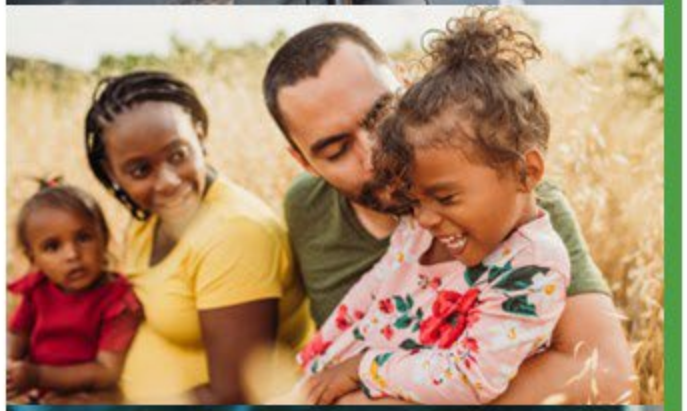

State Health Plan

Board of Trustees Meeting

February 7, 2025

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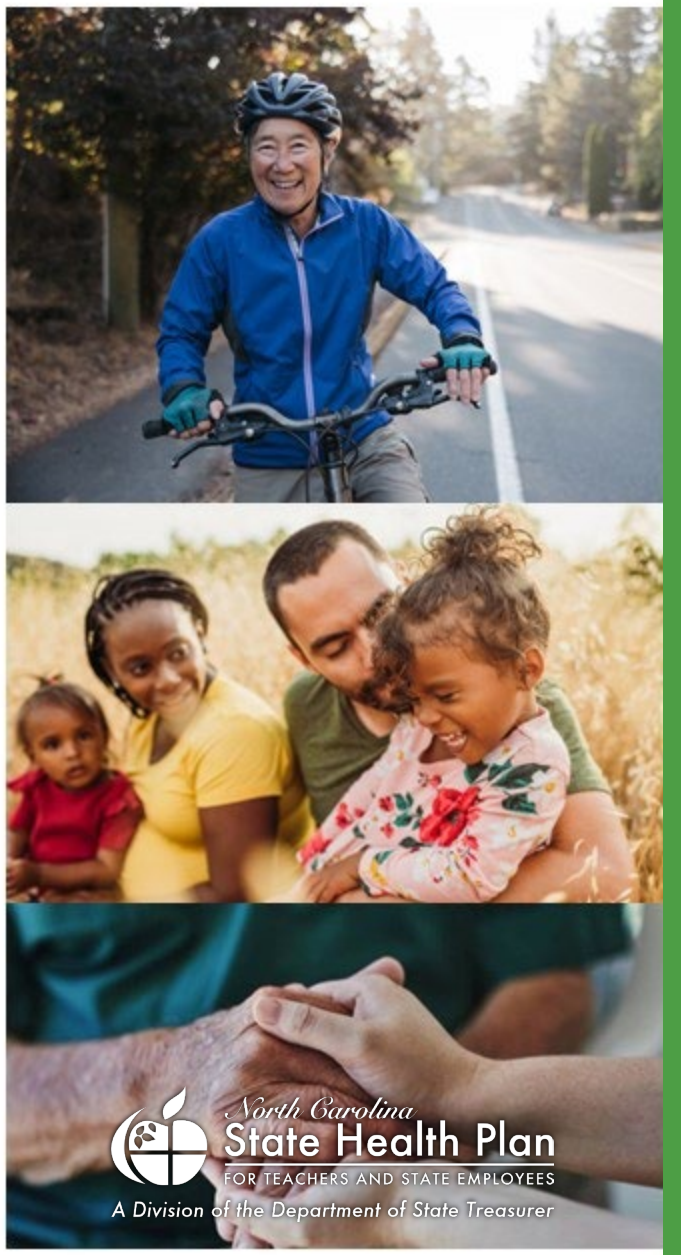

2025 Open Enrollment

2025 Open Enrollment – Where We Stand

Reminder: While the 2025 Open Enrollment period officially ended on October 25, 2024, there's still a lot of movement happening within the **MEDICARE PRIMARY POPULATION**.

- **Enrollment in other Plans –** Medicare primary members that either intentionally or unintentionally enroll in another Medicare Advantage and/or Medicare Prescription Drug Plan are disenrolled from the Plan's Medicare Advantage Plan and are automatically enrolled in the 70/30 Plan.
- **Medicare Advantage Open Enrollment Period** *(January 1 – March 31)* allows members enrolled in a Medicare Advantage Plan to make one plan change.
- **New Medicare Primary Members** – Combination of new retirees and newly eligible Medicare members.

2025 Medicare Primary Enrollment	End of OE	Early January	End of January (Change Since OE)
70/30 Plan Enrollment	18,317	26,811 (+8,494)	28,633 (+10,316)
Humana Base Enrollment	174,310	165,167 (-9,143)	163,789 (-10,521)
Humana Enhanced Enrollment	19,304	19,133 (-171)	19,112 (-192)
TOTAL	**211,931**	**211,711 (- 220)**	**211,534 (-397)**

2025 Open Enrollment – Non-Medicare

Here's how the **NON-MEDICARE PRIMARY ENROLLMENT** changed between 2024 and 2025.

Year	80/20	70/30	HDHP	TOTAL
As of 12/31/2024	291,199	248,497	461	**540,157**
Effective 1/1/2025	288,378	250,935	556	**539,869**

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Financial Update

State Health Plan Budget

- Staff develop the Plan's budget using projections of revenue and expenses in consultation with the Plan's external actuaries.
- **Budget Assumptions:**
  - No changes to benefits, premiums, or contribution rates, except changes that have been approved by the board.
- The board requires the Plan's budget to maintain a year-end cash balance that exceeds the Target Stabilization Reserve (TSR).
- TSR is the minimum required balance to pay for services already provided to members.

TSR = 9% of Calendar Year Claims

~$395M

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Reserve Adequacy

- TSR is the minimum required balance to pay for services already provided to members.
- Reserves above the required minimum balance are needed to:
  - Support long-term financial planning ensuring stable and reliable benefits without sudden changes.
  - Help manage the inherent unpredictability of healthcare costs.
  - Provide cushion due to uncertainty in forecast during times of transition.

- New TPA Transition
- Unpredictable MA Premiums
- Pharmacy Benefit Volatility

} Forecast Uncertainty

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Estimated Actual vs. Budget: Calendar Year 2024

($s in millions)	CY 2024 Adj. Actual	CY 2024 Budget	Difference
Premiums & Subsidies	$4,288.5	$4,282.5	$6.0
Investment Earnings	$33.1	$23.2	$9.9
Total Revenue	**$4,321.7**	**$4,305.7**	**$16.0**
Net Medical Claims	$3,246.1	$3,244.0	$2.1
Net Pharmacy Claims	$919.0	$984.1	($65.1)
Medicare Advantage Payments	$21.5	$18.5	$3.0
Administrative Expenses	$147.2	$138.0	$9.2
Total Expenses	**$4,333.8**	**$4,384.6**	**($50.8)**
Plan Income/(Loss)	**($12.1)**	**($78.9)**	**$66.8**
Ending Cash Balance	**$658.8**	**$590.4**	**$68.4**

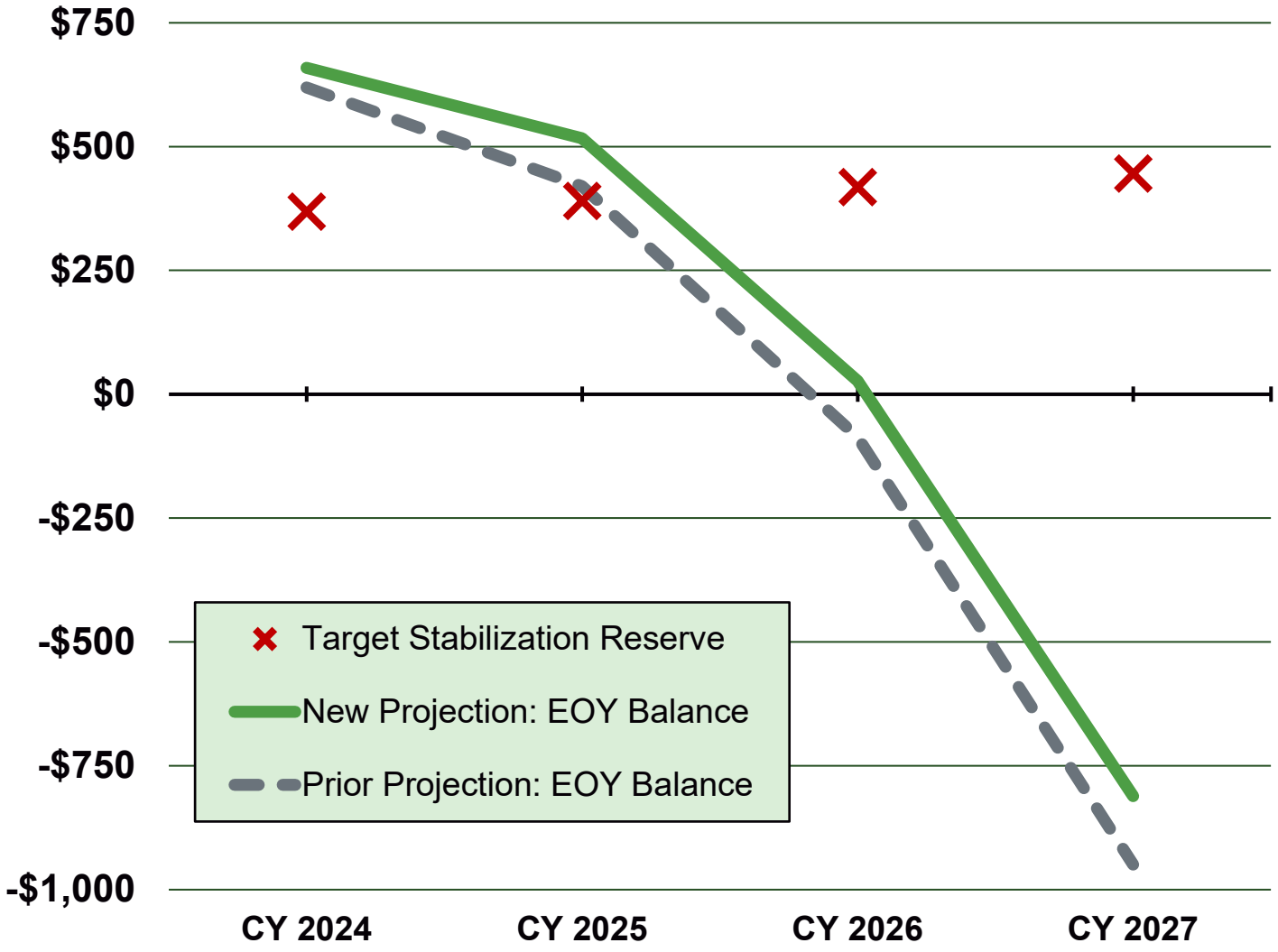
Estimated actuals after adjusting for timing. Budget has been adjusted for the exclusion of weight-loss GLP-1s & to correct interest rate.

Projection vs. Budget: Calendar Year 2025

($s in millions)	CY 2025 Projection	CY 2025 Budget	Difference
Premiums & Subsidies	$4,477.8	$4,489.0	($11.2)
Investment Earnings	$19.7	$20.1	($0.4)
Total Revenue	**$4,497.5**	**$4,509.1**	**($11.6)**
Net Medical Claims	$3,369.6	$3,377.5	($7.9)
Net Pharmacy Claims	$960.1	$1,009.5	($49.4)
Medicare Advantage Payments	$108.8	$91.0	$17.8
Administrative Expenses	$201.3	$197.1	$4.2
Total Expenses	**$4,639.8**	**$4,675.0**	**($35.2)**
Plan Income/(Loss)	**($142.3)**	**($165.9)**	**$23.6**
Ending Cash Balance	**$516.5**	**$425.1**	**$96.6**

Budget has been adjusted for increased administrative expenses under new TPA. Projection has been updated to reflect experience.

Financial Projection Update



- Projection improved due to:
  - Larger than expected rebate payment in Q3
  - Reduction in expected medical and net pharmacy claims
- Cash balance now expected to exceed TSR by $125 million at end of 2025.
- Changes are required to prevent cash balance from falling below TSR in mid-2026.

FY 2025-2027 Budget Requests

- New Obesity Management Program
- Increase in employer and retirement system contribution rates
- Increase in salary-related contribution rates for retiree health

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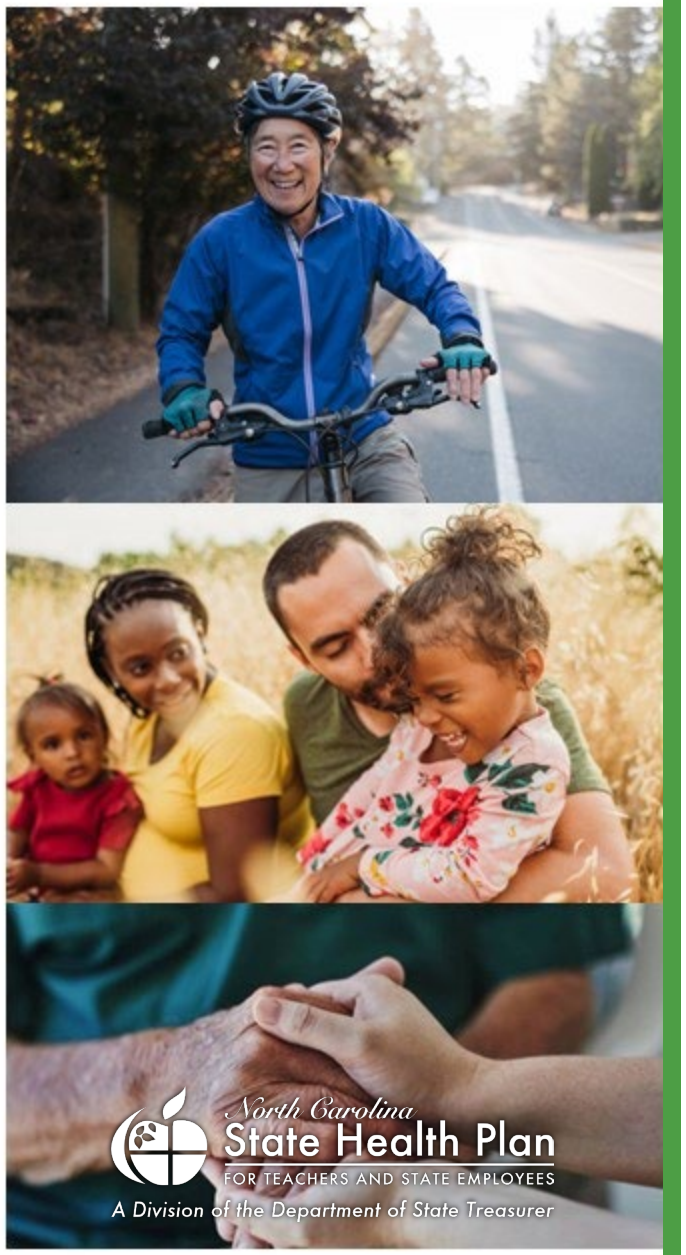

2026 Strategy Discussion

Overview

Drivers of Our Current Financial Challenge

Levers to Drive Down Cost (*short-term*)

- Clear Pricing Project
- Medicare Advantage
- Plan Design
- Formulary
- Member Premiums

Process and Timeline to Final Decision

Salary Based Premiums (Vote required)

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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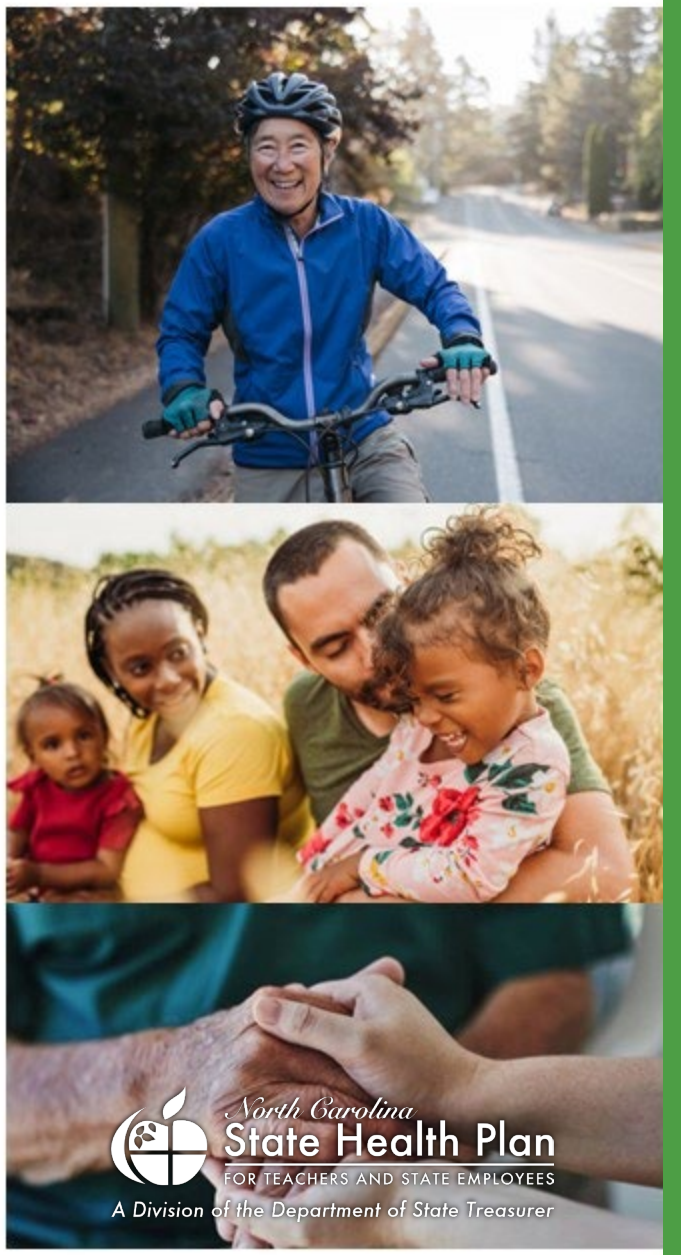

How We Got Here

Challenges Inherited:
How We Got into a Financial Challenge

- Deploying funds into the Retiree Health Benefit Trust Fund.
- Medical and Pharmacy trend have exceeded growth in employer contributions and employee premiums.
- Unchanged premiums and benefits.
- The employer contribution, while growing, hasn't fully offset the difference between trend and lack of changes to premiums and benefit changes.
- Unintended consequences of the Clear Pricing Project (CPP).
- Lack of population health focus.
- **We have a $500M shortfall in 2026 and an additional $800M shortfall in 2027.**

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The Health Care Cost Balloon

The health care cost balloon is pushing costs.
We need to shrink the cost balloon vs. push air around.

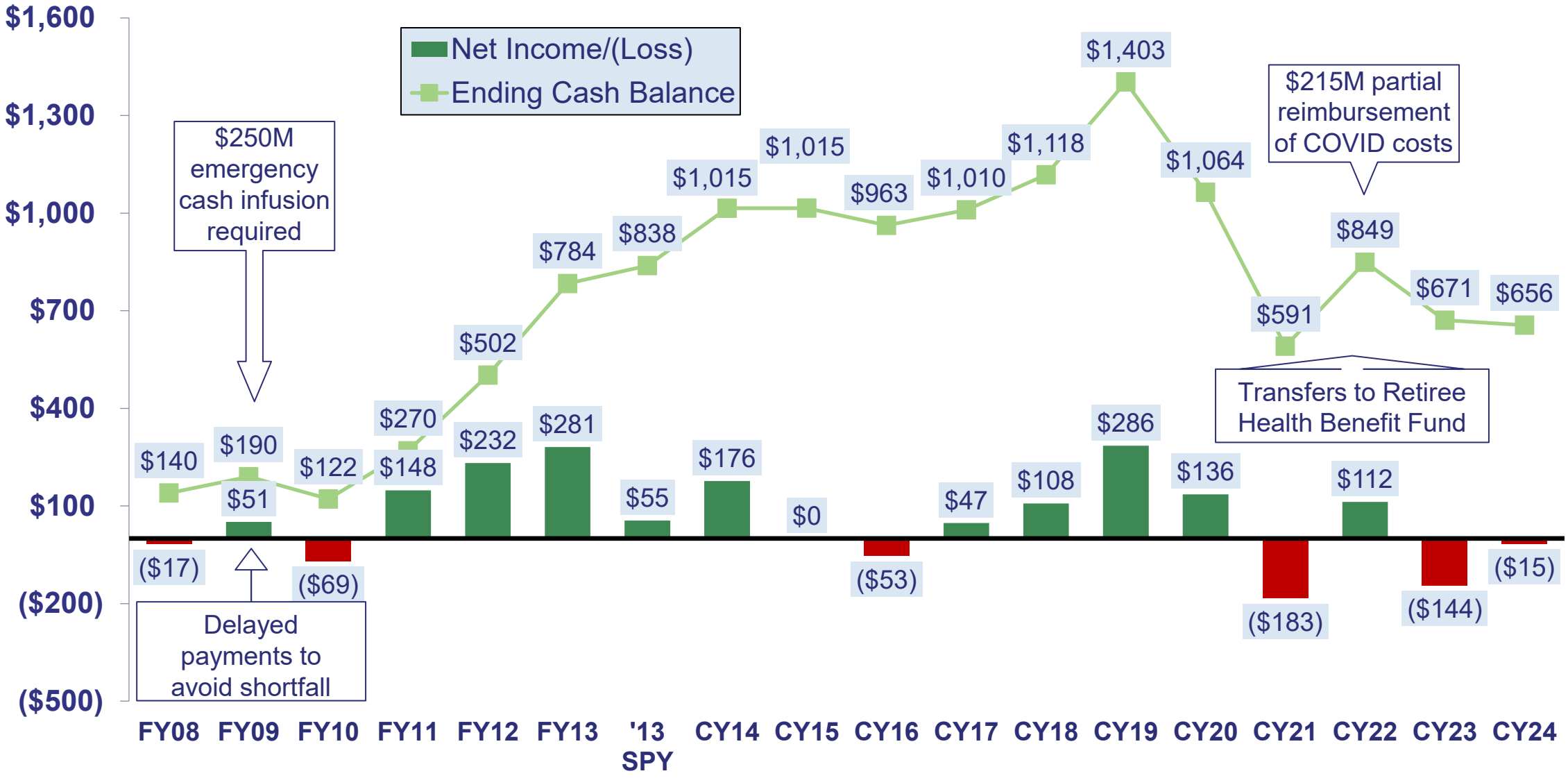
We need to tackle not just our short-term needs but address our overall cost.

COST COMPONENTS:

- UNIT PRICE
- VOLUME
- SERVICE MIX
- MEMBER ACUITY

By multiple measures, North Carolina ranks toward the bottom on cost and affordability.

Historical Financial Results by Plan Year



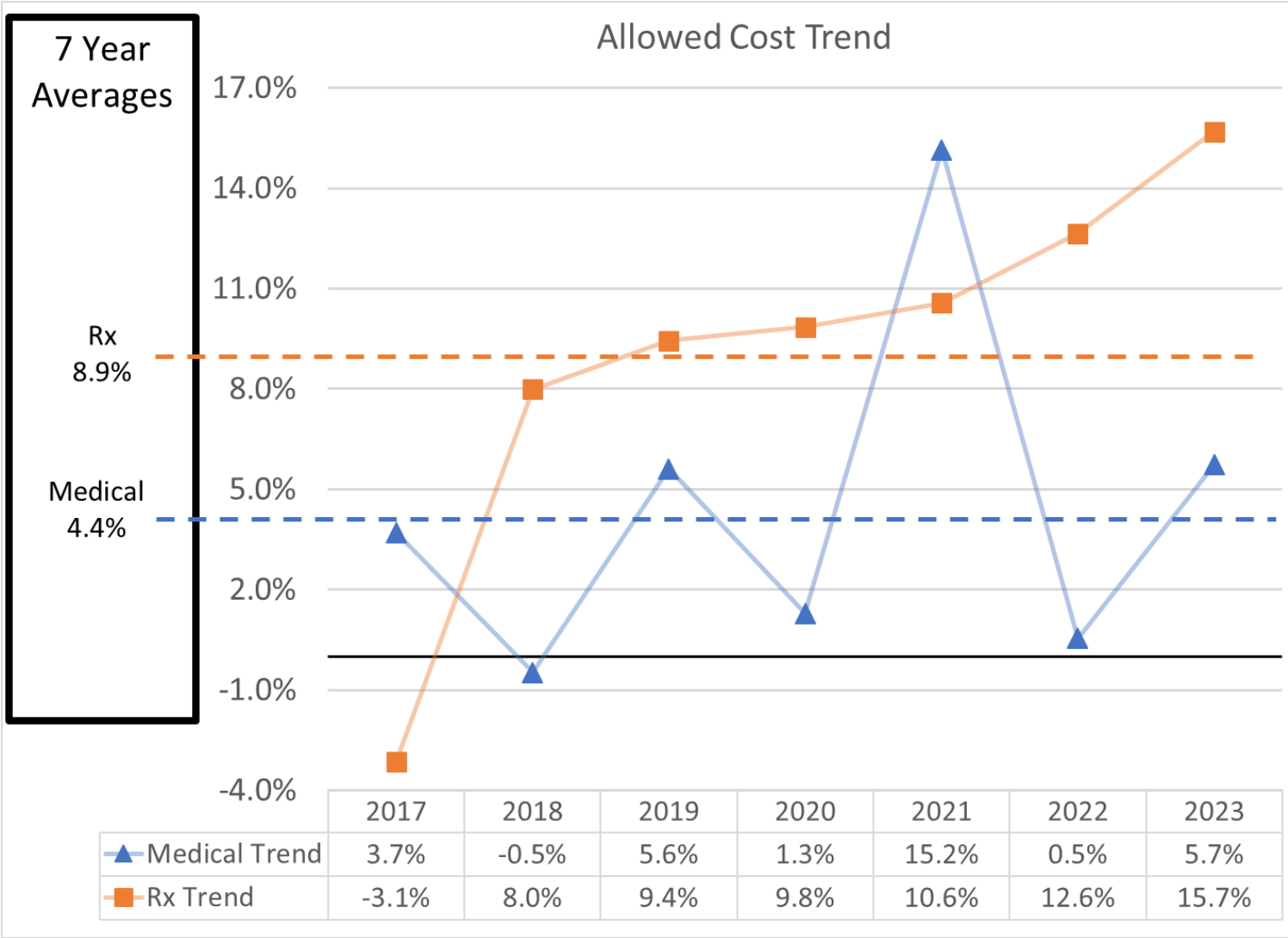
SPY=Short Plan Year Due to Conversion to Calendar Year Basis to Fiscal Year Basis

Medical and Pharmacy Trend

Plan Portion + Member Portion = Allowed Costs

Post-COVID Medical Trend was significantly high at 15.2%.

Pharmacy trends have increased each year up to 15.7% in 2023 (GLP-1).



	2017	2018	2019	2020	2021	2022	2023
Medical Trend	3.7%	-0.5%	5.6%	1.3%	15.2%	0.5%	5.7%
Rx Trend	-3.1%	8.0%	9.4%	9.8%	10.6%	12.6%	15.7%

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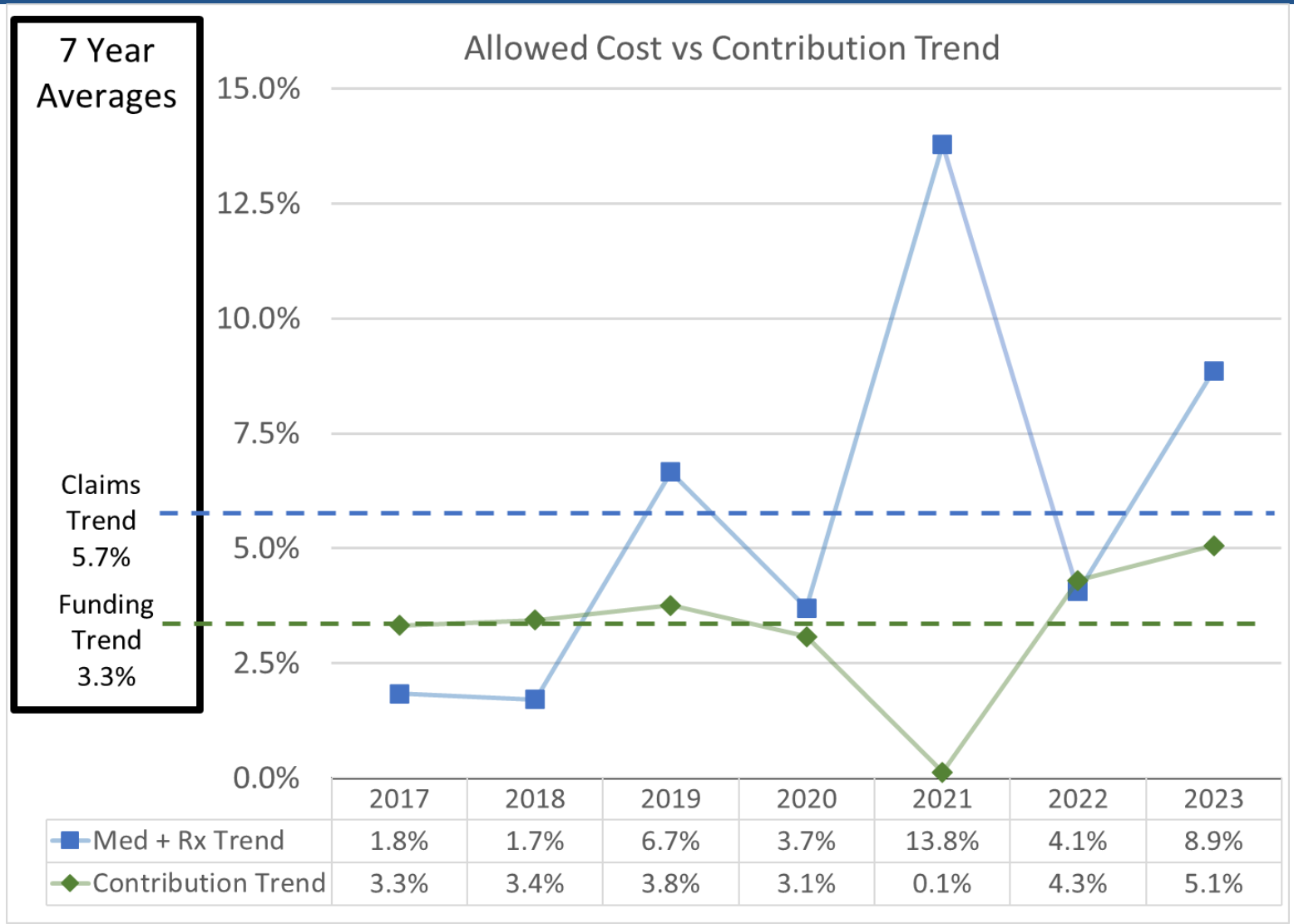
Employer Contribution Growth

GA reduced funding in FY 2021, with rebounds after.

Employee premiums have been flat (0%) during this time.

Self-insured claims (Non-MA) have increased on average at 5.7% while GA funding has been on average 3.3%.

We are assuming the employer contribution will be 4%.



	2017	2018	2019	2020	2021	2022	2023
Med + Rx Trend	1.8%	1.7%	6.7%	3.7%	13.8%	4.1%	8.9%
Contribution Trend	3.3%	3.4%	3.8%	3.1%	0.1%	4.3%	5.1%

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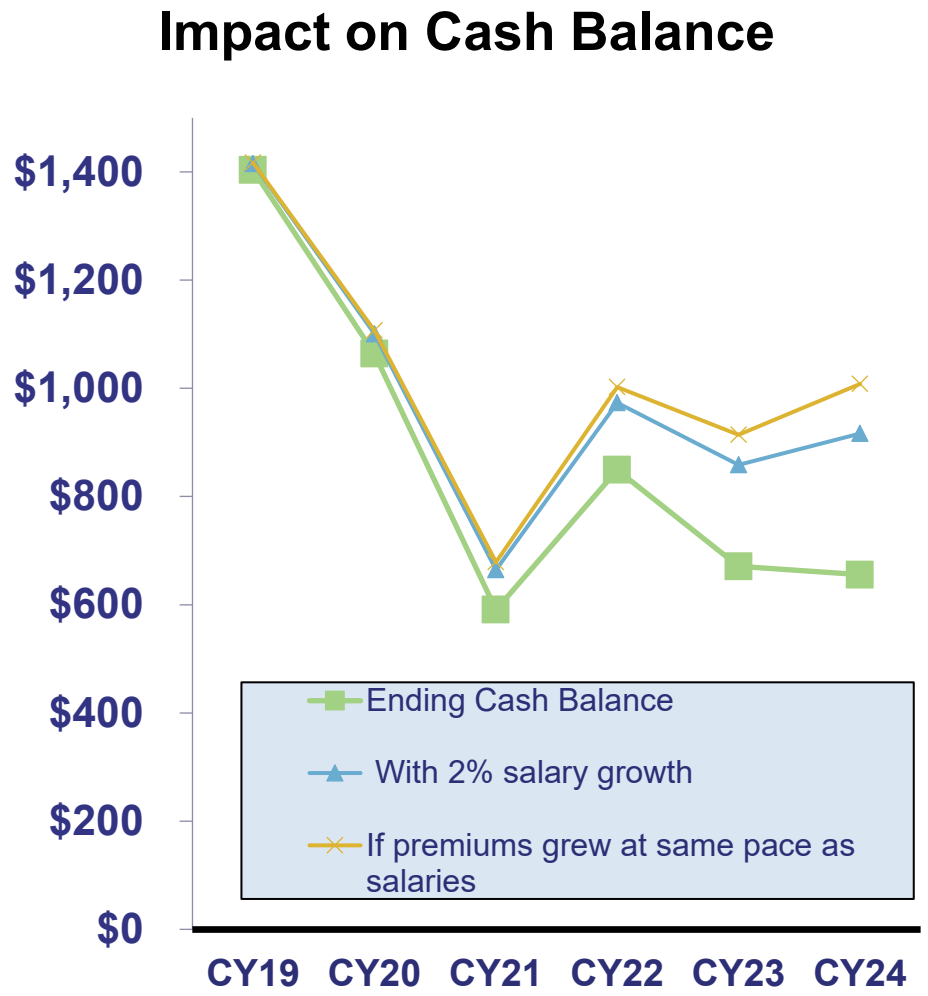
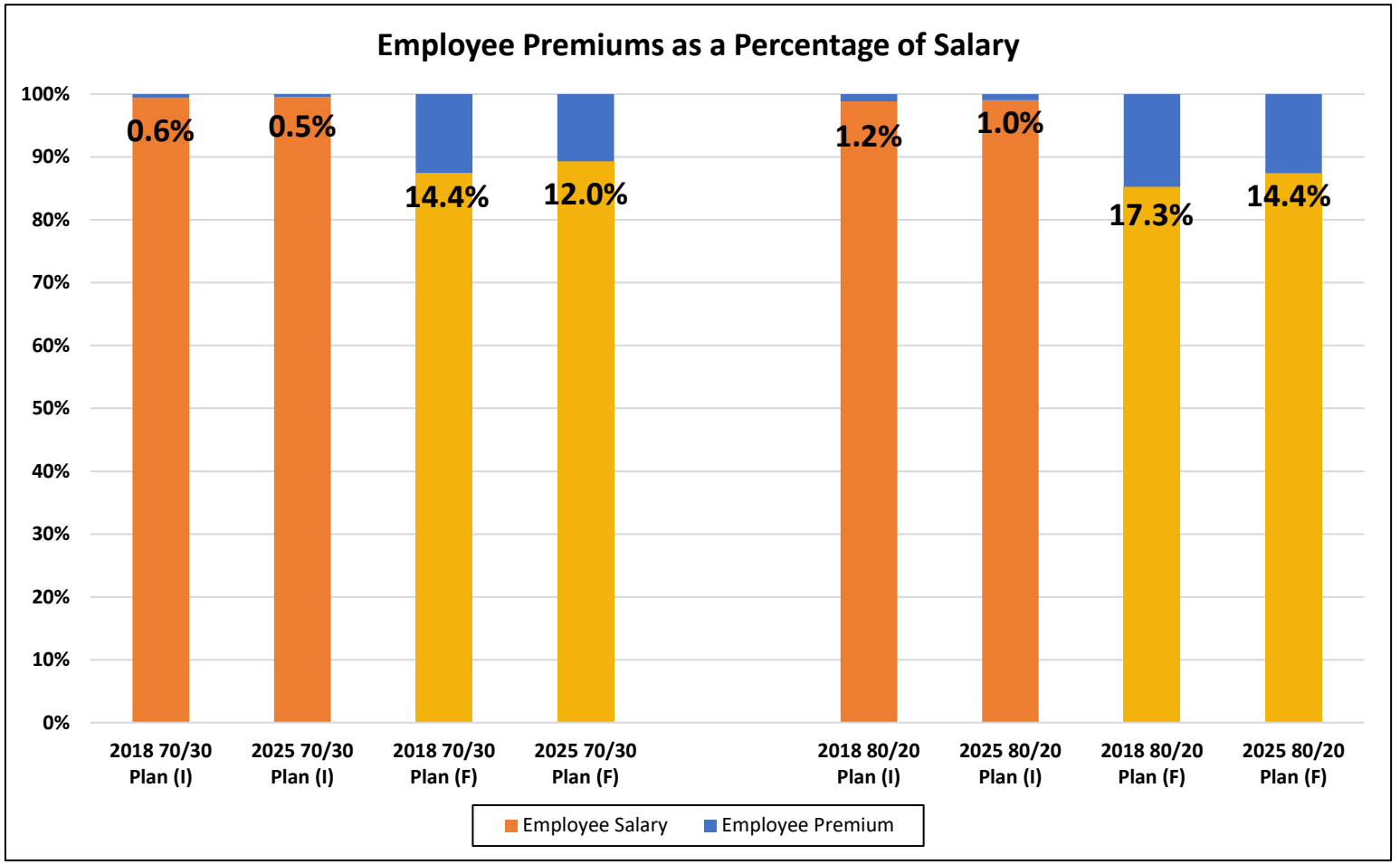
Hypothetical Impact of Gradual Premium Changes

- Employee premiums and benefits have not been adjusted for seven years, despite rising health care costs.
- A 2% annual premium increase since 2017 could have prevented the projected 2026 budget shortfall.
- Aligning premium adjustments with state employee salary growth could have resulted in $165 million in reserves above the required minimum cash balance; softening future premium increases.
- Proactive adjustments are vital to maintain the Plan's financial stability as costs continue to rise and support our ability to attempt to manage costs in more member friendly ways.



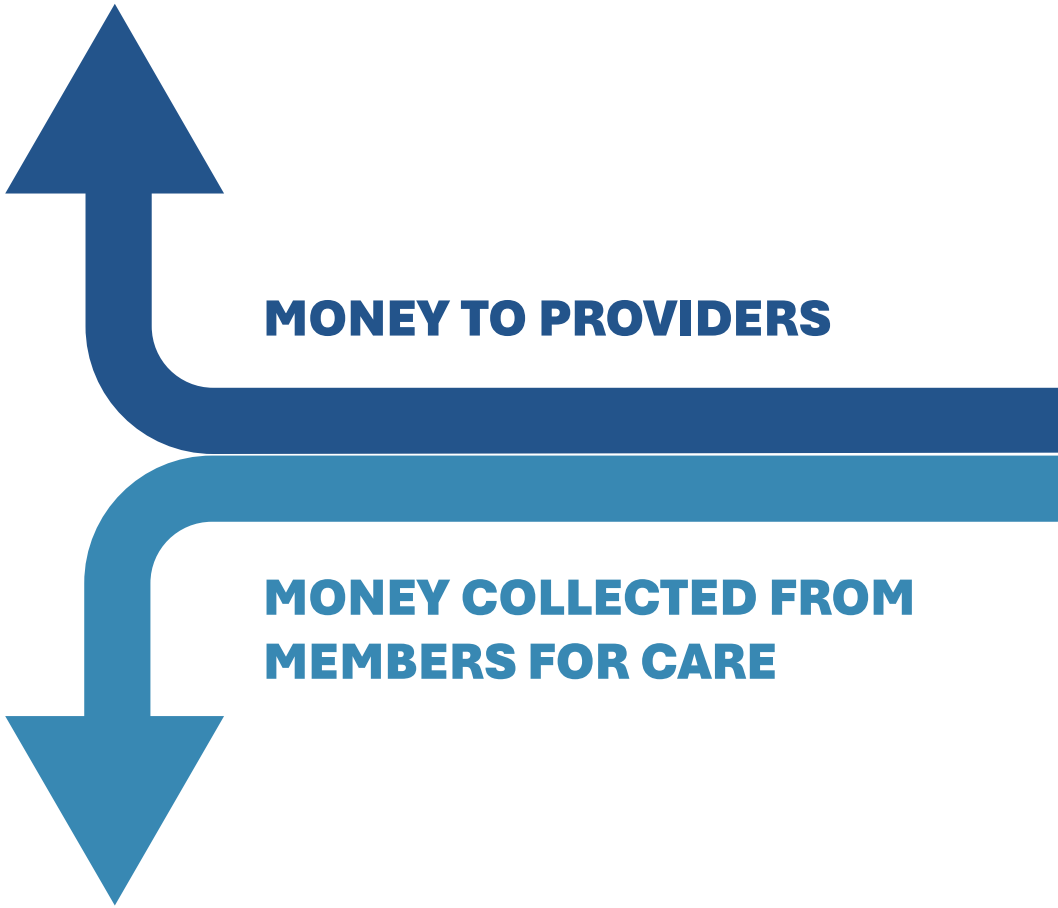
Premium Changes as a Share of Wage Growth

- Premiums as a share of employee compensation has declined over time while overall costs have increased.
- Similarly, due to static or declining cost sharing, cost-sharing for members has declined as a percentage of total expenditures.
- The employer contribution is picking up a continually larger share of the cost.



Clear Pricing Project

- Increased reimbursement rates for specific services (e.g., primary care, behavioral health, therapy) combined with reduced copays led to significant Plan costs.
- Cost was originally estimated to be $100M for the initial two years, with no ongoing cost. Actual cost has significantly increased cost above zero.
- The program is being reassessed to strike a balance between improving member health, financial sustainability, and provider quality.



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Lack of Population Health Strategy

COMPONENTS OF COST

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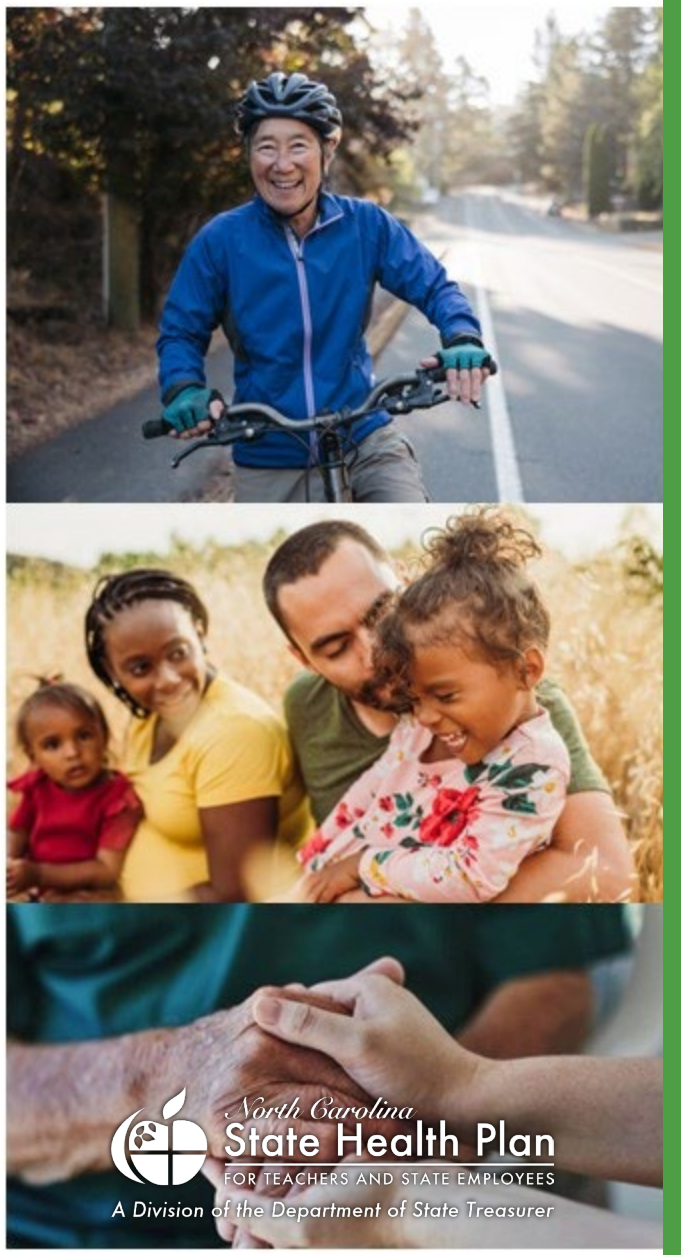

Go Forward Strategy

State Health Plan Strategy

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)

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

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What Empowering Health Looks Like

- Better understand our member's health needs and unique drivers that we can support (access, social determinants, cost-sharing) through listening to our members and leveraging our data.
- Identify 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
- Align 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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Targeted Enhancements *(Non-Medicare)*

Focus on improving access, quality, and out-of-pocket cost

- The Plan does benefit from our partnerships with Aetna and CVS Caremark. We believe there are areas within the Plan's authority to contract directly with providers to generate additional savings and benefits for members.
- These programs might have some geographic constraints based on local provider options.
  Key areas we intend to explore in 2025:
  - Orthopedic Surgery
  - Surgical Eye Care
  - Maternity Care
  - Weight Loss Medication and Surgery (*more coming in March 2025*)
  - Direct or ACO Driven Primary Care
  - Imaging and Labs
- The goal of these programs will be to improve access to high quality care for Plan members while reducing costs to both the member **and the Plan.**

Next steps: Evaluate opportunities and who can administer them.

Address the Financial Cliff: 2026 Plan Changes

Evaluating Solutions

Balancing Impact and Feasibility

To address the budget shortfall responsibly, every proposed change is evaluated with a holistic view of its impact. We are committed to making changes that consider member needs, operational capacity, and financial sustainability.

- **MEMBER IMPACT**
  - Will this change maintain or enhance member access to quality care?
  - Are potential financial benefits worth any trade-offs in member experience?
- **OPERATIONAL IMPACT**
  - Can this change be implemented efficiently within existing systems and resources?
  - Will it introduce complexity or risk that could unnecessarily disrupt services or create unintended challenges?
- **FINANCIAL IMPACT**
  - Will this change meaningfully contribute to closing the budget gap?
  - Are the financial gains substantial enough to justify potential impacts on members or operations?

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Action Items for 2025 and 2026

ELIMINATE

Tobacco Credit for all members (Effective 1/1/2026)

INVEST

in Population Health infrastructure

LAUNCH

provider pilots focused on access, quality, and cost for members and the Plan

PARTNER

to build out a rural health strategy to enhance access

Options for Closing Budget Gap for 2026

	Estimated 2026 Budget Impact		
	Lowest	**Moderate**	**Significant**
CPP Transition	$30M	$75M	$150M
Adjust Medicare Primary Plan Options	$10M	$40M	$80M
Rx: Formulary and Benefit Structure	$10M	$20M	$50M
Increase Copays/Deductibles/OOP Max	$30M	$100M	$250M
Increase Premiums	$10M	$100M	$500M

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Amount needed to close the gap = $500M

CPP Transition

Lowest	Moderate	Significant
adjust rates, copays	maintain for behavioral health only	end program
+$30M	**+$75M**	**+$150M**

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Medicare Advantage Plans

	Base		Enhanced	
	Current	**Proposed**	**Current**	**Proposed**
Out of Pocket Max	$4,000	$4,500	$3,300	$3,700
Specialist	$40	$50	$35	$45
Adv. Imaging - OP	$100	$175	$100	$150
Radiology - OP	$40	$75	$40	$50
Therapies (PT, OT, ST, AT)	$20	$30	$20	$20
Premium Per Member Per Month	**$126.46**	**$95.96**	**$203.05**	**$172.55**

- $30.50 Per Member Per Month reduction expected to have $60M in savings
- Medicare Advantage plan must remain preferable to 70/30

Medicare Plan Options

- We have a few options for this population.
  - Try more incentives to encourage enrollment into Medicare Advantage plans.
  - Offer Medicare Advantage plan option only.
  - Redesign the Base 70/30 Plan.

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Formulary and Benefit Structure

- Currently, we have a closed formulary that balances cost and cost-sharing across generic, brand, and specialty medications.
- We are pursuing detail around the following options to rebalance our approach to our Pharmacy Benefit Manager (PBM) spend:
  - Generics first formulary.
  - We can fully leverage drug maker benefits by utilizing our deductible/coinsurance tier for specialty medications. Our current strategy underutilizes these benefits and leaves a significant amount of money on the table.
  - Manage utilization and better support members with complex conditions.

Formulary and Benefit Structure

Lowest	Moderate	Significant
+$10M	+$20M	+$50M

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Current Benefits

	70/30 Plan	80/20 Plan
Subscriber Premium	$25*	$50
Deductible	$1,500/$4,500	$1,250/$3,750
Coinsurance	70%	80%
Out-of-Pocket Max	$5,900/$16,300	$4,890/$14,670
IP and ER Copay	$337+ded/coins	$300+ded/coins
Primary Care	$45/$30/CPP $0	$25/$10/CPP $0
Specialists	$94/CPP $47	$80/CPP $40
Mid-Tier	$72/CPP $36	$52/CPP $26
Rx-Tier 1/Tier 2	$16/$47	$5/$30
Rx-Tier 3/Tier 6	Ded/Coinsurance	Ded/Coinsurance
Rx-Tier 4/Tier 5	$200/$350	$100/$250
Actuarial Value	**79.8%**	**83.9%**

**Premium for most retirees is $0*

Increase Copays/Deductibles/OOP Max

	70/30 Plan		80/20 Plan	
	Current	Proposed	Current	Proposed
Deductible	$1,500/$4,500	$5,000/$15,000	$1,250/$3,750	$2,500/$7,500
Out-of-Pocket Max	$5,900/$16,300	$9,000/$18,400	$4,890/$14,670	$5,000/$15,000
IP and ER Copay	$337+ded/coins	$450+ ded/coins	$300+ded/coins	$350+ded/coin
Rx-Tier 1/Tier 2	$16/$47	$40/$75	$5/$30	$10/$35
Rx-Tier 4/Tier 5	$200/$350	$350/$500	$100/$250	$150/$300
Actuarial Value	**78.6%**	**70.2%**	**83.9%**	**80.7%**

+$250M

What Parameters to Adjust?

	70/30 Plan	80/20 Plan
Subscriber Premium	$25*	$50
Deductible	$1,500/$4,500	$1,250/$3,750
Coinsurance	70%	80%
Out-of-Pocket Max	$5,900/$16,300	$4,890/$14,670
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Rx-Tier 3/Tier 6	Ded/Coinsurance	Ded/Coinsurance
Rx-Tier 4/Tier 5	$200/$350	$100/$250
Actuarial Value	**79.8%**	**83.9%**

**Premium for most retirees is $0*

Address the Financial Cliff: 2026 Plan Changes – Premiums

Active Employee Premiums

Current (Base/Enhanced)	Lowest	Moderate	Significant
$25/$50	$35/$60 (+$10)	$55/$80 (+$30)	$140/$210 (+$115/+$160)
$140M	**+$35M**	**+$100M**	**+$500M**

These amounts do not reflect salary-based premiums.

Address the Financial Cliff: 2026 Plan Changes – Premium Structure

(Salary Based Premiums)

Premium Structure

As we consider a new benefit structure and raise premium costs, we propose considering **TWO UNIQUE CHANGES**:

- Can we mitigate the impact to our lowest paid employees?
- Should we consider resetting family premiums to limit impacts on active members choosing the 70/30 Plan for their families?

Advantages

Addresses concerns about active family premiums, while supporting our lowest-salaried employees.

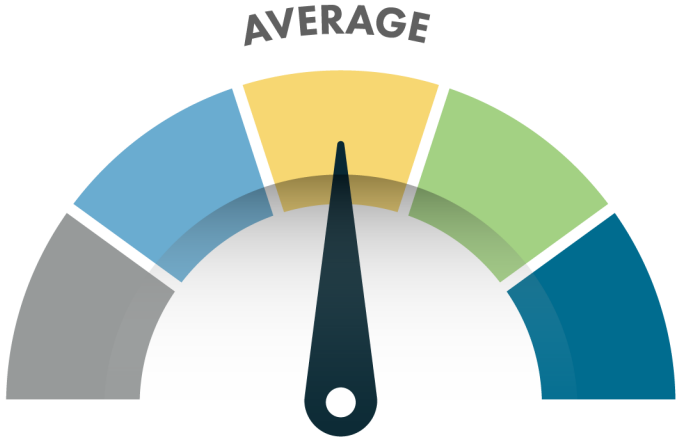
Considerations

Any cost reduction for one group means higher costs for another.

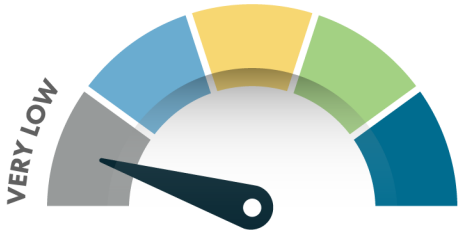
EMPLOYEE COSTS PEER COMPARISON

North Carolina STATE HEALTH PLAN

Our **TOTAL COSTS** are average relative to our peers, but the rapid consolidation of health care providers in N.C. has led to steep increases that exceed the capacity and planned growth in Legislative funding.



GRAND TOTAL PROGRAM COSTS for Employees & Employers

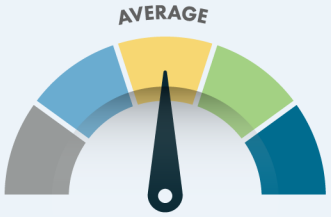


Employee Premium

Employee Premium as Share of Total Cost

INDIVIDUALS

Total Employee Costs



Total Employer Costs

Employer Subsidy Percentage

FAMILIES

Total Employee Costs

Total Employer Costs

Employer Subsidy Percentage*

*Statute forbids using employer funds to subsidize family premiums.

Active Employee Premiums: Salary Bands

Salary Band	Estimated Count	%
Under $40,000	47,000	16%
$40,000 - $65,000	112,000	37%
$65,000 - $100,000	107,000	36%
Over $100,000	24,000	11%
Total Employees	**300,000**	**100%**

For illustrative purposes only.

Active Employee Premium: Example

Moderate

+$30 average

+$100M

Salary Band	Premium	Change	Average % Change
Under $40,000	$45/$70	+$20	+60%
$40,000 - $65,000	$50/$75	+$25	+75%
$65,000 - $100,000	$60/$85	+$35	+105%
Over $100,000	$75/$100	+$50	+150%

For illustrative purposes only.

CONTRIBUTION RATIOS

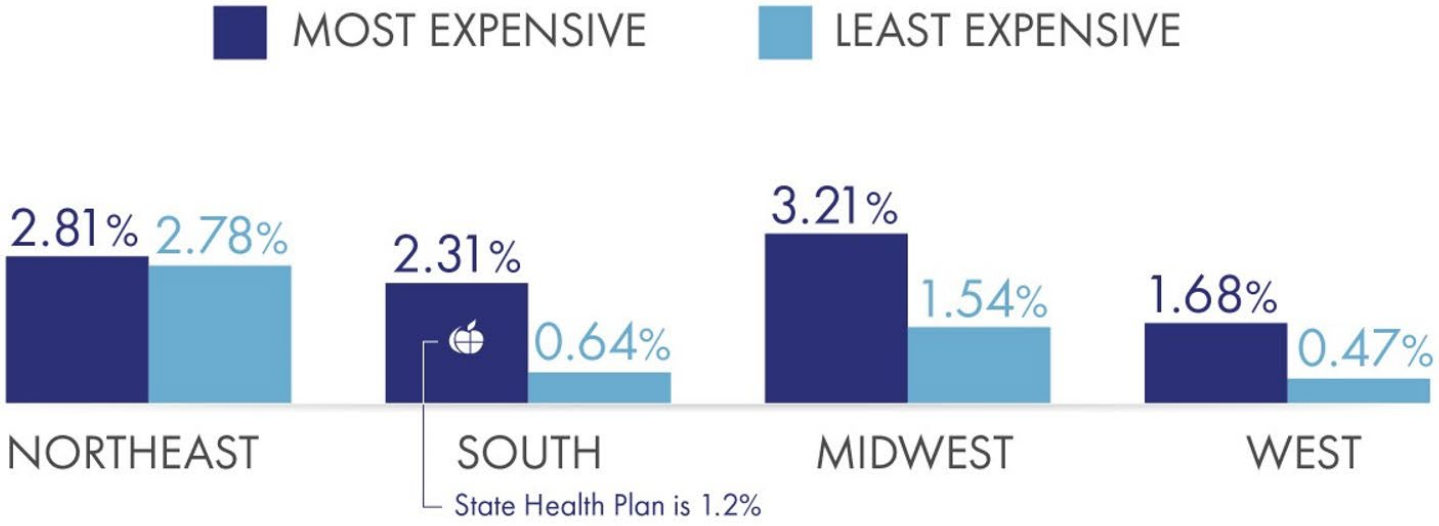
by Plan Type and Region

Source: Segal, 2024

For most state health plans, premium levels vary by plan types as well as coverage tier. However seven state plans also vary contributions based on an employee's salary level so that coverage is more affordable for lower-wage earners.

Region	State Employee Salaries (2022)
Midwest	$56,100
Northeast	$65,800
South	$54,700 (NC $56,220)
West	$60,600

VARIATION IN THE MEDIAN EMPLOYEE-ONLY CONTRIBUTION AS A PERCENTAGE OF AVERAGE STATE SALARY*



*Salary only reflects employees and, consequently, does not account for dual-income households.

Active Employee Premiums: Example

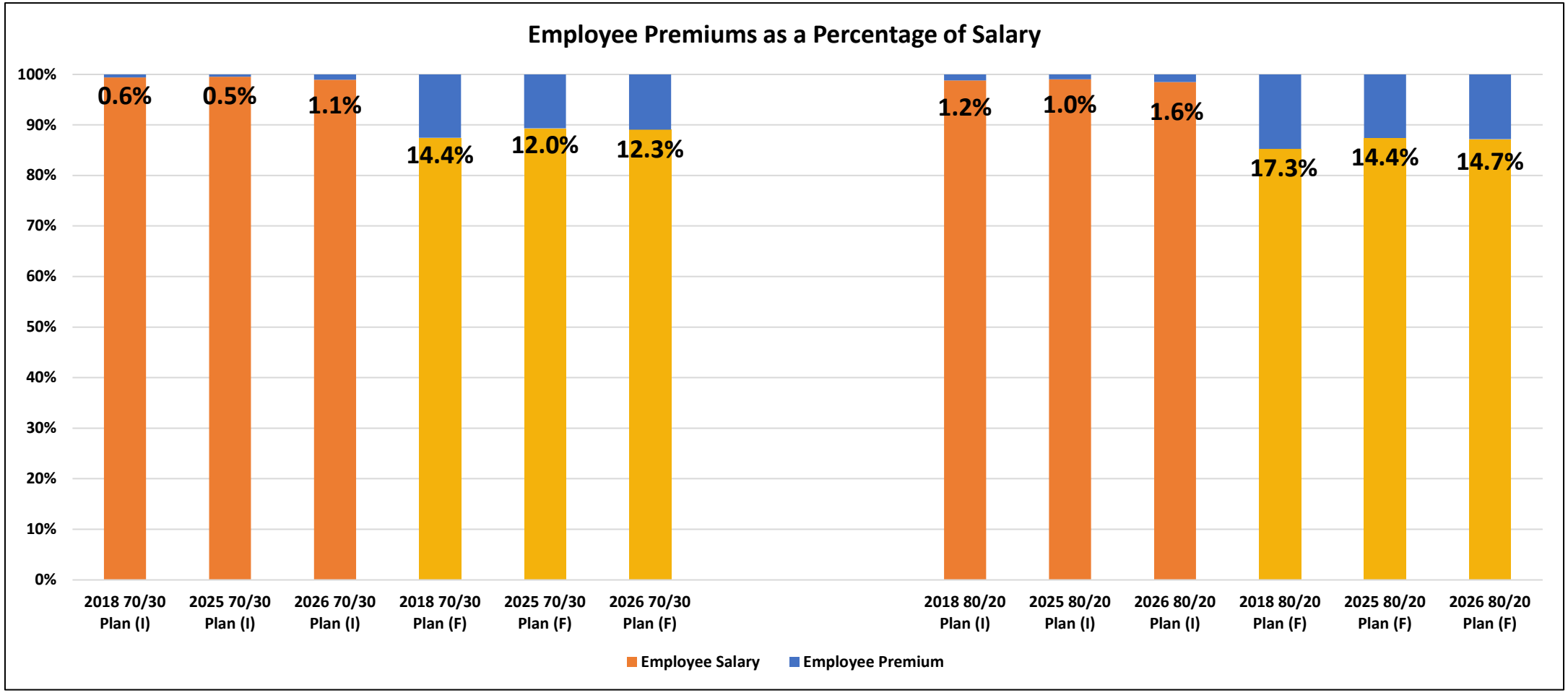
Salary Band	Premium	Highest Premium as Share of Salary
Under $40,000	$45/$70	1.8%
$40,000 - $65,000	$50/$75	1.7%
$65,000 - $100,000	$60/$85	1.3%
Over $100,000	$75/$100	0.8%

State employees in the South pay an average of **2.31%** of their **annual salary** for the **most expensive health plan** offered by their State.

For illustrative purposes only.

Illustrative Impact

While premiums will increase, we would be with in range of other regional plans.



Vote on Ability to Implement Salary-Based Premiums

Ability to Implement Salary Based Premiums

- The Board is required to vote on the Plan's ability to implement premiums based on member salary:
  - We are **not** voting on the amount of premiums
  - We are **not** voting on the specific dollar thresholds
  - If the Board elects to go back to one premium rate that would be workable under this structure

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Next Steps and Discussion

Targeted Enhancements

Focus on improving access, quality, and out-of-pocket cost.

- The Plan does benefit from our partnership with Aetna and CVS Caremark, we believe there are areas within the Plan's authority to contract directly with providers to generate additional savings and benefits for members.
- These programs might have some geographic constraints based on local provider options.
  Key areas we intend to explore in 2025:
  - Orthopedic Surgery
  - Surgical Eye Care
  - Maternity Care
  - Weight Loss Medication and Surgery
  - Direct or ACO Driven Primary Care
  - Imaging and Labs
- The goal of these programs will be to improve access to high quality care for Plan members while reducing costs to both the member **and the Plan**

Next steps: Evaluate opportunity and who can administer – *Will bring more detail in March.*

2026 Benefits Decision Timeline

	CY 2026 PLAN DEADLINES
February 2025	Finalize Enrollment Strategy for 2026 (Vote on Salary Band Option)
March 2025	Stakeholder Feedback and Deep Dive Scenarios Based on Discussion Today
May 2025	Finalize Benefit Designs for 2026
August 2025	Finalize Premiums for 2026
October 2025	Open Enrollment for 2026

What Should We Explore Further to Close the Gap?

	Estimated 2026 Budget Impact			Estimated 2027 Budget Impact
	Lowest	Moderate	Significant	
CPP Transition	$30M	$75M	$150M	More Work to Be Done
Adjust Medicare Primary Plan Options	$10M	$40M	$80M	
Rx: Formulary and Benefit Structure	$10M	$20M	$50M	
Increase Copays/Deductibles/OOP Max	$30M	$100M	$250M	
Increase Premiums	$10M	$100M	$500M	
Amount Needed to Close the Gap	**$500M**			**Additional $400M**

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Discussion

- What options seem most palatable for the Board?
- Programmatically, how do we address long-term health need?
- We need to identify 2027 plan design now; what will success look like?
  (Closing budget gaps, member savings for complex care, improving health, etc.)
- What to expect in March meeting.

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Appendix

Balancing the Budget

To achieve a balanced budget, the Plan needs a strategic approach that combines increased funding and reduced expenditures.

TAXPAYERS

- Employer contributions
- Federal subsidies

PROVIDERS & VENDORS

- Rates and Fees
- Service Efficiency

EMPLOYEES & RETIREES

- Premiums
- Benefit Design

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Guiding Principles: Premiums and Benefits

ACTIVE EMPLOYEES

- Strive to keep premiums and benefits aligned with comparable plans, while addressing budget constraints.
- Adjust plan designs to create clearer distinctions between the Base and Enhanced PPO plans, reflecting their intended benefit levels.
- Set premiums to better align with the value and benefits of each plan.
- Consider options to limit growth in family premiums.

NON-MEDICARE RETIREES

- Base PPO plan for individuals to remain “substantive equivalent” with $0 premium.
- Explore feasibility of Enhanced PPO plan design remaining aligned with active plan.
- Consider premium adjustments to better align with the value and benefits of each plan for the retiree population.

MEDICARE RETIREES

- Adjust Medicare Advantage (MA) plan design to limit increase in plan cost.
- Explore feasibility of Base PPO plan design remaining aligned with active plan.
- Begin multi-pronged strategy to encourage members to enroll in MA and optimize subsidy opportunities within the 70/30 Base PPO.

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What Does the Lake Supreme Court Decision Allow?

- **What does the Supreme Court's ruling allow us to change for Medicare eligible retirees?**
  - Must offer a plan that is at least "substantively equivalent" to the "vested" plan for each retiree.
  - Doesn't dictate type of plan or specific benefits.
  - The State Health Plan has kept the Base PPO Plan (70/30) as premium free for all eligible retirees during the Lake litigation in an abundance of caution, even though the Medicare Advantage Plans offer a better value to the eligible members and are significantly cheaper for the Plan.
  - With the clarity now provided in the Court's opinion, the Plan could offer the Medicare Advantage plan as the sole premium free option.
  - We could create exceptions for Medicare-eligible retirees who are ineligible for Medicare Advantage plans.
- **For 2025 this would have saved $4,200 per affected member or at least $75 million.**

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