



*North Carolina*  
**State Health Plan**

FOR TEACHERS AND STATE EMPLOYEES

*A Division of the Department of State Treasurer*

# 2026-2032 STRATEGIC PLAN





## TABLE OF CONTENTS

- 04** Introduction
- 05** Mission, Vision & Values
- 06** Strategic Priorities and Initiatives
- 12** Pathways to Success
- 13** Operational Roadmap
- 13** Measures of Success
- 14** Accountability Metrics

# INTRODUCTION

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**THE NORTH CAROLINA STATE HEALTH PLAN (PLAN) EXISTS TO SUPPORT THE HEALTH AND WELL-BEING OF MORE THAN 750,000 TEACHERS, STATE EMPLOYEES, RETIREES, AND THEIR FAMILIES.**

As one of the largest purchasers of health care in the state, the State Health Plan has both a responsibility and an opportunity to influence how care is delivered, accessed, and experienced with members always at the center.

In recent years, health care costs rose faster than premiums, and payments to providers increased without corresponding improvements in outcomes. Combined with the elimination of care management programs, this led to a significant financial shortfall for the Plan. That gap was ultimately addressed through legislative appropriations, benefit changes, and higher member premiums. Costs continue to significantly outpace funding growth threatening the long-term **AFFORDABILITY** and **SUSTAINABILITY** of the Plan.

Fundamentally, **COST** is the problem the Plan needs to address. The biggest contributing factors to the problem are lack of **PRICE TRANSPARENCY** and continued erosion of our members' health.

With more than 70% of members with a chronic condition, the challenge is not simply one of funding, but how the Plan supports better health outcomes while managing costs responsibly. Earlier detection and timely treatment can lead to better outcomes and lower overall health care costs, which helps the Plan protect both member well-being and long-term affordability.

The Plan must take a **DIFFERENT APPROACH**, one that changes how providers and members think, act, and consume care. This requires greater focus on prevention, overall health, improved access to high-quality and convenient care, with a more engaging, multimodal, member-focused experience that empowers informed decision-making.

The Plan recognizes when we are successful, we will create significant disruption within the North Carolina health care community. We cannot expect different outcomes by using the same playbook. Aligning incentives around members, the Plan, and participating preferred providers is the right thing for all involved parties; however, there will be **WINNERS AND LOSERS**. Providers who can't fit into our model will lose both patients and volume that is critical to their bottom line. In time, we hope to be able to partner with everyone, but we need to first start with resetting and partnering where our **VALUES ALIGN**.

This strategic plan outlines a clear path forward built around three core strategies. These strategies position the Plan to deliver **BETTER VALUE AND BETTER HEALTH** outcomes for members, a more sustainable cost trajectory, and a system that works more effectively for everyone it serves.

# MISSION, VISION & VALUES



**MISSION:** Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.



**VISION:** Affordable and timely access to quality health care and wellness supports for every member.



## **VALUES:**

### ■ **COST EFFECTIVENESS**

Addressing where health care dollars are spent and how care is delivered, the Plan must work to balance costs among members and providers in a fair and sustainable way.

### ■ **OPERATIONAL EFFICIENCY AND SUSTAINABILITY**

Ensuring that the Plan and its vendor partners have the operational infrastructure, processes and procedures to guarantee a seamless administration of the benefit and efficient use of funds to best advance member health.

### ■ **COLLABORATION**

Partnering with members, provider organizations, and other stakeholders on behalf of our members.

### ■ **TRANSPARENCY**

Acting in an open manner with the highest possible degree of integrity in all we do.

### ■ **QUALITY**

Striving for the best quality of care and service for our members.

### ■ **INTENTIONALLY INNOVATIVE**

Recognize the status quo needs to be changed but we don't want change for the sake of change.



# STRATEGIC PRIORITY

## 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 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 shock for members, with special attention paid to those with least financial resources.
- Incent the behavior necessary to keep costs low by creating immediate financial rewards for using preferred providers.



# 1 PROTECT AFFORDABLE PREMIUMS AND STABLE BENEFITS STRATEGIC INITIATIVES

## WHY IS THIS IMPORTANT:

To avoid future premium spikes, benefit reductions, or reliance on emergency funding, the Plan must act. Taking a proactive, balanced approach helps protect members from “sticker shock” while ensuring the Plan remains financially strong and reliable long term.

**1.1 DEVELOP A TIERED NETWORK OF PREFERRED PROVIDERS**, that includes both primary care and specialists, that will provide lower total cost of care while maintaining or improving quality and incentivize members to utilize those providers by reducing their cost share and raising awareness through tailored communications. The preferred provider concept will consist of multiple year partnerships evaluated on ability to improve health status and slow cost growth. Members will access provider lookup tools to identify preferred providers so they can better anticipate their cost sharing obligations.

**1.2 MAXIMIZE PARTNERSHIPS** with the Plan’s Third-Party Administrator (TPA) and Pharmacy Benefit Manager (PBM) through strong contracts that focus on increased transparency, flexibility, and the Plan’s ability to manage programs effectively.

**1.3 IDENTIFY AND EXECUTE ALTERNATIVE PAYMENT STRUCTURES WITH PROVIDERS** that incent the elimination of waste, the provision of high value and high-quality care, and result in a lower total cost of care. For example, share in the savings generated from the utilization of high quality, lower cost providers.

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## HOW WE WILL MEASURE SUCCESS:

- Procure TPA and PBM vendors that support steerage and value-based models while implementing and growing preferred provider options, develop staff operational road map.
- Identify and implement at least three remote or mobile approaches to address chronic diseases such as diabetes, cancer, and heart disease where there are not currently robust clinical options.

# STRATEGIC PRIORITY

## 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.

### 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.



# 2 HELP MEMBERS ACHIEVE BETTER HEALTH STRATEGIC INITIATIVES

## WHY IS THIS IMPORTANT:

When care is delivered in higher-cost settings, members often pay more without seeing better results. By improving engagement, strengthening primary care relationships, and coordinating care more effectively, the Plan can support better health outcomes, lower out-of-pocket costs, and a more seamless experience for members and their families.

**2.1 LEVERAGE INDEPENDENT PRIMARY CARE PROVIDERS** to improve health and manage costs while driving members to lower-cost commodity services through partnerships with Clinically Integrated Networks (CINs). Establish a network of preferred primary care providers based on quality and cost who are incentivized to coordinate member care and not beholden to traditional system-driven referral models, but instead focus on referring to providers that share the Plan's values around quality, cost, and access.

**2.2 INCENTIVIZE THE USE OF HIGH-QUALITY, LOWER COST PROVIDERS** by reducing members' out of pocket costs by identifying and engaging with high quality, lower cost providers and incentivize members to utilize those providers resulting in lower costs to the Plan and the member without sacrificing positive health outcomes.

**2.3 ASSIST MEMBERS IN EFFECTIVELY MANAGING HIGH COST, HIGH PREVALENCE CONDITIONS** with focused programs designed to support members and their providers to effectively manage member condition(s) such as diabetes, cardiovascular disease and as well as maternity events, behavioral health, and other episodes of care.

**2.4 OPTIMIZE MEMBER ENGAGEMENT** by helping members navigate choices and benefits using tailored communication efforts, appropriate tools and resources.

**2.5 ENGAGE IN NON-MEDICAL DRIVERS** of health like Food as Medicine programs to support members between health care encounters.

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## HOW WE WILL MEASURE SUCCESS:

- Reduce the average medical risk score of the Plan by prioritizing prevention, primary care, and better access to high quality care.
- Increase the number of members that utilize a Preferred Provider or at home care targeted at improving health.

# STRATEGIC PRIORITY

## 3 ENSURE MEMBERS HAVE ACCESS TO CARE

### WHAT IT MEANS:

The Plan is working to make getting care easier, no matter where members live. 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. While access to care isn't equitable today, we must strive to break down barriers and improve care options for both rural and urban members. Access isn't limited to the distance driven to receive care; it is also measured by affordability and the time it takes to get an appointment. Practices with nine-month wait times for an appointment that cost \$2,000 are not more accessible whether they are one mile away or 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 mobile care brought directly 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.



# 3 ENSURE MEMBERS HAVE ACCESS TO CARE STRATEGIC INITIATIVES

## WHY IS THIS IMPORTANT:

When access barriers are reduced, members spend less time traveling, waiting, or delaying care, and more time focusing on their health.

**3.1 MANUFACTURE ACCESS THAT DOESN'T EXIST** through unique care delivery models, partnering with existing providers and innovators to shore up existing gaps, and leverage existing infrastructure such as schools, community sites, or community colleges to deliver care.

**3.2 FOCUS ON PROVIDING INCENTIVES FOR PRACTICES** to prioritize health plan members or providing alternative hours that better meet the needs of teachers and state employees.

**3.3 PROVIDE LOW-COST OPTIONS** in geographies where there are multiple care delivery options to ensure that members have the means to make care accessible.

**3.4 EXPLORE BETTER OPPORTUNITIES** to deliver care at home.

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## HOW WE WILL MEASURE SUCCESS:

- Increase in members engaging with Preferred Primary Care Providers.
- Increase in members engaging with a Preferred Provider Specialist.



# PATHWAYS to SUCCESS

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## **BRING AN INVESTMENT MINDSET TO HEALTH IMPROVEMENT**

The Plan can't be afraid to take chances to improve health and reduce costs. Those chances need to be achievable and operationally feasible; they must be grounded in the reality of possible. Our chances must be treated like long-term investments in a portfolio; they must be smart, calculated, and achievable. The Plan should be able to quantify potential returns, the likelihood of the outcomes, and any new risks created.

## **BUILD AND MAINTAIN ACTIONABLE PLAN-LED ANALYTICS**

With over five billion dollars in spending, rising trend, and nearly 70% of members with at least one chronic condition there is no shortage of potential interventions to try, payment models to attempt, or new partnerships to explore. The Plan needs to be intentional, and data driven in our attempts to reduce costs and improve health given the limited communication bandwidth and ensure that the behavior changes we are asking members to make will lead to meaningful and measurable results.

## **DEPLOY A ROBUST COMMUNICATION AND MEMBER ENGAGEMENT PLAN**

There is no shortage of complexity existing in health care, prices are opaque, quality is confusing, experience is subjective, everyone is in a different part of their cost sharing journey, and everyone absorbs information differently with variable amounts of time to focus on health care. The Plan needs to balance adding layers of decision making while decreasing the complexity by making the right choice the easy choice. The Plan needs to build a culture of lower cost to the members, which means equal or higher quality and a better financial deal for everyone. The Plan needs to develop a multi-modal platform to assist members in their health care decision making using a variety of different channels of communication to meet the needs of all members. It is the Plan's duty to engage the 750,000 members of the Plan in a way they will find most helpful to optimize their benefit and their health.

## **SOCIALIZE AND CODIFY OUR PROVIDER EXPECTATIONS**

The Plan is fundamentally changing from a passive acceptor of health care networks to an active partner and purchaser of health. Building out our provider playbook that clarifies expectations and incentives will be critical in building provider trust and member engagement.

## **EXECUTE ON A TRANSPARENT OPERATIONAL ROADMAP**

Plan staff is taking on a significant, transformative endeavor and we need a mechanism to show our board and members what we are doing, how we are prioritizing and providing regular updates on progress, roadblocks, and where we need to pivot.

# OPERATIONAL ROADMAP

METRICS	2026		2027				2028			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>STRATEGIC PRIORITY 1: PROTECT AFFORDABLE PREMIUMS AND STABLE BENEFITS</b>										
BOT Premium Votes	X				X			X		
Premium Strategy				X			X			
Out-of Pocket Strategy				X				X		
Track Utilization and Impact of Steerage			X		X		X		X	
<b>STRATEGIC PRIORITY 2: HELP MEMBERS ACHIEVE BETTER HEALTH</b>										
Benefit Design Vote					X		X			
HBR and Member Outreach	ONGOING		ONGOING				ONGOING			
Consumer Segmentation Study	X	X								
AI Deployment Strategy Development		X	X							
Patient Navigation Deployment							X	X		
<b>STRATEGIC PRIORITY 3: ENSURE MEMBERS HAVE ACCESS TO CARE</b>										
Build Accountability Metrics and External Dashboarding			X							
Publish Population Health Report	X				X				X	

## MEASURES of SUCCESS

<b>STRATEGIC PRIORITY 1: PROTECT AFFORDABLE PREMIUMS AND STABLE BENEFITS</b>	
<b>2027 2031 Markers</b>	<b>2032 Target</b>
1. Successfully implement TPA and PBM contracts. 2. Identify and implement at least 3 remote or mobile approaches to address chronic conditions.	Reduce the number of members with an active chronic condition by 4%.
<b>STRATEGIC PRIORITY 2: HELP MEMBERS ACHIEVE BETTER HEALTH</b>	
<b>2027 2031 Markers</b>	<b>2032 Target</b>
1. Reduce the average medical risk score of the Plan by 4%. 2. Identify and implement at least 3 point solutions for chronic conditions. 3. Increase the number of members that engage with programs to manage a chronic condition.	90% of members are seeing a Preferred or Access provider.
<b>STRATEGIC PRIORITY 3: ENSURE MEMBERS HAVE ACCESS TO CARE</b>	
<b>2027 2031 Markers</b>	<b>2032 Target</b>
1. Increase virtual utilization for rural members.	100% of members have multiple pathways to Preferred Providers.

# ACCOUNTABILITY METRICS

## A KEY PORTION OF ANY STRATEGIC PLAN IS HOW THE STAFF HOLDS THEMSELVES INTERNALLY AND EXTERNALLY ACCOUNTABLE FOR THE SUCCESS OF THE PLAN.

This is important not only from an accountability point of view but also from a transparency lens, as it allows the Plan to course-correct and dig deeper into emerging challenges and opportunities. We will delineate our core work to run the Plan (outlined in the operational roadmap) from our accountability measures, as they are table stakes to running the Plan agnostic of this strategy.

### AFFORDABILITY

**PREMIUM & OUT-OF-POCKET STRATEGY** – Plan staff will provide regular updates on the impact of the premium strategy and provide the Board insight on emerging premium strategy across the country, as well as changes in technologies that allow the Plan to think differently about our premium approach. Premiums are not the only cost borne by members; costs vary substantially at point of care and are contingent on member acuity. As we continue to differentiate premiums and cost-sharing by salary and providers we need to continually assess how these strategies impact members.

### ACCESS THROUGH UTILIZATION

**TRACK THE IMPACT OF STEERAGE** – A key portion of the Plan’s strategy is driving members to high-quality, lower cost providers. Plan staff will regularly update the Board and public on how utilization patterns are and are not changing and how successful our preferred provider strategy is in impacting members.

### MEMBER ENGAGEMENT

**HBR AND STAKEHOLDER OUTREACH** – While member outreach and engagement have always been a strength of Plan staff, we are now asking members to behave differently and we must be the best partners in helping people understand the ask. We will be data-driven in our approach to build trust, share information and opportunities, and listen to members to drive savings for themselves and the Plan.

**AI DEPLOYMENT STRATEGY** – Artificial Intelligence can be a force multiplier in reaching and engaging members; however, we need to ensure we are safely and wisely deploying it. The Plan needs to be cautious in how it utilizes AI but given budget constraints and evolving ways to get members information we need an intentional approach to leveraging AI to help the Plan achieve its goals.

**PATIENT NAVIGATION DEPLOYMENT** – Health care is complicated and getting the right care at the right place in a timely fashion is challenging. The Plan needs to create a multimodal approach to helping members navigate the system. Patient navigation should facilitate alignment of incentives, and navigators should be incented to improve health outcomes. Given the diversity of our membership, we need to ensure we aren’t relying on a single solution and consider options including but not limited to mail, apps, text, telephonic, and websites.

### HEALTH DATA TRANSPARENCY

**BUILD ACCOUNTABILITY METRICS & SHARE PUBLICLY** – Being data-driven is a key value of the Department of State Treasurer, as is being accountable and transparent. The staff will build out tools and dashboards to share with the Board and our members that document where we are on our journey and how successful we are at achieving our goals.

**PUBLISH POPULATION HEALTH REPORT** – The Plan publishes a Population Health Status Report annually that highlights multiple components of member health status. This report supports decision making by Plan leaders and is broadly shared with stakeholders.