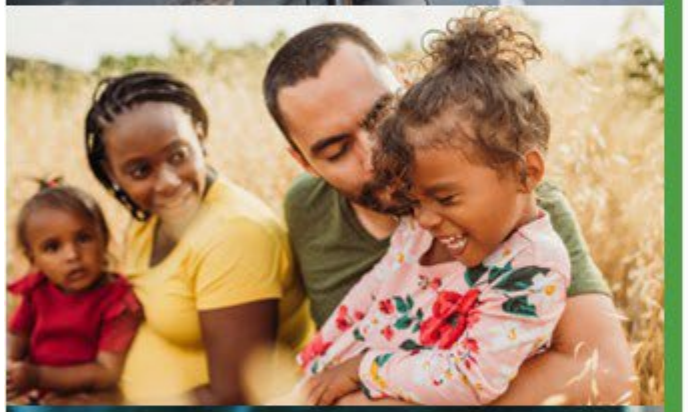

State Health Plan

Board of Trustees Meeting

December 5, 2025

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

Today's Agenda

- A Year in Review
- Local Government Discussion
- Population Risk Report
- Financial Reports
- Retiree Health Benefit OPEB Report
- 2027 Benefit Strategy

A Year in Review

Year in Review

2025

Financial Sustainability

- Ended Clear Pricing Project
- Implemented salary-based premiums and changed premium strategy
- Benefit Design Changes

Refocused Provider Strategy and Health Improvements

- Preferred Provider Model
- Lantern Surgical Benefit
- Medical Advisory Committee Formation

Population Health Return

- Hello Heart
- Hinge Health
- Ventricle Health
- Diabetes Prevention Partnership

Outreach

4,873 WEBINAR ATTENDEES

2,884 BENEFIT FAIR ATTENDEES

2,259 LUNCH-n-LEARN ATTENDEES

3,245,078 eNEWSLETTERS OPENED

1,869 / 3,461 GROWTH / INTERACTIONS ON SOCIAL MEDIA

Stakeholder Outreach

Hospital System Meetings
NC Medical Society
NC Hospital Association
NC Psychiatric Association
NC Psychology
NC Social Workers Association
HR Director Roundtables
Association Stakeholder Roundtables

our People

10

NEW F/T HIRES

2

CONTRACT HIRES

2

DEPARTURES / RETIREMENTS

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

2026 Open Enrollment

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FOR TEACHERS AND STATE EMPLOYEES
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Open Enrollment (OE) was held October 13-31, 2025.

ACTIVE SUBSCRIBERS and
NON-MEDICARE SUBSCRIBERS who did not take action during OE were enrolled in the Standard PPO Plan (formerly 70/30) for 2026.

MEDICARE-ELIGIBLE MEMBERS
who did not take action during OE remained in the plan in which they were currently enrolled.

Medicare Advantage Open Enrollment period is held January 1-March 31 and allows Medicare members to enroll in Medicare Advantage Plans or switch to optional Medicare Plan which is the 70/30 Plan.

TOBACCO ATTESTATION
was removed

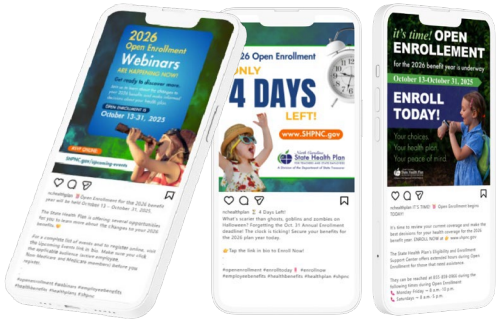
SALARY-BASED PREMIUMS
introduced

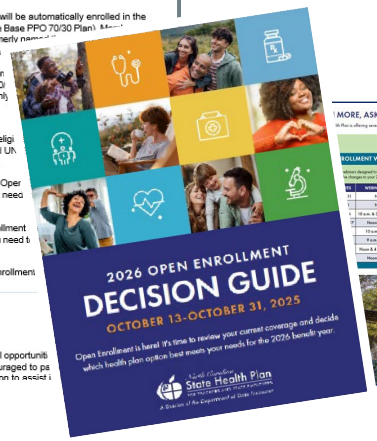
BENEFIT CHANGES
announced

Open Enrollment Communications Strategy

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

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





2026 OE Outreach

3,219 WEBINAR ATTENDEES

2,299 IN-PERSON ATTENDEES

30,513 TELEPHONE TOWN HALL ATTENDEES

453,381 eNEWSLETTERS OPENED

Enrollment Activity

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Open Enrollment was held October 13-31, 2025.

Date	eBenefit Logins	Online Changes	Telephonic Enrollments	Activity Total
WEEK 1	131,499	77,619	8,246	85,865
WEEK 2	106,473	55,066	9,613	64,679
WEEK 3	167,476	75,791	11,469	87,260
TOTAL ACTIVITY	**405,448**	**208,476**	**29,328**	**237,804**

Eligibility and Enrollment Support Center

Extended call center hours were held throughout OE.
Mon-Fri 8am-10pm | Sat 8am-5pm

Open Enrollment Call Volume			
WEEK 1	WEEK 2	WEEK 3	TOTAL
25,415	**23,119**	**39,543**	**88,077**

Plan Changes

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FOR TEACHERS AND STATE EMPLOYEES
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	Standard PPO	Plus PPO	HDHP	70/30	Humana Base	Humana Enhanced	Waived	Member Totals
Start of OE	341,195	13	380	33,798	161,268	18,883	76,626	632,249
WEEK 1	(56,830)	57,924	29		126	154	306	1,409
WEEK 2	(38,873)	39,568	53		(93)	174	558	1,288
WEEK 3	(47,760)	49,652	62		(206)	208	143	1,914
End of OE	197,387	147,009	533	33,222	161,728	19,423	77,773	637,157
NET CHANGE	**(143,808)**	**146,996**	**153**		**460**	**540**	**1,147**	**4,908**

The Standard PPO Plan, Plus PPO Plan and HDHP are subscriber counts. The 70/30 and Humana Plans include subscribers and dependents.

2025 vs 2026 Enrollments

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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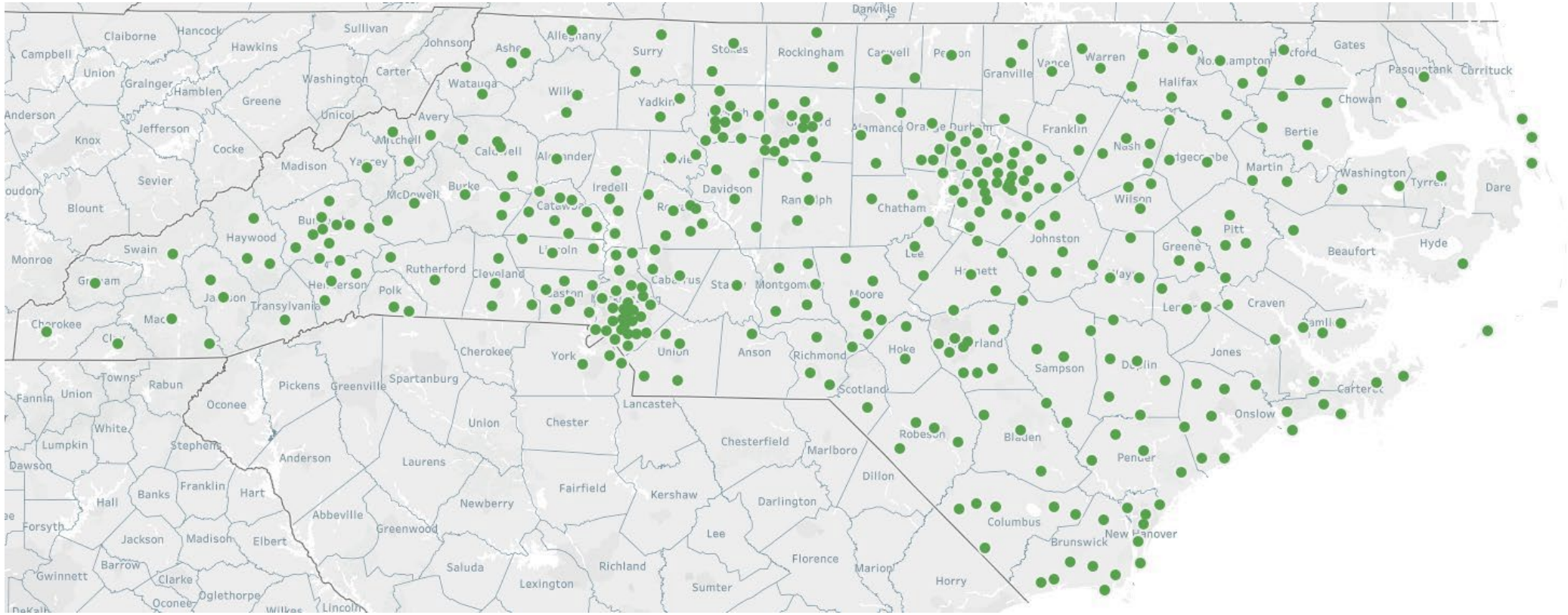
2025	Subscriber	Spouse	Children	TOTAL
70/30 (Med Prime)	33,112	560	40	**33,712**
70/30 PPO Plan	149,204	19,589	79,443	**248,236**
80/20 PPO Plan	192,751	17,081	79,328	**289,160**
HDHP	407	32	57	**496**
Humana Base	140,861	18,307	235	**159,403**
Humana Enhanced	15,936	2,859	28	**18,823**
TOTAL	**532,271**	**58,428**	**159,131**	**749,830**

2026	Subscriber	Spouse	Child	TOTAL
70/30 PPO Plan	33,571	526	46	**34,143**
Standard PPO Plan	194,279	22,931	92,018	**309,228**
Plus PPO Plan	146,388	14,009	66,809	**227,206**
HDHP	515	38	84	**637**
Humana Base Plan	142,052	18,847	232	**161,131**
Humana Enhanced	16,397	2,887	28	**19,312**
TOTAL	**533,202**	**59,238**	**159,217**	**751,657**

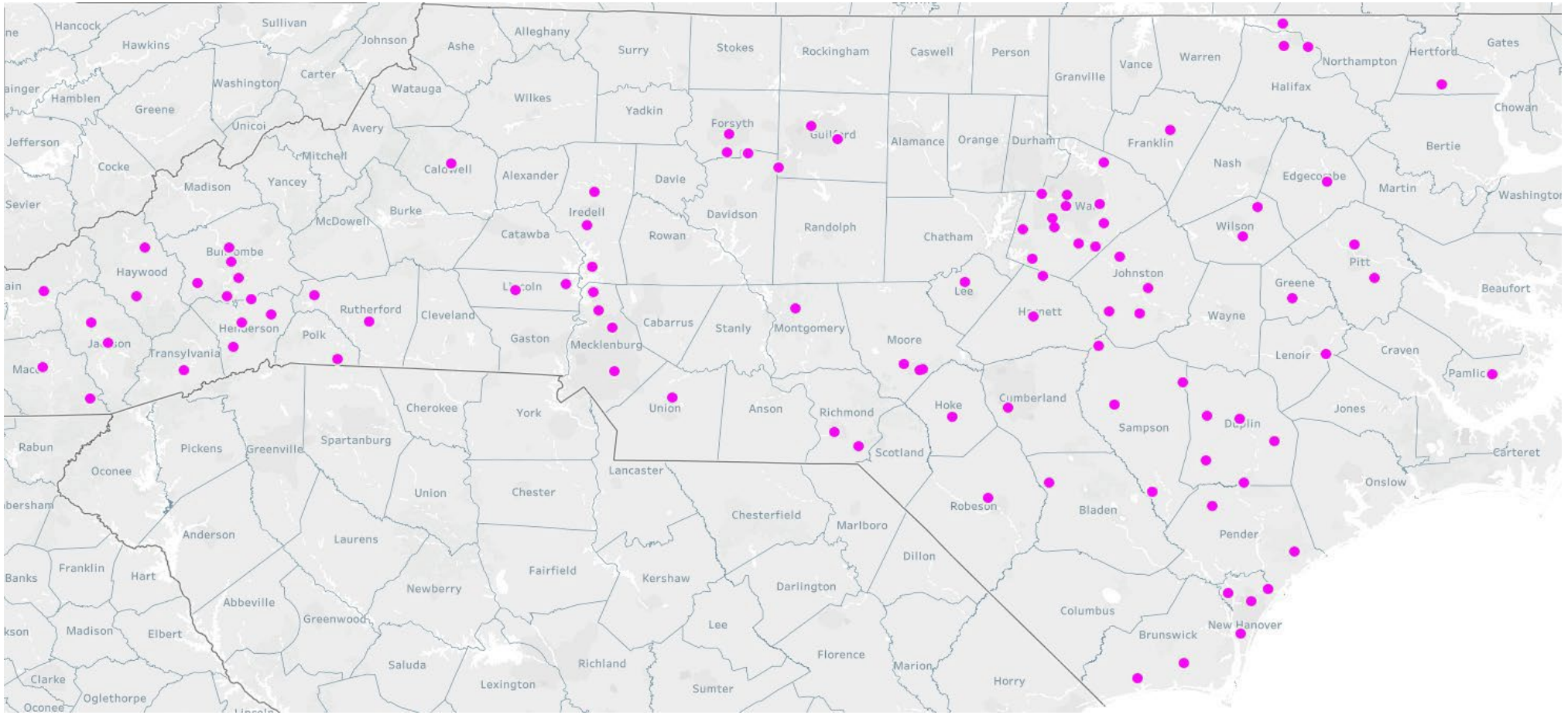
Preferred Providers

Primary Care PRACTICE LOCATIONS for those participating in the preferred provider program.



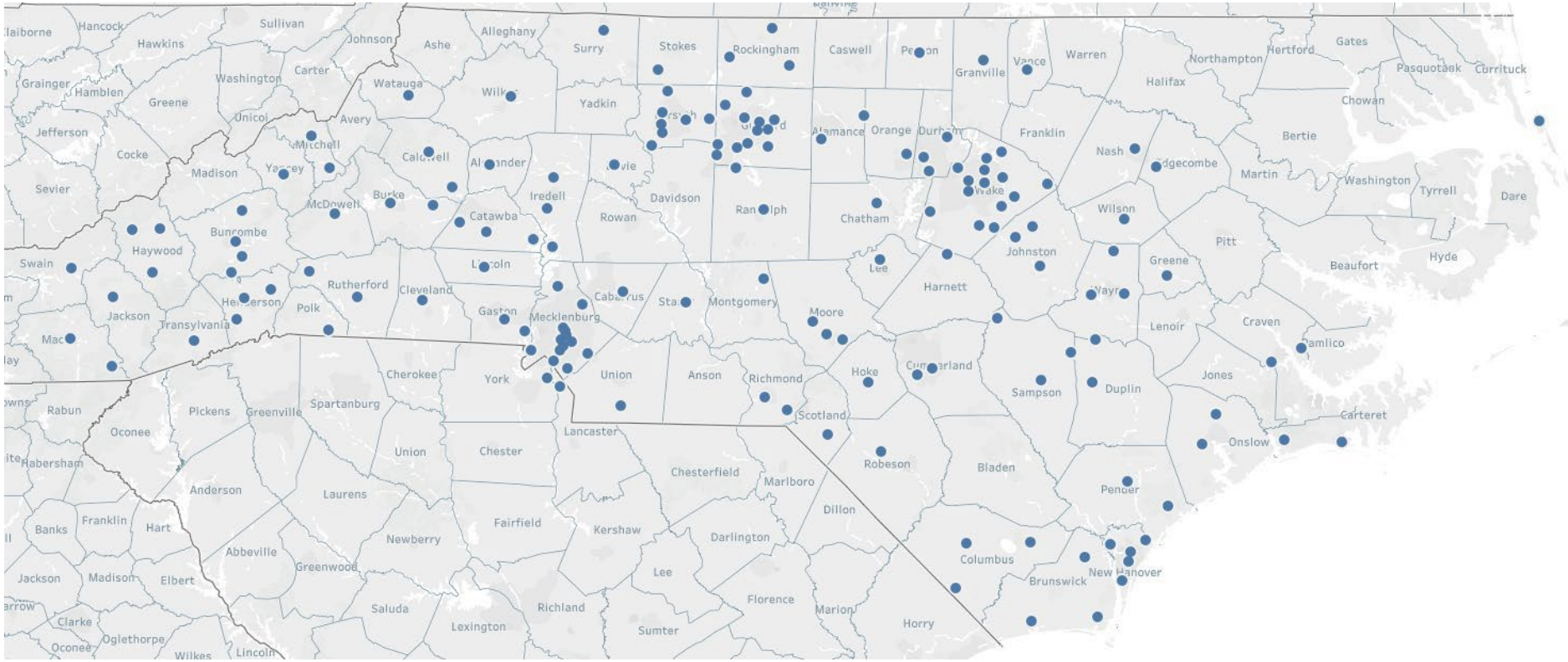
Preferred Providers

OBGYNs PRACTICE LOCATIONS for those participating in the preferred provider program.



Preferred Providers

Specialist PRACTICE LOCATIONS for those participating in the preferred provider program.



Specialty	Providers
Surgery, Orthopedic	634
Gastroenterology	126
Physical Medicine & Rehabilitation	105
Sports Medicine	105
Pulmonary Disease	78
Cardiovascular Disease	75
Cardiology	52
Neurology	50
Pain Management	44
Dermatology	41
Hand/Orthopedic	40
Endocrinology, Diabetes & Metabolism	34
Sleep Medicine	27
Surgery	27
Rheumatology	25
Surgery, Hand	22
Endocrinology	17
Ortho Surgery (Spine)	16
Urology	16
Otolaryngology	11
Other	71
TOTAL	**1,616**

Hinge Health

Offers qualified members **virtual physical therapy** solutions that can reduce joint and muscle aches and pain at home.

1,238 members engaged

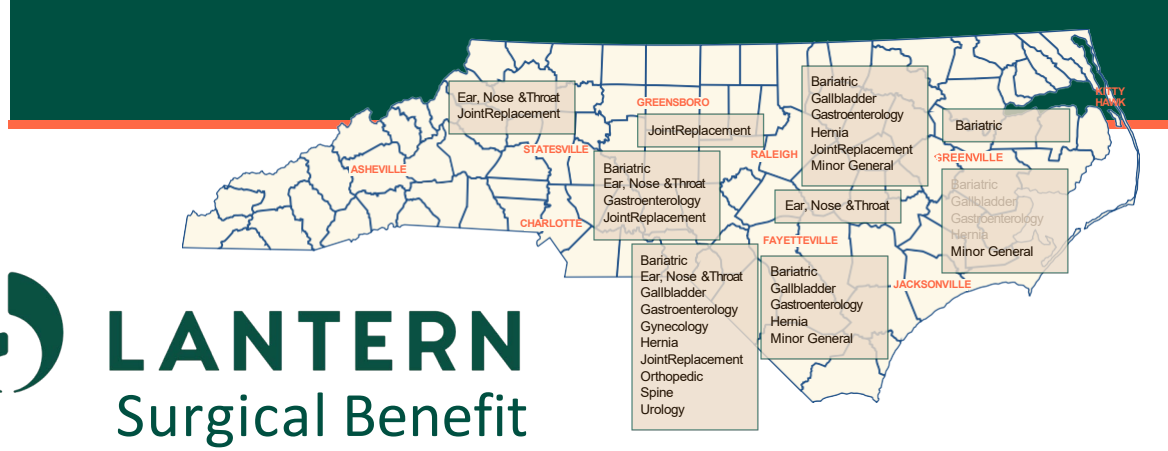
96% of members are **engaged in a pathway** for chronic pain

Top **3** pathways: Back, Knee & Neck

Of members enrolled, **85%** are female, **15%** are male

ventricle health

A value-based **cardiology provider network** that increases access to care, improves outcomes and reduces cost for people with heart failure and other cardiac conditions.



LANTERN Surgical Benefit

High-quality, carefully selected surgeon network for members who need a planned, non-emergency procedure. Members who utilize a Lantern provider will benefit from a $0 cost surgery.

Network is expanding.

Technical delays around eligibility have occurred but production files are scheduled for delivery for this week. This was needed to produce ID cards, which will be sent to members in January.

201 Open Cases as of November 20, 2025

SPINE (6)
BARIATRICS (73)
JOINT REPLACEMENT (48)
ORTHOPEDIC (26)
CARDIAC (0)
GENERAL SURGERY (21)
GASTROENTEROLOGY (GI) (4)
SPINE AND ORTHO INJECTIONS (2)
GYNECOLOGY (GYN) (14)
EAR, NOSE & THROAT (ENT) (7)

Hello Heart

State Health Plan members in 37 rural counties are eligible.

Four months into the partnership:

4.3k
enrolled users
11.3%+ of population[1]

49k
Blood pressure readings taken

26k
Digital insights read

16.2 mmHg
Avg. systolic reduction among Stage 2 users[2]

Heart health is a State Health Plan priority because:

#1 medical condition among SHP members*

Nearly **2x** SHP medical spend for hypertensive members*

80%+ rural NC counties with poor health care access

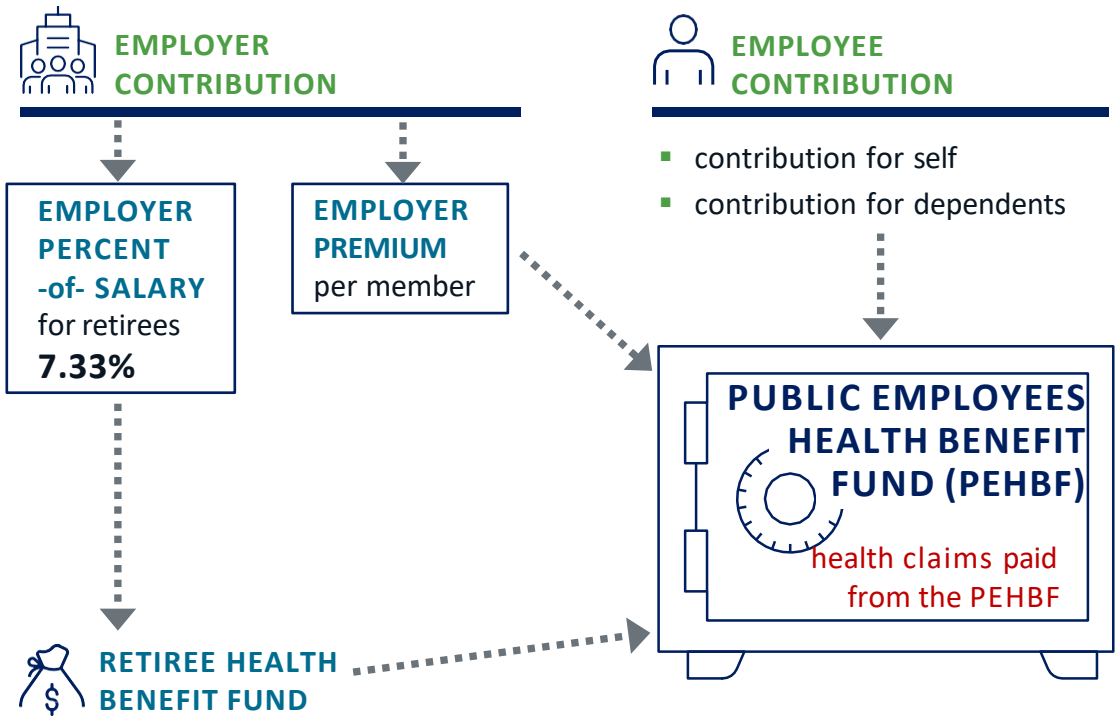
*Source: NC State Health Plan Population Risk Report - CY 2023 (Segal)
1. Based on 38.6k SHP members (18+) in initial 37-county phase; 2. 79.9% of users starting in Stage 2 made a reduction
SHP users who enrolled 7/9/25 - 10/31/25; Results through 10/31/2025

Local Government Discussion

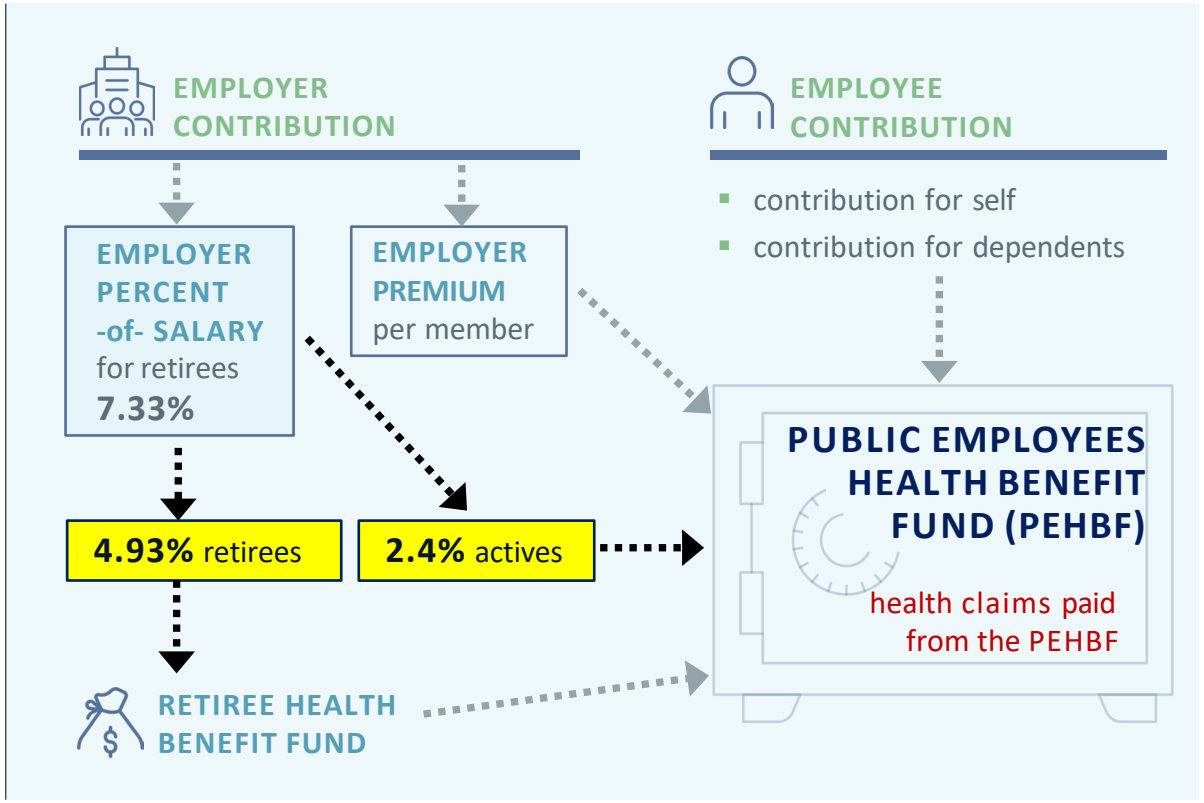
State Health Plan Primary Funding

REALIGNMENT OF ACTIVE AND RETIREE FUNDING

previous model



effective for the 2025-2027 fiscal biennium



STATE HEALTH PLAN EMPLOYING UNIT DATA

Employers who provide **RETIREE** health care *(no employer premium for retirees)*

- State employing units
- Some local government employing units (11 out of 125)
- Some charter school employing units (49 out of 100)

Employers who provide health care to **ACTIVES**

- State employing units
- Participating local government employing units (125)
- Participating charter school employing units (100)

Population Risk Report

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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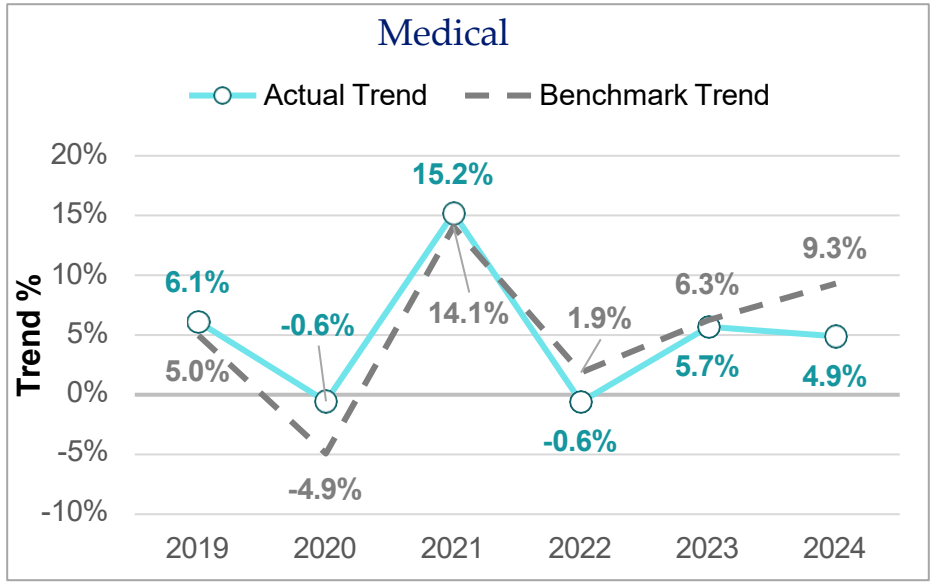
KEY FINDINGS FROM THE 2025 POPULATION RISK REPORT

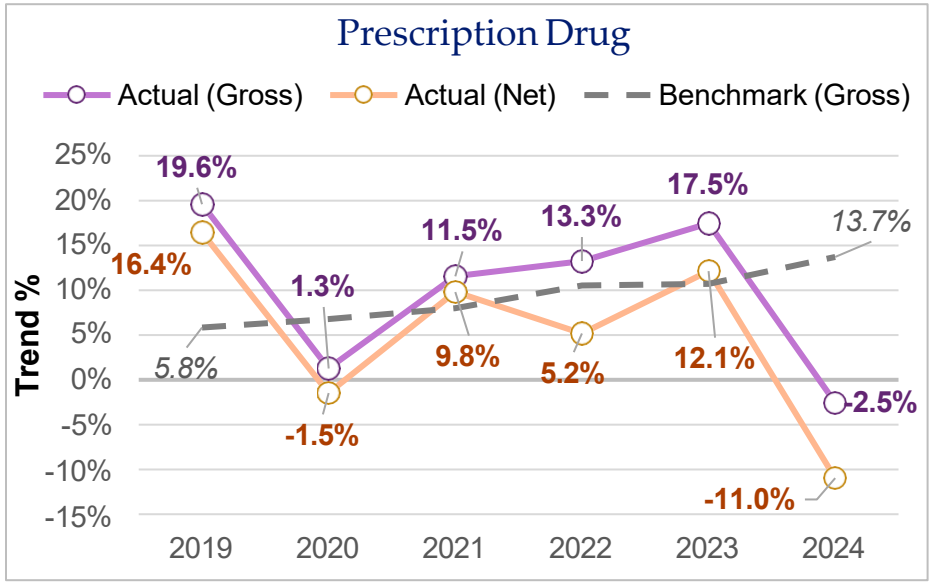
Actives and Non-Medicare Retirees

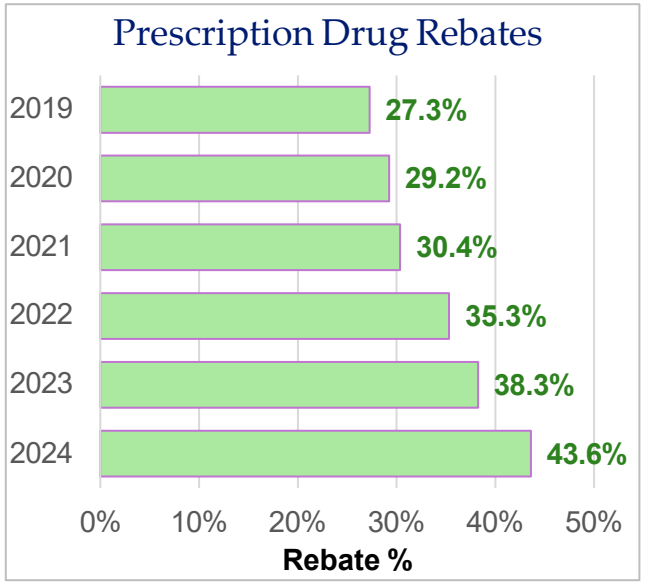
Segal

Medical and Prescription Drug Summary

Trends





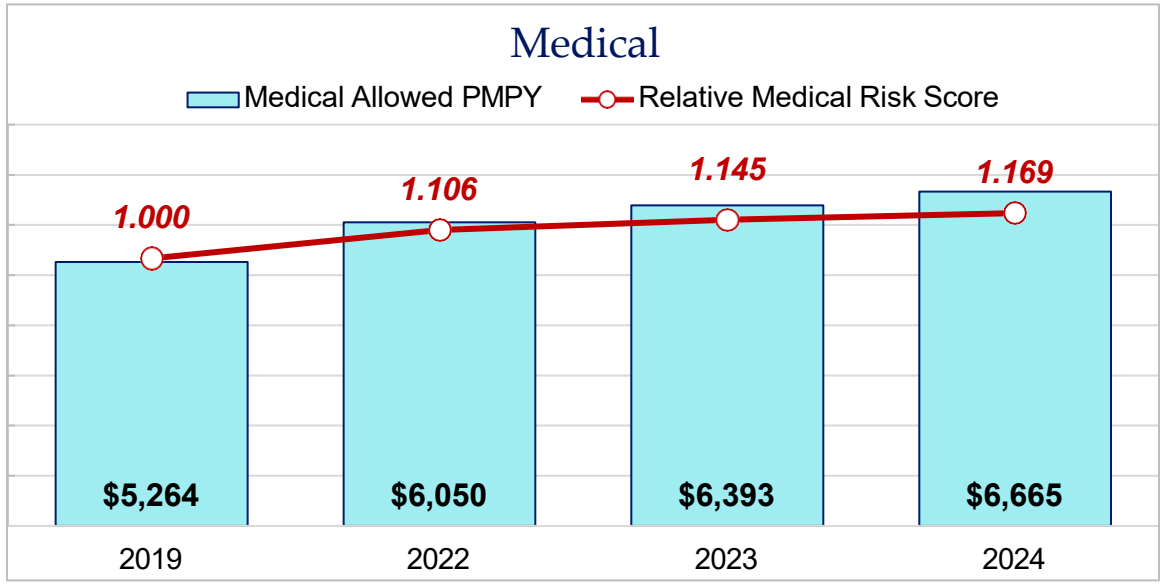


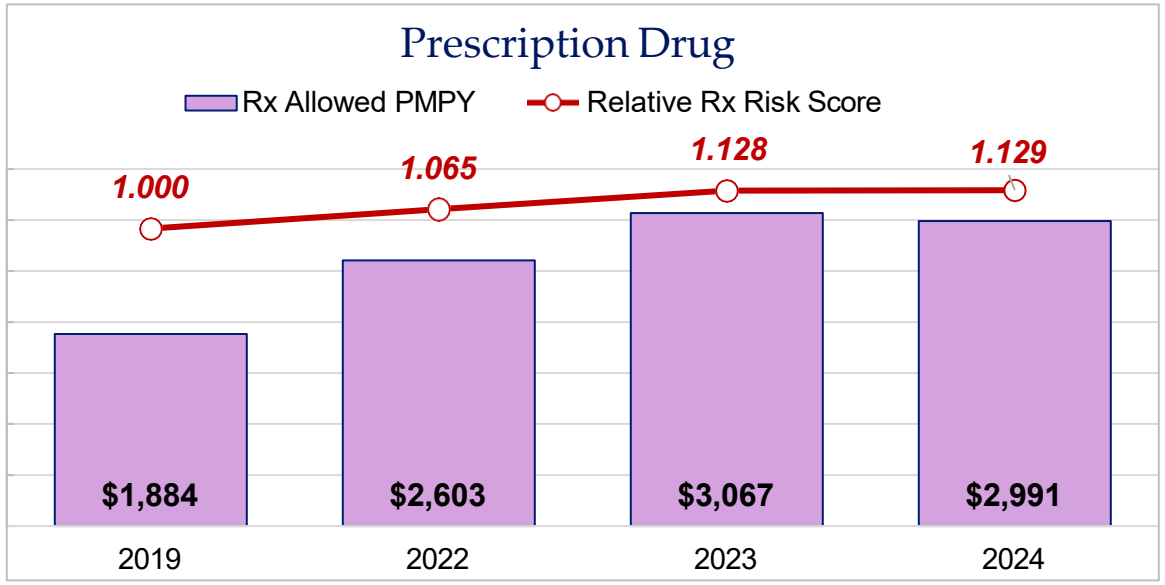
Observations

- 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 book-of-business. Benchmark trend for prescription drugs is gross of rebates.
- Overall, the Plan is doing well at managing medical expenses. Medical trend for the plan was slightly lower than the benchmark in 2022 and 2023 and significantly lower in 2024.
- The Plan has experienced higher prescription drug trend than the benchmark in 2021, 2022, and 2023. However, prescription drug trends were significantly lower for the Plan compared to the benchmark in 2024 (-2.5% vs. 13.7%), which was mainly due to removal of coverage for weight loss medications as well as Humira. Once rebates are factored in, prescription drug trend in 2024 decreases further to -11.0% due to improved rebates.

Medical and Prescription Drug Summary

Cost and Risk



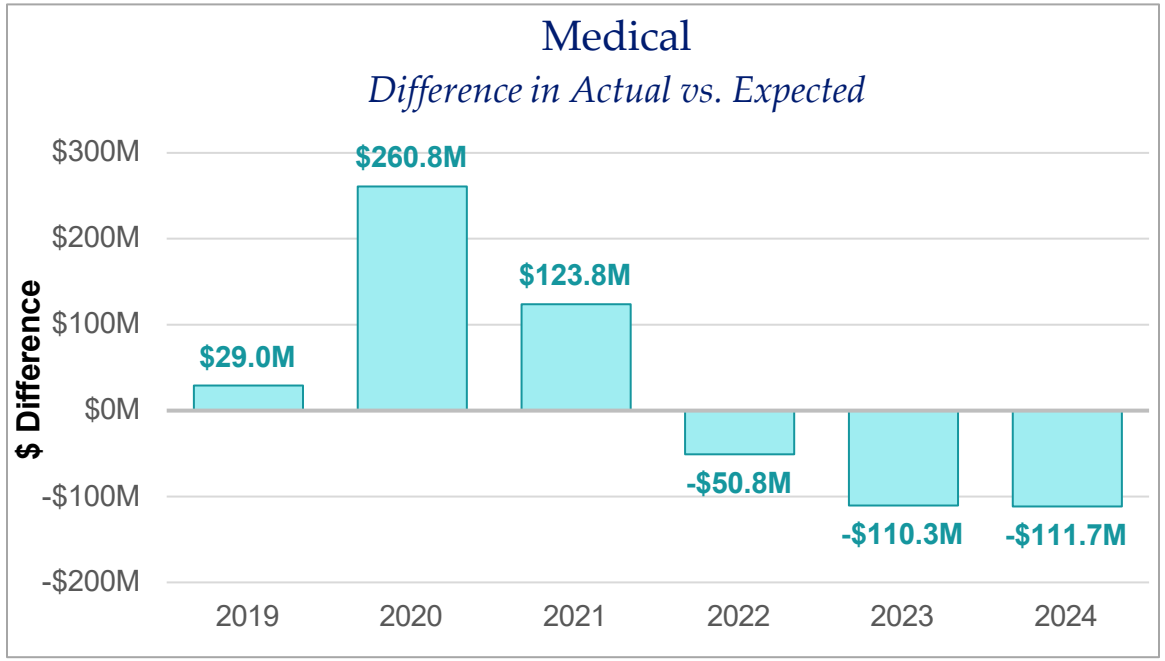


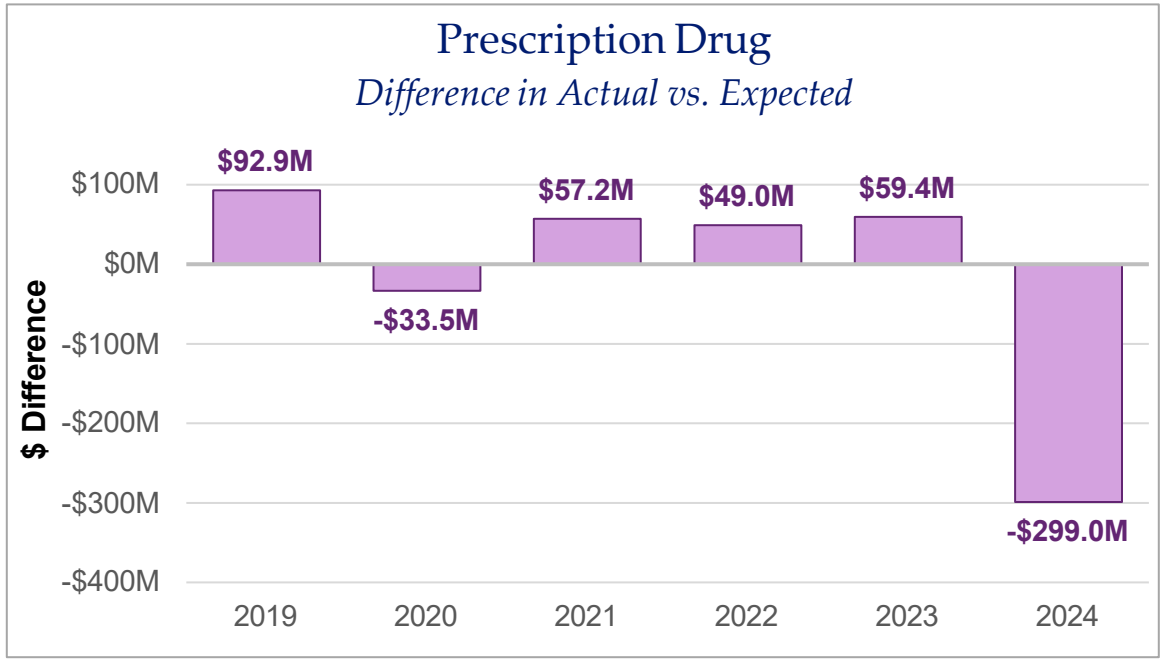
Observations

- Medical risk scores have increased significantly since 2019 and have been driven by mental health disorders (e.g., anxiety, trauma, ADHD, autism), bacterial infections, nutritional deficiencies, hyperlipidemia, diabetes, and obesity.
- Prescription drug risk scores have also increased significantly since 2019 and have been driven by medications used to treat diabetes, psoriasis, headaches, depression, ADHD, and skin disorders.
- Summaries of cost and risk by region (e.g., Piedmont Triad, Metrolina, Triangle) are provided in the appendices in the full report.

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 $140.8 million more than expected during the last six years, mainly due to unfavorable experience in 2020 and 2021.
- On the prescription drug side, the Plan has paid approximately $73.9 million less than expected during the last six years, mainly due to favorable experience in 2024. 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.

Emerging Trends

Cost Trend Drivers

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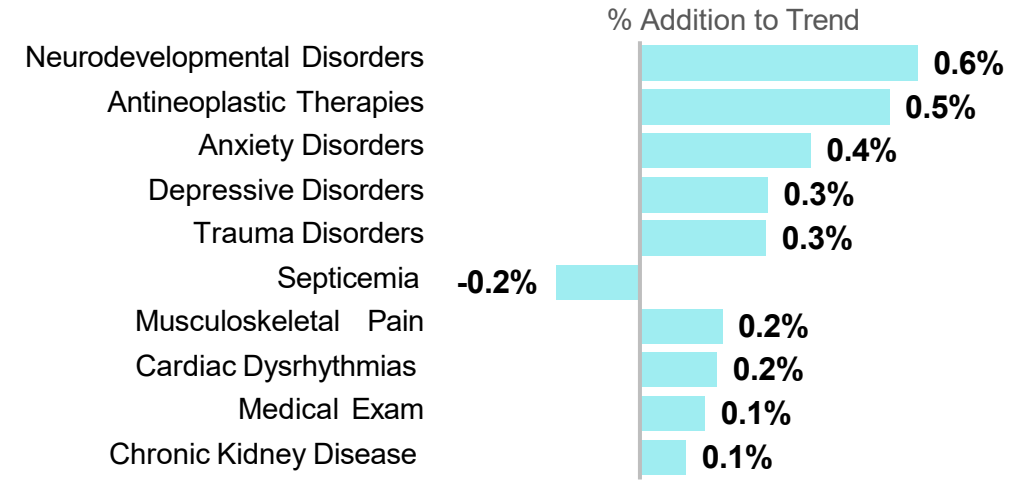
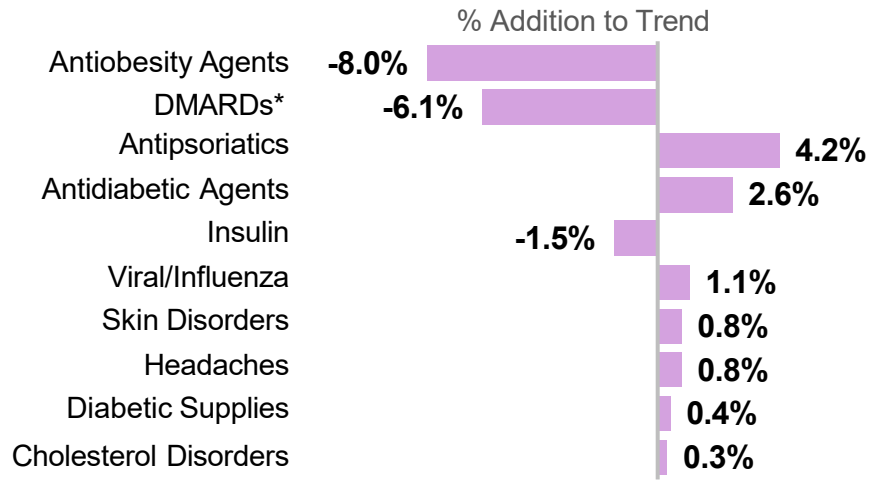
Medical



Prescription Drug



Observations

The graphs above summarize the conditions with the largest impact to trend from 2023 to 2024.

- One of the main factors driving year-over-year (YoY) medical costs have been mental health conditions, including neurodevelopmental disorders (e.g., ADHD and autism), anxiety disorders, depressive disorders and trauma disorders.
  - Costs for neurodevelopmental disorders increased 47% and alone added 0.6% to trend. Said another way, absent the increase in costs for neurodevelopmental disorder between 2023 and 2024, medical trend would have been 4.3% as opposed to 4.9%.
- YoY prescription drug costs have been driven higher mostly due to drugs used to treat psoriasis and diabetes.
  - Costs for anti-obesity agents decreased 66% and reduced prescription drug trends by 8.0% in 2024. Coverage has been discontinued for anti-obesity GLP-1s and some users transitioned to the antidiabetic versions of these drugs, which added 2.6% to prescription drug trends.
  - Costs for DMARDs*, which include Humira, decreased 43% and reduced prescription drug trends by 6.1% in 2024, mainly due to discontinuation of coverage of Humira. Members now have several biosimilar drugs that can be utilized in lieu of coverage for Humira.

* DMARDs = Disease Modifying Antirheumatic Drugs

Population Risk Review

Historical Membership Risk Distribution

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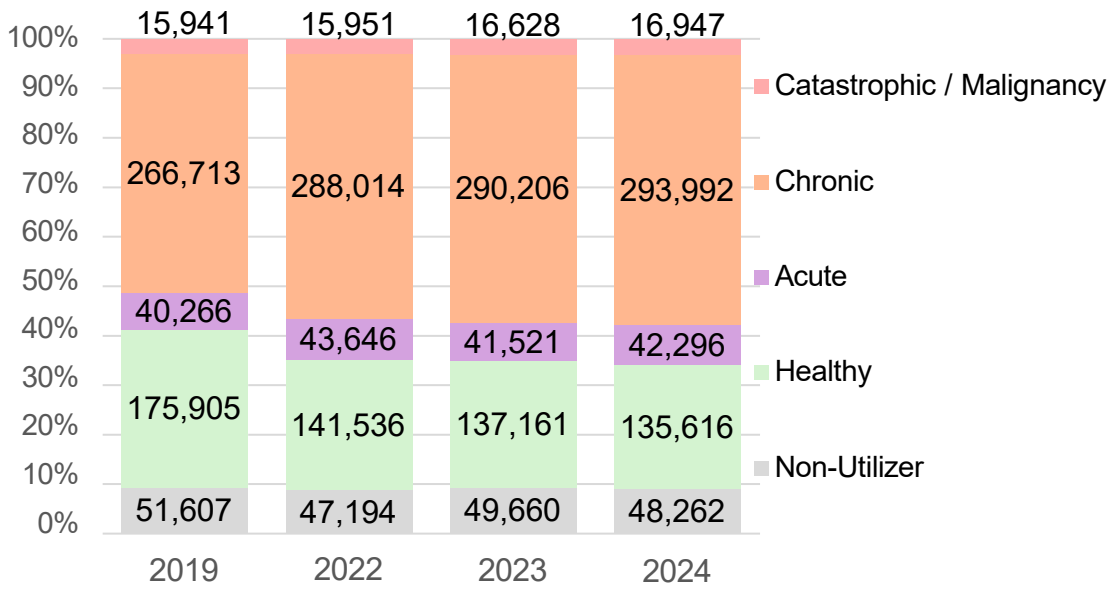
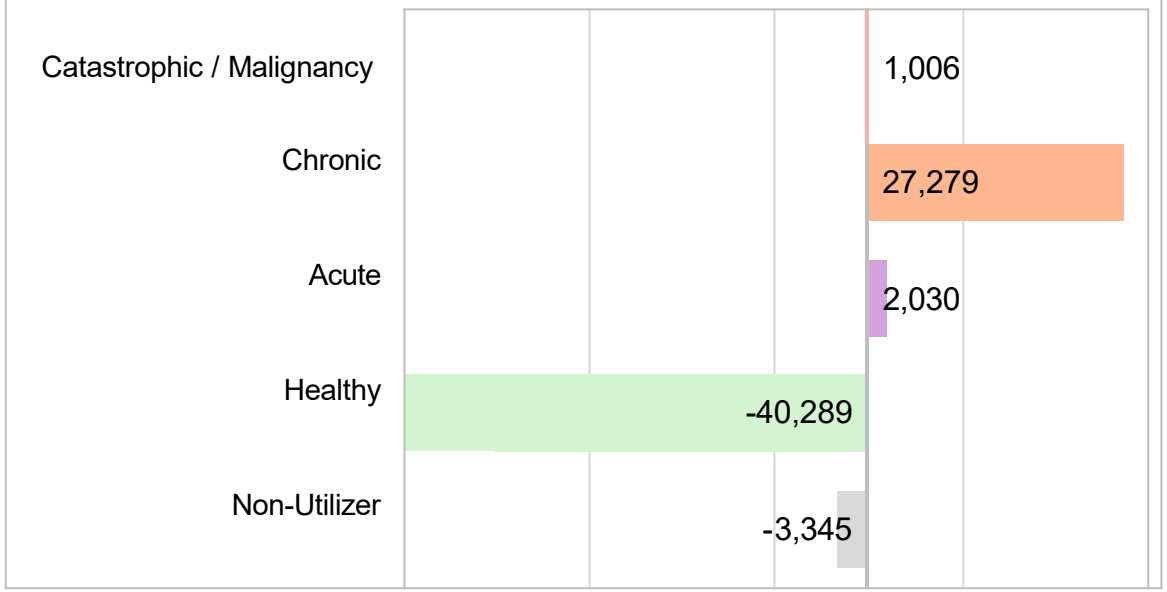
Population Risk Distribution



Historical Change in Members[1]



Observations

The graphs above summarize trends in membership among the risk groups.

- Members with chronic conditions increased the most from 2019 to 2024 with an increase of 27,279 members (+10.2% increase).
- Healthy members had the largest decrease in members from 2019 to 2024 of 40,289 (-22.9% decrease).
- The number of non-utilizers decreased by 3,345 members from 2019 to 2024 (-6.5%).
- Then number of members grouped as catastrophic / malignancy increased by 1,006 members (+6.3%).

[1] Historical change reflects the change in member counts between 2019 and 2024.

Population Risk Review

Urban vs. Rural Comparison

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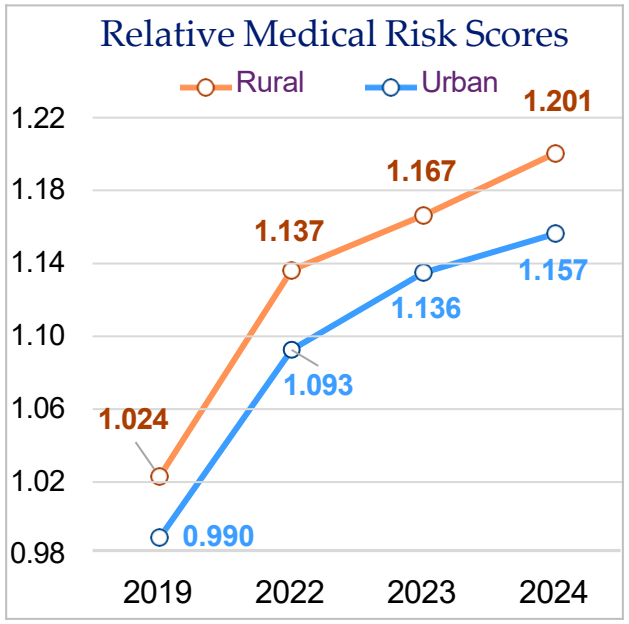

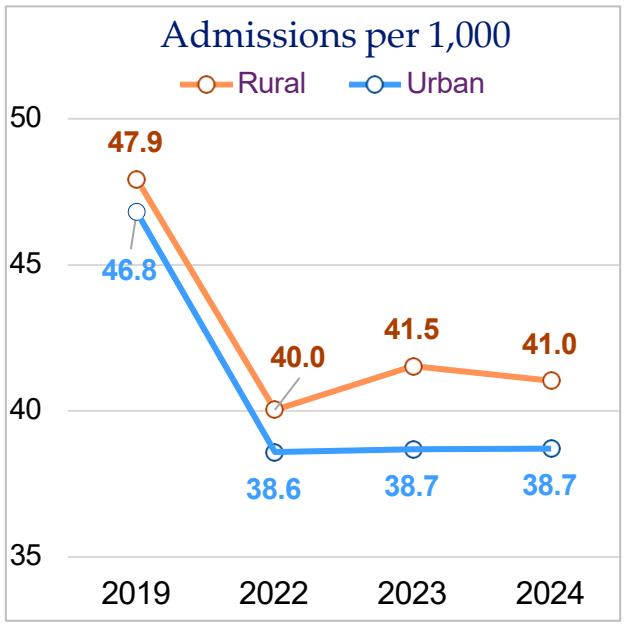

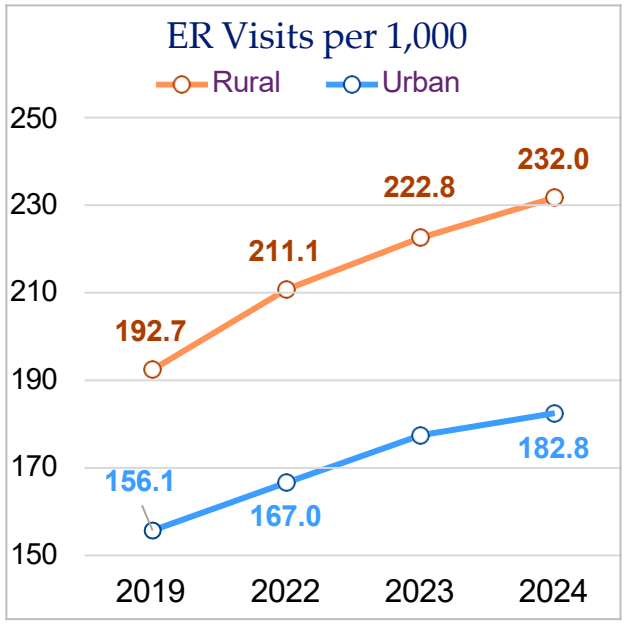

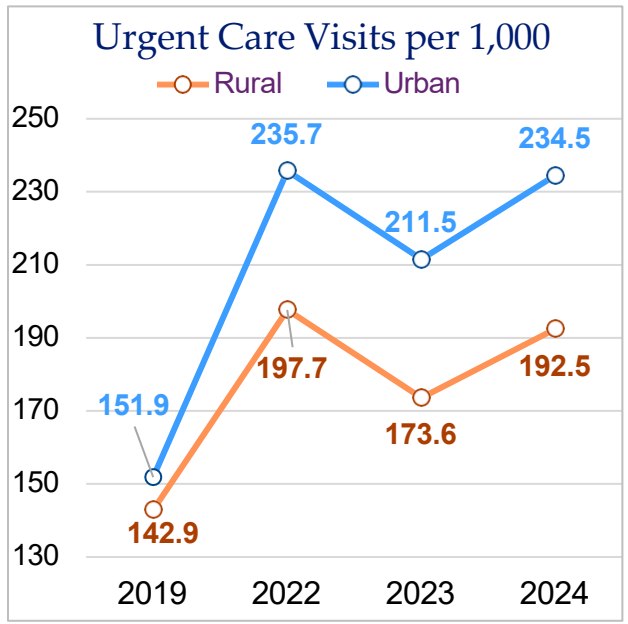

Observations

The charts above summarize differences in risk and outcomes between members who reside in urban versus rural areas[1].

- Medical risk scores have increased similarly for members in urban and rural areas. However, risk scores for members in rural areas are about 4% higher.
- Hospital admissions per 1,000 have historically been about 5% higher for members in rural areas, which is slightly higher than their risk scores would suggest.
- Emergency room (ER) visits per 1,000 have historically been about 25% higher for members in rural areas, which is significantly higher than their risk scores would suggest. This is likely due to inadequate access to care.
- Urgent care visits per 1,000 have historically been about 18% lower for members in rural areas, suggesting that members in rural areas are seeking treatment in the emergency room for conditions that members in urban areas are having treated in the urgent care.

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

Catastrophic Risk Group

Risk Distribution and Top Conditions

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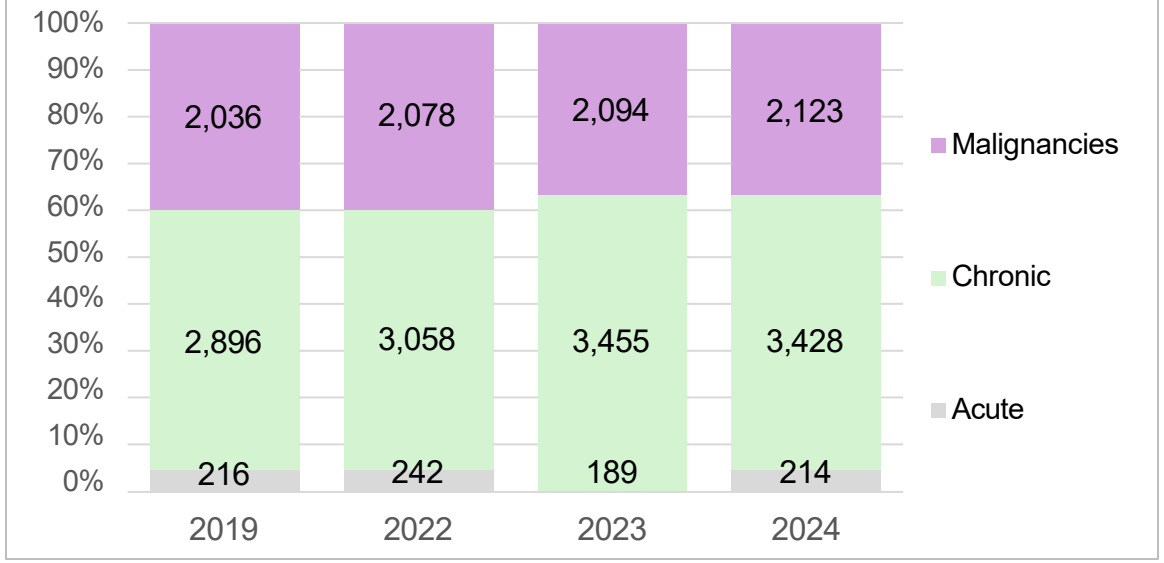
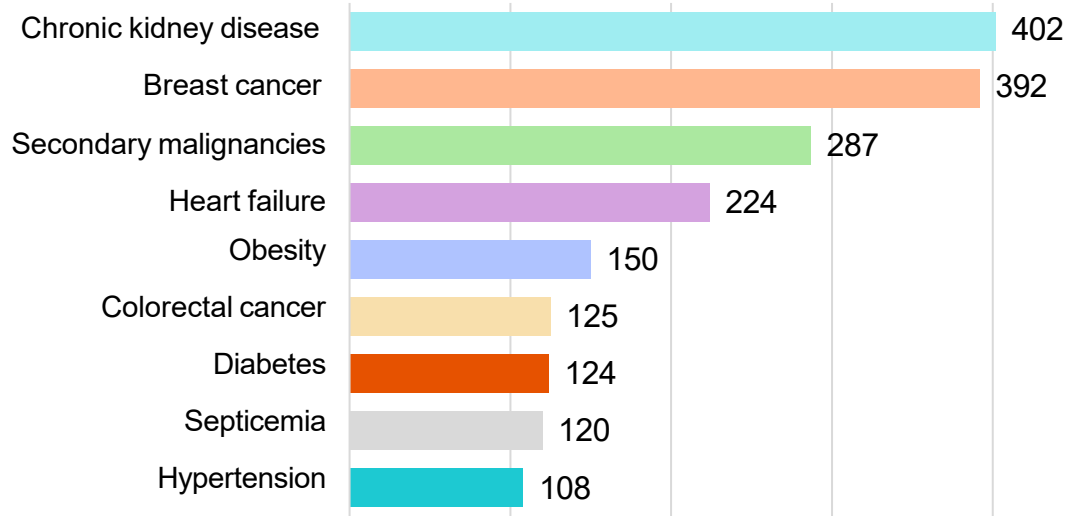
Catastrophic Risk Member Distribution



Top Conditions by Member Count

2024 Only



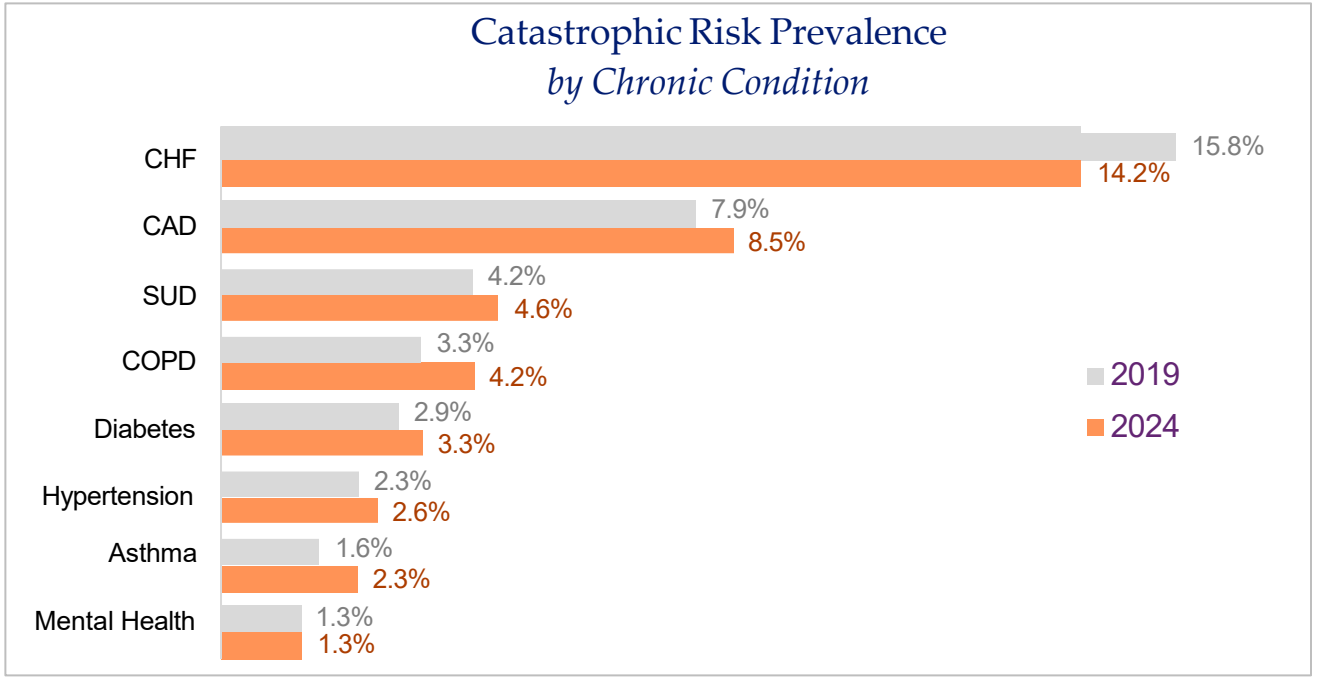
Observations

The graphs above summarize the catastrophic risk group and top catastrophic conditions.

- Approximately 37% of the catastrophic risk group is due to malignancies, 59% is due to chronic conditions, and the remaining 4% is due to acute conditions.
- Catastrophic acute conditions have been relatively stable over the experience period. The increase in the catastrophic risk group has been driven by malignancies and chronic conditions.
- Chronic kidney disease, which is mainly caused by unmanaged diabetes and/or hypertension, is the primary chronic condition in the catastrophic risk group.
- Breast cancer is the primary malignancy in the catastrophic risk group.
- Diabetes, chronic kidney disease, and cancer are all risk factors for development of septicemia. However, it can also be addressed through provider contracting as demonstrated through CMS's Severe Sepsis and Septic Shock Early Management Bundle (SEP-1), a quality measure to standardize and improve sepsis care in hospitals.

Catastrophic Risk Group

Prevalence by Chronic Condition and Region



Catastrophic Risk By Region[1]
Urban vs. Rural

Region	Catastrophic Risk	
	Urban	Rural
Region 1: Western	0.9%	0.9%
Region 2: Piedmont Triad	1.0%	0.9%
Region 3: Metrolina (Charlotte)	1.0%	1.1%
Region 4: Triangle	1.0%	1.2%
Region 5: Cape Fear	1.1%	1.2%
Region 6: Eastern NC	1.0%	1.1%
Total	**1.0%**	**1.1%**

Observations

The graph above summarizes the percent of members with each chronic condition that are in the catastrophic risk group.

- A higher percent of members are in the catastrophic risk group in 2024 compared to 2019 for all chronic conditions except congestive heart failure (CHF).
- 4 out of the 6 regions have a higher percentage of members in the catastrophic risk group in rural areas compared to urban areas, 1 has lower, and 1 region has the same catastrophic risk between urban and rural areas.

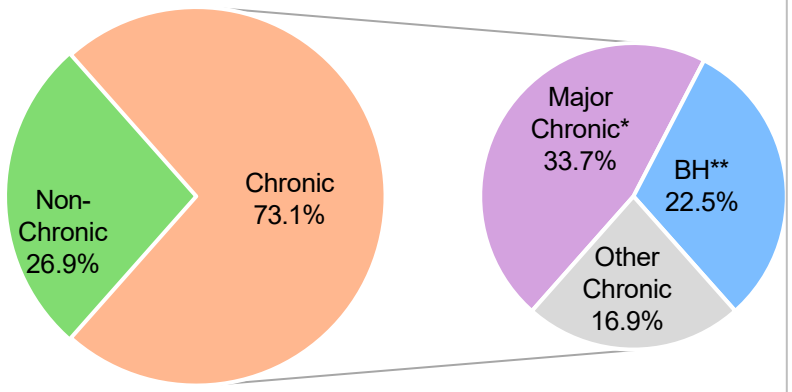
[1] Reflects catastrophic risk from 2022 – 2024.

Chronic Conditions

Prevalence and Risk

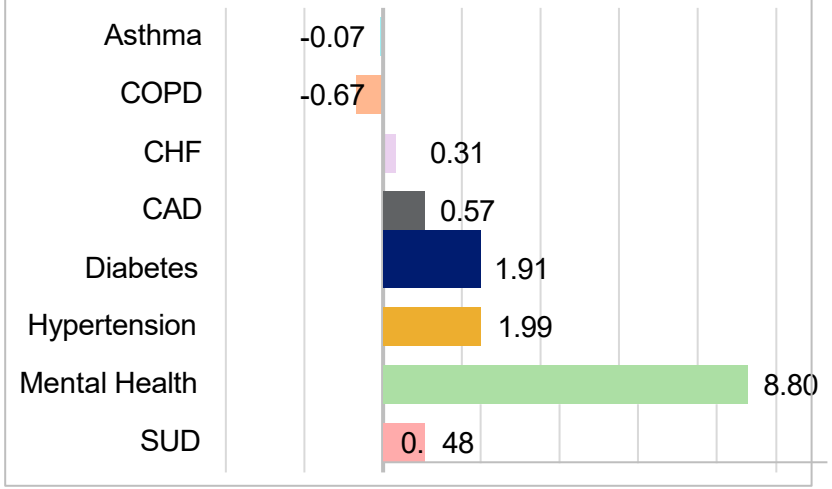
North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Chronic Condition Prevalence

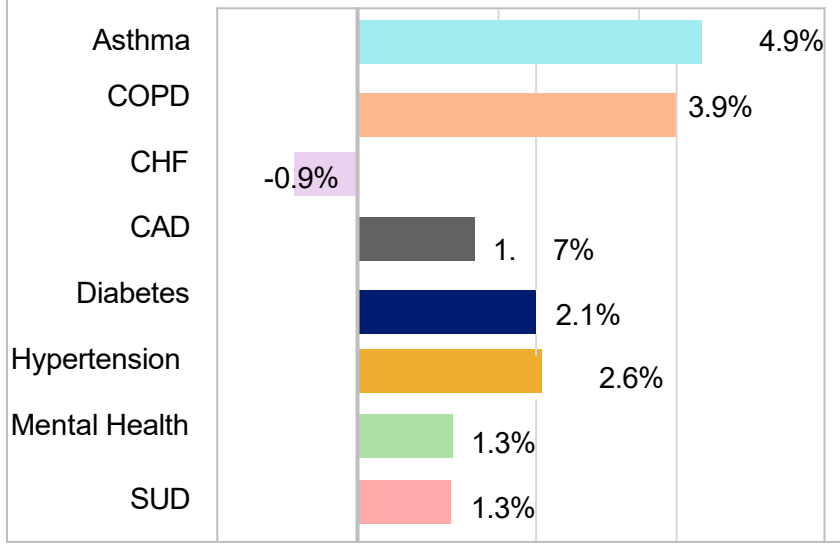


Historical Change in Prevalence[1]

(percentage points)



Historical Risk Trend[2]



Observations

The graphs above summarize prevalence and risk for chronic conditions.

- 73.1% of members had a chronic condition in 2024, which includes 33.7% with one or more of the six major physical chronic conditions*, 22.5% with a behavioral health (BH) condition**, and 16.9% of members with other chronic conditions (e.g., cystic fibrosis, epilepsy, glaucoma).
- All major chronic conditions aside from the respiratory-related (i.e., asthma, COPD) have seen an increase in prevalence over the historical period. Mental health prevalence has increased the most, with an increase of about 1.8% per year since 2019 (i.e., from 28.3% of the population in 2019 to 37.1% of the population in 2024).
- The respiratory conditions (i.e., asthma and COPD) have seen the largest increase in risk over the historical period, although all have increased aside from CHF.

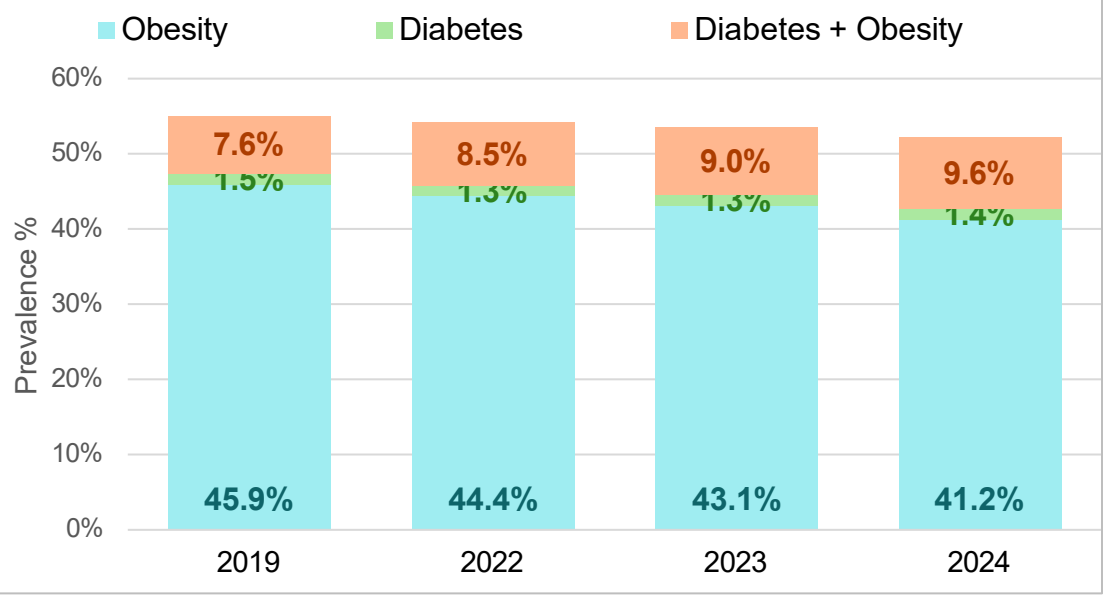
* Major Chronic = asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes, and hypertension.
** BH = behavioral health, which includes both mental health and substance use disorders (SUD).
[1] Historical change in prevalence reflects the total change in percentage points from 2019 to 2024.
[2] Historical change in risk reflects the annualized trend in risk from 2019 to 2024.

Diabetes and Obesity

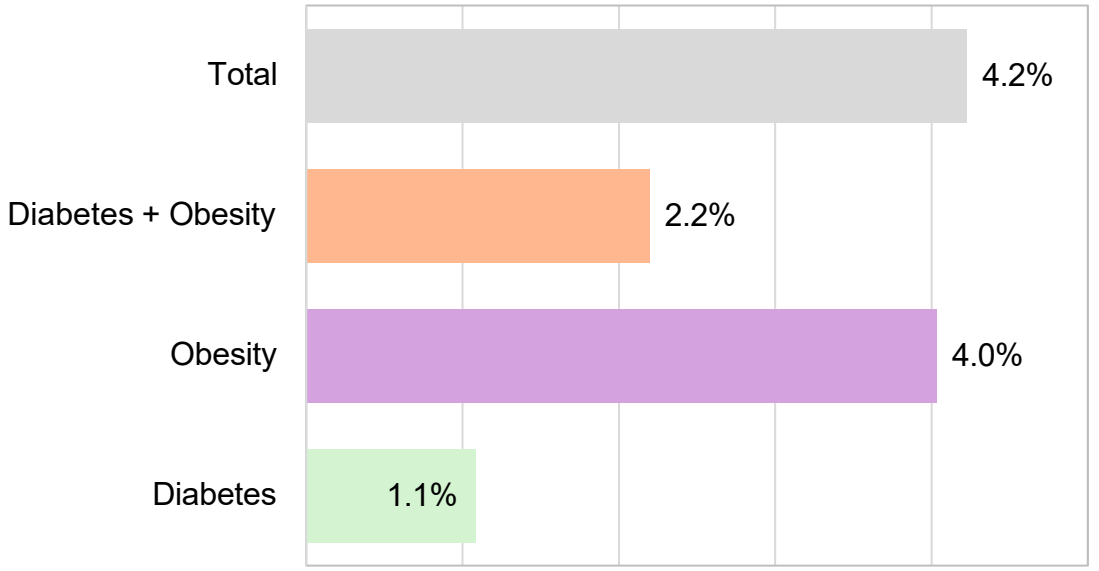
Cost and Utilization

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

Disease Prevalence



Historical Medical Risk Trend[1]



Observations

The graphs above summarize prevalence and risk of diabetes and/or obesity.

- In 2024, 41.2% of the population had diagnosed obesity, 1.4% had diagnosed diabetes, and 9.6% had diagnosed diabetes and obesity.
- Obesity prevalence has decreased each year through the experience period. It's unclear if this is due to members losing weight or members seeking treatment for this condition less frequently and thus not being identified as obese.
- Diabetes-only prevalence has decreased slightly from 1.5% in 2019 to 1.4% in 2024. However, the percent of members with both diabetes and obesity has increased from 7.6% in 2019 to 9.6% in 2024.
- Non-diabetic members with obesity have seen the largest increase in risk of 4.0% per year since 2019.

[1] Historical trend reflects the annualized trend between 2019 and 2024.

Diabetes and Obesity

Population Risk Trends

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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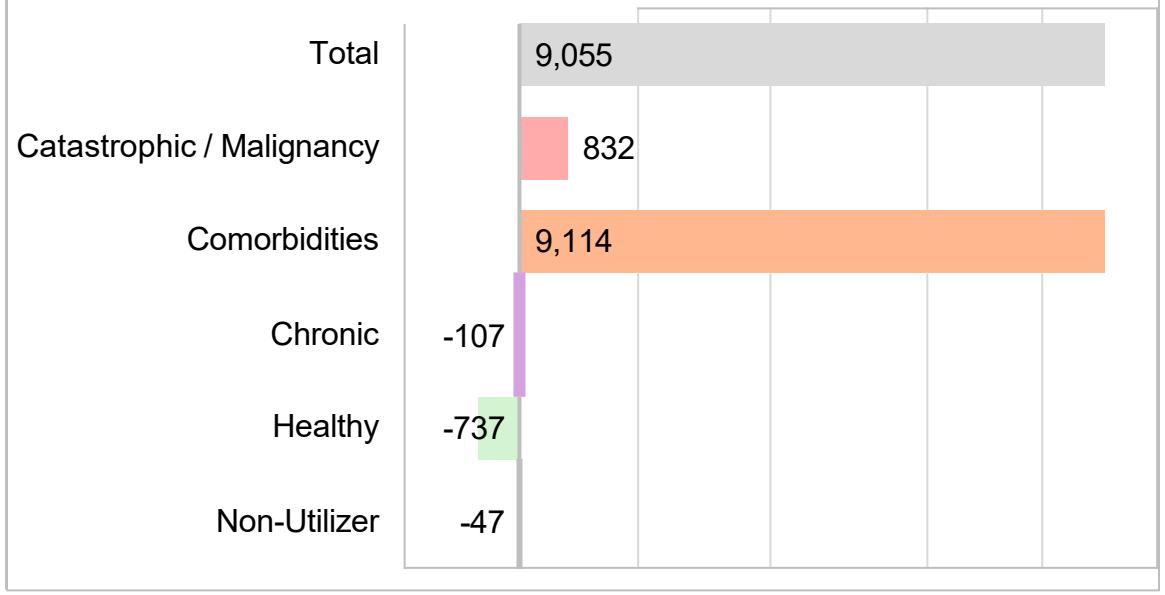
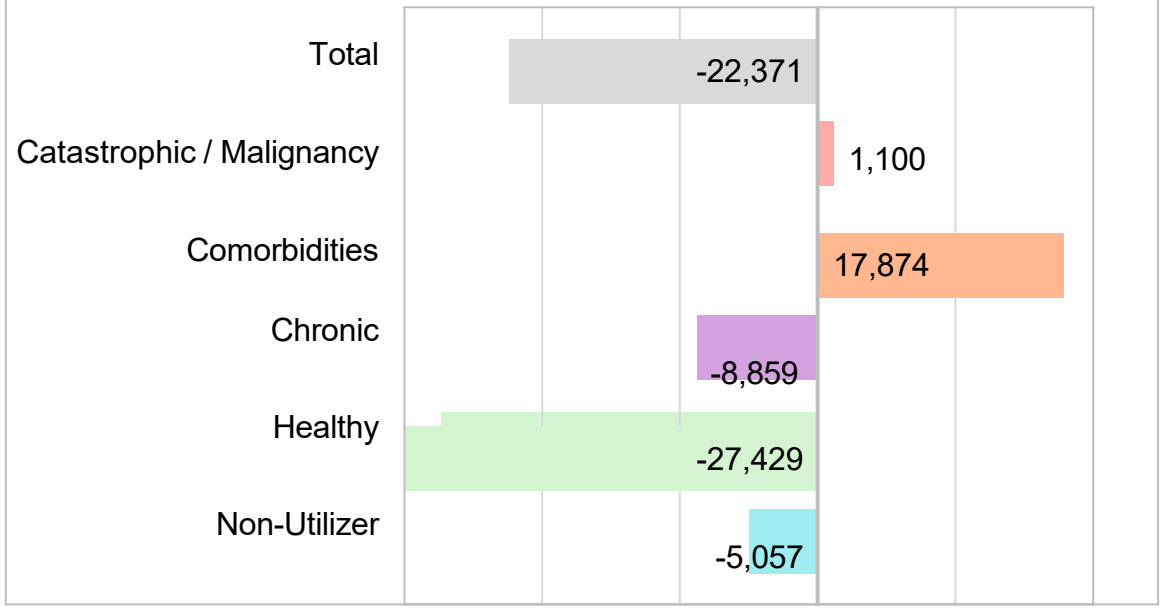
Historical Change in Diabetic Members[1]



Historical Change in Obese Members[1]



Observations

The graphs above summarize population risk group trends for members with diabetes and/or obesity.

- During the historical period, there has been a decrease of 737 healthy diabetic members and an increase of 9,114 diabetic members with comorbidities and an increase of 832 diabetic members in the catastrophic risk group.
- During the historical period, there has been a decrease of 27,429 healthy obese members and an increase of 17,874 obese members with comorbidities and an increase of 1,100 obese members in the catastrophic risk group.

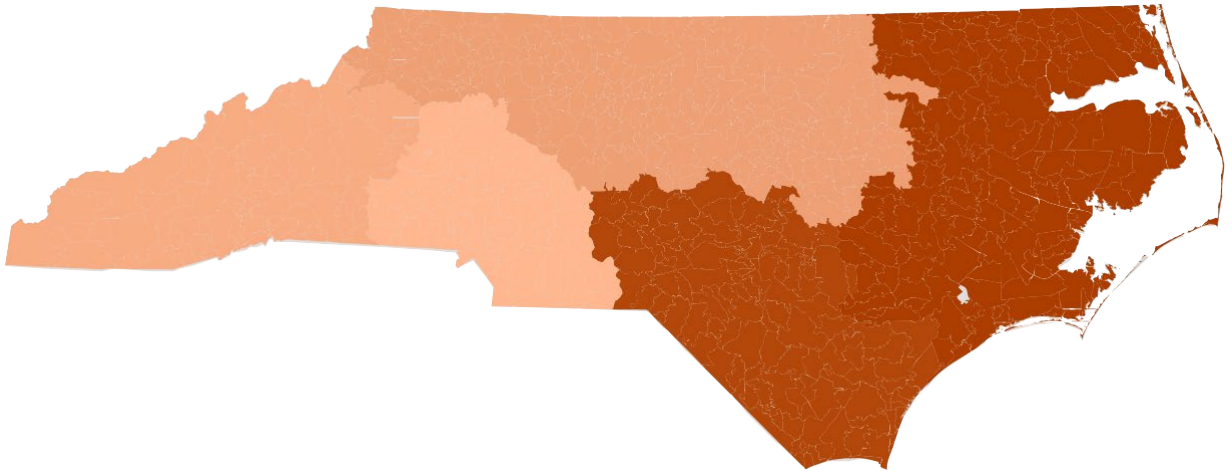
[1] Historical change reflects the change in member counts between 2019 and 2024.

Diabetes and Obesity

Diabetes Prevalence and Outcomes by Region

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

Diabetes Prevalence



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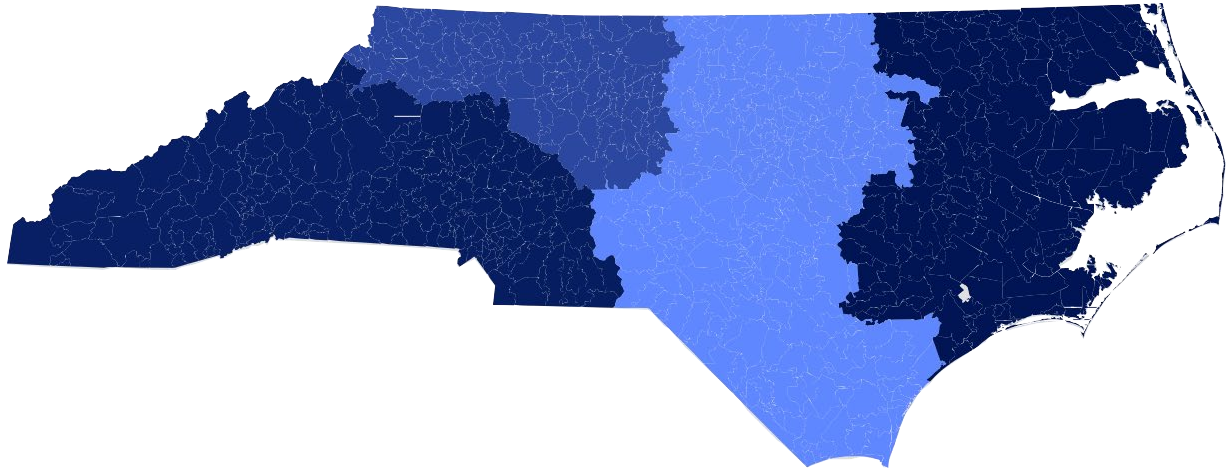
Prevalence
9.7% 13.4%

Hospital Admissions per 1,000



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Hospital Admissions per 1,000
83.6 88.5

Observations

The maps above show diabetes prevalence and hospital admissions for diabetics 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 worst outcomes (i.e., most hospital admissions).

Diabetes and Obesity

Diabetes Urban vs. Rural Comparison

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

Diabetes Prevalence and Outcomes By Region *Urban vs. Rural*						
Region	Disease Prevalence		ER Visits per 1,000		Admissions per 1,000	
	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	9.7%	10.7%	307.8	404.3	86.6	90.2
Region 2: Piedmont Triad	10.7%	9.9%	311.3	348.9	85.0	89.4
Region 3: Metrolina (Charlotte)	9.6%	10.7%	355.4	408.1	86.1	100.3
Region 4: Triangle	9.8%	14.2%	333.5	404.9	82.7	87.9
Region 5: Cape Fear	11.9%	14.3%	419.7	393.6	83.3	83.8
Region 6: Eastern NC	12.8%	14.2%	340.3	442.9	82.8	94.4
Total	**10.6%**	**13.0%**	**341.4**	**404.1**	**83.9**	**90.0**

Observations

The table above summarizes diabetes prevalence and outcomes by region in 2024, separated by rural and urban areas.

- 5 out of the 6 regions have higher diabetes prevalence and ER utilization in rural areas. All regions have higher inpatient hospital admissions for members in rural areas.

Hypertension and Heart Disease

Cost and Utilization

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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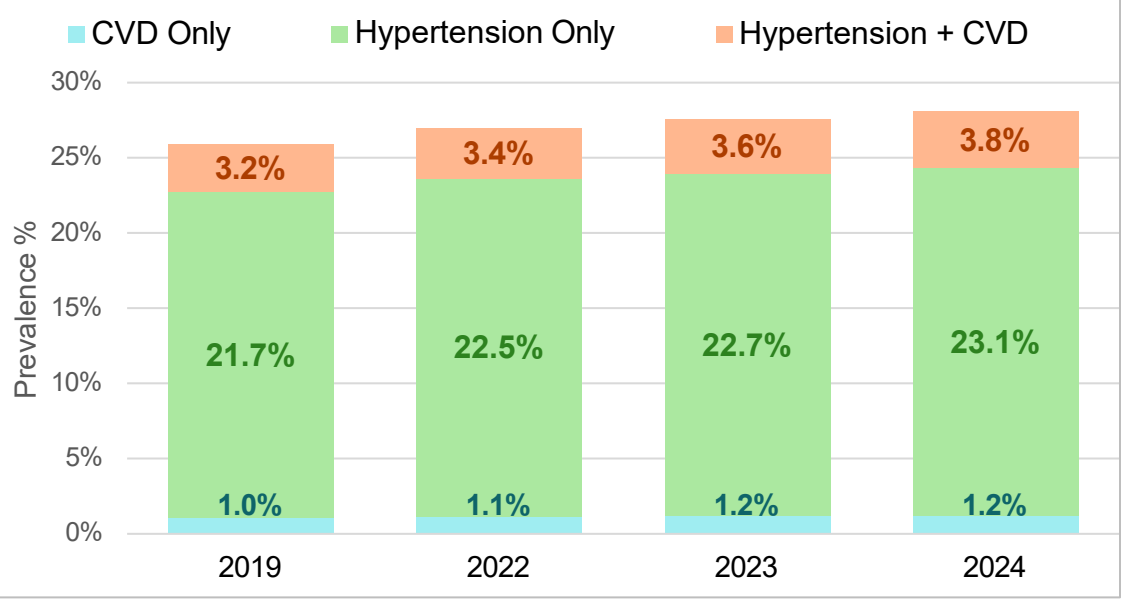
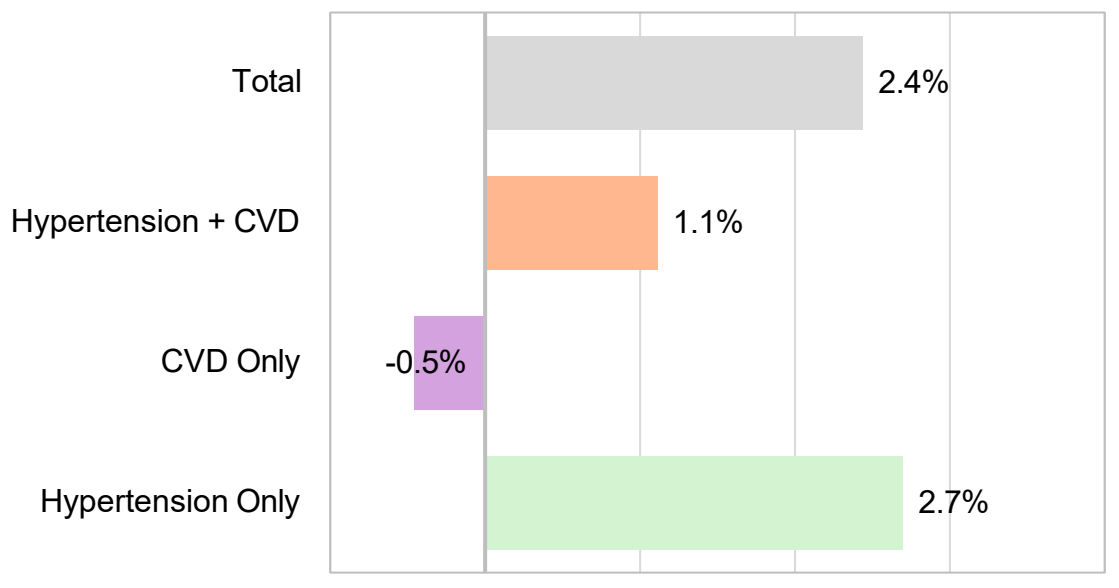
Disease Prevalence



Historical Medical Risk Trend[1]



Observations

The graphs above summarize prevalence and risk for hypertension and/or heart disease (CVD).

- In 2024, 1.2% of the population had diagnosed heart disease, 23.1% had diagnosed hypertension, and 3.8% had diagnosed hypertension and heart disease.
- All disease classifications have increased in prevalence each year through the experience period.
- Hypertensive members without CVD have seen the largest increase in risk of 2.7% per year since 2019.

[1] Historical trend reflects the annualized trend between 2019 and 2024.

Hypertension and Heart Disease

Population Risk Trends

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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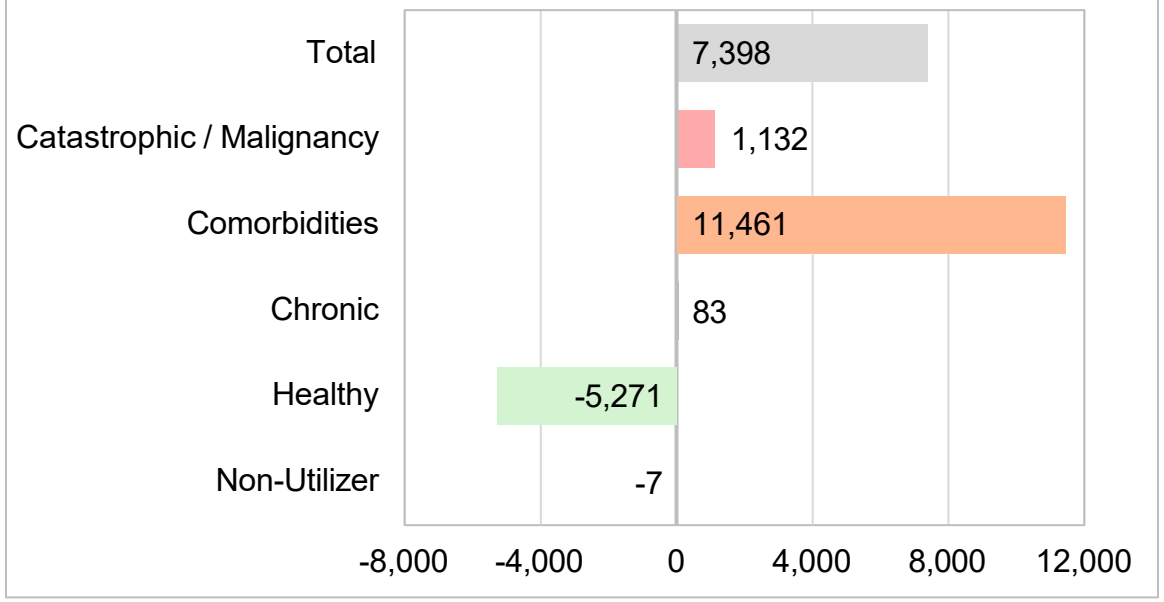
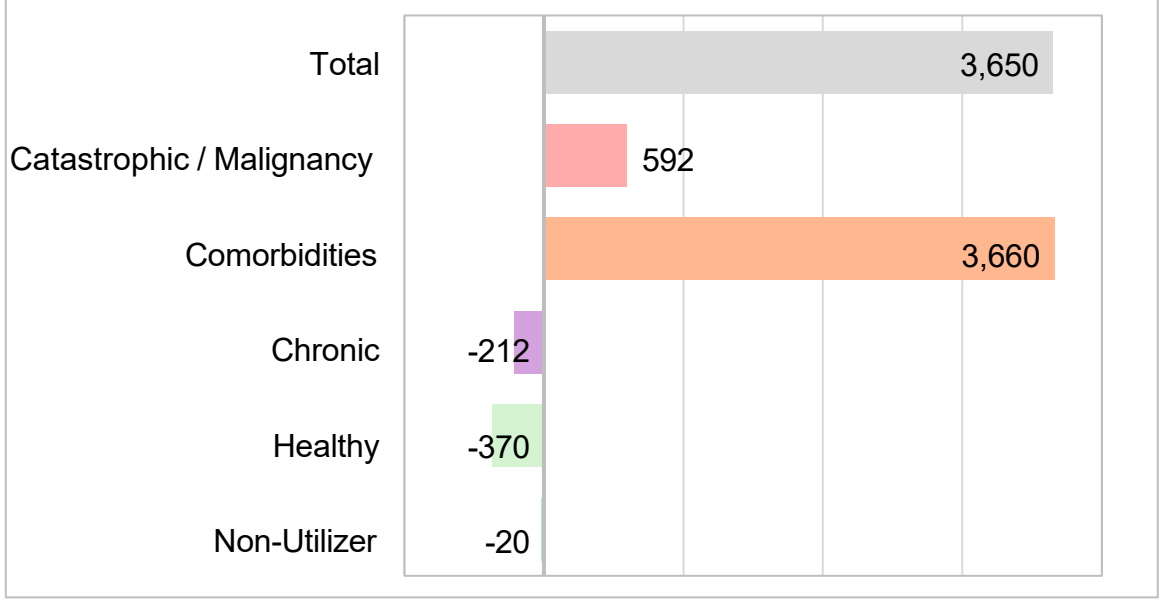
Historical Change in Hypertensive Members[1]



Historical Change in Heart Disease Members[1]



Observations

The graphs above summarize population risk group trends for members with hypertension and/or heart disease.

- During the historical period, there has been a decrease of 5,271 healthy hypertensive members and an increase of 11,461 hypertensive members with comorbidities and an increase of 1,132 hypertensive members in the catastrophic risk group.
- During the historical period, there has been a decrease of 370 healthy members with heart disease and an increase of 3,660 members with heart disease and comorbidities and an increase of 592 members with heart disease in the catastrophic risk group.

[1] Historical change reflects the change in member counts between 2019 and 2024.

Hypertension and Heart Disease

Prevalence and Outcomes by Region

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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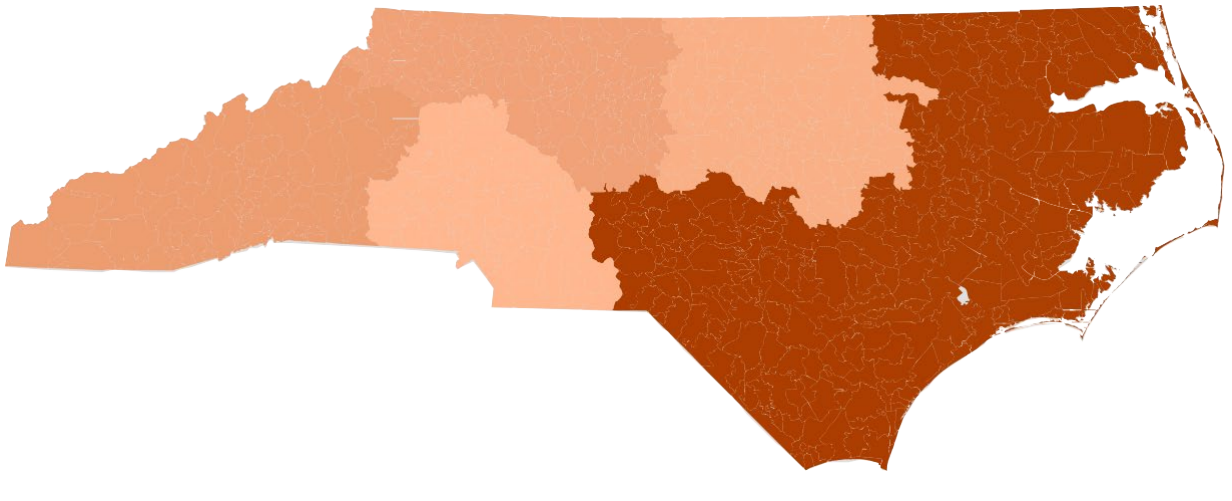
Hypertension/CVD Prevalence



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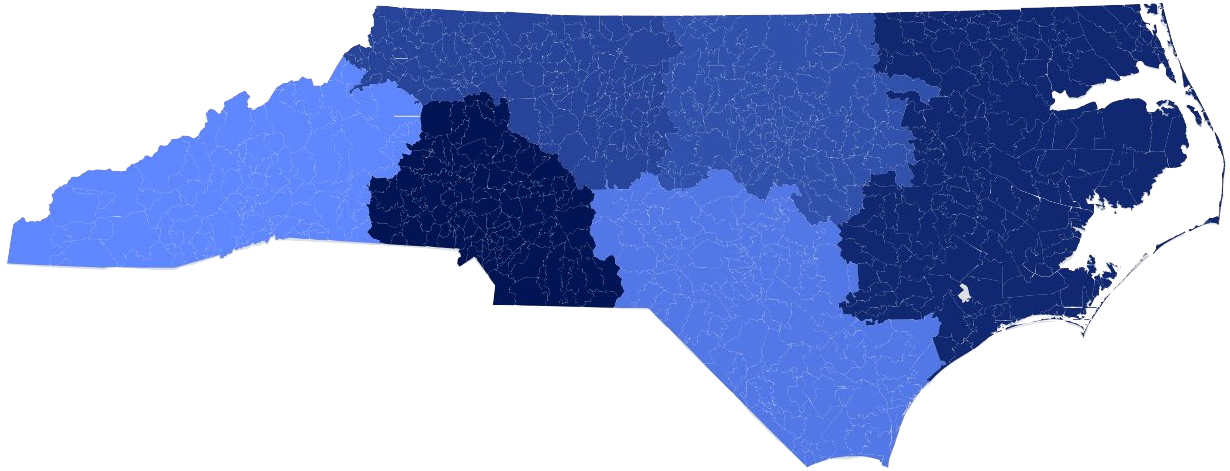
Prevalence
25.6% 33.1%

Hospital Admissions per 1,000



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Hospital Admissions per 1,000
69.4 76.4

Observations

The maps above show hypertension and/or heart disease (i.e., CVD) prevalence and hospital admissions for members with either condition by region.

- The eastern section of the State (i.e., Region 6: Eastern NC) represents the greatest opportunity to improve outcomes for members with hypertension and/or CVD as it has the greatest prevalence of one or both of the diseases and the worst outcomes (i.e., most hospital admissions).

Hypertension and Heart Disease

Urban vs. Rural Comparison

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

Hypertension and/or CVD Prevalence and Outcomes By Region *Urban vs. Rural*						
Region	Disease Prevalence		ER Visits per 1,000		Admissions per 1,000	
	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	26.6%	28.3%	270.1	325.1	71.2	66.5
Region 2: Piedmont Triad	27.0%	26.5%	303.2	318.2	75.0	70.4
Region 3: Metrolina (Charlotte)	25.1%	29.3%	340.5	320.8	76.4	76.9
Region 4: Triangle	24.9%	33.5%	303.0	357.2	72.9	71.9
Region 5: Cape Fear	31.0%	35.2%	357.1	362.0	69.5	71.2
Region 6: Eastern NC	30.8%	35.5%	316.2	409.8	75.7	74.8
Total	**27.1%**	**32.9%**	**314.5**	**359.2**	**73.8**	**72.4**

Observations

The table above summarizes hypertension and/or heart disease prevalence and outcomes by region, separated by rural and urban areas.

- 5 out of 6 regions have higher disease prevalence in rural areas. Emergency room utilization is generally higher in rural areas but hospital admissions are similar overall between urban and rural areas.

Cancer

Prevalence, Cost and Top Cancers

North Carolina State Health Plan
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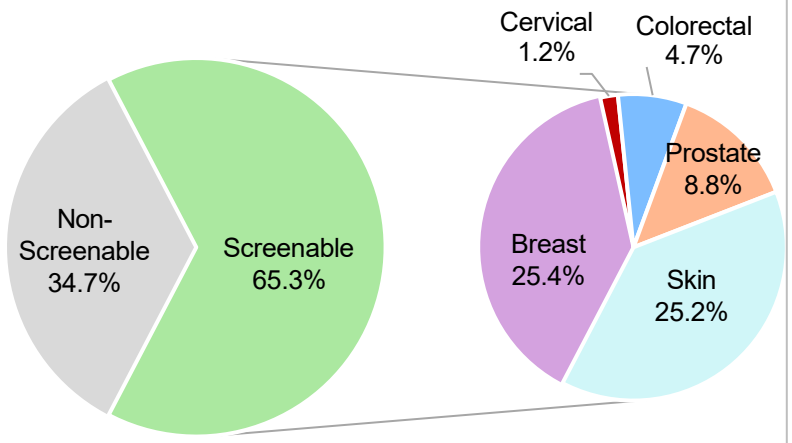
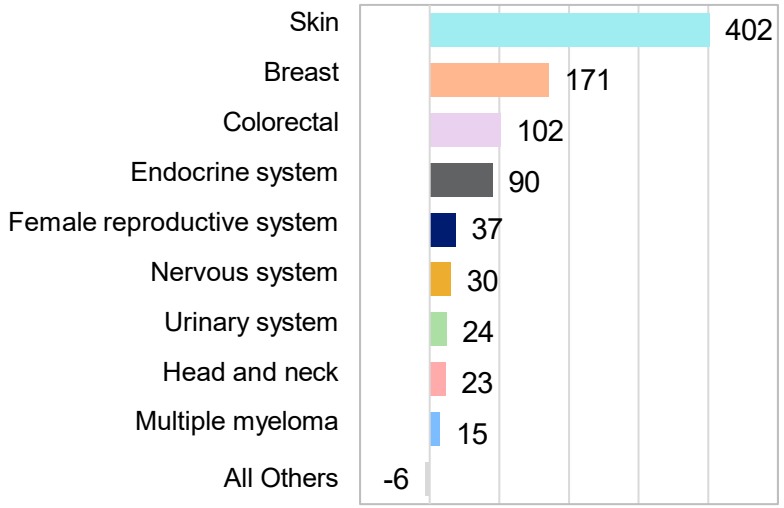
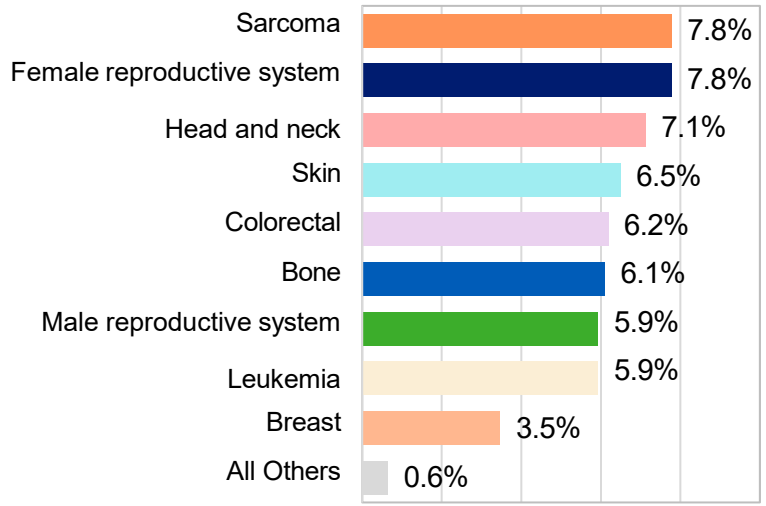
Cancer Prevalence



Historical Change in Diagnoses[1]



Historical Per Capita Cost Trend[2]



Observations

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

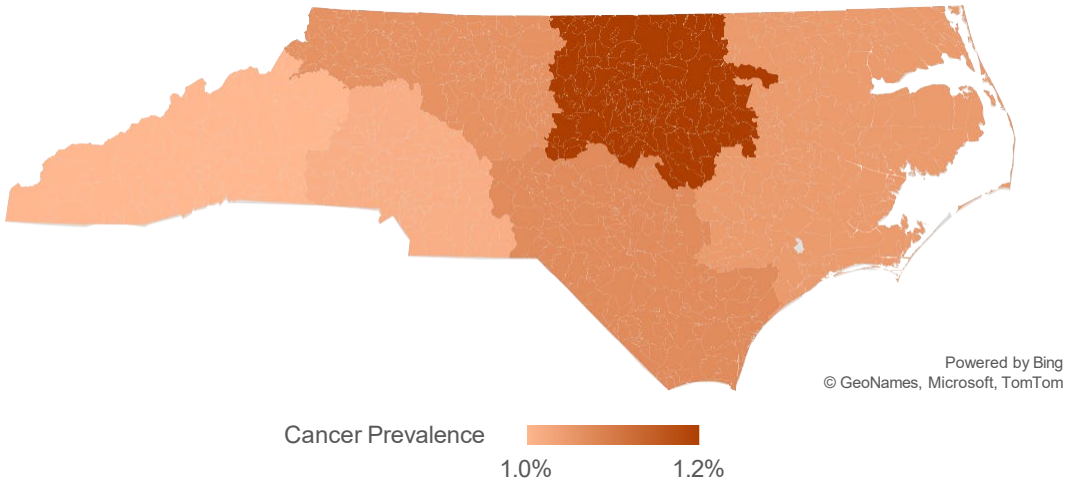
- About 12K members were treated for cancer in 2024, of which 65.3% were for cancers with recommendations for routine screenings (i.e., screenable).
- There were 402 more skin cancers diagnosed in 2024 compared to 2019, representing the largest increase of all cancer types, followed by breast and colorectal. All three of these cancers are screenable.
- Sarcoma cancers had the largest increase in the average cost per member treated per year (medical and prescription drug) during the historical period with an annualized increase of 7.8% between 2019 and 2024, followed by female reproductive system cancers and head and neck cancers.

[1] Historical change in diagnoses reflects the total change in the number of members diagnosed with each cancer type from 2019 to 2024.
[2] Historical change in cost reflects the annualized medical and prescription drug cost trend from 2019 to 2024.

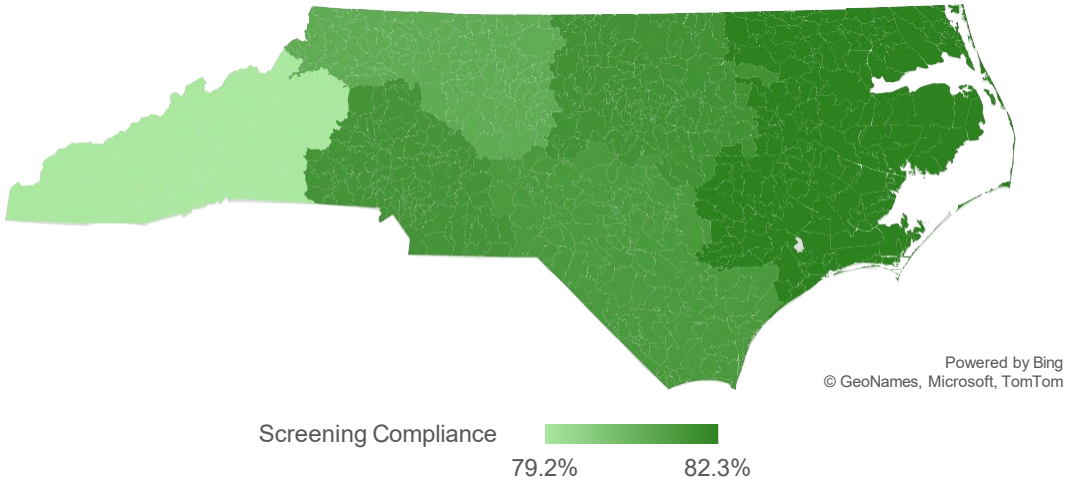
Cancer

Breast Cancer Prevalence and Screening Compliance by Region

Breast Cancer Prevalence



Breast Cancer Screening Compliance



Breast Cancer Prevalence and Screening Compliance by Region
Urban vs. Rural

Region	Cancer Prevalence		Screening Compliance	
	Urban	Rural	Urban	Rural
Region 1: Western	1.04%	0.89%	81.2%	75.7%
Region 2: Piedmont Triad	1.02%	1.11%	81.4%	80.1%
Region 3: Metrolina (Charlotte)	1.00%	1.00%	81.8%	81.5%
Region 4: Triangle	1.18%	1.20%	82.3%	79.2%
Region 5: Cape Fear	1.01%	1.10%	81.4%	81.8%
Region 6: Eastern NC	0.99%	1.08%	81.9%	82.8%
Total	**1.07%**	**1.08%**	**81.8%**	**80.6%**

Observations

- Breast cancer prevalence is similar between urban and rural areas. However, screening compliance is more than 1% lower in rural areas.
- The Triangle has the higher breast cancer prevalence and second largest disparity in screening compliance between urban and rural areas.

Cancer

Prostate Cancer Prevalence and Screening Compliance by Region

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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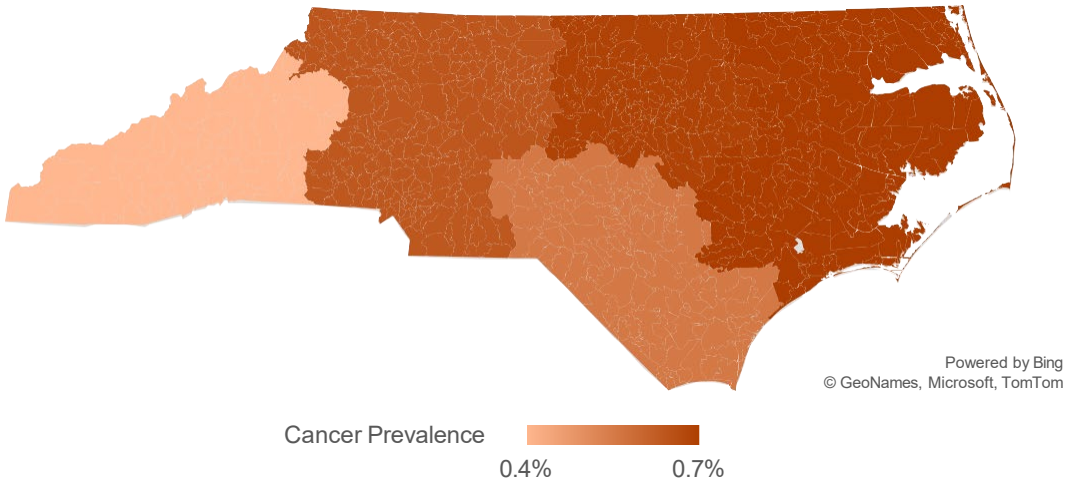
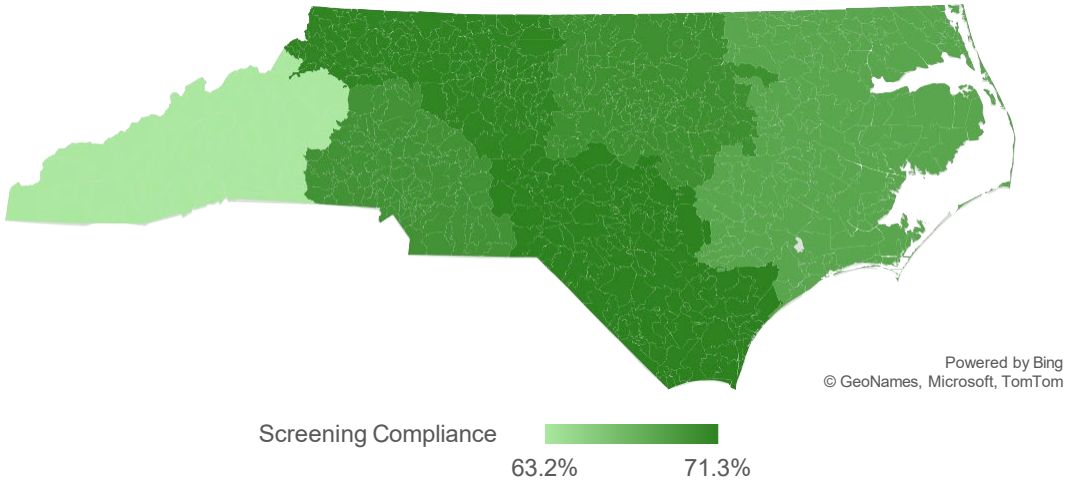
Prostate Cancer Prevalence



Prostate Cancer Screening Compliance



Prostate Cancer Prevalence and Screening Compliance by Region
Urban vs. Rural

Region	Cancer Prevalence		Screening Compliance	
	Urban	Rural	Urban	Rural
Region 1: Western	0.38%	0.48%	62.9%	63.6%
Region 2: Piedmont Triad	0.71%	0.54%	71.6%	70.1%
Region 3: Metrolina (Charlotte)	0.61%	0.85%	69.7%	71.4%
Region 4: Triangle	0.70%	0.63%	70.2%	70.1%
Region 5: Cape Fear	0.47%	0.67%	70.3%	72.1%
Region 6: Eastern NC	0.66%	0.76%	68.3%	68.5%
Total	**0.63%**	**0.65%**	**69.4%**	**69.3%**

Observations

- Prostate cancer prevalence and screening compliance are both similar between urban and rural areas.
- Region 1: Western has the lowest screening compliance in both urban and rural areas.

Musculoskeletal

Cost and Utilization

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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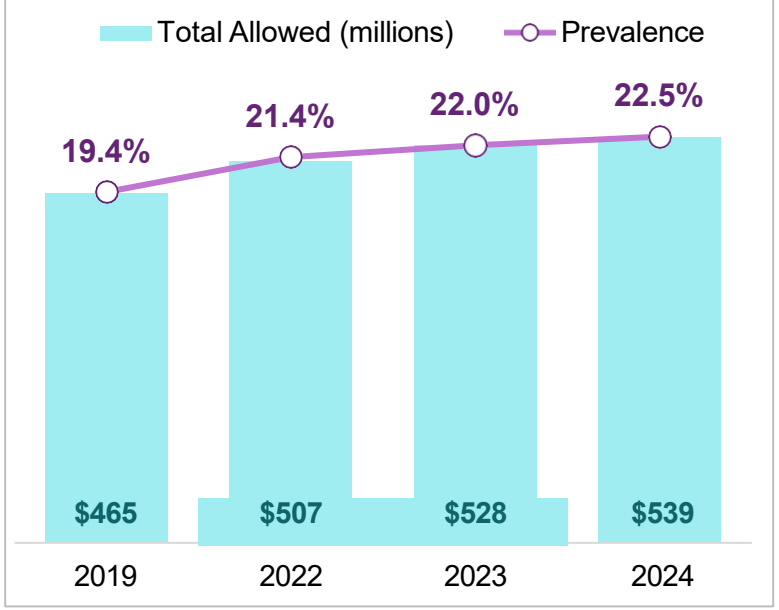
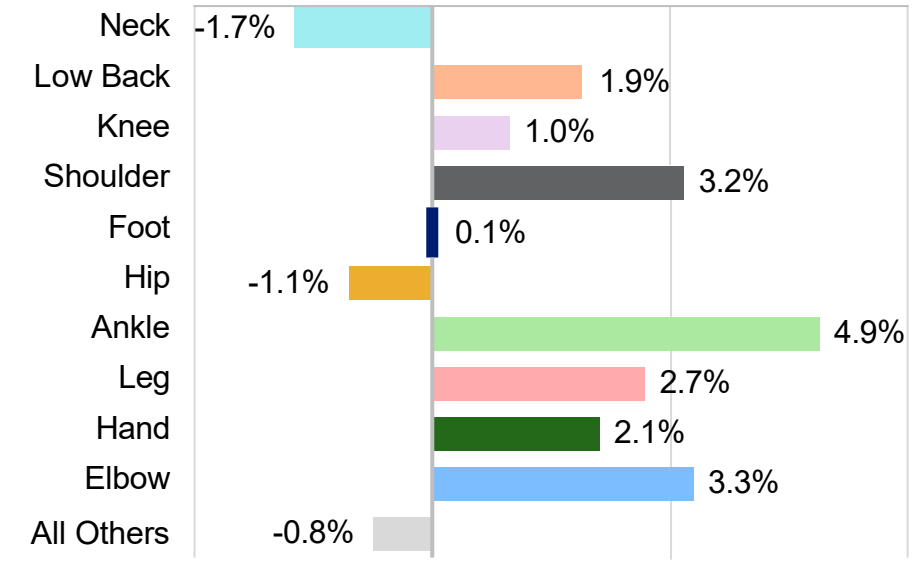
MSK Cost and Utilization



Top MSK Conditions in 2024		
MSK Region	**% of Members**	**Change 2019 - 2024**
Neck	18.2%	1.5pp
Low Back	15.9%	-0.4pp
Knee	14.4%	0.3pp
Shoulder	8.4%	0.2pp
Foot	5.8%	0.0pp
Hip	5.7%	0.3pp
Ankle	3.9%	0.1pp
Leg	3.6%	0.0pp
Hand	2.1%	0.1pp
Elbow	1.9%	0.0pp
All Others	20.1%	0.9pp

Historical MSK Cost Trends[1]



Observations

The graphs above summarize prevalence and cost trends by musculoskeletal conditions.

- 22.5% of members were treated for a musculoskeletal condition in 2024, up from 19.4% in 2019.
- The State spent $539 million directly on musculoskeletal conditions (i.e., one or more of first three diagnosis codes related to MSK), which is a 16% increase from 2019.
- The most common region being treated is the neck, affecting 18.2%, which is up 1.5 percentage points (pp) from 2019.
- Musculoskeletal conditions affecting the ankle, elbow, and shoulder have experienced the greatest increase in costs over the historical period.

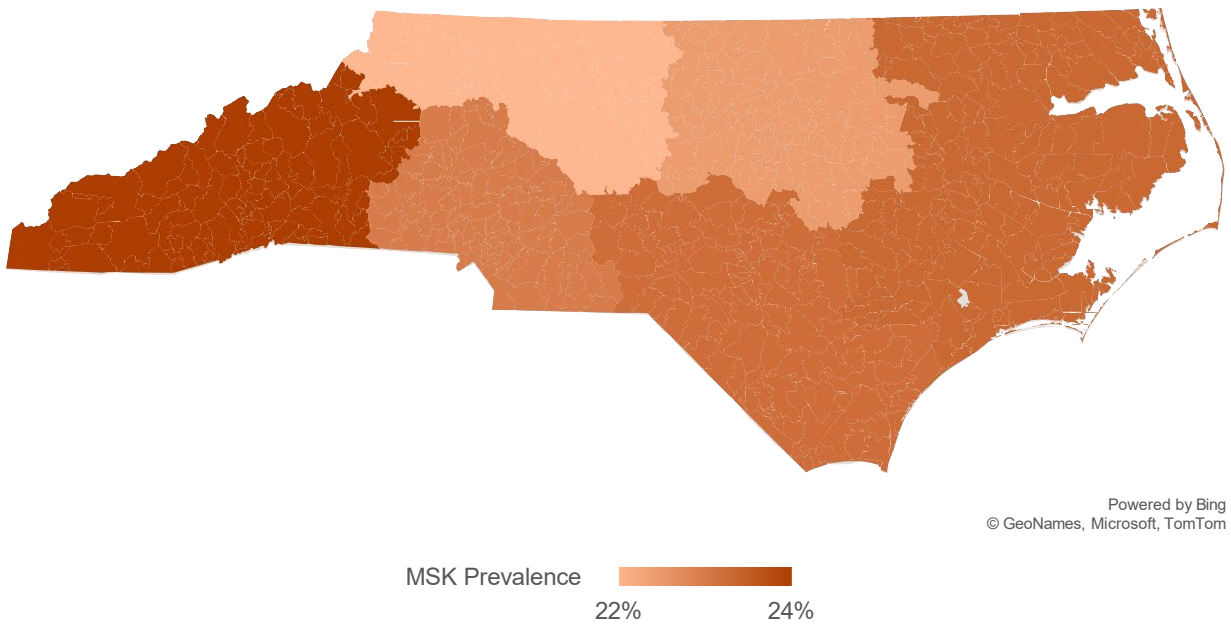
[1] Historical trend reflects the annualized trend between 2019 and 2024.

Musculoskeletal

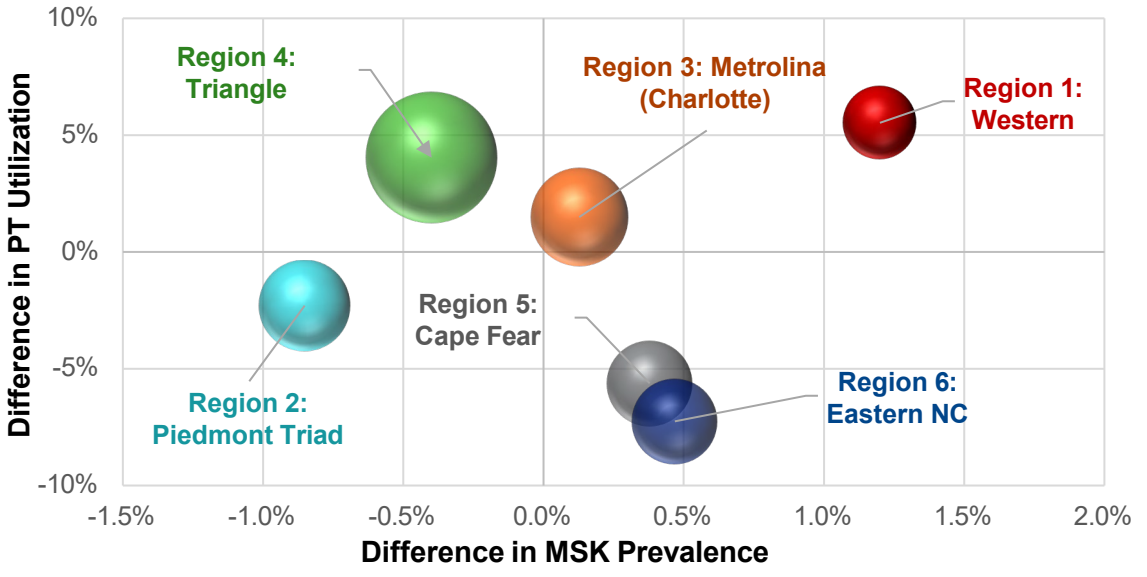
Prevalence and Physical Therapy Utilization

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

MSK Prevalence by Region



MSK Prevalence vs. PT Utilization



Observations

The map and chart above show musculoskeletal prevalence and physical therapy (PT) utilization by region.

- Region 1: Western has the highest prevalence of musculoskeletal conditions.
- The chart in the upper right shows the difference from the baseline (i.e., the entire State population) of musculoskeletal prevalence and PT utilization for each region. The regions with the greatest opportunity for improvement are in the bottom right, where prevalence is high and PT utilization is low. Regions included here are Cape Fear and Eastern NC.

Musculoskeletal

Urban vs. Rural Comparison

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

Musculoskeletal Prevalence and Outcomes By Region *Urban vs. Rural*						
Region	MSK Prevalence		PT Utilization		Surgery Utilization	
	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	23.9%	24.3%	56.7%	57.7%	6.5%	5.4%
Region 2: Piedmont Triad	21.8%	22.2%	48.7%	50.3%	5.9%	6.4%
Region 3: Metrolina (Charlotte)	22.9%	23.1%	53.1%	52.3%	6.3%	6.6%
Region 4: Triangle	22.3%	23.1%	57.2%	45.8%	5.1%	5.7%
Region 5: Cape Fear	22.6%	23.8%	48.9%	43.0%	5.1%	5.6%
Region 6: Eastern NC	23.7%	22.8%	46.5%	41.6%	5.7%	6.6%
Total	**22.7%**	**23.2%**	**53.3%**	**47.1%**	**5.6%**	**6.0%**

Observations

The table above summarizes MSK prevalence along with physical therapy (PT) and surgery utilization by region, separated by rural and urban areas.

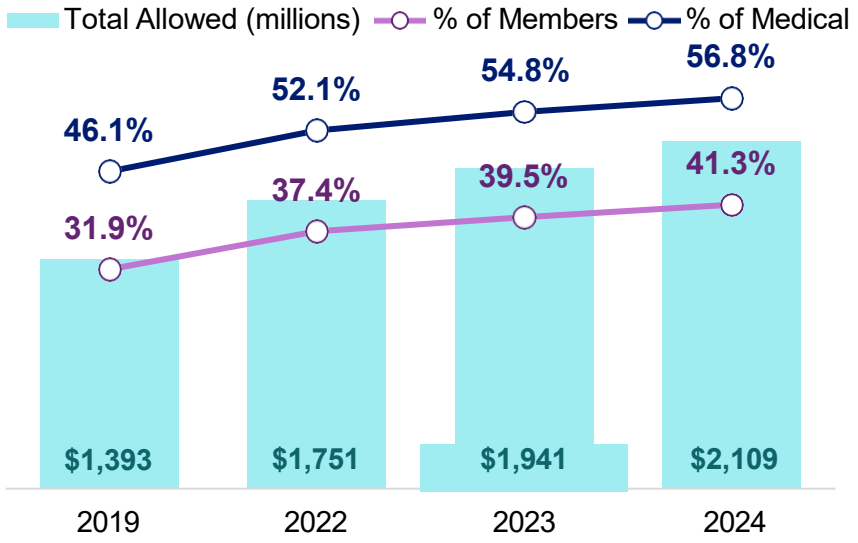
- 5 of the 6 regions have higher MSK prevalence in rural areas.
- 4 out of the 6 regions have lower PT utilization in rural areas. All four of these regions also have higher surgery utilization in rural areas.

Mental Health

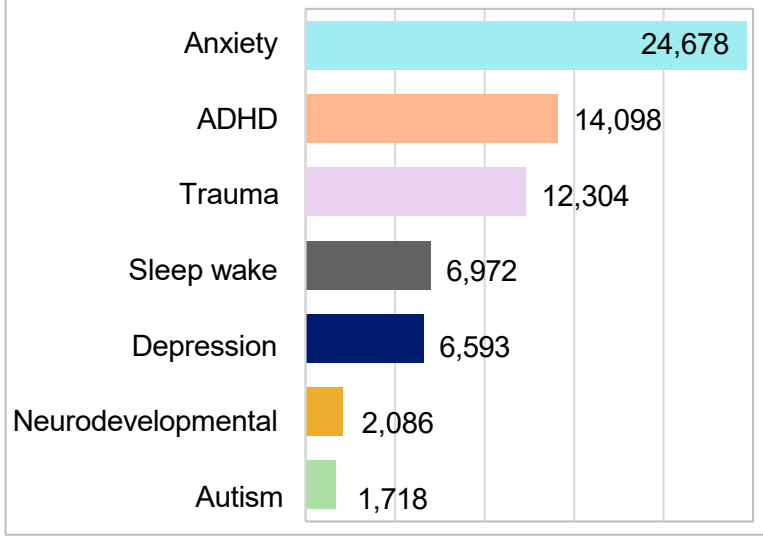
Prevalence, Cost and Top Conditions

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

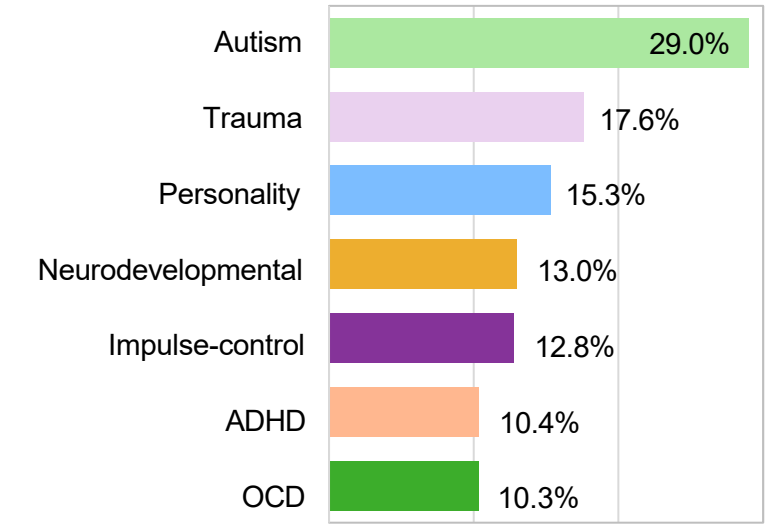
Mental Health Cost and Utilization



Historical Change in Diagnoses[1]



Historical Per Capita Cost Trend[2]



Observations

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

- 41.3% of members were treated for a mental health condition in 2024, up from 31.9% in 2019. Medical costs for members with mental health conditions represented 56.8% of all medical expenses in 2024. Note this includes all medical expenses, not just expenses directly related to mental health.
- There were 24,678 more members treated for anxiety in 2024 compared to 2019, the largest increase of all conditions.
- There were 1,718 more members treated for autism in 2024 compared to 2019, which represents an increase of 93%. Medical costs for members with autism have increased 29% per year since 2019, the largest increase of all mental health conditions.

[1] Historical change in diagnoses reflects the total change in the number of members diagnosed with each mental health condition from 2019 to 2024.
[2] Historical change in cost reflects the annualized medical cost trend from 2019 to 2024.

Substance Use Disorder

Prevalence, Cost and Top Conditions

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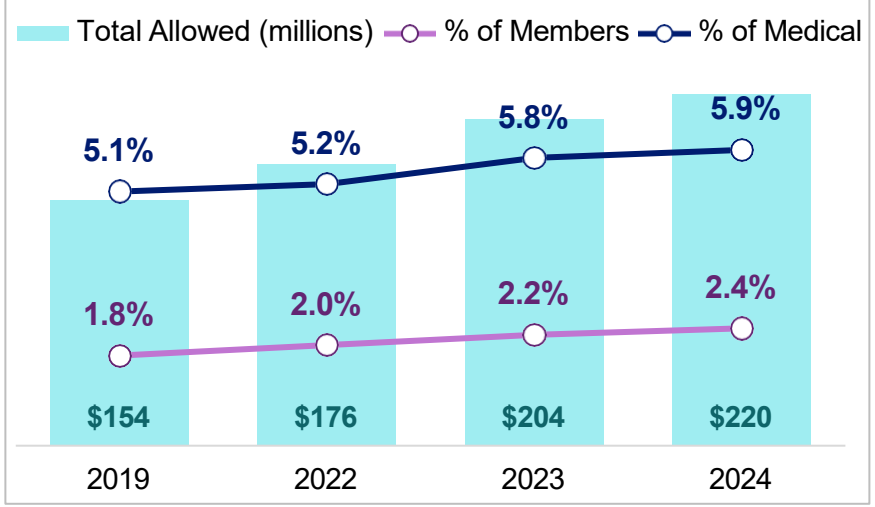
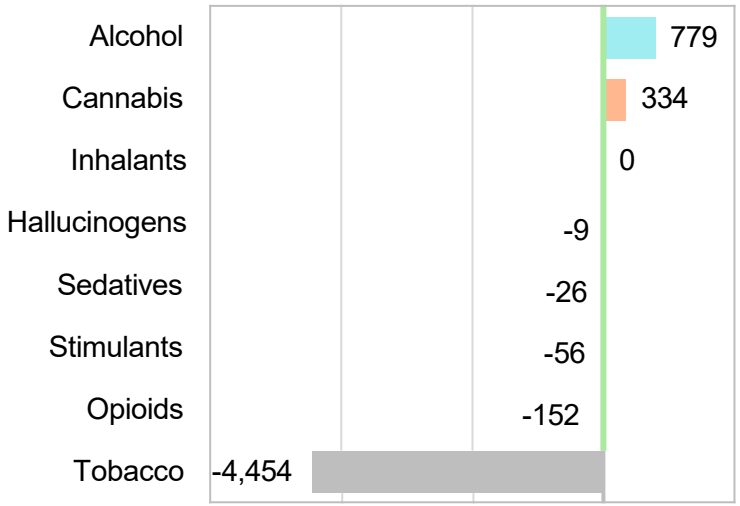
SUD Cost and Utilization

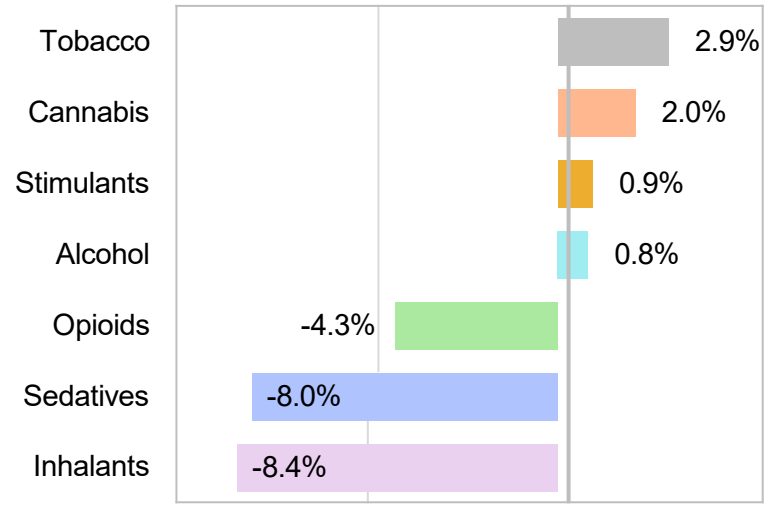
(excludes tobacco)



Historical Change in Diagnoses[1]



Historical Per Capita Cost Trend[2]



Observations

The graphs above summarize prevalence and cost trends by substance use disorder (SUD) conditions.

- Not including tobacco, 2.4% of members were treated for a substance use disorder condition in 2024, up from 1.8% in 2019. Medical costs for members with substance use disorders represented 5.9% of all medical expenses in 2024. Note this includes all medical expenses, not just expenses directly related to substance use disorders.
- There were 779 more members treated for alcohol in 2024 compared to 2019, the largest increase of all conditions.
- There were 4,454 fewer members treated for tobacco addiction in 2024 compared to 2019, which is by far the largest decrease. However, costs associated with tobacco users increased the most out of all substances at 2.9% per year since 2019.

[1] Historical change in diagnoses reflects the total change in the number of members diagnosed with each substance use disorder condition from 2019 to 2024.
[2] Historical change in cost reflects the annualized medical cost trend from 2019 to 2024.

PCP Engagement

Overview

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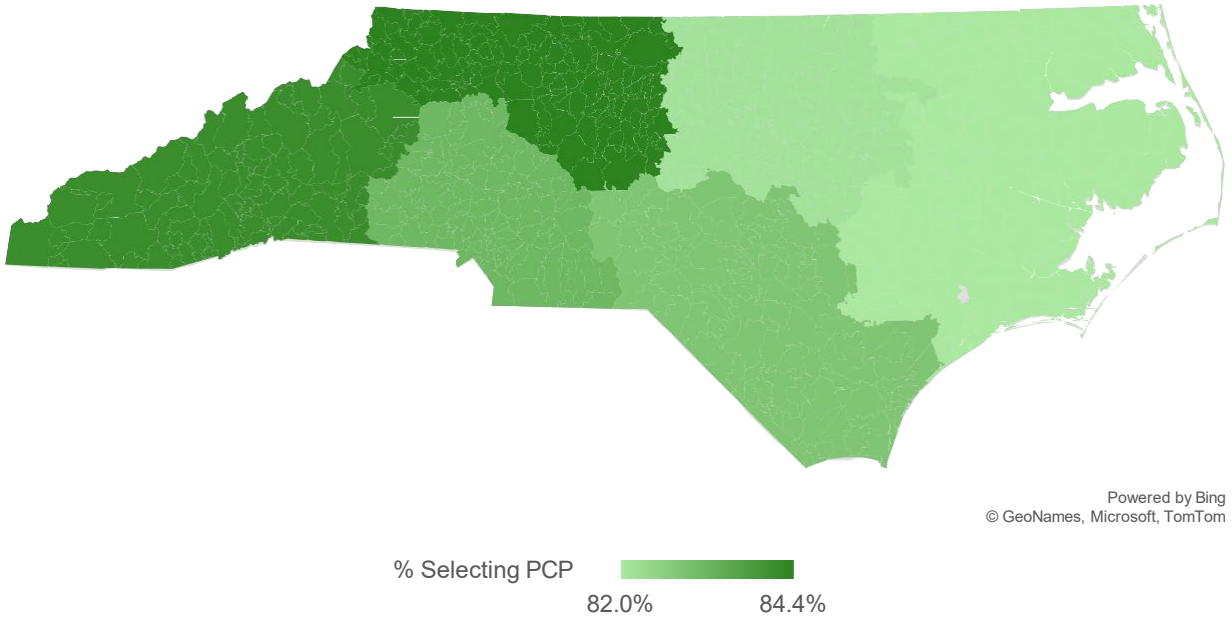
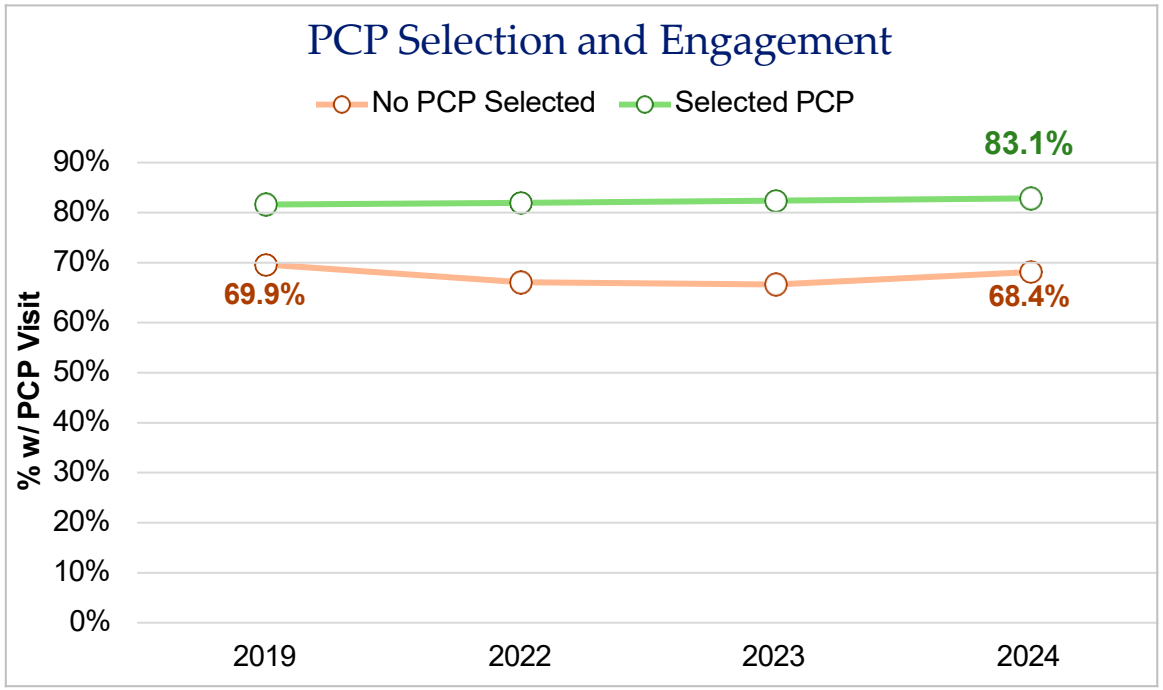
PCP Selection



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 83% of members selecting a PCP. Regions with the highest selection rates include Western and Piedmont Triad.
- Of the members selecting a PCP, 83.1% had an evaluation and management visit in 2024, which has slowly increased over the historical period. For those who did not select a PCP, 68.4% had an evaluation and management visit in 2024.

PCP Engagement

Urban vs. Rural Comparison

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PCP Selection and Engagement By Region *Urban vs. Rural*						
	% Selecting a PCP		% Engaged		Change in Engagement[1]	
Region	Urban	Rural	Urban	Rural	Urban	Rural
Region 1: Western	85.4%	82.1%	80.8%	80.5%	0.2pp	1.1pp
Region 2: Piedmont Triad	83.6%	86.2%	81.1%	82.1%	1.0pp	1.1pp
Region 3: Metrolina (Charlotte)	82.8%	85.6%	81.7%	83.3%	2.0pp	2.1pp
Region 4: Triangle	82.1%	82.5%	79.3%	80.4%	2.0pp	0.9pp
Region 5: Cape Fear	82.1%	83.7%	80.0%	83.1%	0.5pp	1.7pp
Region 6: Eastern NC	81.9%	82.2%	79.9%	78.5%	0.6pp	-0.3pp
Total	**82.7%**	**83.5%**	**80.3%**	**81.2%**	**1.4pp**	**1.0pp**

Observations

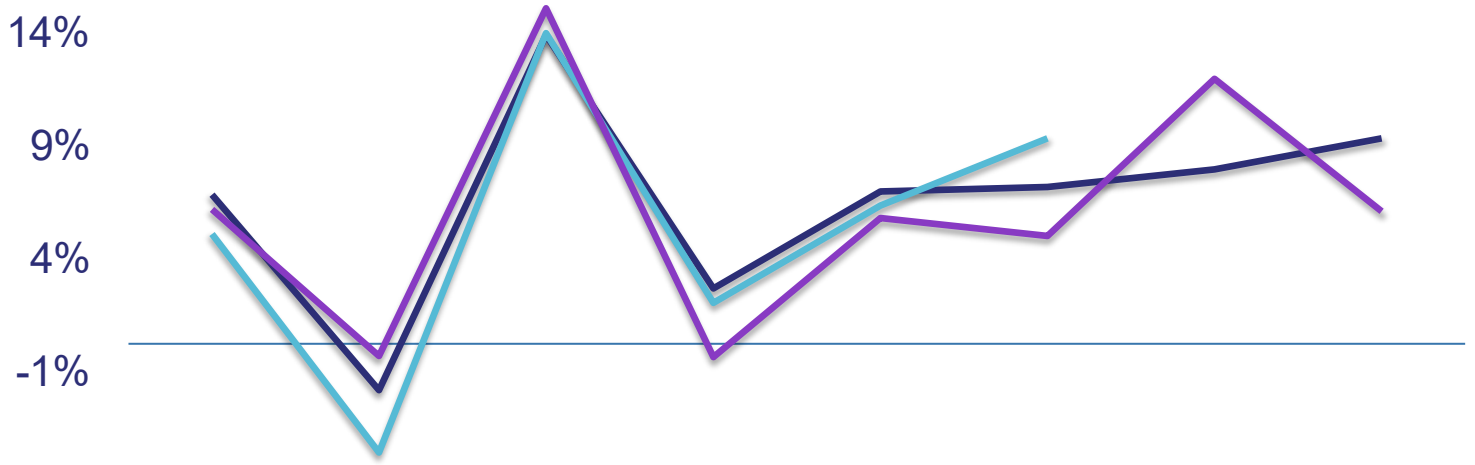
The chart above shows PCP engagement by region, separated by urban versus rural.

- PCP engagement is generally higher in rural areas but has also improved less than urban areas since 2019.

[1] Historical change represents the percentage point (pp) change from 2019 to 2024

Financial Reports

Medical Trends – Comparison to State Health Plan

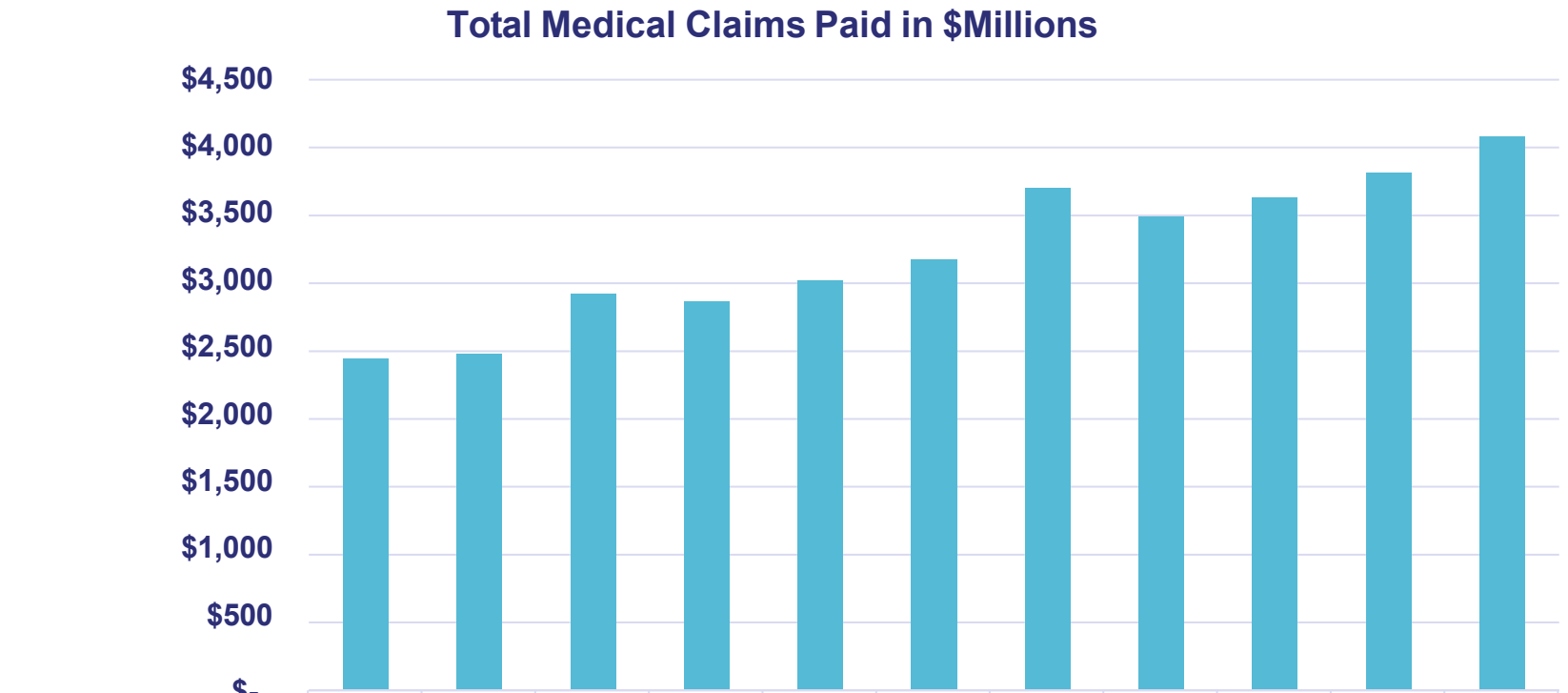


	2019	2020	2021	2022	2023	2024	2025	2026
Trend Survey	6.8%	-2.1%	14.0%	2.5%	6.9%	7.1%	7.9%	9.3%
SHAPE - PS	5.0%	-4.9%	14.1%	1.9%	6.3%	9.3%		
NCSHP	6.1%	-0.6%	15.2%	-0.6%	5.7%	4.9%	12.0%	6.0%

- SHAPE -PS is Segal's Public Sector Book of Business Data loaded into our data warehouse.
- State Health Plan 2025 YTD trend – Jan-Jul incurred w/ 2 months of runout (final likely higher).
- The Plan's trend is below 2022-2024 comparisons but experiencing significantly higher 2025 emerging trend. Over the period 2018 to 2024 the annualized rate was 5.0%, slightly lower than the SHAPE-PS of 5.1% and the Segal Trend Survey of 5.7%.
- Net effective 2026 trend will be approximately 6% lower due to the 2026 benefit changes approved by the BOT.

Source: 2026 *Segal Health Plan Cost Trend Survey*

Medical Claims Paid (Calendar Year)



	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Total Medical Paid	$2,443	$2,481	$2,921	$2,864	$3,019	$3,174	$3,700	$3,493	$3,634	$3,811	$4,084

- 2024 experienced claims lag at the end of year that pushed approximately $60M into 2025.
- 2025 includes actual claims through October with projected November & December.
- Chart includes all members (Non-Medicare & Medicare) who are not enrolled in the fully insured Humana (United Healthcare prior) Medicare Advantage Plan
- Costs expected to increase nearly $400M from 2025 to 2029 due to anticipated trends, even with consideration of significant benefit changes in 2026.

2025 Calendar Year Budget vs. Projection

	CY 2025 *(Actual through 3Q/Projected 4Q)*		
$s In Millions	Budget	Projection	Gain/(Loss)
Premium & Subsidies	$4,489.0	$4,709.1	$220.1
Investment Earnings	$20.1	$33.1	$13.0
Total Revenue	$4,509.1	$4,742.2	$233.1
Net Medical Claims	$3,377.5	$3,699.9	$(322.4)
Net Pharmacy Claims	$1,009.5	$871.1	$138.4
Medicare Advantage Payments	$91.0	$85.3	$5.7
Administrative Expenses	$207.1	$202.2	$4.9
Total Expenses	$4,685.0	$4,858.5	$(173.5)
Plan Income(Loss)	$(175.9)	$(116.3)	$59.6
Beginning Cash Balance	$591.0	$688.2	$97.2
Ending Cash Balance	$415.1	$571.9	$156.8

- Beginning Cash Balance reflects a gain at the end of CY2024, prior to budgets being set.
- Gain on premiums due to House Bill H125-PCCS-MH-3 which added salary-based employer contributions (2.4%).
- Continued high medical trend above expectations – 9.5% loss. This was partially offset by gains in net pharmacy. There was also delays in payment of claims into CY 2025 from CY 2024.

2026 Calendar Year Budget vs. Projection

	CY 2026 *(Projected as of 3Q 2025)*		
$s In Millions	Budget	Projected	Gain(Loss)
Premium & Subsidies	$4,844.9	$4,807.1	$(37.8)
Investment Earnings	$44.2	$24.2	$(20.0)
Total Revenue	$4,889.1	$4,831.4	$(57.7)
Net Medical Claims	$3,381.4	$3,493.3	$(111.9)
Net Pharmacy Claims	$874.5	$851.0	$23.5
Medicare Advantage Payments	$166.1	$165.8	$0.3
Administrative Expenses	$185.7	$185.0	$0.7
Total Expenses	$4,607.8	$4,695.2	$(87.4)
Plan Income(Loss)	$281.3	$136.2	$(145.1)
Beginning Cash Balance	$819.9	$571.9	$(248.0)
Ending Cash Balance	$1,101.3	$708.1	$(393.2)

- Beginning Cash Balance reflects losses in CY 2025 – Q2, Q3 & Q4 (expected) - $248.0M.
- Slight loss on 2026 premiums primarily due to slight drop in enrollment, Retiree Drug Subsidy participation changes and funding seasonality.
- Loss on expected medical claims of 3.3% due to emerging claims experience. Partially offset by a gain in pharmacy due to the Stelara exclusion.

2027 Calendar Year Budget vs. Projection

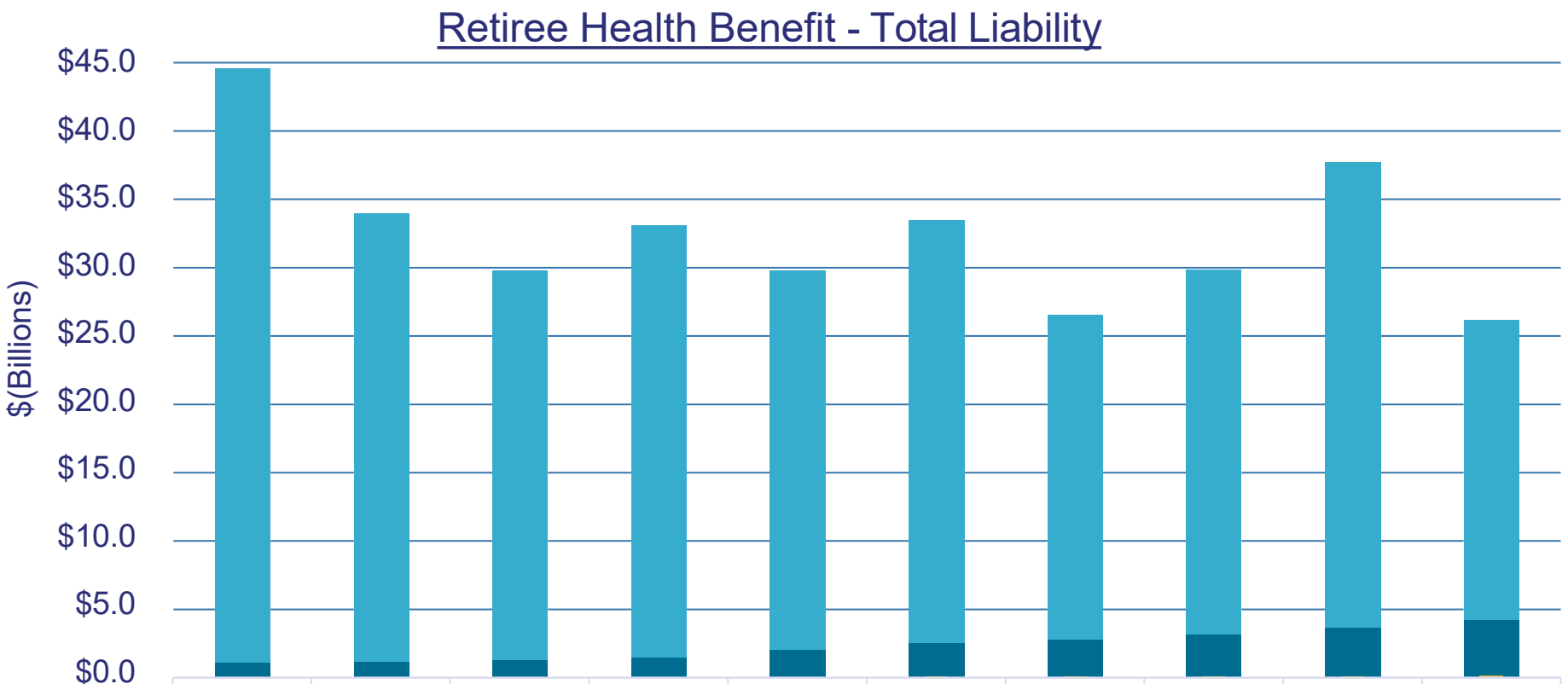
	CY 2027 *(Projected as of 3Q 2025)*		
$s In Millions	Budget*	Projected	Gain(Loss)
Premium & Subsidies	$4,799.0	$4,765.9	$(33.1)
Investment Earnings	$21.4	$12.5	$(8.9)
Total Revenue	$4,820.5	$4,778.4	$(42.1)
Net Medical Claims	$3,517.0	$3,633.8	$(116.8)
Net Pharmacy Claims	$963.3	$943.6	$19.7
Medicare Advantage Payments	$267.4	$266.9	$0.5
Administrative Expenses	$187.7	$187.0	$0.7
Total Expenses	$4,935.4	$5,031.3	$(95.9)
Plan Income(Loss)	$(115.0)	$(252.9)	$(137.9)
Beginning Cash Balance	$1,101.3	$708.1	$(393.2)
Ending Cash Balance	$986.3	$455.1	$(531.2)

**** Preliminary budget based on Q2 2025 projection.***

- Continued Premium similar to CY 2026.
- Continued loss on medical claims offset by slight pharmacy gain.
- Cash Balance projected to fall below the Target Stabilization Reserve of $427.5M in January-2028.

Retiree Health Benefit OPEB Update

OPEB History



	6/2016*	6/2017	6/2018	6/2019	6/2020**	6/2021	6/2022	6/2023	6/2024	6/2025
Unfunded Liability	$43.5	$32.8	$28.5	$31.6	$27.7	$30.9	$23.7	$26.6	$34.0	$22.0
Assets	$1.1	$1.2	$1.3	$1.5	$2.1	$2.6	$2.8	$3.2	$3.7	$4.2
Funding Ratio	2.4%	3.5%	4.4%	4.4%	6.9%	7.7%	10.6%	10.7%	9.8%	16.2%

* 2016 Implemented GASB 74/75

** 2020 First year of PEHBF transfers

OPEB Context

RHBT
TOL: $29.85
FNP: 3.20
NOL: 26.65
Fund: 10.7%

DIPNC
TOL: $0.283
FNP: 0.257
NOL: 0.03
Fund: 90.6%

2023 OPEB Statistics of Comparable AAA Rated States

State	Total OPEB Liability ($B)	Fiduciary Net Pos. ($B)	Net OPEB Liability ($B)	Funding Percentage
Ohio	$14.8	$17.4	($2.6)	117.8%
Tennessee	1.2	0.9	0.3	74.2%
Virginia	7.4	4.0	3.4	53.9%
Georgia	15.0	4.2	10.8	27.9%
North Carolina	30.1	3.4	26.7	11.5%
South Carolina	14.8	1.7	13.1	11.4%
Missouri	2.9	0.2	2.7	6.9%
Texas	66.6	4.1	62.5	6.1%
Maryland	11.6	0.5	11.1	4.0%
Florida	18.9	0.5	18.4	2.8%
Washington	4.3	0.0	4.3	0.0%

Source: 2023 ACFRs and State GASB 74 Reports

GASB 74/75 Funding Rules

- OPEB follows funding guidelines from GASB 74 and 75
- Part of GASB 74/75 rules mandate what Discount Rate is used when calculating Total Liability.
  - **IF there is a funding policy** or reasonable expectation of pre-funding the Trust fund, the actuary may use the Investment Rate or a blend of 20-Year General Obligation (GO) Bond Rate and the Investment Rate.
  - **IF there is NO funding policy** and the plan is funded on a Pay As You Go basis (contributions are relatively equal to payments), then the actuary **MUST use the 20-Year GO Bond Rate**.

Year	2018	2019	2020	2021	2022	2023	2024	2025
20 Yr GO Bond Rate	3.87%	3.50%	2.21%	2.16%	3.54%	3.65%	3.93%	5.20%
Liability Gain/(Loss) ($B)	$1.38	($1.82)	($5.16)	($0.26)	$6.11	$0.48	$1.66	$5.14

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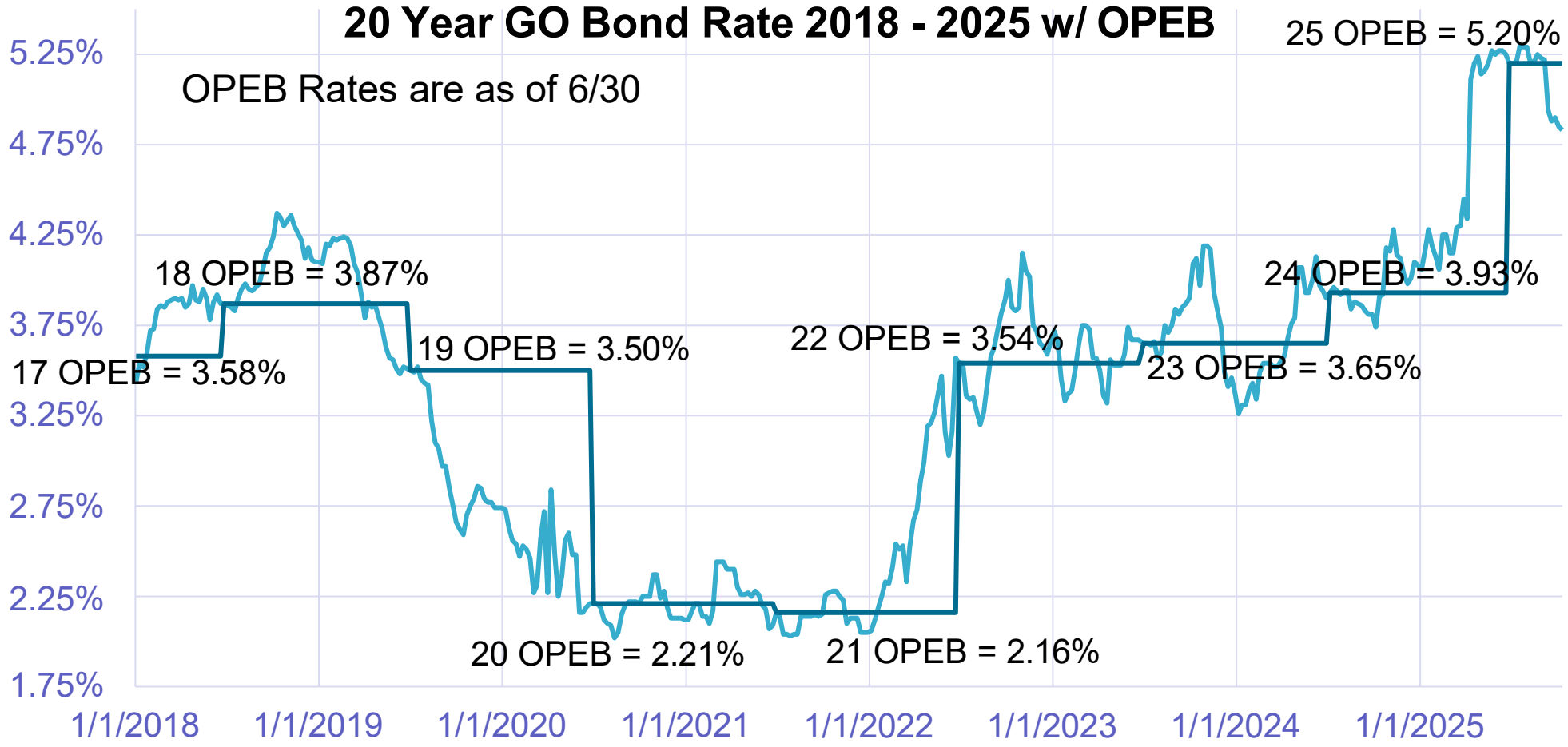
20 Year GO Bond History



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Factors of OPEB Liability Change

- Medicare Advantage (MA) Premiums:
  - ~85% of Medicare Eligible Members have MA Coverage
  - 2020: New RFP reducing PMPM premiums $90 PMPM to $0 effective 2021: $6.2B Gain
  - 2024: Increase MA rates from Inflation Reduction Act (2022): 8.8B Loss
  - 2025: Decrease MA rates (vendor negotiation $50 reduction): $4.6B Gain

- Federal Law Changes:
  - 2020: Removed Health Insurance Tax on MA insurers ($20 PMPM): $2.4B Gain
  - 2020: Removed PPACA Excise Tax for rich benefits: $1.6B Gain
  - 2024: Inflation Reduction Act: See above for impact on MA Premiums: Same as above

- SHP Board of Trustees:
  - New Vendors Contracts: 2022 PBM: $2.2B Gain; 2023 TPA: $0.7B Gain
  - Plan Changes: 2024: $1.4B Gain; 2025: $0.9B Gain
  - Member Contributions for Eligibility: not more than 0.5B gain or less than 0.5B Loss

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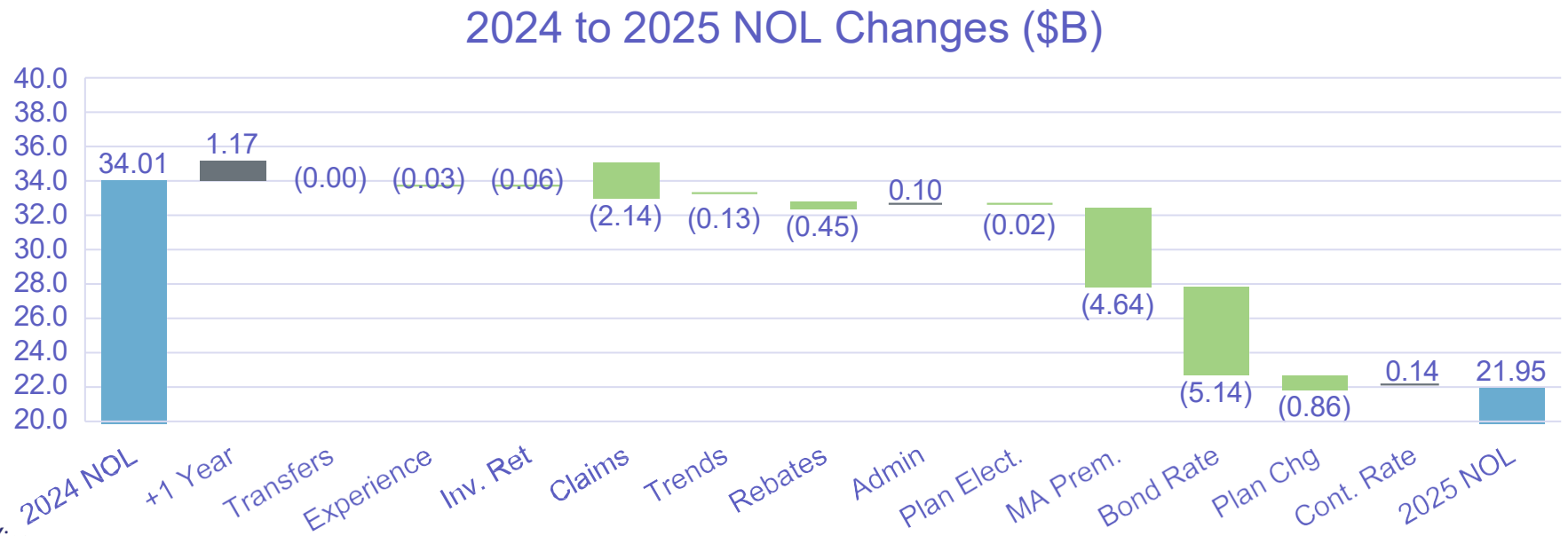
Factors (Cont.) & 2025 Liability Changes

- Member Experience
  - Claims Experience: 2025 $2.1B Gain
  - Member Plan Election: 2021 $1.5B Loss

- Future Trend Growth
  - 2021: $1.0B Loss 2023: $1.3B Loss



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Retiree Health Benefit Trust Fund

- Retiree Health Benefit Trust (RHBTF) is codified by G.S. 135-7(f)
- Funded by a % of Salary in Appropriations Legislation: FY 2026: 4.93% to RHBTF
- RHBTF transfers money monthly to Public Employee Health Benefit Fund (PEHBF that SHP uses for operations) to pay for retiree benefits. CY 2026: $300 per retiree per month
- The PEHBF has also transferred money to the RHBTF 2020: $475.2M; 2021: $187.0M; 2022: $172.0M; 2023: $34.5M

Fiduciary Net Position History

$ Billions	2022	2023	2024	2025
Cash & Rec.	1.36	1.34	1.36	1.32
Investments	1.45	1.86	2.33	2.92
Total FNP	2.81	3.20	3.69	4.24

Fiduciary Net Position Changes

$ Millions	2022	2023	2024	2025
BOY	2,584.6	2,810.3	3,202.7	3,690.1
Contribution	1,197.2	1,366.9	1,483.9	1,524.3
Expense	(1,044.1)	(1,120.7)	(1,222.7)	(1,280.6)
Investment Ret.	(107.9)	111.2	215.9	308.4
Additional Funds	180.5	35.0	10.3	0.0
EOY	2,810.3	3,202.7	3,690.1	4,242.2

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OPEB Liability Impact

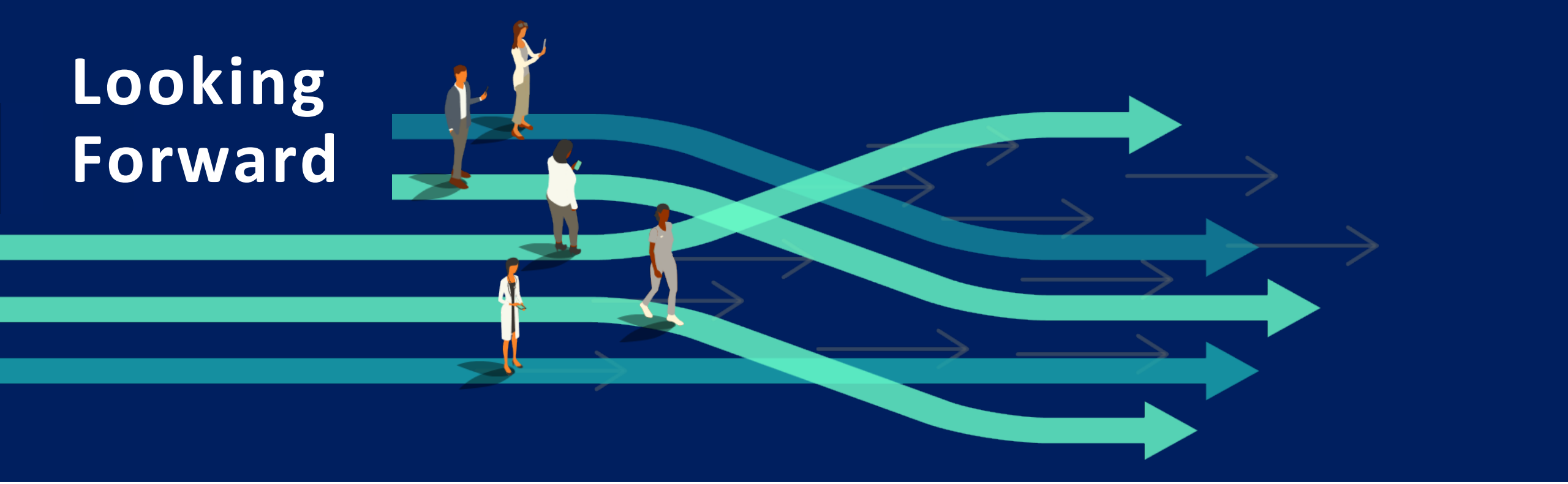
- **Benefits**
  - Modifications affect claims costs.
- **Vendor Contracts**
  - New contracts approved with new guarantees may change overall costs.
- **Wellness Programs**
  - Improve overall health of members reflected by lower claims costs and future trend percentage.
- **Plan Election**
  - Largest impact is Medicare Advantage enrollment.
- **Contributions**
  - As paid by Retirees and Dependents
  - As paid from RHBTF

External Forces on OPEB Liability

- **Discount Rate**
- **Trends**
  - Health costs will consistently grow as well as increased cost for new tests and treatments.
- **Legislation**
  - Federal CMS reimbursements impact MA rates.
  - State Appropriations Legislation
  - Any State or Federal legislation regarding benefits coverage.
- **Experience Study assumptions as approved by TSERS BOT**
  - Retirement, Disability, Termination, Mortality assumptions
  - Marriage Assumptions
  - Investment Return
  - Salary Increase

2027 Benefit Strategy

Looking Forward



Keep an Eye on Trend

Implement New Contracts

Deepen Benefit Design Merging with Provider Strategy

- Make desired outcomes most affordable
- Choice comes with cost

Continue to Communicate with and Advocate for our Members

- Utilize multiple modalities to get messaging out

Third Party Administrator RFP to reflect current administration's values, focus on health and changing market dynamics.

How We Are Targeting The Patient Journey (Illustrative)

We are targeting areas with the HIGHEST STEERAGE and COST IMPLICATIONS.
We are focusing on POPULATION HEALTH through Primary Care and our Specialty Pilot.

Current LARGEST FOCUS of Investment	CIN and PILOT MODEL			Current LARGEST FOCUS of Investment		
PCP Visit	Referral to Specialist	Referral to Imaging / Lab / Diagnostics	Referral to Surgeon	Surgery	Post-surgical Care	Return to PCP
						
LOW-COST Impact at site of care	MEDIUM-COST Impact at site of care	HIGH-COST Impact at site of care	HIGH-COST Impact at site of care	HIGH-COST Impact at site of care	MODERATE Impact at site of care	LOW-COST Impact at site of care
MOST STEERAGE Impact if independent	HIGH STEERAGE Impact if independent	Does not dictate future steerage	Dictates surgery or another modality and Post-surgical care	Already steered at this point	Already steered at this point	MOST STEERAGE Impact if independent
HIGH Population Health Impact	HIGH Population Health Impact	LOW ability to Impact Population Health	HIGH Impact on short-term and long-term future health	HIGH Impact on short-term and long-term future health	MODERATE ability to Impact Population Health; HIGH to avoid future surgery or readmissions	HIGH Population Health Impact

Management of Other Conditions - Behavioral Health Supports - Use of Point Solutions for In-between Care

All roads should lead back to primary care.

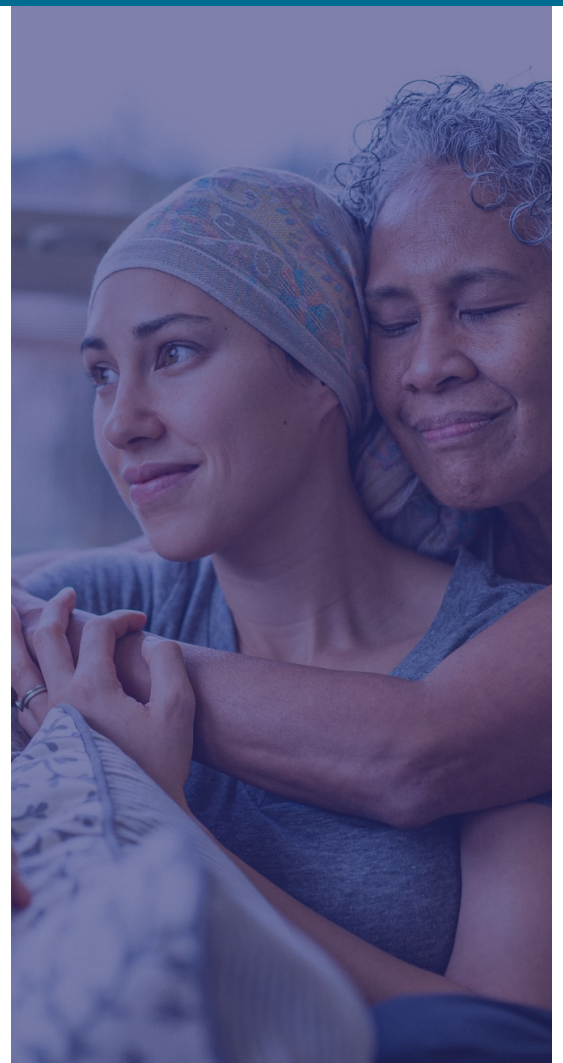
Targeting Spend (Disease Based)

We need to focus on Member Health to Improve Long-Term Sustainability.

our Top Areas of Spending

by DISEASE CATEGORIES

- MUSCULOSKELETAL (*including* ARTHRITIS)
- OBESITY
- DIABETES
- CANCER
- HEART CONDITIONS
- ARTHRITICS



2027 Benefit changes should reflect our desire to ensure members get access to HIGH-QUALITY CARE and leverage our scale.

This is A LONG GAME.

We need sustained support.

We need to target prevention for those not yet in these care buckets.

Spending Targets (Site of Care Differences)

Areas with

High Variance in Cost

that isn't driven by quality

HOSPITAL BASED vs. NON-HOSPITAL BASED IN GENERAL

IMAGING and DIAGNOSTICS

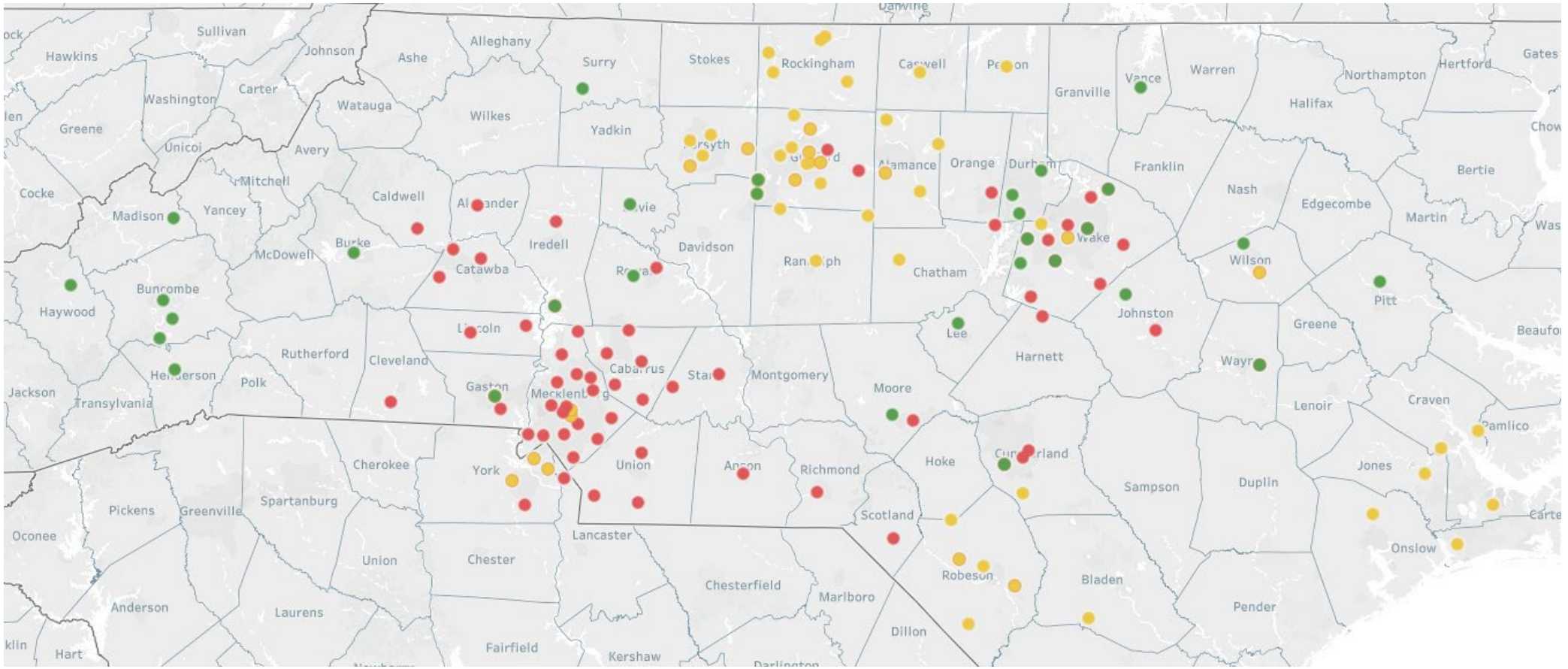
COLONOSCOPIES and LOW ACUITY, HIGH VOLUME PROCEDURES

MEDICAL Rx (INFUSIONS)

KEY CONSIDERATIONS:

GEOGRAPHIC LIMITATIONS | CAPACITY CONSTRAINTS | ALIGNING INCENTIVES

Freestanding Imaging Variation In Cost



Sample Benefit Design Changes

Aligned Incentives

PROVIDERS
MEMBERS
STATE HEALTH PLAN

Benefit Change Example

Steer MRI and Imaging volume **out of the hospital** when possible.

Servicing Provider Type	Average Cost / Visit	Portion of Services	Range of Cost / Visit Top 10 Providers	Average Plan Paid / Visit	Average Member Share / Visit
Outpatient Hospital	$1,252	54%	$900-$2,700	$624	$619
Standalone Radiology Centers	$872	46%	$500-$1,400	$344	$524
TOTAL	**$1,078**	**100%**	**n/a**	**$496**	**$576**

Current benefit is deductible and coinsurance regardless of setting, adding a $100 copay to certain facilities (i.e, hospital-based facilities with local free-standing options) could create up to 15% savings to the Plan and 10% to the member if:

- We can negotiate a VOLUME FOR RATE REDUCTION
- Significant membership (25% or more) SHIFT TO a FREE-STANDING option

PREFERRED CENTERS
make up to 15% more revenue
PREFERRED PROVIDERS
share in savings
MEMBERS pay less
THE PLAN pays less

Sample Benefit Design Changes

Preferred Providers Phase 2

PROVIDERS
MEMBERS
STATE HEALTH PLAN

Proposed Provider Provider Phase 2

- Population Health Management Support
  - Independent Pharmacy Clinically Integrated Network
  - Maternity Bundle
  - Determine next specialty CIN partners
  - Cancer Care (Lantern)
- Cost Variation Reduction
  - Imaging and Diagnostics
  - Medical Infusion (Lantern)

2027 Board Meeting Key Objectives and Next Steps

Proposed Board Agenda

- Agenda always subject to change and there will always be additional topics.
- We need to continue to focus on financial sustainability in the short-term through provider steerage, benefit design, and premiums and in the short- and long-term focus on improving member
  - **March 4 – Benefit Changes, 2025 Finances, and Strategic Plan**
  - **June 5 – RFP and Budget**
  - **July 10 – RFP and Premium Vote**
  - **December 4 – 2028 Benefit Strategy**
- What would the Board like to see more of in 2027?

Population Risk Report Appendix

North Carolina State Health Plan
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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 2024 and paid through July 2025.

Member Profiles: Risk Group Definitions

- **Non-Utilizers:** Members who did not have any medical claims
- **Healthy:** Any member with a DxCG score below 38.2
- **Minor acute:** Members without a chronic condition identified who had a DxCG score between 38.2 and 71
- **Major acute:** Members without a chronic condition identified who had a DxCG score between 71 and 240
- **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 240

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

Appendix
Regions

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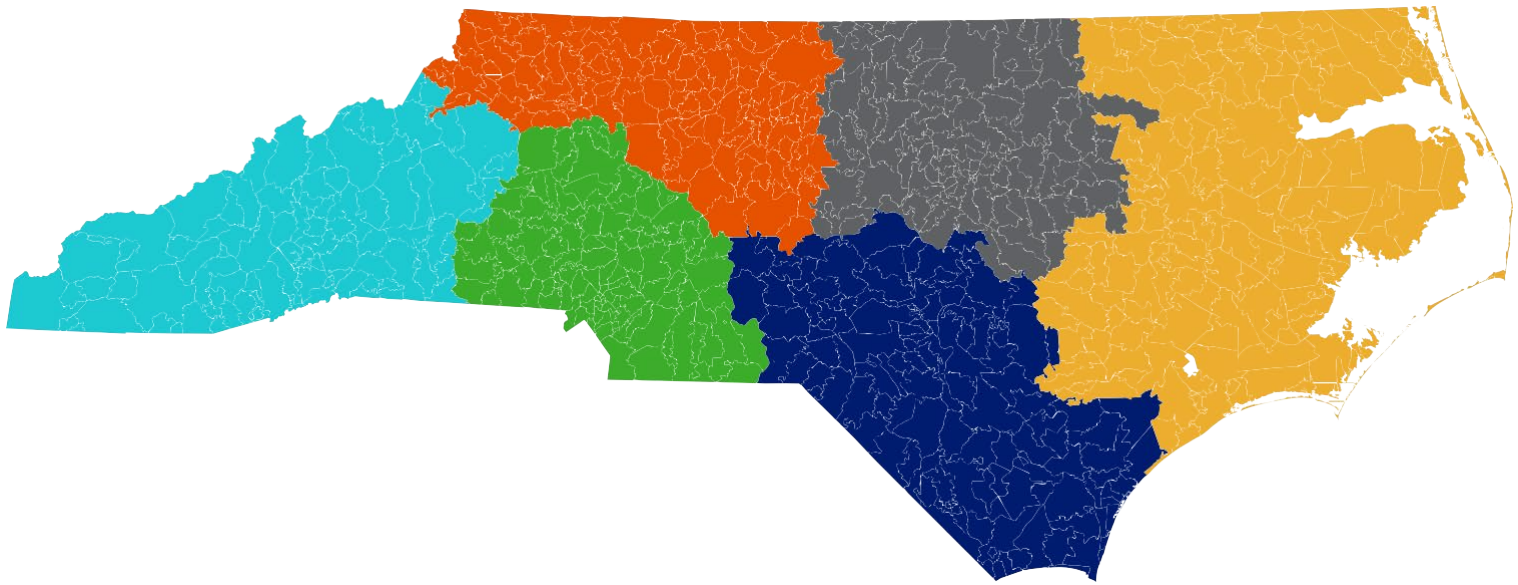
Regions



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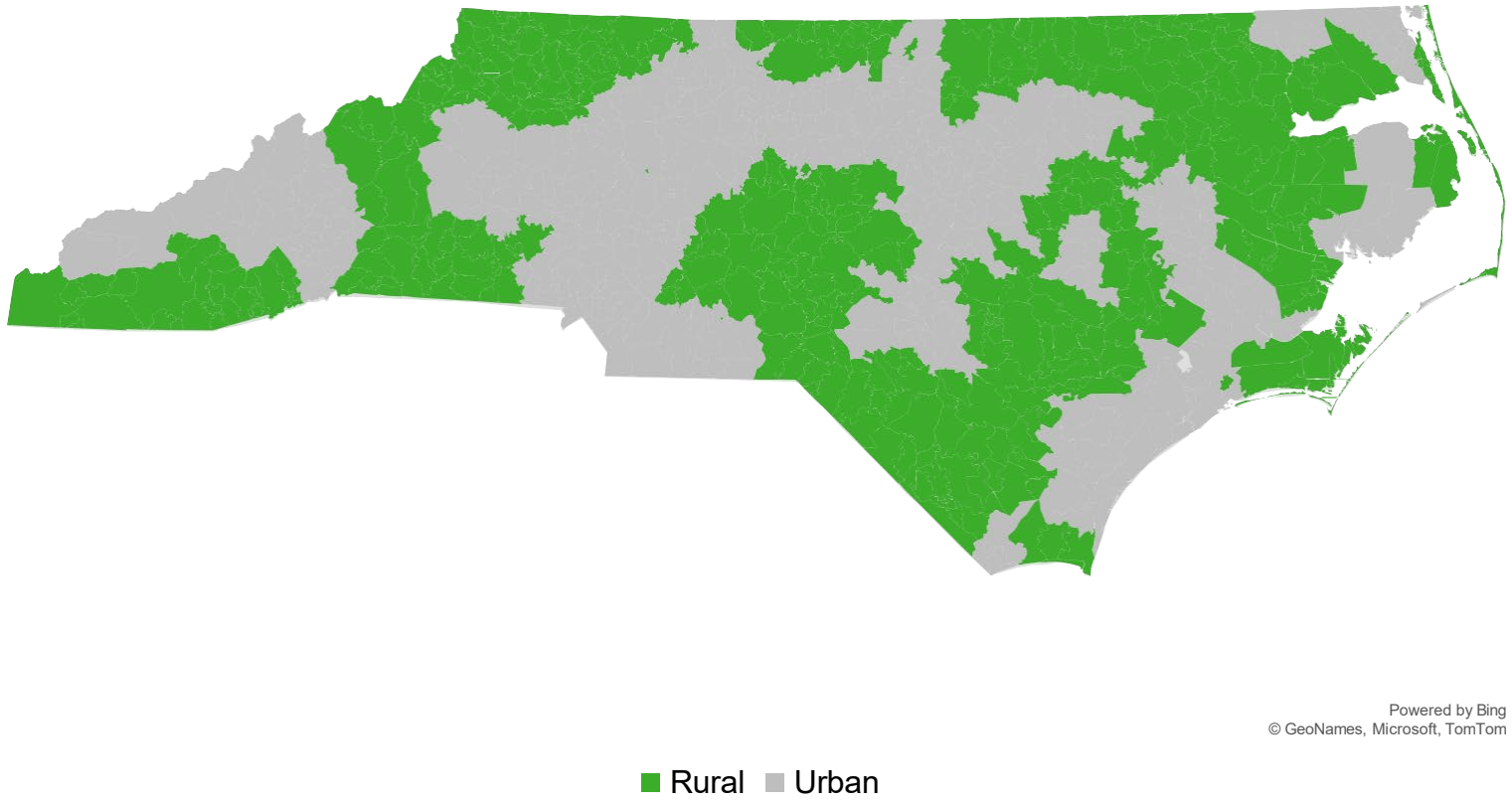
- Region 1: Western
- Region 2: Piedmont Triad
- Region 3: Metrolina (Charlotte)
- Region 4: Triangle
- Region 5: Cape Fear
- Region 6: Eastern NC

Member Counts By Region		
Region	**Member Count**	**% of Total**
Region 1: Western	51,276	9.5%
Region 2: Piedmont Triad	78,334	14.6%
Region 3: Metrolina (Charlotte)	91,963	17.1%
Region 4: Triangle	164,514	30.6%
Region 5: Cape Fear	69,760	13.0%
Region 6: Eastern NC	69,756	13.0%
Out-of-State	11,488	2.1%
Unknown	6	0.0%
Total	**537,097**	**100.0%**

Appendix
Urban vs. Rural

Urban vs. Rural



Member Counts By Region *Urban vs. Rural*			
Region	Member Count		% Rural
	Urban	Rural	
Region 1: Western	32,119	19,157	37%
Region 2: Piedmont Triad	53,659	24,675	31%
Region 3: Metrolina (Charlotte)	79,971	11,992	13%
Region 4: Triangle	141,948	22,566	14%
Region 5: Cape Fear	35,074	34,686	50%
Region 6: Eastern NC	37,569	32,187	46%
Out-of-State	8,035	3,453	30%
Unknown	6	0	0%
Total	**388,381**	**148,716**	**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

A Word About Privacy

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- 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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