

Exhibit 18: Member Navigation

American Health care is complicated, expensive, not incented to improve patient health, and isolates people when they are at their most vulnerable. Given the current health care landscape, to make health care more affordable and improve health outcomes, the State Health Plan (Plan) must either make the Plan Designs more complicated or dramatically remove member choice. The Plan is prioritizing choice to ensure access and focus on aligning incentives between the Members, the Plan, and Providers. The Plan's strategy requires more complicated Plan Design features that prefer some providers over others while balancing the access needs of more than 500,000 Members. For this to work and to align incentives, the Plan needs to invest in Multimodal Patient Navigation, where navigation is independent and rewarded for aligning to the Members' incentives, not their shareholders. As the Plan's benefits become increasingly complex and driven by Members making better choices, the Plan needs to meet people where they are and simplify things where possible.

Why is “more complicated” the reasonable answer to tackle price variation and improve health?

Health care prices vary dramatically and are the byproduct of the rules of a system that thrives on opacity and an assumption that you have financial ability to raise prices annually agnostic of performance.

The broadest solutions to price variation that the industry has undertaken include Consumer Directed Health Plans (CDHP), Transparency Tools, Price Setting, and the repackaging of narrow networks. Yet costs continue to rise, health status continues to worsen, and access hasn't improved. Transparency Tools have moved the needle slightly but are mostly used and discussed by LinkedIn experts. The typical health care utilizer is busy and doesn't have the time or training to be effective consumers of healthcare, particularly in their time of need. The same reason has limited the success of CDHP; which in addition to requiring significant upfront costs for a pool of State employees whose average salary is below \$60k a year. While exclusive networks might have financial incentives in place in the Triangle, Triad, and the broader Charlotte area, leaders of most of those systems have expressed significant capacity concerns and ability to serve other communities if they are accountable for more than 500,000 lives that are sicker than the average North Carolinian. For the last eight years, the Plan tried to set provider rates but unfortunately forgot that consent matters. The consequence was that almost every provider below the set rate signed up for higher reimbursement and almost no one signed if they already made more, which was the bulk of Plan spending.

There is a lot to learn from why these efforts haven't worked or become industry standard. The Plan intends to intends to forge a new path, that avoids the shortcomings.

What is the Plan going to do?

The Plan is going to align incentives between the Members, the Plan, and willing partners (primarily providers). Providers that want to partner with the Plan and meet the criteria will become *Preferred Providers*. The Plan will financially motivate members to utilize lower cost providers and offer steerage to providers to improve their rates; with quality being the front door for steerage. Similarly, in competitive geographies, the Plan will make it more expensive to go to more expensive providers stuck in an existing framework. The Plan is going back to Economics 101 and basic free market principles with a level of transparency and Member support and a commitment to making partners compete for the business of Plan Members in a way that hasn't been fully realized.

The Plan intends to drive its approximately \$3.5B commercial dollars to Plan partners and plainly create winners and losers. The winners will be those high-quality providers focused on better rates through better efficiency, site of service, access, and long-term financial planning. The losers will be those who insist on holding onto the current model or being too rigid to partner.

What and Why the Plan Needs Navigation

To do this effectively the Plan needs to invest in Members to help them navigate through their health care journey. Whether it be a prison guard in Burke County, a teacher in Wake County, a pre-65 retiree in Cherokee County, or DOT worker in Pitt County the Plan needs to empower them with tools to make choices that help them save money and improve their health. The Plan is going to do that in a few ways, including:

- Making high-quality, low-cost providers the most affordable option whether it be \$0 surgeries or \$10 primary care
- Making higher cost providers who are not the Plan's preferred partners more expensive
- Providing low cost virtual/at-home care options to improve health between visits
- Building shared savings contracts to align incentives with Plan providers and other partners when we can improve health

By asking Members to make different choices and holding them accountable to those choices the Plan needs to communicate differently to ensure Member engagement. The Plan recognizes different segments of the population respond better to apps, mail, texts, inbound calls, outbound calls, or mobile messages, and some Members are not reachable with any of these methods. Similarly, people have different values and therefore different incentives; therefore, the Plan needs to understand what drives Members and push options to them in a way they will receive them.

The Plan wants a new approach. One that is holistic and led on behalf of Plan Members, not on behalf of the TPA or the provider. In lieu of the TPA, the new approach will deploy the Plan's

voice and message through multiple modalities and deep data understanding and strategic alignment. The key functions the Plan would like a partner to fulfill:

- Member Navigation (regardless of modality) for:
 - Primary care, specialty, surgical, and diagnostic navigation
 - Directing members to appropriate point solutions or Plan initiatives
 - Work with the Plan on future opportunities to improve health and finances
 - Developing and deploying incentives
 - Identifying members for outreach based on Plan priorities
 - Utilization Management (Optional)
 - Clinical support and appropriateness
 - Integration with existing partners

Members will be offered a one-stop shop to help them optimize their benefits that financially makes sense to them while providing them with the right resources and health care options.

How to align financial incentives?

Everyone has a point of view on who drives member savings. The Plan is unwavering in the belief that the Plan Member drives the savings. Members are picking a different provider, they are improving their health – if the Member doesn't act, the Member doesn't save. To that end, at least 50% of savings will accrue to Members at the point of care or to all Members through lower premiums. Next is the partner that delivered the savings, the Provider that performed the care through higher revenues and lower member cost share, the network that created mechanism to save, or the provider that improved member health status (primary and specialty care). And finally, there is the partner that supported the Member getting to where they needed to go to reduce their cost or improve their health. This is where the Plan sees this partner leading the way along with Primary Care. While the savings pool may be smaller it is significant with over \$5B in total spending and given the health status of the Plan and current utilization patterns there is ample room for growth. The Plan certainly expects to pay fees for these services; however, the Plan will not pay for Members who aren't utilizing services, and the Plan needs to be consistent with the terms and approach.