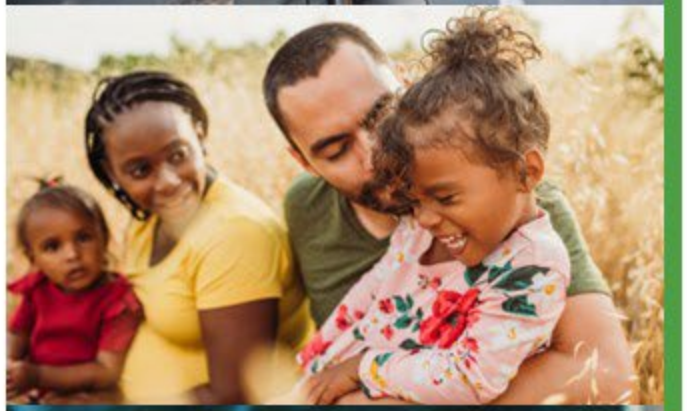

State Health Plan

Board of Trustees Meeting

March 17, 2026

North Carolina State Health Plan
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Presentation Overview

- Executive Administrator Update
- Strategic Planning
- Financial Reports
- 2027 Benefit Strategy

Executive Administrator Update

Medicare Advantage Enrollment

- Historically, the Plan has used auto-enrollment during Open Enrollment to encourage participation into one of the Medicare Advantage Plans, but there hasn't been consistency in the enrollment strategy from year to year.
- The Plan continues to generate significant savings ($4,700) per member, per year for each member that enrolls into one of our Medicare Advantage plans.
- For this population, CONSISTENCY IS KEY.
- Therefore, the Plan will auto-enroll the Medicare 70/30 Plan population into the Base Medicare Advantage Plan each year.

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Preferred Provider Program

Next Steps

- PHASE ONE: Specialty Clinically Integrated Network – *COMPLETE*
- PHASE TWO FOCUS: Maternity
- PHASE TWO FOCUS: Dermatology
- PHASE TWO FOCUS: Independent Pharmacy

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Lantern Benefit Open Cases – 1,848

OPEN CASES AS OF MARCH 4, 2026

Spine 78	Bariatrics 488	Joint Replacement 400	Orthopedic 433	Cardiac 1
General Surgery 168	Gastroenterology (GI) 32	Spine and Ortho Injections 68	Gynecology (GYN) 87	Ear, Nose & Throat (ENT) 93

PENDING PROCEDURES - 319

- Joint Replacement – 110
- Bariatric – 69
- GI – 13
- GYN – 9
- General – 31
- Orthopedic – 70
- ENT – 8
- Spine – 7
- Pain Management – 2

COMPLETED PROCEDURES | 406 as of March 4, 2026

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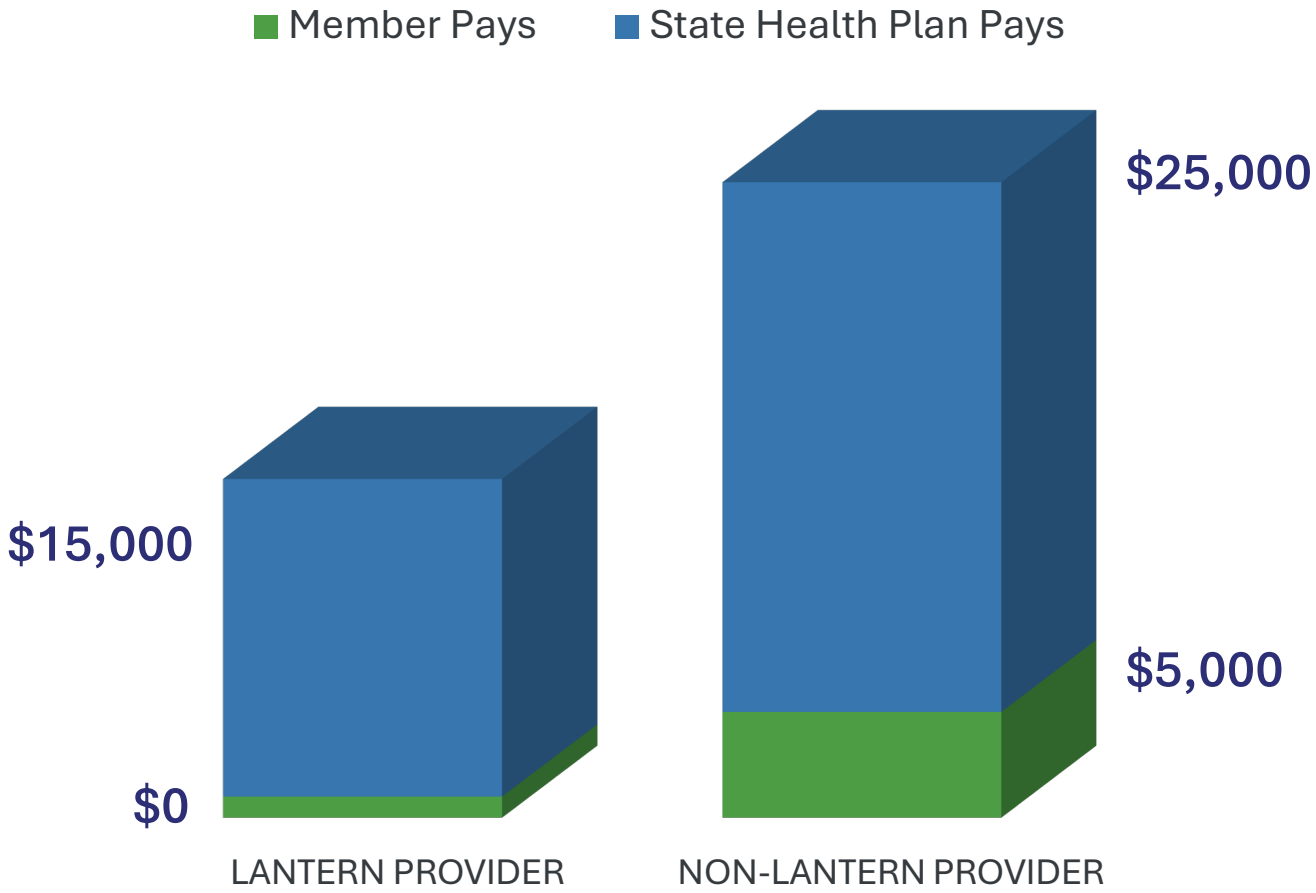
LANTERN

Lantern Surgical Benefit Savings Example



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LANTERN

Medical Policy Advisory Committee

Inaugural meeting of the committee took place February 25, 2026.

- The committee will serve in an advisory capacity to the State Health Plan, offering independent, physician-led clinical insight on benefit design and medical policy decisions.
- The committee is comprised of 17 voting members — all licensed physicians representing a variety of medical specialties across North Carolina.
- Additional information about the advisory committee is posted on the Plan's website.

Medical Policy Advisory Committee

You can view and download information from current and recent Medical Policy Advisory Committee meetings.

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Point Solutions

- Last year, the Plan launched several point solutions to improve health for some of our most vulnerable members and as a strategy to reduce overall cost.
- As we look ahead, we are excited to dig into the evaluation component of these solutions to determine if we're meeting the goals and objectives behind these programs along with the financial impacts they've having.
- When we evaluate, we're looking at data in intervals of:
  - 6 months
  - 12 months
  - 18 months
- Plan staff will report back to the board as evaluation measures are complete.

LANTERN

Hinge Health

Hello Heart

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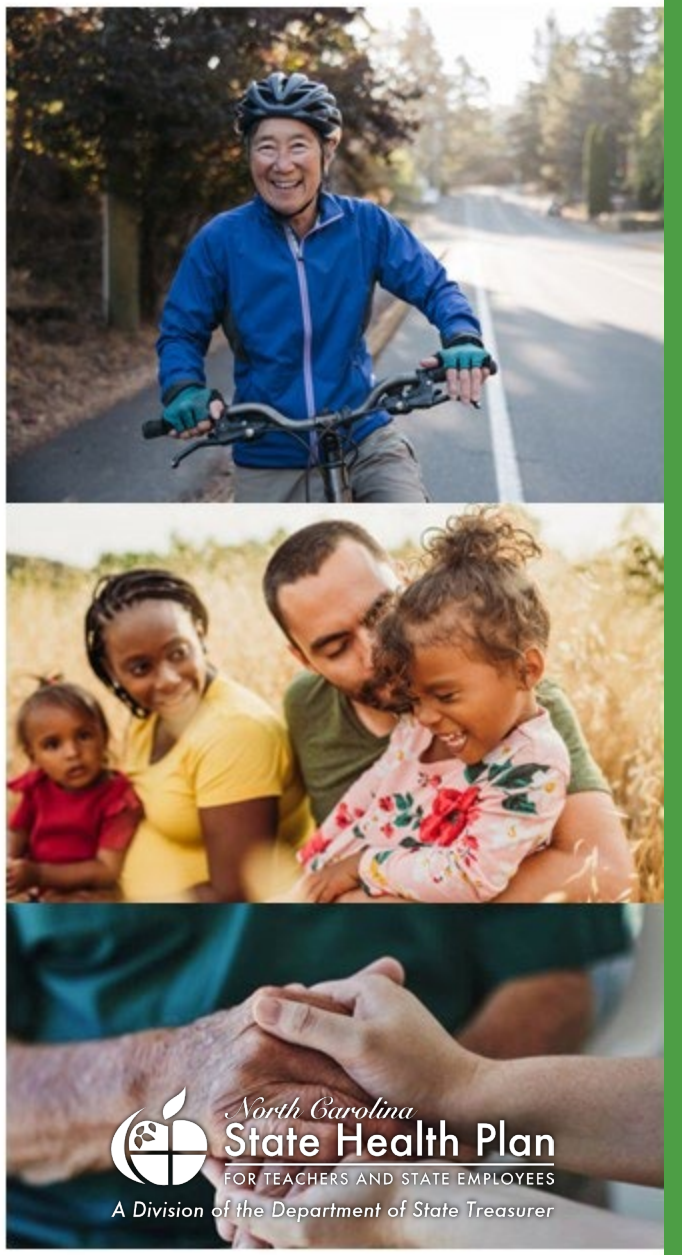


Strategic Planning

State Health Plan Strategic Priorities

1 Protect Affordable Premiums and Stable Benefits

WHAT IT MEANS:

The Plan is committed to keeping health coverage affordable and dependable over time. That means carefully managing health care costs, so member premiums do not increase faster than salary increases, benefits stay strong, and members are not faced with sudden increases or reductions in coverage.

WHAT WE WILL DO:

- Focus on the biggest drivers of health care costs—such as hospital, specialty, and pharmacy expenses—to reduce spending that can lead to higher premiums.
- Moving from a passive payer of claims to an active purchaser with the Plan's medical and pharmacy partners to ensure members receive high-quality care at the best possible value.
- Reward providers for improving health and delivering high quality care, not volume of care they deliver, so members are not paying more for services that do not improve health.
- Build working, transparent, and understandable definitions of quality so that members, providers, and the Plan can align.
- Share responsibility for rising health care costs and cost improvements among providers and members (vs. just the member) to avoid placing an unfair burden on any one group, especially members. Historically, the member and the Plan have borne the brunt of cost increases with no accountability on the provider's side. A shared model of responsibility will push toward aligned incentives.
- Work with stakeholders to best define and implement how salary increases can be tied to premium increases to provide stability and avoid price shocks for members, with special attention paid to those with the least financial resources.
- Incent the behaviors necessary to keep costs low by creating immediate financial rewards for using preferred providers.

State Health Plan Strategic Priorities

2 Help Members Achieve Better Health

WHAT IT MEANS:

The Plan wants to support members wherever they are in their health journey whether it's staying healthy, managing a chronic condition, or working to manage a catastrophic illness. The Plan must make it easier for members to take key health-related actions by connecting those actions to enhanced benefits and lower out-of-pocket costs in a fiscally sustainable manner.

WHAT WE WILL DO:

- Align incentives between the members, providers, and the Plan that reward quality and outcomes rather than volume.
- Work with primary care providers to improve appointment access, care coordination, and participation in value-based care models that focus on better outcomes for members.
- Deploy specialized, condition-specific member support for the management of certain conditions like congestive heart failure and diabetes using digital point solutions to engage members at key moments—such as diagnosis, treatment decisions, or care transitions with timely, relevant support. The majority or all of the cost associated with the tools will be borne by the Plan as an investment in health.
- Invest in multimodal patient navigation, so as the Plan's benefit design changes, we optimize communication to members to assist them in making their best choice.

State Health Plan Strategic Priorities

3 Ensure Members Have Access to Care

WHAT IT MEANS:

The Plan is working to make getting care easier no matter where members live in a fiscally sustainable manner. By reducing geographic and logistical barriers, the Plan will help members access primary care, specialists, and mental health services in ways that are convenient, timely, and close to home. We must strive to break down barriers and improve care options for rural and urban members. Access isn't limited to distance driven to care; it is also measured by affordability and times to appointments. Practices with nine month wait times for an appointment that costs $2,000 are not more accessible if it is one mile away than 500 miles away.

WHAT WE WILL DO:

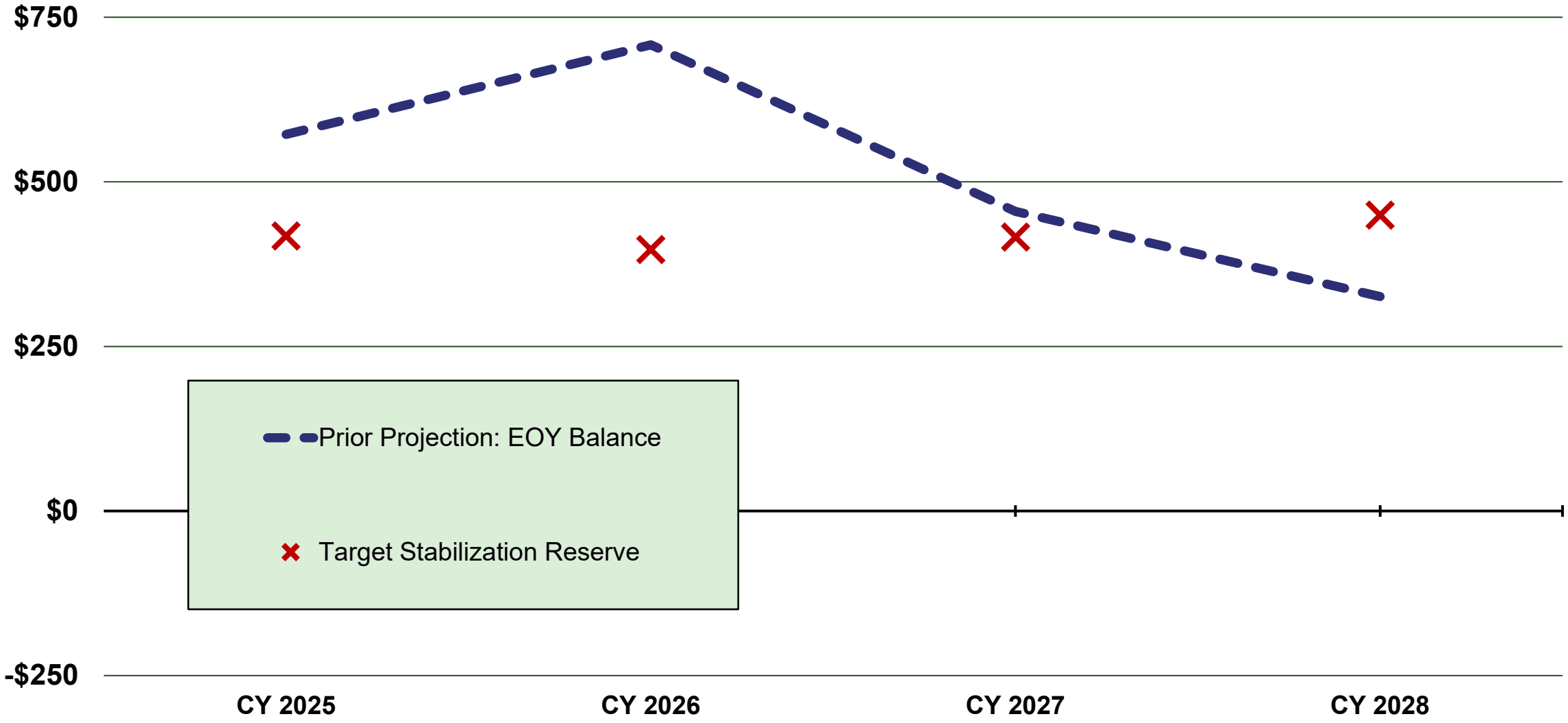
- Bring care to members who need it by expanding digital health options such as e-consults, telehealth, remote patient monitoring, and home-based care to improve access and support better health outcomes.
- Ensure members in rural and underserved areas have reliable access to high-quality care without having to travel long distances to respect the unique aspects of all North Carolinians' health care journey using digital solutions, virtual care, and bringing mobile care to communities.
- Encourage and incent providers to offer more accessible care options, including extended hours and weekend scheduling, shorter wait times by preferencing treatment to Plan members, and virtual visits, so members can get care without unnecessary delays.
- Expand awareness and use of collaborative care models, where common mental health conditions such as anxiety and depression can be treated in primary care and medical settings, reducing barriers to mental health support.

Financial Reports

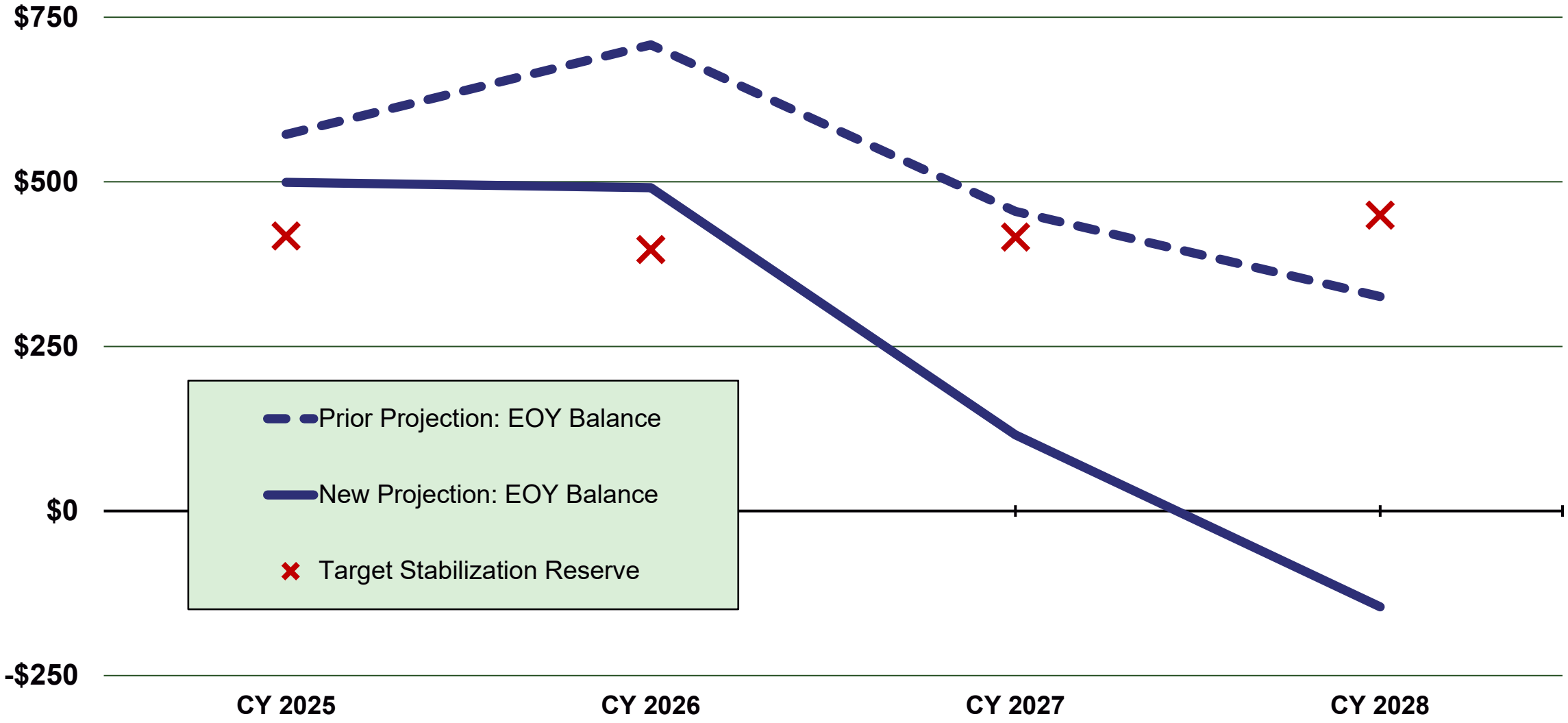
Projection vs. Budget: Calendar Year 2026

($s in millions)	CY 2026 Q4 Projection	CY 2026 Q3 Projection	Difference
Premiums & Subsidies	$4,731.4	$4,807.1	($75.7)
Investment Earnings	$18.1	$24.2	($6.1)
Total Revenue	**$4,749.5**	**$4,831.4**	**($81.9)**
Net Medical Claims	$3,539.7	$3,493.3	$46.4
Net Pharmacy Claims	$869.5	$851.0	$18.5
Medicare Advantage Payments	$164.2	$165.8	($1.6)
Administrative Expenses	$184.1	$185.0	($0.9)
Total Expenses	**$4,757.6**	**$4,695.2**	**$62.4**
Plan Income/(Loss)	**($8.1)**	**$136.2**	**($144.3)**
Ending Cash Balance	**$491.1**	**$708.1**	**($217.0)**

Financial Projection Update



Financial Projection Update



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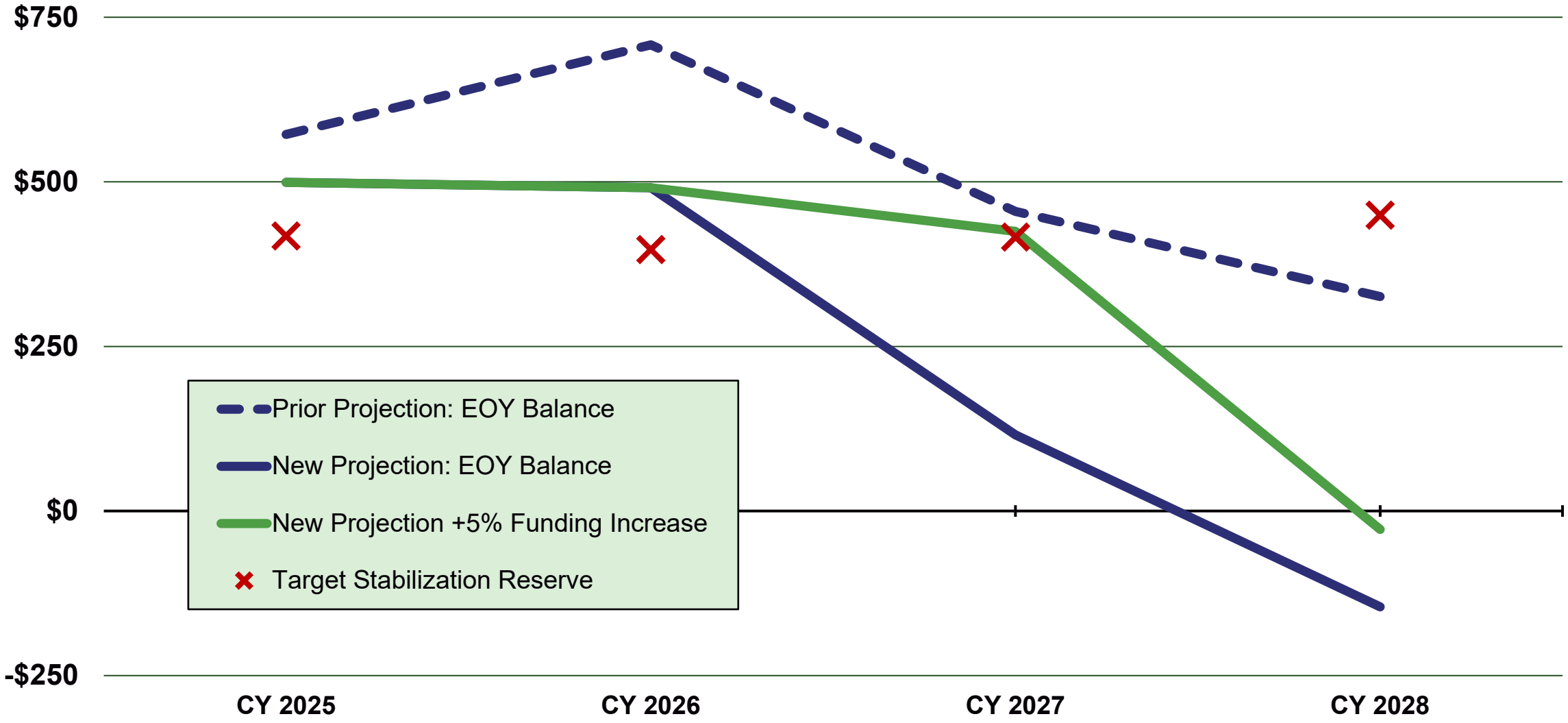
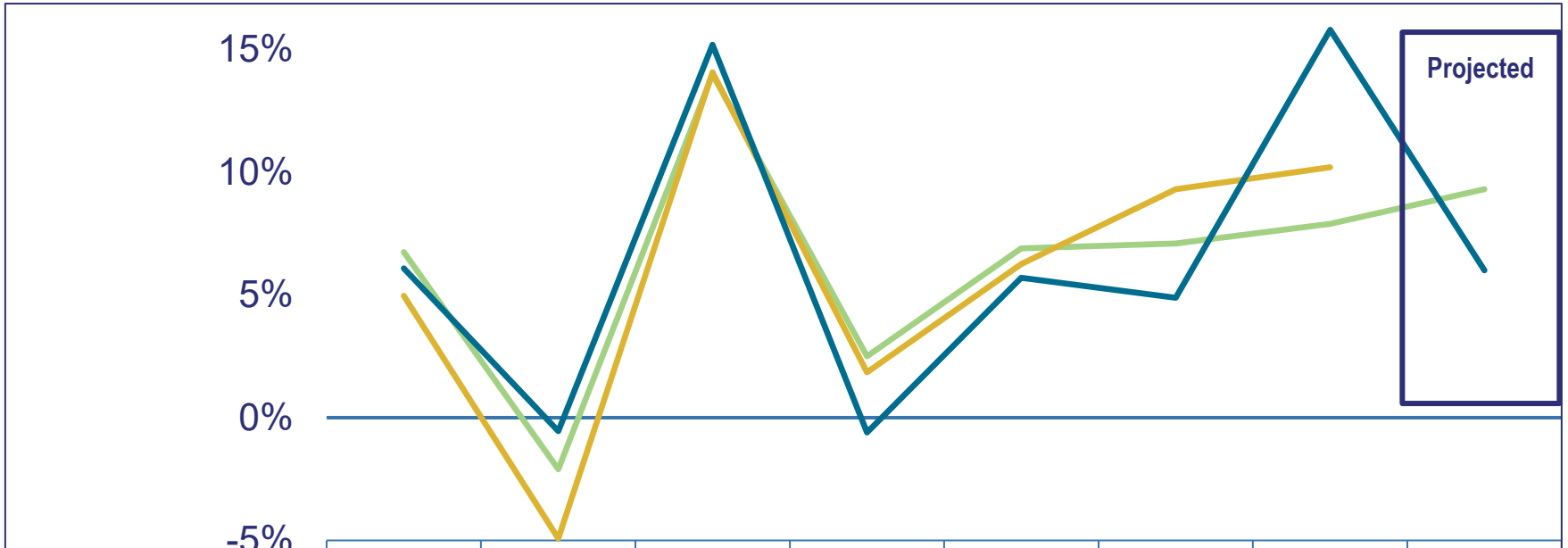


Medical Trends – Comparison to State Health Plan

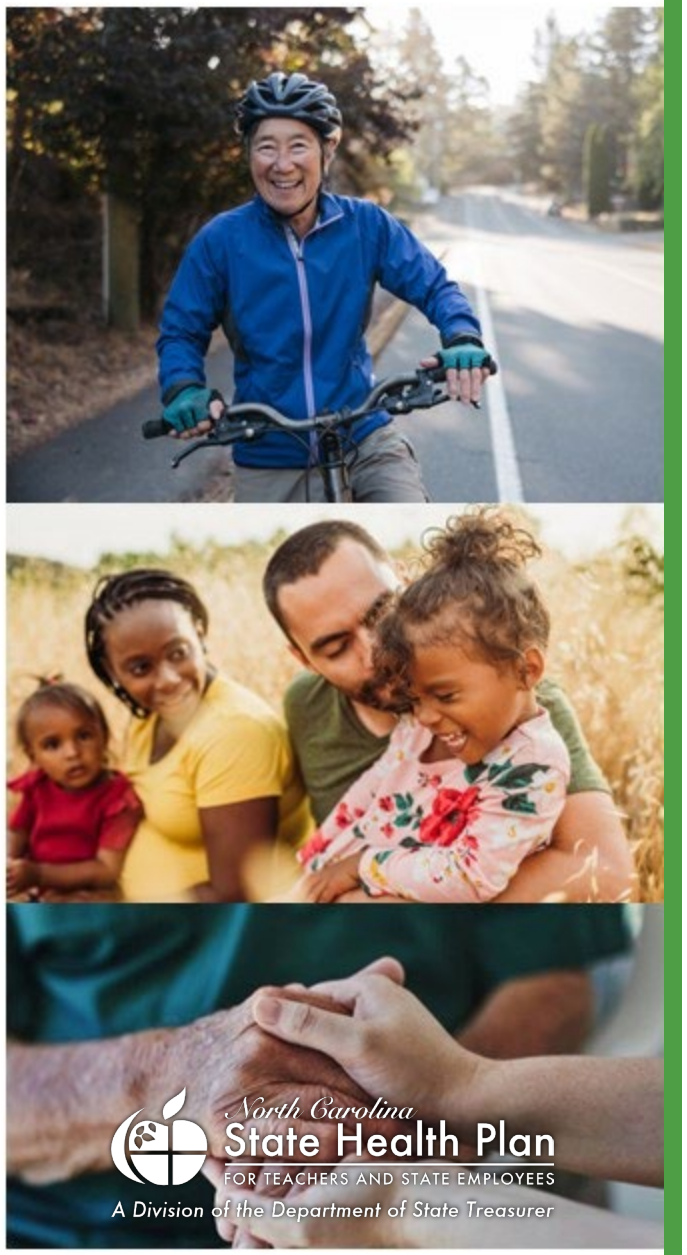


	2019	2020	2021	2022	2023	2024	2025	2026
Trend Survey	6.8%	-2.1%	14.0%	2.5%	6.9%	7.1%	7.9%	9.3%
SHAPE - PS	5.0%	-4.9%	14.1%	1.9%	6.3%	9.3%	10.2%	
NCSHP	6.1%	-0.6%	15.2%	-0.6%	5.7%	4.9%	15.8%	6.0%

Source: 2026 *Segal Health Plan Cost Trend Survey*

- 2025 trend includes actual data through January 2026, and projections of claims incurred in 2025 that had not been reported by the end of January.
- The Plan's trend was below comparisons from 2022-2024 but was significantly higher than comparisons in 2025.
- From 2018 to 2024, the Plan's annualized trend rate was 5.0%, slightly lower than the SHAPE–PS trend of 5.1% and the Segal Trend Survey rate of 5.7%.

Trend Survey is the Segal trend survey, and SHAPE – PS is the Public Sector Book of Business.



2027 Benefits

The Future State of Premium Growth

Moving to salary-based premiums set the stage to tie Premium Increases to Wage Increases.

Once stabilized, our goal is to move towards a structure that ties premium growth to wage growth.

EXAMPLE:

Currently, a member making $55,000 pays:

- $94 a month (~2% of salary) for Enhanced coverage, and
- $50 a month (~1% of salary) for Standard coverage

If that member gets a 1% RAISE to $55,550, they could expect a PREMIUM INCREASE OF 1%

- $94.94 a month (~2% of salary) for Enhanced coverage, and
- $50.50 a month (~1% of salary) for Standard coverage

How We Got Here

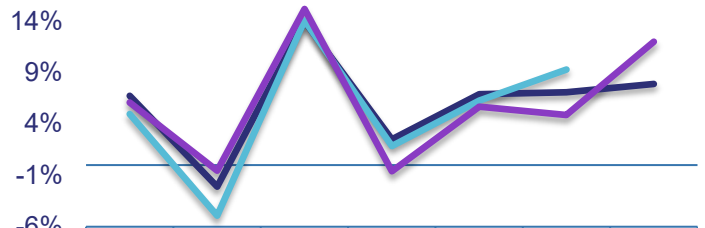
2025

We closed a $507M deficit and are working on $1.4B deficit.

Members Providers General Assembly

2026

Medical and Pharmacy Trends



	2019	2020	2021	2022	2023	2024	2025
Trend Survey	6.8%	-2.1%	14.0%	2.5%	6.9%	7.1%	7.9%
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%

vs Funding

Members Providers General Assembly Partners

Looking Ahead

We Have a Cost Problem

Narrow Provider Approach

– OR –

Decrease Benefits

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Managing Cost: *We're ALL in this Together*

Providers, the State Health Plan, and members all have a role in REDUCING COST GROWTH.

Managing cost growth and maintaining long-term affordability and sustainability will take a COLLABORATIVE EFFORT between our stakeholders.

The Plan needs appropriate incentives and disincentives built in for both providers and members.

Key incentive areas for providers:

PATIENT STEERAGE | REVENUE | DATA | FLEXIBILITY

We will ONLY be SUCCESSFUL IF members choose to access, and are able to access, Preferred Providers or engage in health improvement activities. Healthier members are better for ALL parties.

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

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

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Evolution of the Plan Comparison

	2012		2026	
SERVICES	BASIC (70/30)	STANDARD (80/20)	STANDARD	PLUS
ANNUAL DEDUCTIBLE	$933 Individual $2,799 Family	$700 Individual $2,100 Family	$3,000 Individual $9,000 Family	$1,500 Individual $4,500 Family
COINSURANCE	30% of eligible expenses after deductible	20% of eligible expenses after deductible	30% of eligible expenses after deductible	20% of eligible expenses after deductible
PRIMARY CARE PROVIDER (PCP)	$35	$30	$15 Preferred / ID card $40 Other PCP / ID card $50 Other PCP	$10 Preferred / ID card $30 Other PCP / ID card $40 Other PCP
SPECIALISTS	$81	$70	$50 Preferred Provider $94 Other Provider	$40 Preferred Provider $80 Other Provider
OUTPATIENT HOSPITAL	$0 30% after deductible	$0 20% after deductible	$350 then 30% after deductible	$300 then 20% after deductible
INPATIENT HOSPITAL	$291 then 30% after deductible	$233 then 20% after deductible	$600 then 30% after deductible	$500 then 20% after deductible
AMBULATORY	Deductible / Coins	Deductible / Coins	Deductible / Coins	Deductible / Coins
WALK-IN CLINIC	$87	$87	$100	$70

How We Think about Access and Accessibility

- Access isn't EQUAL or EQUITABLE in NC.
- Most rural patients are ALREADY TRAVELING for care so "disruption" looks different than some might indicate.
  - Despite three options in Brunswick county, YTD only 4% of members get their images in Brunswick county preferring New Hanover and Durham.
  - YTD 77% of members in Henderson county go to Buncombe or Burke for care despite imaging at Advent and UNC Pardee.
- Quality varies.
- Prices vary significantly.
- Capacity varies significantly.
- Over time we can MANUFACTURE ACCESS TO MORE rural communities with low utilization, high cost, and limited access.

Where is the Care Delivered?

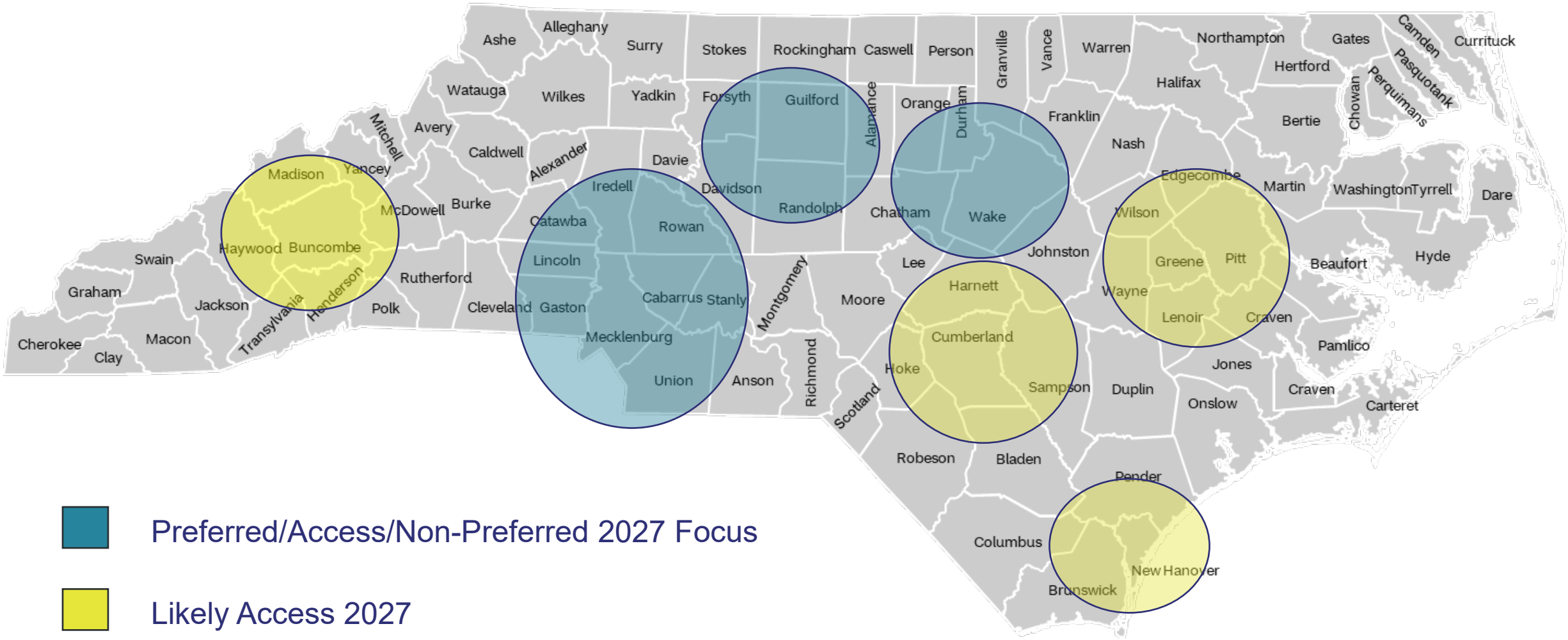
70% of Care is Delivered in 10 COUNTIES.

83% of Care is Delivered in 20 COUNTIES.

County	# of TIN Owner	Sum of SERVICES
Wake	24	8,563
Durham	11	7,157
Orange	6	5,526
Mecklenburg	25	5,601
Forsyth	12	4,679
Pitt	8	4,656
Guilford	16	2,561
New Hanover	8	2,156
Catawba	9	1,334
Buncombe	10	1,264
Grand **TOTAL**	**127**	**43,497**

Primary focus for Preferred Provider Tier and High-cost Tier.

Preferred Provider Focus Areas (Non-PCP)



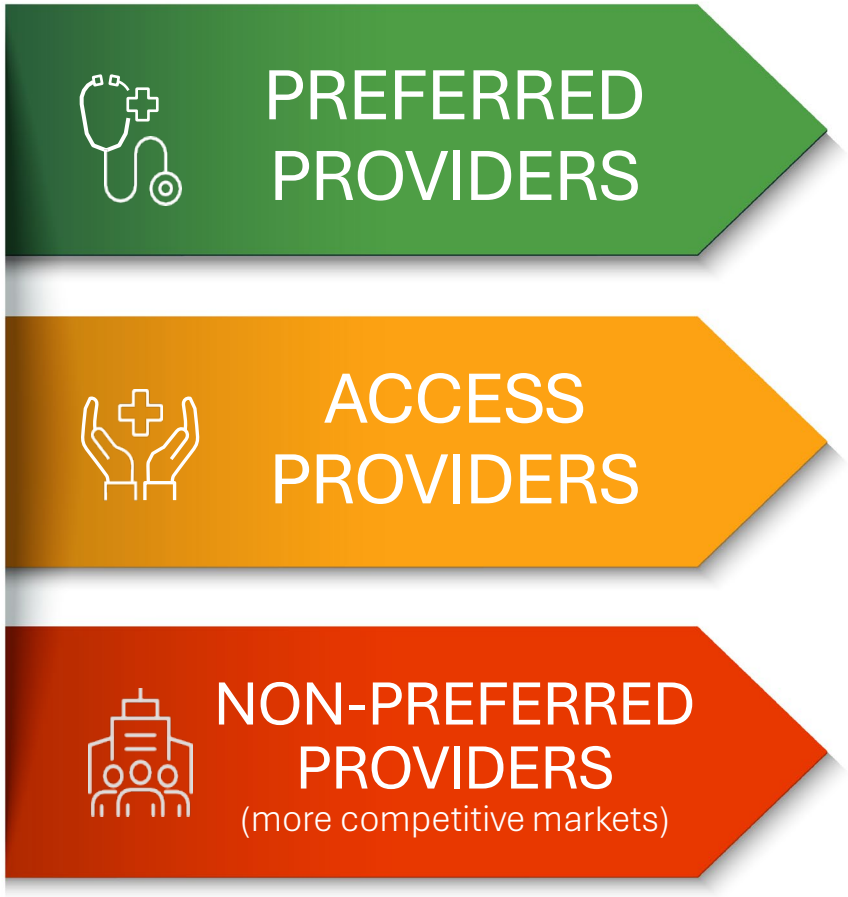
Preferred/Access/Non-Preferred 2027 Focus

Likely Access 2027

Access Communities

Looking Ahead: Three Tier Structure Proposal

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



- Focuses on reducing total cost of care and improving health outcomes
- Trades volume and reduced cost-sharing for discounts and/or a share of savings
- Not all providers can be included in a given geography
- Can be specific to a specialty to play to provider strengths

- Maintains essential access points in rural areas and outside of NC with limited provider options
- Doesn't apply to all specialties or services based on member utilization and price
- Maintains the current benefit integrity
- Median cost provider options is the target

- Higher cost providers who have not participated in the preferred provider program, where lower cost access providers are available
- Misaligned incentives

Aligning Incentives

The BENEFITS

- MEMBER – At point of care, member saves first if they choose a Preferred Provider. Neutral if they utilize an Access Provider and will spend significantly more for a higher cost provider option when a lower option is available.
- PROVIDERS – Preferred Providers make more revenue. Access Providers make the same, and higher-cost providers make less revenue. Creates PROVIDER INCENTIVE to lower costs.
- PLAN – This translates to lower premium increases, lower employer contribution increases, share savings, and investments in population health.

The RISKS

- If members don't change their care patterns where possible THEY WILL PAY MORE.
- Lowers ability to manage premium growth, employer contribution growth and invest in health.
- Disincentivizes future provider discounts.

We're all in this together – Aligning Around Incentives

	Preferred Provider	Access Provider	Non-preferred Provider	TOTAL	Preferred Provider	Access Provider	Non-preferred Provider	TOTAL
	CURRENT BASE				BIG SHIFT			
Member Utilization	100	100	100	300	200	75	25	300
Cost-Share (Avg) ▪ Allowed ▪ Plan ▪ Member	 $2,000 $1,500 $500	 $2,500 $1,950 $550	 $4,500 $3,900 $600		 $1,500 $1,300 $300	 $2,500 $1,950 $550	 $4,500 $3,700 $800	
Total Spend ▪ Allowed ▪ Plan ▪ Member	 $200,000 $150,000 $50,000	 $250,000 $195,000 $55,000	 $450,000 $390,000 $60,000	 $900,000 $735,000 $165,000	 $300,000 $240,000 $60,000	 $187,500 $146,250 $41,250	 $112,500 $92,500 $20,000	 **$600,000** **$478,750** **$121,250**

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Three Tier Structure Proposal

SERVICES	2026 STANDARD	2026 PLUS	PROPOSED 2027 STANDARD	PROPOSED 2027 PLUS
ANNUAL DEDUCTIBLE	$3,000 Individual $9,000 Family	$1,500 Individual $4,500 Family	Preferred Access Non-preferred	Preferred Access Non-preferred
Out-of-Pock Maximum	$6,500 Individual $16,300 Family	$5,000 Individual $15,000 Family	Preferred Access Non-preferred	Preferred Access Non-preferred
PRIMARY CARE PROVIDER (PCP)	$15 Preferred / ID card $40 Other PCP / ID card $50 Other PCP	$10 Preferred / ID card $30 Other PCP / ID card $40 Other PCP	No Change	No Change
WALK-IN CLINIC	$100	$70	Fold into PCP Benefit	Fold into PCP Benefit
SPECIALISTS	$50 Preferred Provider $94 Other Provider	$40 Preferred Provider $80 Other Provider	Preferred Access Non-preferred	Preferred Access Non-preferred
IMAGING	Deductible / Coins	Deductible / Coins	$XXX* / $XX* / $XX* *then 30% after deductible	$XXX* / $XX* / $XX* *then 20% after deductible
OUTPATIENT SURGERY	$0 Lantern $350 then 30% after deductible	$0 Lantern $300 then 20% after deductible	$0 Lantern / $XX* / $XX* *then 30% after deductible	$0 Lantern / $XX* / $XX* *then 20% after deductible
INPATIENT HOSPITAL	$600 then 30% after deductible	$500 then 20% after deductible	$XXX* / $XX* / $XX* *then 30% after deductible	$XXX* / $XX* / $XX* *then 20% after deductible
AMBULATORY	Deductible / Coins	Deductible / Coins	$0 Lantern / $XX* / $XX* *then 30% after deductible	$0 Lantern / $XX* / $XX* *then 20% after deductible

Out-of-Pocket Maximum

The out-of-pocket (OOP) maximum is the maximum amount a member will pay in a year.

CURRENTLY, the Plus and Standard PPO Plans have two separate OOPs:

- In-network OOP
- Non-network OOP

When a member goes to a non-network provider their OOP costs apply to both the non-network and in-network OOP.
When they go to an in-network provider, their OOP costs only apply to the in-network OOP.

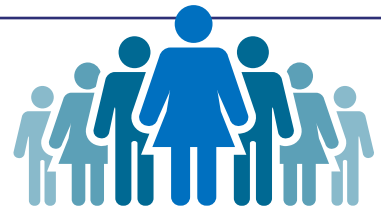
IN 2027, the Plan intends to tier the in-network OOP. Each tier will cross-accumulate with the other. The non-network OOP will be separate.

Cross-Accumulation

Tier	OOP Maximum	Member utilizes a Tier 1 Provider and incurs $1,000 charge	Same member then goes to Tier 3 Provider and incurs a $5,000 charge	Same member then goes to Non-network Provider and incurs a $1,500 charge
		EXAMPLE: **After Tier 1 Claim ($3,000)**	*EXAMPLE:* **After Tier 3 Claim ($5,000)**	*EXAMPLE:* **After Non-Network Claim ($1,500)**
Preferred (In-network)	**$3,000**	$3,000 / $3,000 (Satisfied)	Satisfied	Satisfied
Access (In-network)	**$5,000**	$3,000 / $5,000	$5,000 / $5,000 (Satisfied)	Satisfied
Non-Preferred (In-network)	**$9,000**	$3,000 / $9,000	$3,000 + $5,000 / $9,000 (Satisfied)	$1,000 remaining
Non-network	**$10,000**	$0 / $10,000	$0 / $10,000	$1,500 / $10,000

Alternate Paths

Paths	Advantages	Disadvantages
Across the board rate cuts, or tie to Medicare (CPP 2.0)	▪ Less work on the member ▪ Doesn't impact member choice ▪ Predictable	▪ Most providers where we spend money already said "No" and consent is important ▪ Don't have unilateral authority to do it ▪ No timeframe where this could be executed ▪ Doesn't align incentives or motivate
Narrow Network	▪ Different communication work ▪ Deeper discounts driving costs down further	▪ Capacity constraints ▪ Removes most choice ▪ Politically sensitive ▪ Risks subspecialty access
All in on value-based care	▪ Focus most on health ▪ Aligns incentives	▪ Provider readiness ▪ Technology readiness ▪ Upfront costs, not savings



Example Member Journey *and* Treatment Pathway

67-year-old Member Potential Heart Condition

Eastern NC | Plan Type

MOST EXPENSIVE Journey

- PCP Annual Visit
  Large Health System
- Associated Lab Tests
  Large Health System
- Specialist Referral
  Outpatient Clinic
- Imaging / Diagnostics
  Outpatient Clinic
- Care Plan / Rx Management
  Outpatient Clinic
- Possible Intervention
  Inpatient Surgery
- Rehabilitation & Recovery
  Outpatient Clinic
- Long-Term Monitoring
  Large Health System

MOST COST-EFFECTIVE Journey

- PCP Annual Visit
  Large Health System
- Associated Lab Tests
  Large Health System
- Specialist Referral
  Outpatient Clinic
- Imaging / Diagnostics
  Outpatient Clinic
- Care Plan / Rx Management
  Outpatient Clinic
- Possible Intervention
  Inpatient Surgery
- Rehabilitation & Recovery
  Outpatient Clinic
- Long-Term Monitoring
  Large Health System

Looking Ahead
Between Now and Premium Vote

- Finalize key provider contracts and identify next round of negotiations
- Determine cost-sharing incentives
- Launch the PCP Care Coordination Tool
- P&T Committee and Formulary Revisions
- Administrative Cost Savings
- PBM and TPA RFP review
- Monitor Spend
- Track budget process

How We Plan to Mobilize and Drive Engagement

- Bank on people thinking with their wallets
- Communication strategy touchpoints
  - Open Enrollment
  - Stakeholder Partners
  - Primary Care
  - Specialty Network
  - Lantern Outreach
  - Care Advocates and Patient Navigators

2027 Benefits Vote

- Vote to approve the implementation of a three-tier provider network outlined on slide 32.
- Vote to approve out-of-pocket maximums outlined on slide 33.
- Cost Sharing Final vote will take place in May/June.

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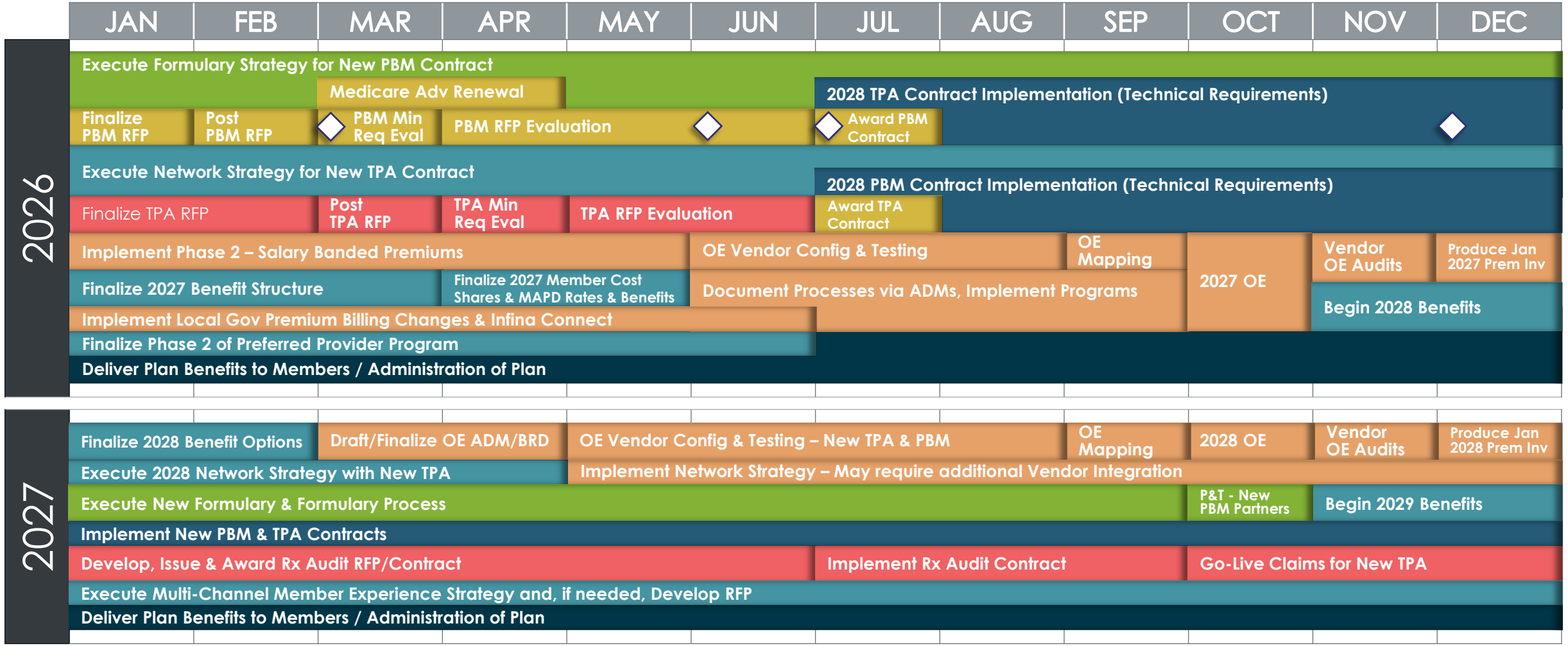
Appendix

2-YEAR PROJECT CHART – STATE HEALTH PLAN



2026 BOT Meetings

BOT 1 – March
BOT 2 – June
BOT 3 – July
BOT 4 – *(if needed)*
BOT 5 – December

- Business/Leadership, Analytics/Strategy
- Ops Teams & Vendors
- Finance, Data, Ops/EDI & Vendors
- **ALL** Plan Teams
- Ops, Finance & Contracting, Analytics/Strategy
- Ops, Contracting, Analytics/Strategy
- Pharmacy Team & Finance