	7.9%	2.9%	47,878	8.2%	2.8%	7,746	1.4pp	2.8%	0.2pp
Other Psychiatric Disorders	40,860	6.9%	0.9%	41,387	7.0%	0.9%	41,555	7.1%	0.9%	1,264	0.3pp	-0.4%	-0.1pp
Hypertension	39,108	6.6%	0.6%	39,022	6.6%	0.6%	40,218	6.9%	0.6%	432	0.2pp	-1.5%	-0.1pp
Persistent Sleep Disorders / Other Chronic Problems	32,801	5.5%	1.4%	35,169	6.0%	1.4%	39,693	6.8%	1.5%	9,474	1.7pp	4.1%	0.2pp
Benign Neoplasms of Skin, Breast, Eye	36,369	6.1%	0.5%	38,404	6.5%	0.5%	37,868	6.5%	0.5%	2,596	0.6pp	-0.3%	0.0pp
Attention Deficit Disorder	29,568	5.0%	0.9%	33,241	5.6%	1.0%	37,408	6.4%	1.1%	11,641	2.1pp	7.1%	0.3pp
Morbid Obesity	38,987	6.6%	1.2%	37,402	6.3%	1.2%	37,303	6.4%	1.1%	3,221	0.7pp	0.8%	0.0pp
Perimenopausal and Other Congenital and Acquired Female Genital Disorders	27,648	4.7%	0.5%	29,254	5.0%	0.5%	34,422	5.9%	0.5%	7,921	1.4pp	3.4%	0.1pp
Asthma	29,122	4.9%	1.2%	30,502	5.2%	1.2%	31,074	5.3%	1.2%	3,325	0.7pp	1.4%	0.0pp
Anxiety Disorders	25,893	4.4%	0.6%	27,837	4.7%	0.6%	30,256	5.2%	0.6%	7,146	1.3pp	4.6%	0.1pp
Other Lung Disorders	23,291	3.9%	0.3%	22,524	3.8%	0.3%	29,291	5.0%	0.3%	2,614	0.5pp	2.0%	0.0pp
Other Non-Chronic Infectious Diseases	34,617	5.8%	0.3%	32,289	5.5%	0.2%	27,910	4.8%	0.2%	2,637	0.5pp	-0.2%	0.0pp
Dyspnea, Distress, Other Respiratory/Chest Symptoms	30,256	5.1%	1.2%	30,526	5.2%	1.2%	27,335	4.7%	1.1%	-1,343	-0.1pp	-2.1%	-0.2pp

¹ Reflects the change in members from 2022 to 2025.

² Reflects the percentage point (pp) change between 2022 to 2025.

³ Reflects the annualized trend in risk between 2022 and 2025.

Appendix

Top-20 CCSR Categories

CCSR Category	CY2023			CY2024			CY2025			Annualized Trend ¹		
	Members	Medical Cost ²	Cost PMPY ³	Members	Medical Cost ²	Cost PMPY ³	Members	Medical Cost ²	Cost PMPY ³	Members	Medical Cost ²	Cost PMPY ³
Encounter for antineoplastic therapies	2,080	\$146.4	\$70,371	2,192	\$165.8	\$75,635	2,189	\$222.2	\$101,489	2.3%	22.3%	19.6%
Medical examination/evaluation	314,781	\$90.4	\$287	324,692	\$95.4	\$294	312,806	\$140.8	\$450	1.1%	16.7%	15.5%
Neoplasm-related encounters	161,743	\$105.2	\$650	165,738	\$108.2	\$653	147,937	\$119.4	\$807	-1.3%	9.4%	10.8%
Osteoarthritis	24,404	\$94.8	\$3,887	25,209	\$96.9	\$3,844	23,521	\$100.7	\$4,279	-0.3%	4.9%	5.2%
Spondylopathies/spondyloarthropathy	41,892	\$99.6	\$2,378	42,867	\$100.1	\$2,335	39,813	\$100.6	\$2,527	-0.8%	1.3%	2.1%
Anxiety and fear-related disorders	58,619	\$65.2	\$1,113	63,649	\$77.9	\$1,224	61,861	\$92.0	\$1,487	5.5%	19.1%	12.9%
Trauma- and stressor-related disorders	35,956	\$66.6	\$1,852	38,450	\$75.9	\$1,974	39,551	\$85.2	\$2,153	6.1%	13.5%	7.0%
Musculoskeletal pain, not low back pain	96,578	\$68.6	\$710	99,282	\$74.8	\$753	88,794	\$77.8	\$876	-1.5%	7.5%	9.1%
Breast cancer	4,520	\$64.1	\$14,184	4,566	\$66.4	\$14,531	4,593	\$77.0	\$16,762	1.3%	5.8%	4.4%
Benign neoplasms	51,773	\$62.5	\$1,207	54,059	\$64.9	\$1,200	52,237	\$75.6	\$1,447	2.4%	9.0%	6.5%
Depressive disorders	36,167	\$51.8	\$1,433	36,754	\$61.4	\$1,671	33,429	\$67.9	\$2,031	1.5%	11.6%	9.9%
Abdominal pain	53,261	\$61.9	\$1,163	53,364	\$63.4	\$1,187	48,309	\$66.1	\$1,369	-2.0%	6.0%	8.1%
Neurodevelopmental disorders	28,559	\$43.7	\$1,532	32,340	\$64.4	\$1,991	34,863	\$60.6	\$1,739	11.8%	26.9%	13.5%
Chronic kidney disease	4,548	\$35.2	\$7,736	5,019	\$37.7	\$7,520	4,751	\$53.4	\$11,233	4.9%	18.6%	13.0%
Cardiac dysrhythmias	9,390	\$42.8	\$4,559	10,013	\$50.2	\$5,016	9,918	\$53.4	\$5,380	3.2%	9.7%	6.2%
Biliary tract disease	4,465	\$40.7	\$9,123	4,510	\$42.9	\$9,512	4,554	\$47.9	\$10,515	3.2%	9.2%	5.9%
Abnormal findings without diagnosis	86,904	\$38.8	\$447	90,165	\$40.4	\$448	74,305	\$46.5	\$626	-3.1%	9.9%	13.4%
Sprains and strains	21,124	\$36.6	\$1,733	21,499	\$37.5	\$1,742	20,492	\$43.5	\$2,123	-0.2%	7.6%	7.8%
Nonspecific chest pain	24,336	\$39.3	\$1,615	24,134	\$38.6	\$1,598	22,848	\$42.6	\$1,867	-0.7%	6.2%	6.9%
Diabetes mellitus with complication	27,752	\$37.2	\$1,340	29,477	\$38.9	\$1,318	27,793	\$42.0	\$1,510	2.8%	6.5%	3.6%

¹ Reflects the average annual trend between 2022 and 2025.

² In millions

³ PMPY = per member per year

Appendix

Top-20 SegalRx Categories

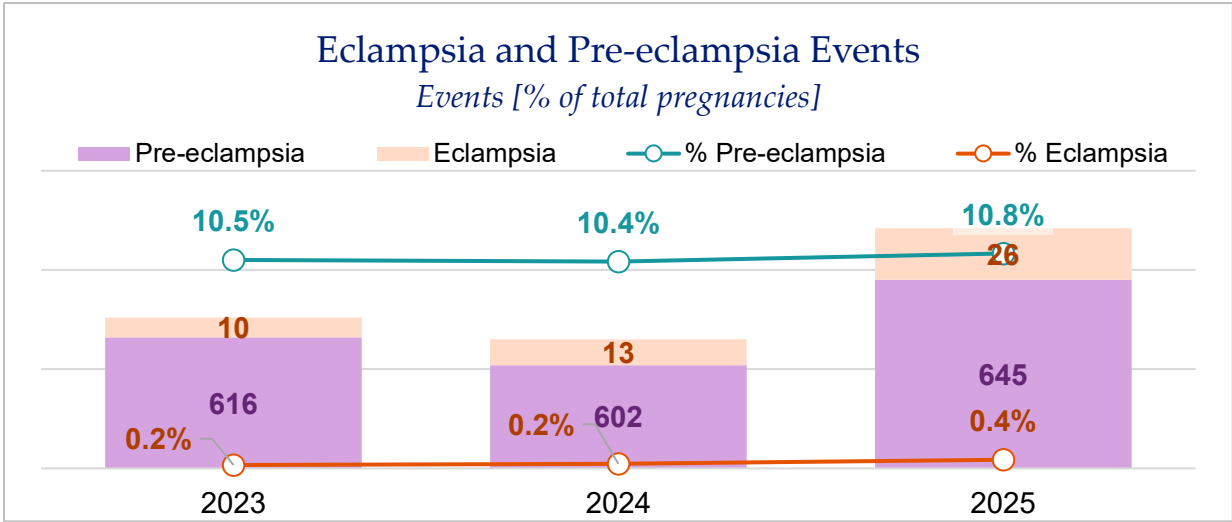
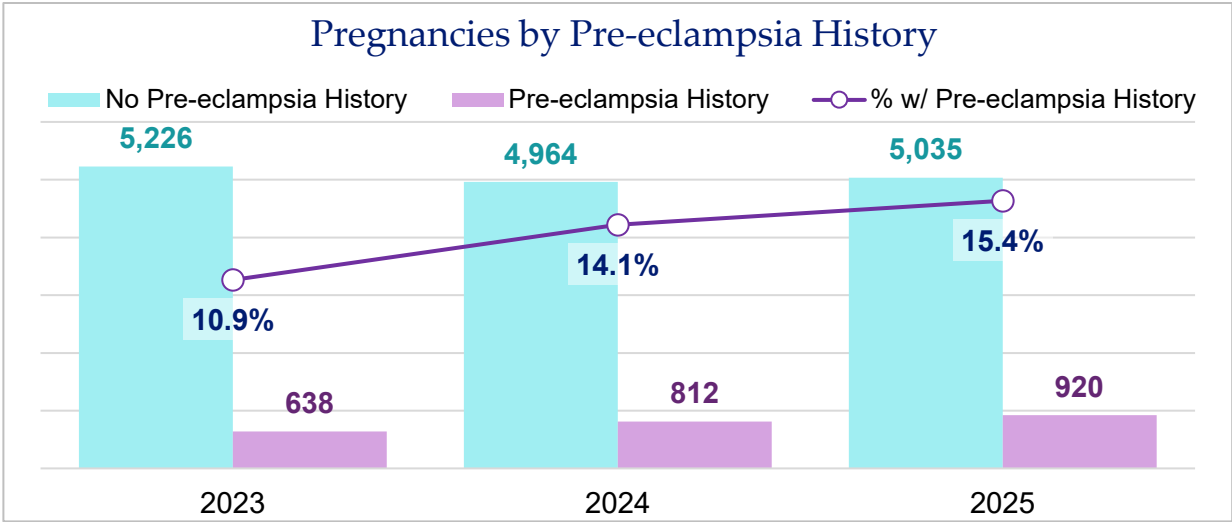
SegalRx Category	CY2023			CY2024			CY2025			Annualized Trend ¹		
	Members	Rx Cost ²	Cost PMPY ³	Members	Rx Cost ²	Cost PMPY ³	Members	Rx Cost ²	Cost PMPY ³	Members	Rx Cost ²	Cost PMPY ³
Antidiabetic Agents, Except Insulin and Metformin Only	34,655	\$217.6	\$6,279	34,558	\$253.9	\$7,346	36,015	\$287.1	\$7,973	7.2%	19.0%	11.0%
Antipsoriatocs	2,956	\$131.3	\$44,435	5,999	\$175.4	\$29,230	10,918	\$223.4	\$20,461	69.5%	26.0%	-25.7%
Disease-Modifying Antirheumatic Drugs	3,319	\$198.9	\$59,930	3,388	\$133.4	\$39,372	3,419	\$136.4	\$39,899	2.1%	-10.7%	-12.5%
Oncology	10,414	\$90.5	\$8,688	10,204	\$99.4	\$9,744	10,755	\$112.6	\$10,469	-2.0%	11.3%	13.6%
Skin Disorders	45,742	\$47.6	\$1,040	47,506	\$59.8	\$1,258	47,620	\$77.2	\$1,620	2.4%	25.5%	22.6%
Asthma/COPD	39,466	\$49.2	\$1,246	39,092	\$54.6	\$1,398	38,860	\$72.2	\$1,859	-0.9%	19.4%	20.4%
Headaches	12,786	\$43.3	\$3,390	13,449	\$54.6	\$4,058	14,015	\$64.4	\$4,593	4.9%	24.9%	19.1%
HIV/AIDS	1,942	\$46.0	\$23,696	2,042	\$49.8	\$24,376	2,191	\$54.5	\$24,877	5.3%	5.2%	-0.1%
Antidepressants	112,854	\$36.7	\$325	113,837	\$39.0	\$342	117,721	\$41.7	\$354	2.0%	8.5%	6.4%
ADHD	32,215	\$37.0	\$1,147	35,150	\$34.7	\$988	39,399	\$38.3	\$972	9.6%	7.6%	-1.9%
Inflammatory/Autoimmune	33,892	\$27.6	\$813	37,706	\$30.2	\$800	37,561	\$38.2	\$1,018	5.7%	15.0%	8.8%
Diabetic Supplies/Monitoring	7,952	\$15.9	\$2,001	8,861	\$22.0	\$2,481	10,422	\$28.3	\$2,715	17.2%	46.1%	24.6%
Insulin	8,826	\$50.9	\$5,762	9,093	\$29.8	\$3,280	9,013	\$27.9	\$3,095	-1.7%	-20.8%	-19.5%
Lipid/Cholesterol Disorders	70,904	\$18.0	\$254	73,437	\$23.8	\$324	77,463	\$27.4	\$353	3.8%	24.3%	19.7%
Anticoagulants	7,676	\$22.0	\$2,870	7,693	\$24.9	\$3,239	7,875	\$25.8	\$3,277	1.5%	8.9%	7.3%
Antipsychotics	8,883	\$17.1	\$1,925	9,130	\$21.7	\$2,377	9,585	\$25.3	\$2,642	4.5%	10.4%	5.7%
Blood Disorders	12,362	\$19.7	\$1,594	13,319	\$22.8	\$1,714	13,895	\$23.9	\$1,722	5.4%	23.6%	17.3%
Antihypertensive	129,583	\$20.2	\$156	130,269	\$16.8	\$129	131,980	\$19.3	\$146	0.8%	-2.0%	-2.8%
Antiobesity Agents	21,046	\$160.3	\$7,614	14,543	\$55.5	\$3,814	5,524	\$18.6	\$3,369	-20.8%	-36.6%	-20.0%
Heart Disease	3,522	\$12.7	\$3,592	3,511	\$15.4	\$4,394	3,486	\$18.6	\$5,323	0.7%	14.8%	14.0%

¹ Reflects the average annual trend between 2022 and 2025.

² In millions

³ PMPY = per member per year

Pregnancy Outcomes by Year										
Year	Livebirth		C-Section		Stillbirth/Miscarriage		Ectopic/Abnormal		Unknown	
	Infertility	No Infertility	Infertility	No Infertility	Infertility	No Infertility	Infertility	No Infertility	Infertility	No Infertility
2023	633 [69.8%]	4,177 [84.3%]	49 [5.4%]	284 [5.7%]	189 [20.8%]	271 [5.5%]	14 [1.5%]	25 [0.5%]	22 [2.4%]	200 [4.0%]
2024	707 [71.6%]	4,069 [85.0%]	44 [4.5%]	191 [4.0%]	179 [18.1%]	287 [6.0%]	22 [2.2%]	25 [0.5%]	36 [3.6%]	216 [4.5%]
2025	798 [74.6%]	4,276 [87.5%]	44 [4.1%]	164 [3.4%]	163 [15.2%]	199 [4.1%]	18 [1.7%]	24 [0.5%]	46 [4.3%]	223 [4.6%]



Observations

- Pregnancy outcomes improved across over the last 3 years, with live birth rates increasing among members with and without infertility while rates of stillbirth/miscarriage declined. However, stillbirths/miscarriages still occur in over 15% of pregnancies for those with infertility compared to 4.1% for those without.
- Pre-eclampsia affected approximately 11% to 15% of pregnancies, exceeding typical U.S. population estimates of 3% to 7%, indicating a higher-risk maternal population. Eclampsia remained uncommon at 0.2% to 0.4% of pregnancies, though rates were above published population benchmarks (<0.1%), consistent with the elevated prevalence of hypertensive pregnancy disorders in the cohort.

Appendix

Biologic Mechanisms of Action and Indications

Branded Name	Non-Proprietary Name	Mechanism of Action	Major Indications
Humira	Adalimumab	TNF- α inhibitor	Rheumatoid arthritis (RA), Psoriatic arthritis (PsA), Plaque psoriasis (PsO), Ankylosing spondylitis (AS), Non-radiographic axial spondyloarthritis, Crohn's disease (CD), Ulcerative colitis (UC), Hidradenitis suppurativa (HS), Uveitis, Juvenile idiopathic arthritis (JIA)
Humira Biosimilars	Adalimumab biosimilars	TNF- α inhibitor	Same indications as Humira
Stelara	Ustekinumab	IL-12/23 inhibitor (binds p40 subunit shared by IL-12 and IL-23)	Psoriasis, PsA, Crohn's disease, Ulcerative colitis
Stelara Biosimilars	Various	IL-12/23 inhibitor	Same indications as Stelara
Bimzelx	Bimekizumab	Dual IL-17A and IL-17F inhibitor	Plaque psoriasis, PsA, Ankylosing spondylitis, Non-radiographic axial spondyloarthritis
Cimzia	Certolizumab pegol	TNF- α inhibitor	RA, PsA, Psoriasis, Crohn's disease, AS, Non-radiographic axial spondyloarthritis
Cosentyx	Secukinumab	IL-17A inhibitor	Psoriasis, PsA, AS, Non-radiographic axial spondyloarthritis, Hidradenitis suppurativa
Enbrel	Etanercept	Soluble TNF receptor fusion protein that binds TNF- α	RA, PsA, Psoriasis, AS, JIA
Kevzara	Sarilumab	IL-6 receptor antagonist	RA, Polymyalgia rheumatica (PMR)
Otezla	Apremilast	Phosphodiesterase-4 (PDE4) inhibitor, reducing inflammatory cytokine production	Psoriasis, PsA, Behçet's disease oral ulcers
Remicade	Infliximab	TNF- α inhibitor	RA, PsA, Psoriasis, Crohn's disease, UC, AS
Rinvoq	Upadacitinib	Selective JAK1 inhibitor	RA, PsA, AS, Non-radiographic axial spondyloarthritis, Atopic dermatitis, Crohn's disease, UC, Giant cell arteritis

Appendix

A Word About Privacy

- Data presented has been “de-identified,” which means it does not contain names or SSNs, etc.
- Specific medical conditions are identified.
- If the plan administrator knows the identity of individuals with a specific condition, that information is considered PHI.
- PHI is subject to the HIPAA Privacy Rule’s protections, which means it must be kept confidential and cannot be used for any reason other than health plan administration (e.g., using it for employment purposes, or by other benefit plans, is prohibited).

Appendix

Disclaimer

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