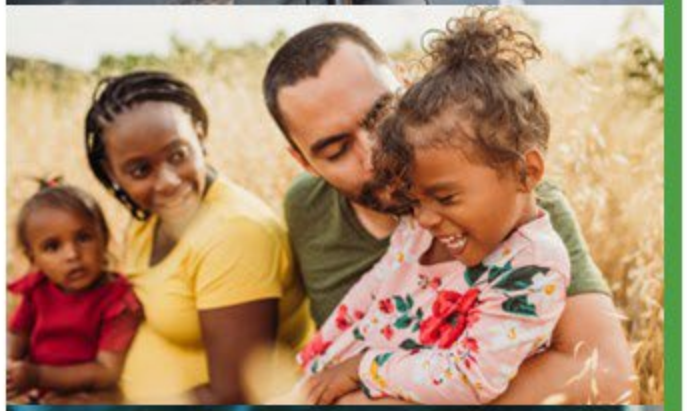


State Health Plan

Board of Trustees Meeting

May 20, 2025

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

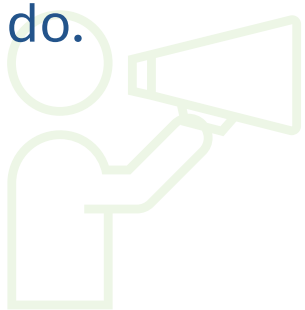
Presentation Overview

- Executive Administrator Update
- Legislative Update
- Provider Engagement Update
- Benefits Strategy and 2026 Plan Design Comparison
- Financial Update

Executive Administrator Update

Since Our Last Meeting

- We've begun to communicate the ending of the Clear Pricing Project (CPP) to providers and are working to determine what comes next.
    - We are not going to have all the answers for 2026.
- We've reached a threshold on new things, point solutions, and pilots. There is a lot to work on and potentially bigger challenges ahead; we need to continue to be operationally excellent.
- We've welcomed/welcoming 4 new staff members and still have 8 outstanding positions. If you love state service and have deep expertise, we'd love to have you!
- We are making progress on the provider front, but we still have more work to do.



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Follow-ups and Clarifications

- We are doing away with the Tobacco Credit and giving members the full credit of the benefit.
- Prior Authorization was a big discussion at the last Board Meeting. We are working to remove all medical prior authorizations for identified preferred provider practices.
- Medical plan changes we are discussing today apply to both Active, Non-Medicare and Medicare members.
- Plan staff have been working on premium projections and we're trending positive based on Plan design changes and renewal information.

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How We Envision Growth Going Forward?

- Builds on what we are prioritizing (Bundling and Independent Primary Care).
- Brings quality access to communities where it does not exist.
- Scalable across the state.
- Push patients to the lowest cost, least invasive care setting (local, in-home, primary care, etc.).
- Aligns financial incentives in a sustainable manner.

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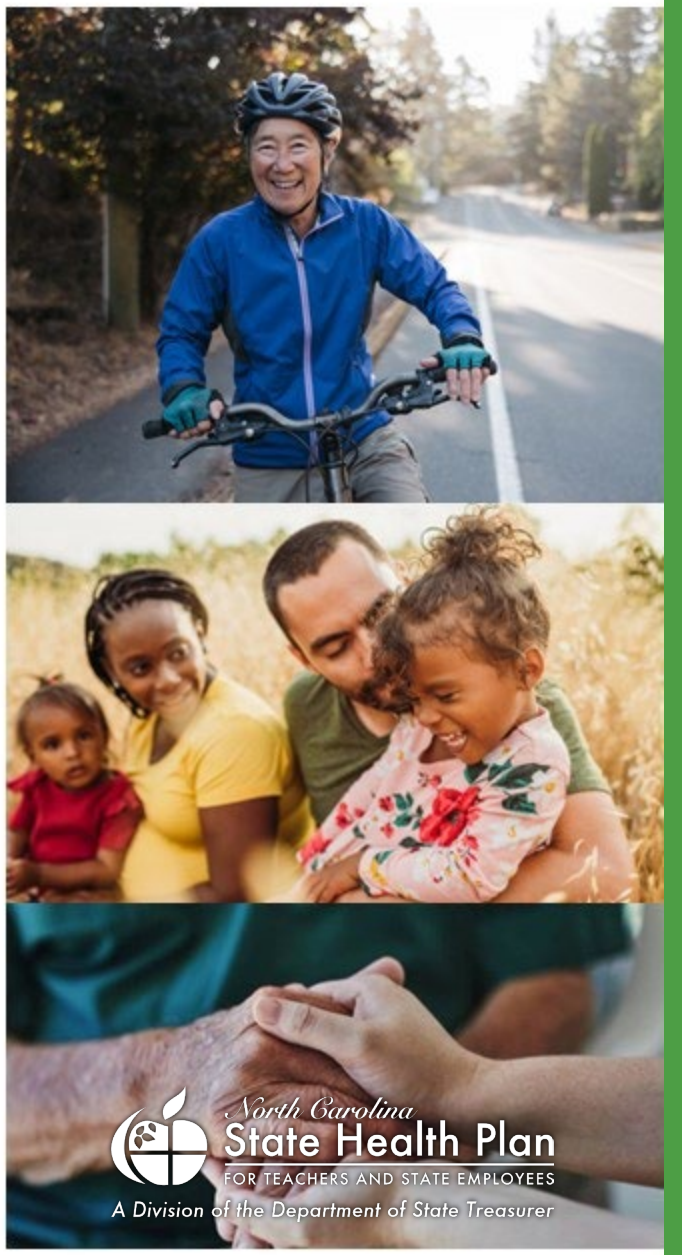


Legislative Update

Provider Engagement Update

PRINCIPLES for SUCCESS

Build a sustainable model that allows the State Health Plan (SHP) to address health care costs while improving health outcomes. This model supports high-quality, high-access independent practices to thrive and retain their independence.

Access to care required for success; the Plan will focus on:

- Most FAVORABLE COST-SHARING to incent members
- MONTHLY PAYMENTS for greater financial predictability and sustainability
- REGULAR COMMUNICATION and LISTING of "Preferred Practices"
- Support of AFTER-HOURS and VIRTUAL BILLING codes to enhance access
- REMOVAL of medical prior authorization for providers in this program
- Enhanced billing options for primary care to do as much as they can in the PCP office
- ENHANCED DATA SHARING to inform care delivery and coordination

Recognize the model might NEED TO LOOK DIFFERENT in different geographies and practice sizes.

This will take time to ramp up and need to PROVIDE PROTECTION for providers in the short-run.

Areas of Focus for ENHANCED PAYMENT

QUALITY

- Quality of care and care gap closures
- Focus on closing care gaps (screenings, labs, etc.)
- Ensuring access during transitions of care

ACCESS

- Multi modal (in clinic, telehealth, after hours)
- Open scheduling
- Services offered

SITE of SERVICE and STEERAGE

- Optimize services offered at practice level
- When necessary, reward for high quality, lower cost referring behavior

PROPOSED TIMELINE

Q1 and Q2

- PMPM: Attempt to keep providers around 160% of Medicare (timing sensitive)
- Build out data and steerage competencies
- Focus on access and quality

Q3 or Q4
and beyond

- PMPM and Steerage Bonus show clear pathway to 180% of Medicare if targets are met
- Establish targeted goals and benchmarks and tie payment to them; Q4 would be the first time a practice could make less than Q1-Q3

ANNUAL
Tune up and assessment of performance

QUESTIONS TO ASSESS:

Did Quality Improve?

Did Access Improve?

Did Costs go down for the Plan? How do we continually share in our success?

Are providers in an equal or better place than before?

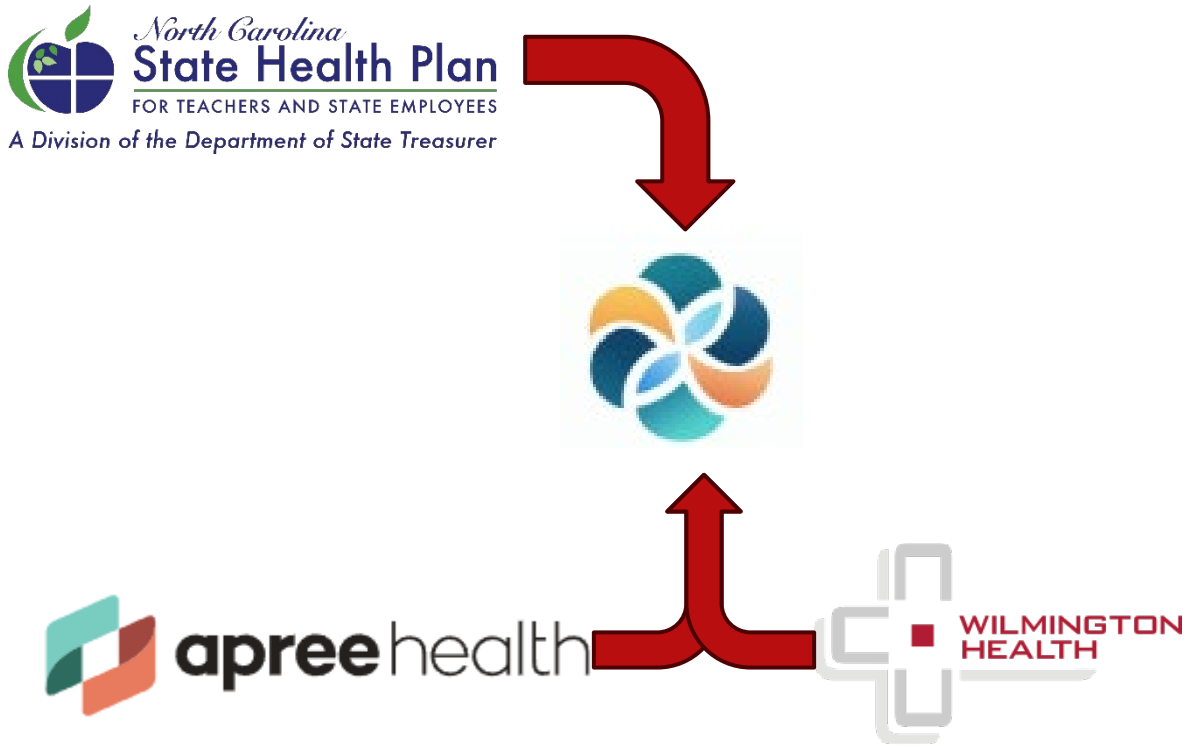
How to and how much do we reinvest in and grow independent primary care?

PMPM=Per Member Per Month

PARTNERING WITH HIGH PREFORMING INDEPENDENT PRACTICES: A PILOT

THE PILOT

Wilmington Health and Apree Health formed Wilmington Coordinated Care to take financial and quality risk for all State Health Plan members in a 4-county area.



A New System for Health and Care

☆☆☆☆☆

A Better Experience

Convenience | Access | Trust

Improved Health Outcomes

Quality of Care | Clinical Outcomes

Affordable Healthcare

Medical Cost Savings

WE ARE PARTNERING TO BUILD THE NEXT GENERATION VALUE BASED CARE

High Quality Care by Independent Multispecialty Groups
Care delivered by high value provider - Wilmington Health

Targeted Engagement, Attribution & Retention
Gap closure, AWV and preventive care adherence

Care Management & Care Guidance
Post-discharge follow-ups, diverting ER utilization and health coaching

Site of Care Steerage
Procedure transitions to high-value ASC, through engagement

Access to Data
Claims data, coupled with EMR data drives performance

PROVIDER COLLABORATIVE: PILOT RESULTS

The Wilmington Coordinated Care (WCC) pilot in our focused four-county coastal Carolina geography has demonstrated success in curbing rising cost of care for the approximating 30,000 State Health Plan active members and their families living in this geography

Quality Metrics[A]

WH		MKT
87%	Breast Cancer Screening (WH PCP vs Non WH PCP)	76%
79%	Colorectal Cancer Screening (WH PCP vs Non WH PCP)	54%
60%	Influenza Immunization (WH PCP vs Non WH PCP)	24%

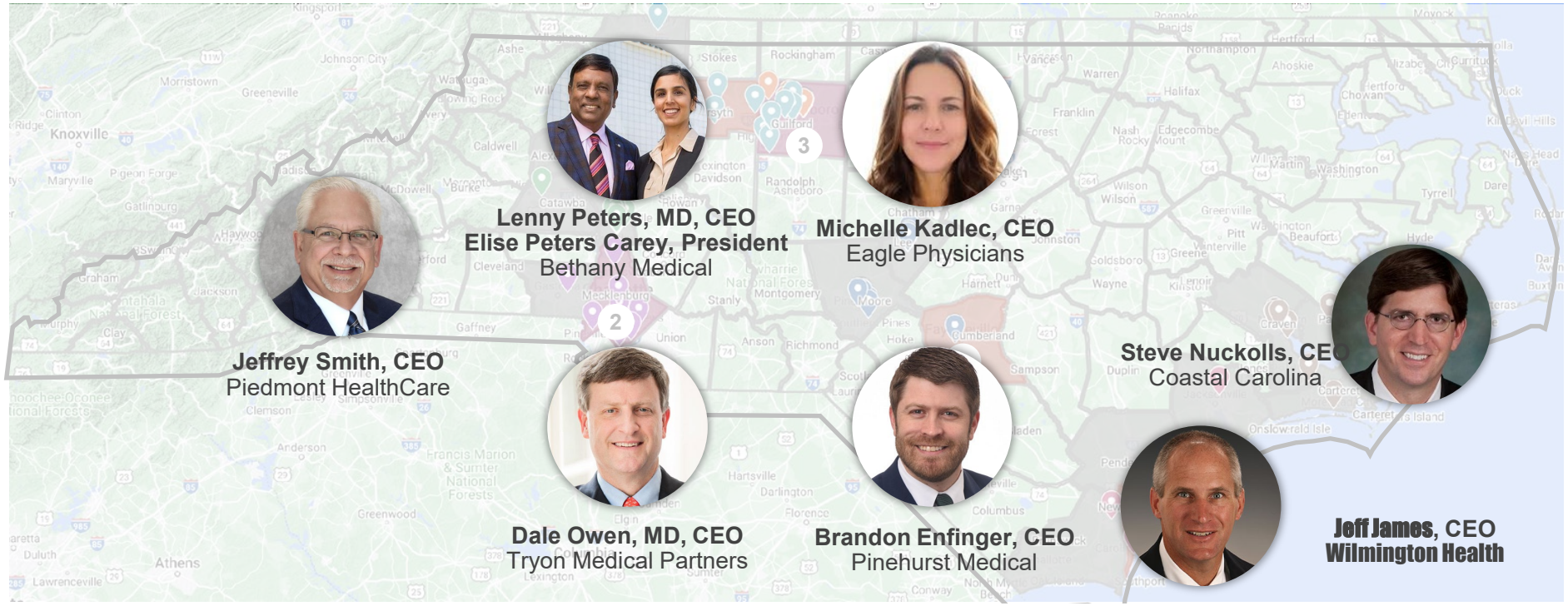
Utilization[B]

WH		MKT
71	Emergency Department Admissions per Thousand (ED/K)	100
3.9%	Readmission Rate	5.9%
33	Inpatient Admissions per Thousand (IP AD/K)	35

[A] Patient Population w/established PCP

[B] Total population 4-county geo

BUILDING A NORTH CAROLINA PROVIDER COLLABORATIVE



Building a Provider Collaborative with select provider partners across the State's top 15 counties

Piedmont HealthCare · Tryon Medical Partners · Bethany Medical · Eagle Physicians · Pinehurst Medical Clinic · Wilmington Health · CCHC Coastal Carolina Health Care, P.A.

SERVICES PROVIDED BY INDEPENDENT MULTISPECIALTY GROUPS

- FAMILY MEDICINE
- INTERNAL MEDICINE
- OB/GYN
- CARDIOLOGY
- GENERAL SURGERY
- ORTHOPEDIC SURGERY
- RHEUMATOLOGY
- GASTROENTEROLOGY
- UROLOGY
- VASCULAR SURGERY
- ONCOLOGY
- PEDIATRICS
- ENDOCRINOLOGY
- EAR NOSE AND THROAT

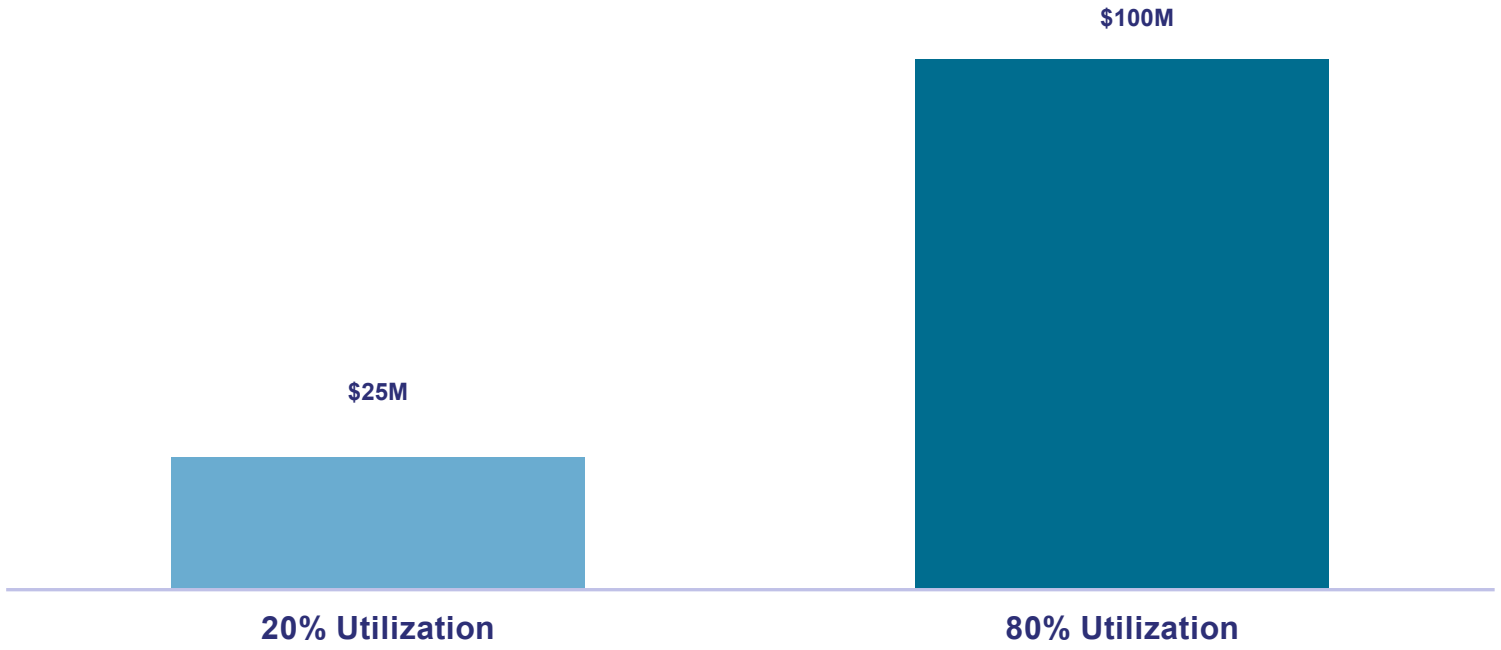
POTENTIAL ENGAGEMENT OPPORTUNITIES

Physician Group	Region	County Members	Attributed	Engagement
Wilmington Health	Wilmington	27,129	5,400	20%
Eagle Physicians	Greensboro	45,655	3,878	8%
Bethany Physicians	Greensboro	45,655	1,397	3%
Pinehurst Medical Clinic	Fayetteville	24,153	3,673	15%
Piedmont HealthCare	Statesville	16,645	3,711	22%
Coastal Carolina Health Care	New Bern	8,338	2,736	33%
Tryon Medical Partners	Charlotte	43,995	3,232	7%
Total for Partners	**All Regions**	**165,915**	**24,027**	**14%**

Bundle Program Opportunities

Significant Savings Potential

Net savings increase with more awareness and thus higher utilization.



- Savings assumes a wide range of surgical categories, including:
  - Joint Replacement
  - Other Orthopedics
  - Spine
  - Bariatrics
  - Gastrointestinal
  - Women's Health
  - Ear, Nose, Throat
  - Cardiac
  - General Operations

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Figures shown are utilization scenarios for potential savings. Calculation is based on the historical plan paid amounts and assumes $0 member cost share.

Next Steps

PICK A PARTNER

BEST and FINAL PRICING

DETERMINE ROLL OUT and IMPLEMENTATION STRATEGY

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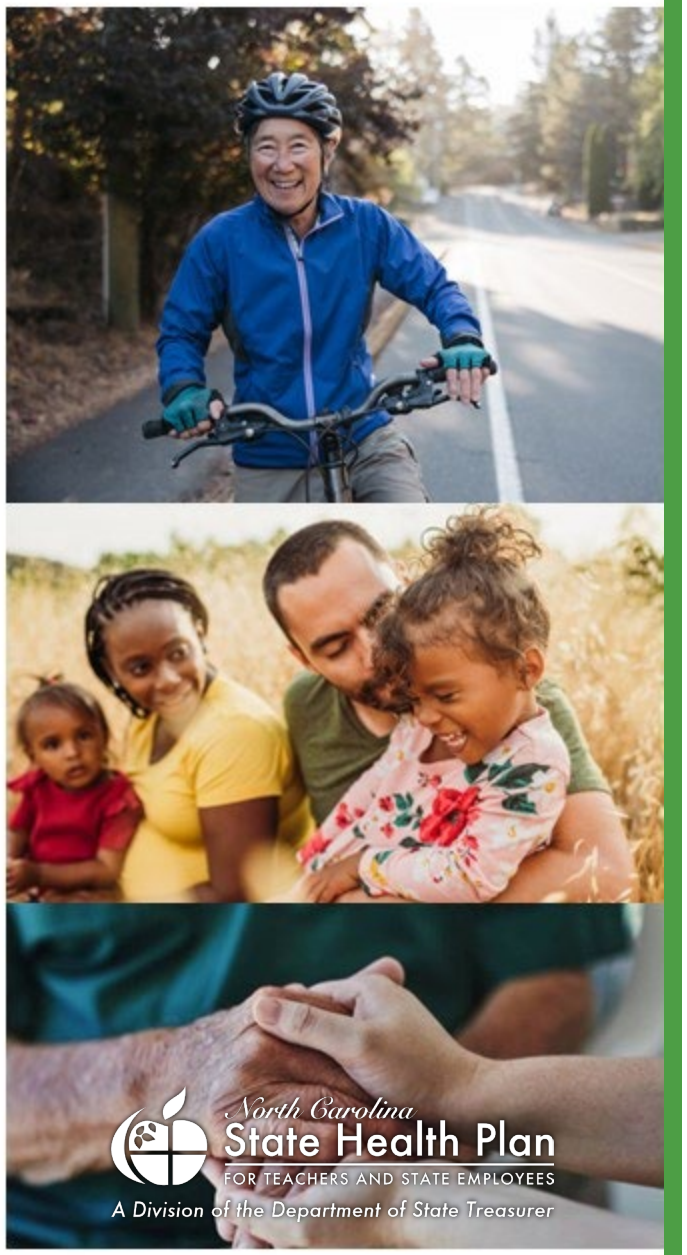

Benefits Strategy and 2026 Plan Design Approval

Topics to Discuss

EVOLUTION OF CPP*

BUNDLE STRATEGY

POINT SOLUTIONS

PLAN DESIGN

*Original Clear Pricing Project program sunsets 12/31/2025 with enrollment terminating.

State Health Plan Strategy

2025 → → → LONG-TERM / ONGOING

ADDRESS THE FISCAL CLIFF

- Premiums
- Plan Design
- Formulary

ENSURE THE CLIFF WON'T COME BACK

- Price/Quality Transparency
- Be the partner of choice to improve price and access
- Bring back population health
- Support screenings

EMPOWER LONG-TERM HEALTH

- Member-friendly structures to improve health and reduce chronic disease
- Quality first network
- Strengthen rural health access (especially specialty care)

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Empower Long-Term Health

RISK GROUP	MEMBERS	MEMBERS
Non-Utilizers	43,722	8.0%
Healthy	98,039	18.0%
Minor Acute	46,532	8.5%
Major Acute	24,974	4.6%
Single Chronic	104,782	19.2%
Chronic w/Comorbidities	220,062	40.3%
Malignancies	6,026	1.1%
Catastrophic	1,272	0.2%
TOTAL	545,410	100.0%

IMPROVE HEALTH

- Over 350k members who need more support.
- Ability to reduce cost by $15k per person in some cases.
- We need a portfolio of solutions to get there.

PROMOTE ACCESS

- Ensure Plan members have access to specialty care and screenings.
- Significant number of members do not have specialists in their county.

What Empowering Health Looks Like

BETTER UNDERSTANDING of our members' health needs and unique drivers that we can support (access, social determinants, cost-sharing) through listening to our members and leveraging our data.

IDENTIFYING PARTNERS who can locally support members.

- Clinical Access
- Care at home solutions
- Focus on integration and data-sharing to reduce duplication
- Services that support patient health when they aren't in the doctor's office

ALIGNING INCENTIVES to engage.

- Favorable cost-sharing to members
- Predictable revenue for providers
- Guarantees or performance thresholds for the Plan

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Ensure the Cliff Won’t Come Back

DILIGENT PRICE MANAGEMENT

- We need to improve transparency around prices to better manage member and Plan costs.
- Through our Aetna contract, we have enhanced our ability to dig into our data and identify opportunities to compete on price.
- Continually manage the formulary structure to ensure the best prices and high-quality care (i.e.; Weight Loss, High-Cost drugs).

STEERAGE AND SCALE

- Through CPP, we learned that provider steerage is a tool that can drive provider engagement; however, we need to refine the approach to be more mutually beneficial.
- Areas of Focus on Cost/Access: Ortho, Eyes, Weight Loss, and Maternity Care.

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Vision for State Health Plan After Reset

The State Health Plan will sustainably partner with members and providers to create wins for all stakeholders where quality and access to care is the front door and financial sustainability is aligned for ALL PARTIES.

What we understand we need to AMPLIFY and where we need to FOCUS.

MEMBERS

- Affordability
- Quality Care
- Make it Easy to Make Good Financial Choices
- Access

PROVIDERS

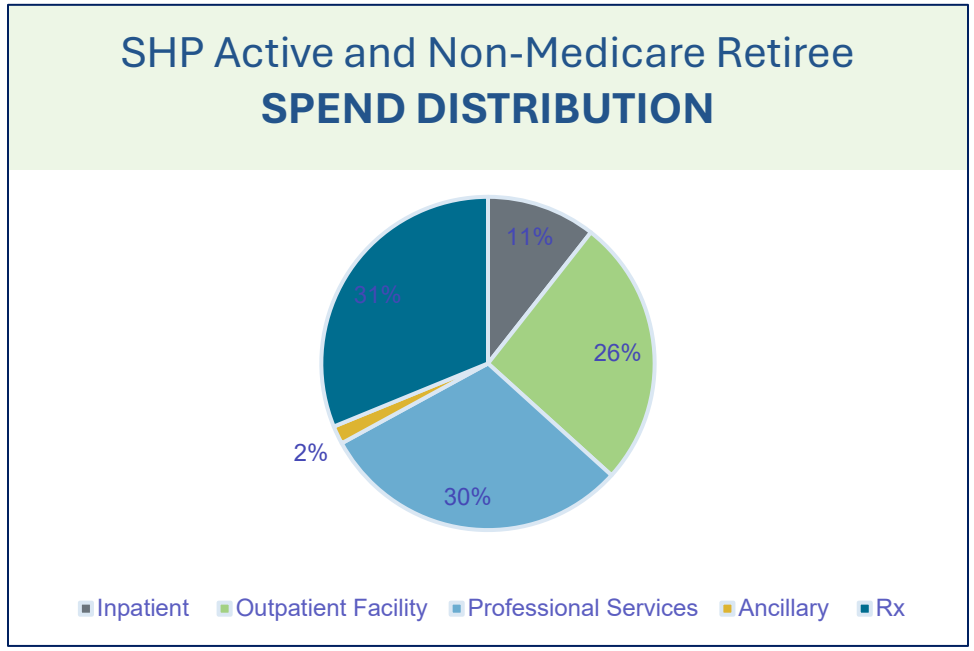
- Financial Sustainability
- Financial Predictability
- Ability to Focus on Care and Not Administration

STATE HEALTH PLAN

- Financial Sustainability: Short-term
- Improve, Maintain, and Sustain Member Health
- Invest in Member Health
- Operational Excellence

Where is the Money Going and What is Driving Spend?

We re-oriented from a plan where the cost is primarily in Inpatient spend to a smoother distribution between Outpatient Facility, Professional Services, and Rx. This re-calibrates our strategy from a hospital-focused approach to an approach focused on steering impactable care to the RIGHT SITE OF SERVICE with the RIGHT PARTNER who commits to quality and value.



TOP IMPACTABLE CATEGORIES	Percent of SPEND	Percent of MEDICAL SPEND
INPATIENT	**10.6%**	**15.4%**
Surgical	5.1%	7.3%
Maternity and Neonate	1.7%	2.5%
OUTPATIENT FACILITY	**26.1%**	**37.9%**
Surgery	9.4%	13.7%
Radiology	3.1%	4.5%
Lab/Pathology	1.0%	1.5%
PROFESSIONAL SERVICES	**30.3%**	**44.1%**
E&M and Preventive	11.8%	17.1%
Procedural	3.8%	5.5%
Mental Health	3.4%	4.9%
Office Administered Drugs	2.5%	3.7%
Therapies	2.4%	3.5%
Radiology	2.0%	2.9%
Lab/Pathology	1.6%	2.3%

Focusing on the Impactable

100% of cost will be impactable through PROVIDER LED HEALTH MANAGEMENT; that is the long-term strategy. We need to FOCUS ON THE 69% of medical costs that are impactable.

What Do We Need to Do?

Steer and incent patients to utilize lower cost, high quality providers.

Why This Works and What Does It Mean?

People trust their doctor more than their health plan: Build a network of preferred providers across the state and empower them with data and incentives to steer members to high quality / lower cost services.

Eliminate the shopping responsibility and limit the financial burden for members: Make it attractive to members – both financially and in terms of access – to engage with these preferred providers.

Build financial sustainability and predictability for providers and the Plan, and improved administration for providers: In exchange for a commitment to more favorable finances to the member and the Plan, members will drive the commercial volume to providers and reduce administrative burden through removing Medical Prior Authorization.

Our Partnerships to Success

The member's health is the mission and focus so we will MEANINGFULLY REDUCE COST-SHARING for members (as close to zero as viable) for engaging with providers; the more members that convert the greater the savings to the member and the Plan.

INDEPENDENT PROVIDERS

(Primary through Multidisciplinary Specialty)

Leverage Aetna commercial rates as starting point.

Empower them with the data to make the right referral for the member and the Plan.

Provide clear predictable funds for achieving meaningful population health goals.

Eliminate Medical Prior Authorization for participating providers.

BUNDLES

(Inpatient, Outpatient Hospital, ASC, and Procedural)

Incentivize members through reduced cost-sharing (flexible on structure).

Focus on access across North Carolina and cost-conscious steerage.

Balance between hospital avoidance, cost reduction, and cost avoidance.

Expand scope of services.

Clear Pricing Project Evolution

The Clear Pricing Project taught the Plan a lot about contract direction, and those learnings are the framework going forward.

Clear Pricing Project Provider

Members benefited from lower out-of-pocket costs and better access and was easy to understand.

Providers received financial sustainability and predictability and there were certainly high-quality providers in the network. HOWEVER, the incentive was designed around volume.

The Plan has concrete evidence that positive member steerage works BUT the Plan carried the full financial risk that led to a $450M variance from stated projections and actual results.

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CPP Will Evolve Into Preferred Providers

Focus remains on patient steerage, improving financials, but adding quality and access specificity.

CURRENT STRUCTURE

Anyone eligible who will take 160% of Medicare

Reduced member cost share

PREFERRED PROVIDERS

Focus on PCP, Behavioral Health, and multi-disciplinary specialty

Enhanced payment from Aetna fee schedule through care management fees, shared saving, steerage bonuses

Enhanced data access for decision making

No Medical Prior Authorization

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Preferred Providers Program – Primary Care

CURRENT STRUCTURE

$0 Member Copay

Provider reimbursement 160% of Medicare for all services rendered in office

PREFERRED PROVIDERS

$10-$15 Member Copay based on Plan selected

Provider reimbursed at current Aetna contract

No Medical Prior Authorization

+ Monthly Per Member Per Month for achieving care management goals

+ Referral bonus for steerage to low-cost imaging, labs, specialists, and procedures

+ Referral bonus for member utilizing low-cost provider

Preferred Providers Program – Specialty Care

CURRENT STRUCTURE

$40-$47 Member Copay

Provider reimbursement 160% of Medicare for all services rendered in office

PREFERRED PROVIDERS

$40-$50 Member Copay based on Plan selected

Provider reimbursed at current Aetna contract

+ Monthly Per Member Per Month for achieving care management goals

+ Referral bonus for steerage to low-cost imaging, labs, specialists, and procedures

+ Referral bonus for member utilizing low-cost provider

Potential for shared savings in Year 2-3

Preferred Providers Program – Behavioral Health

FUTURE STRUCTURE

$10-$15 Member Copay based on Plan selected

Most common Behavioral Health CPT codes for (BH providers only) reimbursed at 140% of Medicare (down from 160%)

One sign-up to accept rates; all providers eligible

Expanding virtual access for NC providers only

FUTURE TARGET FOR ENHANCEMENTS

Bundled payments for long-term patients with one copay

Better financial and/or administrative arrangement for Plan, providers and members

Clear Pricing Project Terming - Other Programs

With the current version of the
Clear Pricing Project ending Dec. 31, 2025;

the State Health Plan continues its COMMITMENT to PROVIDING OUR MEMBERS access to HIGH QUALITY and AFFORDABLE BEHAVIORAL HEALTH SERVICES.

Chiropractor / Physical Therapy / Occupational Therapy:
IN PROGRESS to develop an alternative path forward (likely 2027).

Other services: ENDING

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Bundle Program Cost Sharing/Administrative Flexibility

Under N.C.G.S. 135-48.30, the Treasurer and, as delegated, the Executive Administrator, as fiduciaries for the Plan have the power to administer benefits through bundle programs, as well as modify or end these programs. The member cost-sharing amount for bundles is approved by the Board.

For the 2025 and 2026 plan years, members who receive covered benefits through providers or facilities participating in a bundle program will have a set cost-sharing amount for that specific program. The cost-sharing amount for each bundle program will be set by the Treasurer and will meet all of the standards detailed below.

1. The cost share is LESS THAN the share paid by members who use providers or facilities not participating in the bundle program.
2. As determined by the Treasurer or as delegated by the Treasurer to the Executive Administrator, the cost share is an amount that will likely have the effect of INCENTIVIZING MEMBERS to utilize bundle-participating providers or facilities.
3. The reduction in cost-sharing does not exceed the expected rate reduction from the bundle program.
4. The cost share is not less than $0 .

Point Solution Considerations to Improve Member Experience and Health Where Access is Limited or Based on Feedback

SOLUTION	RATIONALE
Hello Heart	Provide rural members with tool to monitor Blood Pressure daily and receive coaching and assistance.
Ventricle health	Provide rural members with a Cardiovascular Care Physician after discharge (focus on low access communities).
Hinge Health	Provides in home option to support MSK Health.
FOOD AS MEDICINE	Works to identify geographies with food diseases. Provide high quality food to improve health and reduce Emergency Room use. (PILOT PROGRAM)

Plan Design Summary

GOAL: Eliminate the ~ $500M shortfall.

NEW PLAN NAMES will be introduced in an effort to move away from numerical/actuarial plan names.

70/30 Plan ⟶ Standard PPO Plan
80/20 Plan ⟶ Plus PPO Plan

Humana® Group Medicare Base and Enhanced Plans
⟶ Humana® Medicare Advantage & Humana® Prescription Drug Base (PPO) and Enhanced (PPO) Plans

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Making no benefits changes will result in higher premium increases.

2026 Plan Design Changes *Active and Non-Medicare*

	2025		2026	
SERVICES	70/30	80/20	STANDARD	PLUS
Annual Deductible	$1,500 / $4,500	$1,250 / $3,750	$3,000 / $9,000	$1,500 / $4,500
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	$5,900 / $16,300	$4,890 / $14,670	$6,500 / $16,300	$5,000 / $15,000
In-Patient Hospital / Emergency Room	$337 +ded/coins	$300 +ded/coins	$600 +ded/coins	$500 +ded/coins
Out-Patient Surgical Copay	ded/coins	ded/coins	$350 +ded/coins	$300 +ded/coins
Primary Care Provider Office Visit	$45 / $30 / CPP $0	$25 / $10 / CPP $0	$50 / $40 / $15*	$40 / $30 / $10*
Specialist Visits	$94 / CPP $47	$80 / CPP $40	$94 / $50*	$80 / $40*
Behavioral Health Provider	$45 / CPP $0	$25 / CPP $0	$15	$10
Speech, Occupational, Chiropractic and Physical Therapy	$72 / CPP $36	$52 / CPP $26	$62	$42
Rx Tier 1	$16	$5	$25	$15
Rx Tier 2	$47	$30	$75	$55
Rx Tier 4	$200	$100	$200	$100
Rx Tier 5	$350	$250	$600**	$500**
Actuarial Value	79.8%	84.6%	74.8%	81.5%
Active Average Premium***	$25	$50	$40	$100
Estimated Premium Range	--	--	$30-$70	$70-$130
Retiree Premium	$0	$50	$0	$70

*Lowest copay for preferred providers. **Manufacturer's coupons would generally cover increased copay. ***Premiums to be determined in Aug.

Tier 5 Specialty Medications: Impact of Coupons

Common Tier 5 Specialty Medications: COUPON EXAMPLES			
Specialty Drug	Patient Pays	Coupon Pays Copays up to	Percent of Claims with Coupons
STELARA	$5	$750+	95%
DUPIXENT	$0	$1000+	96%
SKYRIZI	$0	$1000+	95%
RINVOQ	$0	$1000+	96%
CONSENTYX	$0	$1300+	95%

- Manufacturer's coupons would generally cover the cost of increased copay.
- 53% of members taking Tier 5 drugs paid $0 in 2024 for their specialty drugs.
- 89% of members paid less than $10/month.

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GLP-1 and Weight Management

NUTRITION AND WEIGHT LOSS COACHING
through Betr Health

AVAILABILITY:
Everyone

BARIATRIC SURGERY

AVAILABILITY:
Everyone but qualification required

GLP-1 FOR WEIGHT LOSS

AVAILABILITY:
Program in development

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2026 Medicare Advantage Changes

The 2026 Final Rate Notice released by CMS finalized a change in the calculation of the Rx normalization factor, resulting in higher payment for Prescription Drug Plans and lower payments for Medicare Advantage Prescription Drug Plans.

THE SAVINGS IS MEANINGFUL, especially to Employer Group Waiver Plans.

As a result, splitting the Medicare Advantage (Medical) and Prescription Drug Plan (Pharmacy) while running them concurrently with a sole carrier, Humana®, is advantageous.

Running them concurrently is largely a back-end functionality.

THE POSSIBLE MEMBER IMPACT INCLUDES:

- 2 ID cards – one for medical, one for pharmacy
- 2 confirmations of enrollment – one for medical, one for pharmacy (these are CMS required, and system generated)
- Some duplicated mandated notices
- Extra communication will need to occur on the pharmacy side of things.

This allows for only one slight change to benefits for BOTH Humana® Medicare Advantage Plans for 2026.

While possible duplicative mailings and two ID cards may cause some confusion, the ability to hold benefits largely steady and create savings for the Plan with little disruption is encouraging.

2026 Plan Design *Medicare Advantage Plans*

SERVICES	2025 Humana® GROUP MEDICARE Advantage BASE PLAN	2025 Humana® GROUP MEDICARE Advantage ENHANCED PLAN	2026 Humana® Medicare Advantage & Humana® Prescription Drug BASE PLAN	2026 Humana® Medicare Advantage & Humana® Prescription Drug ENHANCED PLAN
Annual Deductible	$0		$0	
Out-of-Pocket Maximum (Medical)	$4,000	$3,300	$4,000	$3,300
Out-of-Pocket Maximum (Pharmacy)	$2,000		$2,100	
In-Patient Hospital / Emergency Room	Days 1-10: $160/day Days 11+: $0 / $65 ER	Days 1-10: $125/day	Days 1-10: $160/day Days 11+: $0 / $65 ER	Days 1-10: $125/day
Out-Patient Surgical Copay	$250		$250	
Primary Care Provider Office Visit	$20	$10	$20	$10
Specialist Visits	$40	$35	$40	$35
Chiropractic Visits	$20		$20	
Rx Tier 1	$10		$10	
Rx Tier 2	$40		$40	
Rx Tier 4	25% coins up to $100		25% coins up to $100	
Rx Tier 5	N/A		N/A	
Actuarial Value	90.2%	91.0%	90.2%	91.0%

Only one benefit adjustment: to OOP per CMS requirement.

2026 Plan Design Changes *Medicare 70/30*

	2025	2026
SERVICES	Base PPO (70/30)	70/30 PPO
Annual Deductible	$1,500 / $4,500	$3,000 / $9,000
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	$5,900 / $16,300	$6,500 / $16,300
In-Patient Hospital / Emergency Room	$337 +ded/coins	$600 +ded/coins
Out-Patient Surgical Copay	ded/coins	$350 +ded/coins
Primary Care Provider Office Visit	$45 / $30 / CPP $0	$50 / $40 / $15*
Specialist Visits	$94 / CPP $47	$94 / $50*
Chiropractic Visits	$72 / CPP $36	$62
Rx Tier 1	$16	$25
Rx Tier 2	$47	$75
Rx Tier 4	$200	$200
Rx Tier 5	$350	$600
Actuarial Value	90.4%	88.6%

*Lowest copay for preferred providers.

Calls to Action

How we will SUCCEED TOGETHER to improve health and reduce cost.

STATE HEALTH PLAN

- Continue to build provider relationships and a preferred provider network focused on quality, access, and cost
- Communicate, communicate, communicate
- Execute on our commitments
- Build a pharmacy (both medical and point of sale) strategy

PROVIDERS

- Propose and execute on mutually beneficial partnerships that can be scaled
- Lean into our incentive structure
- Help us with rural access
- Recognize that the Plan and members cannot hold all the risk on success

MEMBERS AND MEMBER GROUPS

- Leverage our preferred provider network to save yourself and the Plan money
- Share the opportunities with your peers and network
- Let us know what is working and what isn't working

Fiduciary Responsibility

N.C. Gen. Stat. § 135-48.2(a)

The Treasurer, Executive Director, and Board of Trustees are designated as fiduciaries for the Plan.

"The State Treasurer, Executive Administrator, and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan."

The powers and duties of the Treasurer are set forth in statute at **N.C.G.S. § 135-48.30(a)** and include setting benefits, premium rates, copays, deductibles, and coinsurance percentages and maximums subject to approval of the Board of Trustees.

The Board of Trustees' powers and duties are set forth at **N.C.G.S. § 135-48.22** and include approving large contracts, approving premium rates, copays and deductibles proposed by the Treasurer, consulting with and advising the Treasurer, and developing and maintaining a strategic plan.

The General Assembly determines member eligibility rules and provides state funding for the Plan.

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Vote

- Vote to approve the member cost shares outlined on slide 38 for the new bundle programs.

- Vote to approve the changes to the benefit plan design as outlined on slides 41, 45 & 46.
  - No vote on premiums until August.

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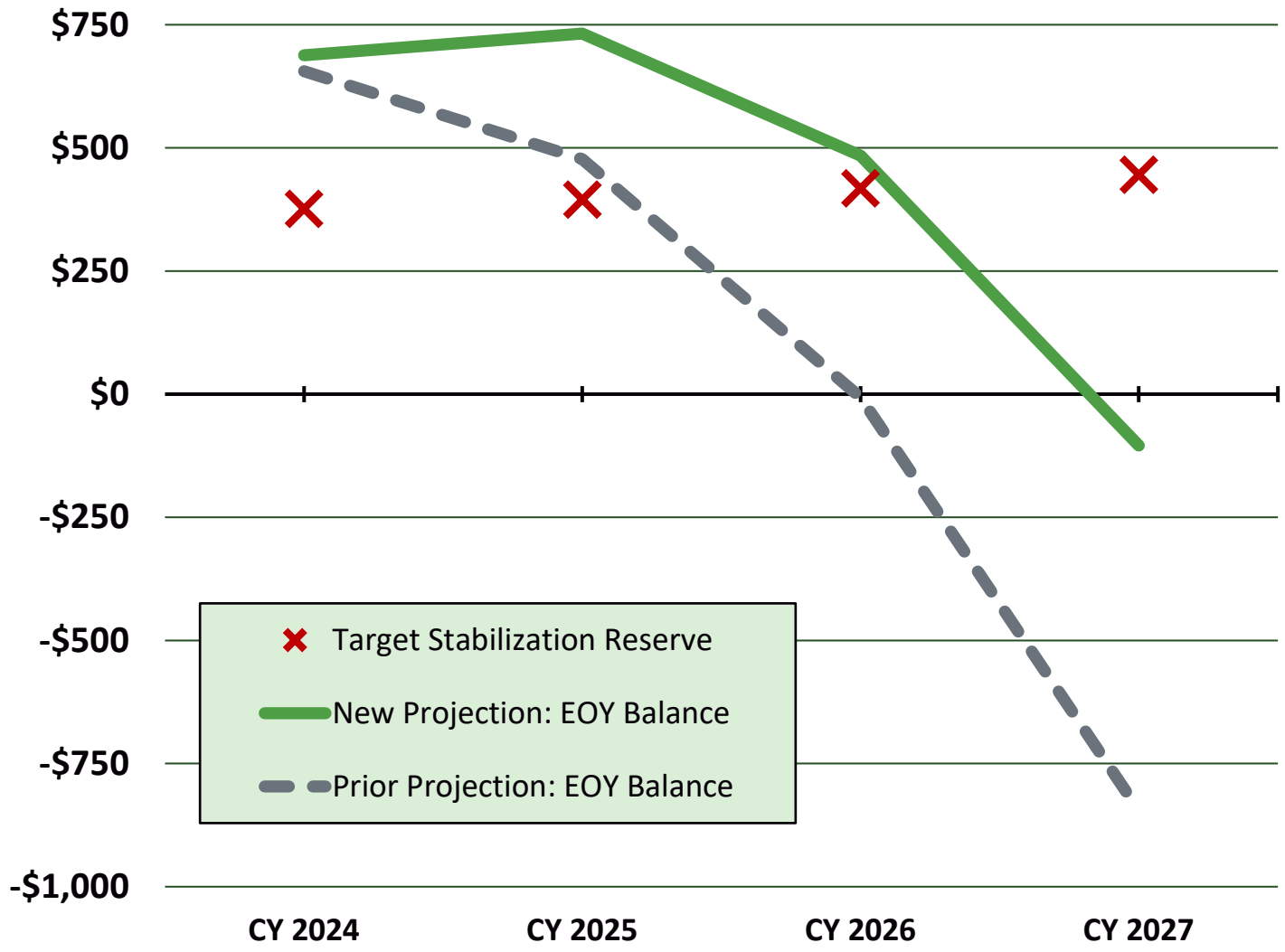
Financial Update

Projection vs. Budget: Calendar Year 2025

($s in millions)	CY 2025 Adj. Projection	CY 2025 Adj. Budget	Difference
Premiums & Subsidies	$4,499.9	$4,489.0	$10.9
Investment Earnings	$35.8	$20.1	$15.7
Total Revenue	**$4,535.6**	**$4,509.1**	**$26.5**
Net Medical Claims	$3,328.9	$3,377.5	($48.6)
Net Pharmacy Claims	$851.3	$1,009.5	($158.2)
Medicare Advantage Payments	$104.5	$91.0	$13.5
Administrative Expenses	$207.0	$207.1	($0.1)
Total Expenses	**$4,491.7**	**$4,685.0**	**($193.3)**
Plan Income/(Loss)	**$44.0**	**($175.9)**	$219.9
Ending Cash Balance	**$732.1**	**$415.1**	**$317.0**

Budget has been adjusted for increased administrative expenses under new TPA and costs associated with new programs.

Financial Projection Update



- Projection improved due to:
  - Lower than expected pharmacy and medical claims
  - Revision to projected pharmacy trend
- Cash balance now expected to exceed TSR by $87 million at end of 2026.
- Changes are required to prevent cash balance from falling below TSR in 2027.
- Forecast continues to be subject to significant uncertainty.

Next Steps

COMMUNICATE, COMMUNICATE, COMMUNICATE.

PARTNER WITH a bundle provider to fill out our network across N.C. and launch pilots to generate savings early.

FINALIZE primary care and specialty terms.

TRAIN and ROLLOUT price transparency for providers in 2025.

August 15 SET PREMIUMS for 2026.

October 13-31 OPEN ENROLLMENT for 2026.

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