The Honorable Brett Guthrie (R-KY)

1. **Please provide complete, detailed information and/or data, as appropriate, with respect to your group purchasing organization (Zinc, Ascent, Emisar), regarding:**
    a. **The total number of employees presently working within each of your GPOs.**
    b. **The current remuneration arrangements (such as fees or other forms of compensation paid to or retained by your GPO) with manufacturers, as well as health payors, including, but not limited to, health insurance plan sponsors, employers, or pharmacy benefit managers (PBM).**
    c. **When your GPO began levying each fee or requiring such form of compensation.**
    d. **An explanation of the services rendered for each of the fees charged or for which compensation was paid to or retained by your GPO, as well as whether any such fees are charged or compensation is required for similar classes of services also performed by your PBM.**
    e. **Whether any such remuneration arrangements (such as fees or other forms of compensation paid to or retained by your GPO) are in any way linked to the list price of a drug.**
    f. **How much of these fees or this compensation (as a percentage of total revenue) is retained by your parent company as profit, by year, since its establishment.**

Response: Ascent Health Services was founded in 2019 with a mission to aggregate volume and negotiate greater discounts from drug companies than any of the participants in Ascent could achieve alone. United States drug costs are driven by a combination of high prices and elevated demand – fueled in part by U.S.-only direct-to-consumer advertising, which for many large drug companies rivals or exceeds R&D spending.[1,2] In this environment, Ascent helps lower health care premiums and other costs for more Americans by serving as a critical counterbalance to multinational drug companies that derive most of their profits from the U.S., despite it representing only 5% of the global population.

Express Scripts, Inc. was one of two participants when Ascent was founded and is the only participant affiliated with The Cigna Group. Since its inception, additional participants representing a diverse range of interests have joined Ascent, including other PBMs and health plans. In addition to Express Scripts, current participants include Kroger, Prime Therapeutics, and Health Transformation Alliance (a cooperative of 58 self-insured employers), among others.

Importance of Collective Buying Power

Group Purchasing Organizations (GPOs) have been utilized in health care and many other industries for decades to aggregate purchasing volume to obtain larger discounts than any one entity could achieve on their own. The U.S. Supreme Court has recognized the economic and pro-competitive benefits of GPOs.[3] In health care, community and retail pharmacies, hospital

[1] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. *Comparing U.S. and International Market Size and Average Pricing for Prescription Drugs, 2017-2022* (Dec. 2024).
[2] Campaign for Sustainable Rx Pricing (CSRxP), *Direct-to-Consumer Pharmaceutical Advertising Spending and Its Impact on Prescription Drug Costs* (Mar. 2025).
[3] *Northwest Wholesale Stationers, Inc. v. Pacific Stationers & Printing Co.,* 472 U.S. 284, 295 (1985).

systems, nursing homes, home health agencies, drug and device companies, drug wholesalers, and others use GPOs.

U.S. Plan Sponsor and Patient Needs Drive PBM Competition
U.S. health care purchasers, including health insurers, large and small employers, and unions, are the ultimate decision makers behind the coverage offered to their employees. No plan sponsor is required to use a PBM or a GPO, and PBMs must undergo a rigorous, competitive process to secure new business, aligning their services and incentives with the needs of sophisticated plan sponsors in order to win their business. Plan sponsors often use detailed Request for Proposal (RFP) processes to secure bids from several PBMs, incentivizing PBMs to compete to best serve the plan sponsor's detailed needs, as outlined in the RFP. Plan sponsors are sophisticated purchasers and there are a range of pharmacy benefit consultants that further support these negotiations on behalf of plan sponsors.

Ascent Increases PBM Industry Competition and Expands Savings to U.S. Patients and Businesses
Smaller PBMs often market themselves to plan sponsors as industry disruptors through differentiated technology and business models, and the savings they realize via Ascent – either directly or via a relationship with another Ascent participant – are likely greater than they would otherwise be able to achieve on their own. This likely helps enable their success and results in more U.S. patients and businesses benefiting from savings than would otherwise occur.

Ascent's Transparency
Ascent's participants negotiate for and pay a participation fee as compensation for the services Ascent provides, including rebate contracting. In addition, drug companies may negotiate for and pay fees separate from any applicable rebate amount in exchange for services provided by Ascent, such as the processing and reporting of utilization data and analytics services. Ascent is subject to regular audits from participating entities to ensure compliance with contractual arrangements.

"Landmark" Federal Trade Commission Settlement Addresses Potential Concerns
The recent settlement with Express Scripts announced by the Trump-Vance Federal Trade Commission reinforces our commitment to pharmacy benefits that put Americans first. The settlement confirms meaningful actions by both Ascent and Express Scripts to accomplish the following:

- Support the American economy by moving Ascent's rebate contracting operations conducted on Express Scripts' behalf to the U.S.;
- Ensure that Express Scripts members pay the lowest available cost for their medicines, whether it is the Express Scripts negotiated cost, their copay, or a cash discount price. For example, Express Scripts will now integrate cash pricing available through TrumpRx into the benefit and count member payments made through TrumpRx toward their deductible, provided legislative or regulatory changes are made under the Medicaid Drug Rebate Program and Section 340B of the Public Health Service Act;
- Ensure more lower-priced medicines, including insulins, are covered across all Express Scripts standard formularies – and make the Patient Assurance Program that caps the monthly cost of insulin at $25 the standard for all Express Scripts clients;

- Ensure that Express Scripts' industry-leading and transformative rebate-free model is widely available to employers and health plan sponsors to lower the cost of all brand medications for their members as our new standard model; and
- Ensure that Express Scripts' new reimbursement model based off the pharmacy's actual acquisition costs is available to retail community pharmacies, and that retail community pharmacies are compensated for other essential clinical services (e.g., certain diagnostic testing and vaccinations).

2. **I have heard from healthcare providers who have raised serious concerns regarding vertically integrated health services businesses, including Optum Health, Carelon Health, Evernorth Health Services, and others. Providers have reported that these businesses unilaterally imposed more restrictive and non-transparent clinical criteria that conflict with published and publicly available health plan medical policies for which they manage prior authorizations. With that responsibility in mind, I would like answers to the following questions.**

    a. **Does your health plan possess legal and operational authority to unilaterally overrule any clinical or coverage decision made by your company's health services line of business (or vice versa)?**

    Response: Each request for coverage is reviewed individually, and medical necessity decisions are based on the patient's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies, and the coverage and benefit design terms of the individual's plan. As stated in Cigna Healthcare's publicly posted coverage policies, medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations.

    When we pursue integration of services and solutions offered by Evernorth Health Services into coverage offered by Cigna Healthcare – a coordinated care model approach – it is for one goal: to accelerate the development of solutions that enable more coordinated, whole-person, high-quality care that improves patient outcomes, reduces total costs, and simplifies the consumer experience.

    b. **Does your company's health services line of business utilize any clinical algorithms or internal guidelines that result in a denial of service?**

        i. **If so, why?**

    Response: The Cigna Group – inclusive of Evernorth Health Services and Cigna Healthcare – does not use artificial intelligence (AI) to deny coverage or claims, only to accelerate approvals. Our approach to ethical AI practices is publicly available.[4]

    All reviews for medical necessity involve human oversight. Each medical necessity denial is reviewed by a board-certified physician. Technology, including automation and data-driven tools, is used to accelerate claims processing efficiency and accuracy.

[4] The Cigna Group, *The Cigna Group's Approach to Ethical AI Practices*, Cigna Newsroom (2023).

Medical necessity determinations are subject to human review and are governed by publicly available Cigna Healthcare clinical coverage policies.

c. Does your parent company provide financial incentives or performance bonuses to your health services line of business based on meeting specific 'utilization management' targets or reduction in medical spend?

i. If so, how are these bonuses defined?

Response: Cigna Healthcare bases utilization management decisions on appropriateness of care and services, standardized evidence-based criteria, and the terms of a member's plan. We do not reward decision makers for issuing denials of coverage. There are no financial incentives in place for utilization management decision makers to encourage or influence decision making.

d. Does your company's health services line of business ever deny a claim that satisfies both a drug's FDA label instructions and your health plan affiliate's own published medical policy?

Response: Each request for coverage is reviewed individually, and medical necessity decisions are based on the member's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies, and the terms of the individual's health plan. Even where a claim meets clinical coverage policy criteria for approval, approval is subject to the coverage and benefit design terms of the member's benefit plan.

For example, Cigna Healthcare offers clients a suite of solutions that provide choice and flexibility for coverage of GLP-1 weight loss and diabetes medications. In some cases, a patient may meet the clinical criteria for coverage, but the specific benefit design chosen by the employer or plan sponsor may not include coverage for these medications.

e. Are the specific internal criteria used by your company's health services line of business to evaluate a claim made available to the provider and patient prior to the submission of a treatment request?

Response: Yes, Cigna Healthcare's clinical coverage policies are publicly available, including coverage policies utilized by integrated service providers.

f. As of today, has your company issued any formal directives requiring your company's health services line of business to eliminate any internal criteria that are more restrictive than the public-facing policies of your health plan business?

Response: We do not maintain separate internal coverage criteria. However, it's important to emphasize again that each request for coverage is reviewed individually, and medical necessity decisions are based on the member's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies, and the coverage and benefit design terms of the individual's health plan. Even where a claim meets clinical coverage policy criteria for approval, approval is subject to the terms of the member's benefit plan.

g. **Do your parent companies or health plan lines of business provide financial incentives or performance bonuses to your service business based on meeting specific 'utilization management' targets or reduction in medical spend?**

   i. **If so, how are those bonuses determined?**

Response: Cigna Healthcare bases utilization management decisions on appropriateness of care and services, standardized evidence-based criteria, and the terms of a member's plan. We do not reward decision makers for issuing denials of coverage. There are no financial incentives in place for utilization management decision makers to encourage or influence decision making.

h. **Are internal criteria in any way communicated or made public to network providers and/or patients?**

   i. **If so, how?**

Response: Cigna Healthcare makes its clinical coverage policies and prior authorization requirements publicly available. Cigna Healthcare has primarily educated providers through provider-facing digital communications and step-by-step training resources, available on the Cigna for Health Care Professionals portal (CignaforHCP.com) and the Provider Newsroom (providernewsroom.com). For example, Cigna Healthcare uses Provider Newsroom announcements to introduce new portal capabilities – such as a real-time precertification (prior authorization) check, a precertification dashboard to track submitted requests, and the ability to appeal denied precertification requests directly within the portal – and explain what changed, who has access, and how to use the features.

Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.

3. **The Energy and Commerce Committee is responsible for the expansion of technology in federal government programs – while stewarding taxpayer dollars. Many of the health innovations that the Committee oversees, such as remote patient monitoring and enhanced chronic disease management, are intended to change the trajectory of chronic disease and improve outcomes while reducing costs by leveraging technology over multiple plan years.**

   a. **How does your business approach coverage and investments in innovative technologies (i.e., artificial intelligence, remote patient monitoring, wearables, chronic disease management innovations)?**

Response: Our approach to innovative health technologies emphasizes evidence-based coverage decisions, responsible adoption, and strategic investment to improve outcomes and affordability.

From a coverage perspective, we evaluate emerging technologies such as AI-enabled tools and remote patient monitoring (RPM) through formal medical coverage policies

that assess clinical validity, U.S. Food and Drug Administration (FDA) status, and demonstrated benefit for defined populations.

Our use of AI supports claims processing, benefit navigation, and predictive analytics to identify care gaps earlier and personalize interventions while operating within formal AI governance and compliance frameworks.

We also strive to advance innovation through targeted partnerships and venture investments. Through The Cigna Group Ventures, our strategic corporate venture capital fund, we invest in and partner with digital health companies focused on virtual care, analytics, and chronic condition management, such as Omada Health for cardiometabolic conditions.

b. How does your business weigh long-term patient health improvements and taxpayer savings, which may not materialize over multiple plan years?

Response: Broadly, The Cigna Group's solutions and coverage offerings are designed to account for the long-term value of patient health improvements even when those benefits or savings accrue over multiple plan years. We apply evidence-based coverage policies, outcomes- and prevention-oriented care models, and alternative payment approaches that consider clinical benefit, durability, and downstream health system impact, rather than focusing solely on short-term utilization or cost.

For high-cost therapies with potential long-term benefits, such as cell and gene therapies, we evaluate the clinical evidence and real-world outcomes and may pair coverage with outcomes-based or value-aligned contracting, specialized care coordination, and longitudinal monitoring. We also use risk-pooling and financing solutions to support access to therapies with high upfront costs while recognizing their potential to avert future medical spending and improve long-term outcomes. As evidence evolves, we regularly update coverage policies to reflect demonstrated long-term value, ensuring that access decisions evolve with the science.

In parallel, we focus on maximizing each member's long-term health while minimizing total cost of care through earlier engagement, prevention, and integrated management across medical, behavioral, and pharmacy benefits. Patients with chronic conditions often have comorbidities, making integrated medical, behavioral, and pharmacy coverage essential to improving outcomes and avoiding downstream complications. We invest in targeted preventive outreach for populations at higher risk of chronic disease progression, recognizing that earlier engagement and education can help avert later-stage complications. When we can proactively identify and reach out to members earlier in the health care process, we have a better opportunity to positively impact and support health-related decisions.

c. How is your business leveraging health technology today to improve patient experience and outcomes; address waste, fraud and abuse; reduce administrative burdens; improve the provider experience; and otherwise improve the U.S. health care system? Please provide specific examples.

Response: The Cigna Group is leveraging health technology across our businesses – Cigna Healthcare and Evernorth Health Services – to improve the patient experience

and health outcomes while addressing systemic inefficiencies in the U.S. health care system.

On the member and patient side, we have deployed AI-powered digital tools to simplify benefit navigation, improve access to care, and support better decision making. In 2025, Cigna Healthcare launched an industry-leading generative AI virtual assistant within the myCigna portal that helps members understand coverage, estimate costs, track claims, and find in-network providers using clear, conversational language. Early results showed high proactive use and improved comprehension of benefits.

Through Evernorth, we're making significant investments in advanced analytics and predictive modeling to identify and engage patients earlier in their care journey with clinical and wrap-around support, including chronic disease management, virtual care, and earlier intervention – such as MDLIVE's virtual primary and chronic care services and digital programs like Omada Health for diabetes and cardiometabolic conditions – helping improve outcomes while reducing avoidable acute care utilization.

We are also applying technology to reduce waste, fraud, and abuse and lower administrative burden for providers and the health system. AI and rules-based automation are used to streamline claims processing, payment integrity, and utilization review, enabling faster, more accurate decisions while maintaining compliance and clinical oversight. Non-AI coding accuracy policies apply claims-based criteria developed by certified coders and clinicians to address inappropriate upcoding by a limited number of providers to support high-quality patient care and minimize disruption to provider practices.

For providers, Evernorth has invested in digital tools that reduce friction – such as virtual care platforms, asynchronous care capabilities, and data-driven clinical decision support – freeing clinicians from administrative tasks and allowing more time for patient care.

Collectively, our strategy reflects a system-level approach – using technology as an enabler of simpler experiences, better outcomes, reduced administrative waste, and a more efficient and sustainable U.S. health care system – rather than a standalone solution.

d. Should Congress consider further opportunities to incentivize adoption of innovative technologies in the managed care space?

i. If so, how?

Response: Yes. Federal incentives can accelerate the adoption of innovative health technologies that improve outcomes, lower costs, and modernize managed care. However, current regulatory structures often lag behind innovation. Tools such as AI, RPM, virtual care, and digital chronic disease management can enable earlier intervention, reduce avoidable hospitalizations, and support value-based care, particularly for high-cost chronic conditions like diabetes, heart failure, and COPD. Successful adoption of such innovative tools depends on clear coverage pathways, predictable reimbursement, and alignment across Medicare, Medicaid, and commercial markets – areas where Congressional action can help scale proven technologies quickly and equitably.

We believe Congress should consider targeted incentives, such as reimbursement modernization, pilot authorities, and regulatory flexibility, to encourage managed care organizations to deploy technologies that strengthen care coordination, reduce waste, and advance a more efficient and sustainable U.S. health care system.

4. **Several states have advanced legislation to institute some form of provider 'gold carding' programs, which exempts high-performing providers from certain prior authorization requirements.**
    a. **Do your companies operate any type of gold carding or prior authorization pass-types of programs?**
        i. **Which lines of business do you operate these programs in?**
        ii. **How do you determine provider/service eligibility, as well as eligibility renewal?**
        iii. **How many providers qualify for your gold carding programs?**
            1. **If applicable, what percentage of qualifying providers are in some way affiliated with your parent company?**
            2. **What types of providers are most likely to qualify for these gold carding programs?**
        iv. **How do you advertise or otherwise educate your network participating providers regarding the existence of these programs?**
    b. **Do you plan to roll out any types of gold carding or prior authorization pass programs in the future?**

Response: Cigna Healthcare operates gold carding programs where required by state law. State gold carding laws generally require insurers operating state-regulated plans to exempt specific providers from certain prior authorization requirements, with the scope and applicability of these programs varying significantly by state. For example, service applicability, eligibility thresholds, look-back periods, and the duration of the exemption are not uniform across states.

Importantly, in practice, gold carding has had limited real-world impact, benefiting a small fraction of providers, while asking patients to accept a level of potentially inappropriate care. For example, Texas' gold carding law went live in October 2022. However, a recent Texas Department of Insurance presentation showed that only 4% of providers met the threshold to be exempted for one or more services, a significantly smaller impact than expected.[5]

While gold carding is often framed as a way to reduce administrative burden, it has been shown to ultimately increase inappropriate care and costs, create confusion for providers, and eliminate key benefits of utilization review that protects patients. Approval history alone does not ensure continued evidence-based care, and studies show that removing utilization review leads to regression in provider behavior, higher utilization, and increased premiums.[6]

[5] TX Department of Insurance, NAIC Summer National Meeting (Aug. 2023).
[6] Mark Minchin, Martin Roland, et al., *Quality of Care in the United Kingdom after Removal of Financial Incentives*, New England Journal of Medicine (Sep. 2018).

Maintaining different rules for different providers also adds complexity and administrative burden across provider networks, increasing delays and errors, and eliminates important safeguards like evidence-based alternative recommendations, checks on self-referral, and support for gaps in clinical expertise – each of which improves care quality.

A more effective approach to address friction in the system is to simplify and modernize the prior authorization process. Today, nearly 4 in 10 patients receive care that does not meet the latest medical evidence and more than 90% of providers have reported negative impacts from low-value care (i.e., services that provide little to no benefit to patients, may cause harm, and result in unnecessary costs).[7,8] Prior authorization takes on those challenges and applies evidence-based clinical guidelines to providers' requests to make sure they are in line with current science and medical best practices.

The Cigna Group has publicly committed to improving prior authorization for both patients and providers, in recognition that more can be done to reduce administrative burden while maintaining quality of care.[9] In 2025, less than 6% of Cigna Healthcare and Express Scripts customers went through our prior authorization process.[10] In early 2026, The Cigna Group released the first annual Customer Transparency Report detailing meaningful progress to reduce prior authorizations, enhance electronic communications, improve turnaround times, and provide more customer support and transparency.[11] We have made important progress, but recognize there is more work to do in these multi-year efforts.

5. Prior authorization can help control costs in both commercial insurance and Medicare Part D plans. HHS OIG has reported that major Medicare Part D plans are restricting timely access to life-saving cancer drugs.

a. How does your company's utilization management criteria for cancer drugs align with published clinical guidelines and how does it differ?

Response: In a June 2025 report, the Department of Health and Human Services Office of the Inspector General (HHS OIG) concluded that, "[a] majority of 2025 Part D plan formularies covered almost all commonly used drugs, and only a small number of commonly used drugs were not covered by most formularies."[12] HHS OIG went further to say that this is "consistent with OIG's annual findings since 2011."[13]

[7] Jed Duff, Laura Cullen, et al., *Determinants of an Evidence-Based Practice Environment: An Interpretive Description*, Implement Sci Communications (Oct. 2020).
[8] Ishani Ganguli, Nitya Thakore, et al., *Longitudinal Content Analysis of the Characteristics and Expected Impact of Low-Value Services Identified in US Choosing Wisely Recommendations*, JAMA Internal Medicine (Feb 2022).
[9] The Cigna Group, *The Cigna Group Launches Actions to Drive Positive Change for Customers and Patients*, Cigna Newsroom (2025).
[10] The percentage of customers subject to our prior authorization process is calculated based on the number of unique customers who receive initial prior authorization decision(s) (i.e., approved or denied) and average quarterly membership for the year ending December 31, 2025. Prior authorization data reflects Express Scripts Pharmacy Benefit Services business and Cigna Healthcare U.S. core medical business, including behavioral services paid under a medical policy. Stand-alone behavioral prior authorizations are excluded. Customers with multiple prior authorizations are counted once, which is calculated separately for pharmacy and medical prior authorizations. Average quarterly membership includes customers of Express Scripts Pharmacy Benefit Services and Cigna Healthcare U.S. core medical, regardless of whether a client uses our prior authorization services.
[11] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).
[12] U.S. Department of Health and Human Services, Office of Inspector General, *Part D Plans Generally Include Drugs Commonly Used by Dual-Eligible Enrollees: 2025,* Report No. OEI-05-25-00120 (June 2025).
[13] *Id.*

While The Cigna Group does not currently offer Medicare Part D or Medicare Advantage products, Express Scripts Pharmacy Benefit Services serves Medicare plan sponsors, including offering standard formularies aligned with Medicare Part D benefit requirements.

Express Scripts' utilization management criteria for Medicare Part D oncology drugs are grounded in FDA-approved indications and nationally recognized clinical compendia, including the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium. Consistent with Medicare Part D requirements, Express Scripts may apply prior authorization and other utilization tools to ensure therapies are evidence-based, clinically appropriate, and supported by sufficient documentation, with expedited review available.

6. **How does your plan deploy utilization management strategies, like requiring primary care referrals ahead of specialist encounters?**

    a. **For certain specialists managing patients with chronic conditions (e.g. nephrologists managing patients with dialysis and vascular access services on a continuous basis), what steps does your company take to streamline utilization management, and its associated administrative burden, for these specific patients and providers?**

Response: Cigna Healthcare does not require primary care provider (PCP) referrals for most of our standard benefit offerings given many of our products are designed for open access. Patients may select an in-network specialist in accordance with their plan benefits and PCPs are always encouraged and incentivized to support care coordination with specialists. Referral requirements primarily apply to a limited number of HMO-style and select narrow-network plans but are never required for certain services including emergency or urgent care, behavioral health services, and obstetrics and gynecology. Requirements can vary by plan design and, in some cases, by state law.

Specific to dialysis services, Cigna Healthcare partners with DaVita, Fresenius, and U.S. Renal Care, Inc. Treatment for dialysis is based on the place of service and subject to the customer's benefit plan. The program is initiated by a call from the provider to notify Cigna Healthcare of the customer's need for dialysis. We also identify any customer trying to receive services at a non-participating provider and contact the customer regarding their network options. The customer is given a list of the closest participating facilities and provided with assistance to schedule appointments.

As part of our support for members in dialysis (or at risk of progressing to dialysis), we use our proprietary data and analytics capabilities to identify members with chronic kidney disease (CKD) and end-stage renal disease (ESRD) who can benefit from our services. Our RN case managers provide support and guidance for those members with ESRD on dialysis and screen for behavioral health and social determinants of health needs in alignment with our whole-person model.

The Honorable Diana Harshbarger (R-TN)

1. **The 340B program allows eligible hospitals to purchase certain medicines at steeply discounted prices—sometimes for as little as a penny—while charging insurers and patients hundreds or thousands of dollars. MedPAC reports that more than half of all hospitals participate in 340B, and analysis has shown that these large margins encourage hospitals to buy up physician practices so they can extend 340B discounts to more**

patients, further fueling consolidation. These incentives also push hospitals to steer patients toward higher cost medicines to maximize revenue from the spread.

a. **As an insurer, do you believe it is fair for large hospital systems to acquire life-saving medicines at essentially no cost and then bill insurers and patients at exponentially higher rates?**

b. **And in your view, is the consolidation driven by these 340B incentives contributing to higher premiums for employers and families?**

Response: The Cigna Group supports the unique role 340B covered entities and their contract pharmacies perform in providing affordable access to health care for America's most vulnerable populations. That said, excessive subsidization of hospitals could come at the expense of our employer clients, who also depend on affordable health care solutions. By supporting thoughtful constraints, we aim to maintain the integrity of the 340B program while ensuring that all stakeholders, including employers, benefit from a system that is both affordable and sustainable.

2. **In behavioral health care, clinicians recommend treatment plans based on a patient's individual clinical needs. However, your plans frequently impose "fail first" requirements — insurance rules that deny coverage for a clinician-recommended treatment unless a patient first tries and fails one or more insurer-preferred options. These policies substitute insurer cost preferences for medical judgment, forcing patients to endure delays, medication changes, or ineffective care before accessing the treatment their doctor has already determined is appropriate. In mental health and substance use treatment, such forced delays and switches can destabilize patients and place their health and safety at serious risk.**

a. **Why does a health insurance carrier such as yours continue to substitute insurer judgment for that of treating clinicians by requiring patients to "fail first" before receiving clinically appropriate care?**

b. **Does your company require patients to try and fail first before you'll cover what their doctor originally prescribed?**

c. **In mental health and substance use treatment, what happens to patients when you force them to wait and try treatments that their own doctor already determined likely won't work? Do they get better? Or do they get worse?**

d. **When patients fail and perhaps relapse, does that cost more or less than covering the right treatment the first time?**

e. **In effect, are you requiring patients to fail first to save money in the short term, even though it harms patients and costs more overall?**

Response: Evernorth Behavioral Health powers Cigna Healthcare's behavioral health offerings. Evernorth's approach to behavioral health for the clients and customers we serve is centered on early identification, timely engagement, and coordinated care to prevent escalation and avoidable costs. Behavioral health services are covered in accordance with plan terms and parity laws, including the Mental Health Parity and Addiction Equity Act (MHPAEA).

Over the past four years, Evernorth has significantly expanded access to behavioral health services by more than doubling our behavioral health network, offering one of the largest virtual behavioral networks available, and building an integrated care model that supports individuals across the full continuum of need. This includes, but is not limited to, early-state support such as coaching, navigation, and family support, as well as therapy, medication management, and higher-acuity services. 24/7/365 crisis support and urgent behavioral care are available to provide immediate support to patients.

Utilization management (UM) tools, when used, are designed to support high-quality, evidence-based care. Today, nearly four in 10 patients receive care that doesn't meet the latest medical evidence and more than 90% of providers have reported negative impacts from low-value care (i.e., services that provide little to no benefit to patients, may cause harm and result in unnecessary costs).[14,15] UM requirements are based on nationally recognized clinical guidelines, regularly reviewed by licensed clinicians, and applied with appropriate human oversight. These processes are designed to promote patient safety, improve outcomes, and reduce low-value or duplicative services.

We continuously evaluate our UM policies, including behavioral care policies, and remove or modify requirements when clinical evidence evolves, if requests almost always get approved, or if authorization denials often get overturned on appeal. Additionally, our independent, actively practicing Pharmacy & Therapeutics (P&T) Committee always considers important disruptions in care and ensures that step therapy and prior authorization policies allow continuation of therapy for critical treatments, including for antidepressants, antipsychotics, antiseizure medications, and many others.

For example, routine outpatient services and substance use treatment do not require prior authorization, allowing patients to seek care from any in-network provider. Clinicians are also not required to submit a prior authorization request to enroll a patient in an intensive outpatient program. Additionally, we recently removed prior authorization requirements for partial hospitalization (PHP) level of care[16] and transcranial magnetic stimulation (TMS).[17] For the rare services where prior authorization is required, such as inpatient, residential, and intensive autism treatments, a dedicated team of advocates is available 24/7 to review requests.

More broadly, The Cigna Group has publicly committed to improving prior authorization for both patients and providers, in recognition that more can be done to reduce administrative burden while maintaining quality of care.[18] In early 2026, The Cigna Group released the first annual Customer Transparency Report detailing meaningful progress to reduce prior authorizations, enhance electronic communications, improve turnaround times, and provide

[14] Jed Duff, Laura Cullen, et al., *Determinants of an Evidence-Based Practice Environment: An Interpretive Description*, Implement Sci Communications (Oct. 2020).
[15] Ishani Ganguli, Nitya Thakore, et al., *Longitudinal Content Analysis of the Characteristics and Expected Impact of Low-Value Services Identified in US Choosing Wisely Recommendations*, JAMA Internal Medicine (Feb 2022).
[16] Evernorth Health Services, *Update to Prior Authorization Requirements for Partial Hospitalization Level of Care Effective January 1, 2025,* Evernorth Newsroom (Jan. 2025).
[17] Evernorth Health Services, *TMS Prior Authorization Requirements to be Removed for Contracted Providers,* Evernorth Newsroom (Mar. 2026).
[18] The Cigna Group, *The Cigna Group Launches Actions to Drive Positive Change for Customers and Patients*, Cigna Newsroom (2025).

more customer support and transparency.[19] We have made important progress, but recognize there is still more work to do in this multi-year effort.

3. **What specific measures has your company implemented to address persistent complaints from at-risk rural hospitals about the use of proprietary algorithms that override treating physician judgments on medical necessity, potentially leading to dangerously extended patient stays, sharply increased costs, and heightened closure risks for those facilities?**

   Response: The Cigna Group – inclusive of Evernorth Health Services and Cigna Healthcare – does not use AI to deny coverage or claims, only to accelerate approvals. Our approach to ethical AI practices is publicly available.[20]

   All reviews for medical necessity involve human oversight. Each medical necessity denial is reviewed by a board-certified physician. Technology, including automation and data-driven tools, is used to accelerate claims processing efficiency and accuracy. Medical necessity determinations are subject to human review and are governed by publicly available clinical coverage policies.

   Cigna Healthcare makes its clinical coverage policies, including prior authorization and step therapy policies, publicly available. Our approach is grounded in evidence-based clinical policies and standards, with oversight by our more than 3,000 clinical colleagues at The Cigna Group including nurses, pharmacists, social workers, therapists, and physicians.[21] Authorization decisions are grounded in plan-specific benefits, clinical guidelines, and individual information submitted with each request. Emergency services are not subject to prior authorization.

   While prior authorization is an important checkpoint for certain procedures, treatments, and complex services, in early 2025, The Cigna Group committed to helping our customers by making our processes simpler, easier, and faster. We have made meaningful progress:

   - **Reducing Prior Authorizations:** Over the past year, we reduced paperwork and the time providers and patients spend obtaining approvals for more routine services by removing 345 tests, procedures, and services from the Cigna Healthcare U.S. prior authorization process. [22] This change has decreased the volume of medical prior authorizations by approximately 521,000 annually.[23] In 2025, less than 6% of Cigna Healthcare and Express Scripts customers went through our prior authorization process.[24]

[19] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).
[20] The Cigna Group, *The Cigna Group's Approach to Ethical AI Practices*, Cigna Newsroom (2023).
[21] Based on internal analysis of clinicians (nurses, pharmacists, physicians and social workers) directly involved in medical and behavioral Cigna Healthcare U.S. utilization management and prior authorization processes. Includes contractors and part-time as of December 31, 2025.
[22] Based on absolute number of prior authorization codes removed during the year ended December 31, 2025, related to Cigna Healthcare U.S. business. Cigna Healthcare publishes a Master Precertification List quarterly. https://www.cigna.com/health-care-providers/coverage-and-claims/precertification
[23] Reflects estimated prior authorizations that would have been avoided in 2024 if the codes removed in 2025 had been removed for the calendar year 2024. Population consists of core medical prior authorizations and excludes pharmacy.
[24] The percentage of customers subject to our prior authorization process is calculated based on the number of unique customers who receive initial prior authorization decision(s) (i.e., approved or denied) and average quarterly membership for the year ending December 31, 2025. Prior authorization data reflects Express Scripts Pharmacy Benefit Services business and Cigna Healthcare U.S. core medical

- **Streamlining Prior Authorizations:** In addition, in 2025, we were pleased to begin a partnership with AHIP, the U.S. Department of Health and Human Services (HHS), and industry peers to streamline, simplify, and reduce prior authorization by:[25]
    - Standardizing electronic submissions
    - Reducing prior authorization volume
    - Honoring existing approvals during patient changes in insurance to ensure continuity of care
    - Boosting real-time approvals
- **Electronic Communications**: Today, nearly 65% of medical prior authorization requests are submitted electronically to Cigna Healthcare, an increase of 3.7% year-over-year.[26] Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.
- **Improved Turnaround Times**: We continue to focus on making prior authorization decisions faster. In 2025, 80% of Cigna Healthcare U.S. medical prior authorizations were approved in one day or less.[27] More than half of the submissions submitted electronically were approved within minutes.[28]
- **More Customer Support**: Over the past year, we've strengthened our customer support, creating distinct teams to help customers navigate their health care and pharmacy benefits. Our high-touch advocate teams helped approximately 155,000 medical customers with prior authorization and post-care claim processes in 2025, 79% more customers than the year prior.[29]
- **Digital Status Tracker:** In June 2025, we launched a medical prior authorization status tracker for Cigna Healthcare. This new tool shows timely updates and provides answers to frequently asked questions, as well as information on decisions and next steps. It's

business, including behavioral services paid under a medical policy. Stand-alone behavioral prior authorizations are excluded. Customers with multiple prior authorizations are counted once, which is calculated separately for pharmacy and medical prior authorizations. Average quarterly membership includes customers of Express Scripts Pharmacy Benefit Services and Cigna Healthcare U.S. core medical, regardless of whether a client uses our prior authorization services.

[25]America's Health Insurance Plans (AHIP), *Health Plans Take Action to Simplify Prior Authorization* (2025).

[26] The percentage of medical prior authorization requests submitted electronically reflects the proportion of total prior authorizations for Cigna Healthcare U.S. core medical business including behavioral services paid under a medical policy that were submitted electronically via the Cigna Healthcare web portal. Data is based on the twelve month period from October 1, 2024 through September 30, 2025, updated as of December 31, 2025 to reflect a 90 day run-out period. Stand-alone behavioral prior authorizations are excluded.

[27] The percentage of medical prior authorizations approved in one day or less is based on the total approved volume that reached an approval status for the same population and time period described in footnote 26.

[28] The percentage of prior authorizations electronically submitted that were approved within minutes is based on the same population and time period described in footnote 26. It considers prior authorizations that were electronically submitted and reached a final approval decision. Voided requests are excluded from the population. Near real-time decisions are generated without manual review through system-based rules and business logic.

[29] Based on internal analysis of the number of customers who called the Cigna Healthcare call center and interacted with a member of our high touch advocate teams during the year ended December 31, 2025.

available to every Cigna Healthcare customer through our myCigna platform, which is used by 79% of customers.[30]

4. **How does your company address concerns about retroactive downcoding of claims, which significantly reduces payments for services already provided and imposes crippling financial pressure on at-risk rural hospitals with minimal operating reserves?**

   Response: More than 80% of our U.S. medical customers are enrolled in self-insured (ASO) coverage, meaning employers and unions fund medical claims and bear the financial risk. In this role, employers and unions rely on Cigna Healthcare to administer their plans responsibly by ensuring claims are paid accurately – preventing unsupported or inflated billing that contributes to health care waste and fraud, while ensuring providers are reimbursed appropriately for services actually rendered.

   Coding accuracy is one of several mechanisms used across the health care system to address inflated or unsupported billing that contributes to waste, fraud, and abuse and rising health care costs. Cigna Healthcare's narrowly defined coding accuracy policy is designed to promote accurate coding and payment consistent with the American Medical Association's (AMA's) nationally recognized coding guidelines. Federal oversight entities, including the Centers for Medicare & Medicaid Services (CMS) and the HHS Office of Inspector General, as well as other national payers, have identified an increasing pattern of Evaluation & Management (E/M) services being billed at higher levels than supported by the services performed.[31]

   Cigna Healthcare recognizes the unique financial pressures facing providers and the importance of timely, predictable reimbursement for services. Additionally, we appreciate that the vast majority of providers bill E/M claims consistently with their peers and within AMA coding guidelines. For these reasons, our coding accuracy policy only applies to a defined group of in-network providers for certain professional claims that are billed with a narrow set of Current Procedural Terminology (CPT) E/M codes when a claim lacks sufficient encounter-level criteria to support the higher-level code. This policy does not apply to certain services, such as oncology, transplant, behavioral, and care for infants under one year.

   Since implementing this policy in October 2025, almost 99% of all in-network providers are unaffected by this policy. This includes more than 97% of providers who bill more comprehensive level 4 and 5 E/M codes. While we believe the policy protects our customers and helps ensure appropriate billing, we also appreciate that some providers may believe that we have incorrectly adjusted a claim line or that we have misidentified them as having a consistent pattern of coding. If a code is adjusted, the affected provider has the right to request reconsideration by submitting the customer's full record of the encounter. If the record supports the original level of coding, the claim will be reimbursed at the original level billed. If the initial determination is upheld, the provider has the right to an administrative appeal.

[30] The percentage of customers who are digitally engaged by using the myCigna platform. This reflects Cigna Healthcare U.S. core medical customers over the age of 18 that have registered on the platform.
[31] U.S. Department of Health and Human Services, Office of Inspector General, *Medicare payments for evaluation and management services provided on the same day as eye injections were at risk for noncompliance with Medicare requirements*, Report No. A-09-23-03014 (May 27, 2025). U.S. Department of Health and Human Services, Office of Inspector General, *Improper payments for evaluation and management services cost Medicare billions in 2010,* Report No. OEI-04-10-00181 (May 28, 2014).

We have also implemented an additional exemption process for providers who have experienced at least five adjusted claims and believe they are billing in alignment with AMA coding guidelines. An affected provider may request to have their claims bypassed from the policy and Cigna Healthcare will request clinical documentation for a subset of the provider's claim history for review prior to making an exemption determination.

In summary, by carefully applying this policy to only a select group of providers and upholding rigorous review standards, we are able to reinforce our commitment to supporting providers who practice within established clinical coding guidelines while protecting patients, clients, and the health care system from unnecessary costs. The policy will be continuously reviewed and reevaluated to ensure it accomplishes its intended objective of ensuring accurate coding and claims processing.

The Honorable Earl L. "Buddy" Carter (R-GA)

1. **In ERISA self-funded dental plans you administer, who sets or controls: (a) coverage rules, (b) claim edits and payment policies, (c) downcoding and bundling logic, and (d) appeal outcomes, the plan sponsor or your organization?**
    a. **Can you provide the Committee with the contractual language that allocates authority and responsibility?**

Response: The plan sponsor retains authority over benefit design and coverage. Cigna Healthcare is a third-party administrator (TPA) that exercises delegated discretionary authority to adjudicate claims, apply coding logic, and resolve appeals in accordance with ERISA guidance and the governing plan documents. Cigna Healthcare may offer standard coverage policies to plan sponsors, but they only apply if the self-funded employer chooses to adopt them.

2. **After care is received, patients are the ones to face the repercussions of billing errors and overcharges without recourse due to a lack of price transparency. All too often, this ends in medical debt lawsuits, foreclosures, and wage garnishments.**
    a. **Are you confident in the accuracy and completeness of your Transparency in Coverage (TiC) Machine-Readable Files (MRFs)?**
    b. **Would you sign an attestation of such?**
    c. **Would you oppose a requirement that a senior executive attest to the accuracy of your transparency data?**

Response: The Cigna Group is committed to the goal of providing meaningful, consumer-facing transparency that will inform health care decision-making. We are concerned, however, that the Transparency in Coverage (TIC) machine-readable file (MRF) requirements are not designed to make health care information user-friendly and actionable for consumers.

To date, the MRF requirements and the publicly posted files generated (containing in-network negotiated rates and out-of-network allowed amounts) have yielded transparency geared toward making data available to researchers and other third-party data analysts, and not to consumers. Policymakers have expressed the goal of seeing such third parties share information or create tools to give consumers the information they need to make well-informed health care decisions. Unfortunately, this downstream goal has yet to materialize.

Cigna Healthcare is committed to meeting all current and future CMS requirements, and we are compliant with the current Transparency in Coverage Final Rules (CMS-9915-F) finalized in 2020. We also proactively collaborate with outside experts to gain independent perspectives and identify opportunities for improvement in our data quality and member usability.

Importantly, the U.S. Departments of Health and Human Services, Labor, and Treasury issued a new proposed rule on Transparency in Coverage in December 2025 (CMS-9882-P). It will be important to give plans and issuers at least 18 months following issuance of this final rule and technical implementation guidance to come into compliance with new TIC requirements as these changes will likely be complex and costly.

Bearing in mind our consumer-centric health care goals and policy priorities, in 2025, The Cigna Group accelerated the implementation of tangible actions to help drive better health outcomes and health care experiences.[32] Additional transparency is a key element of our efforts, along with easier access to care, better support, delivering better value, and accountability. Our initial transparency-related commitments include taking the following steps:

- Providing Express Scripts customers an annual personalized summary about how they benefit directly from discounted prices negotiated;
- Providing plan sponsors an annual standardized report with disclosures of costs and related pharmacy claim-level reporting; and
- Publishing an annual Customer Transparency Report to make our enterprise's progress toward our full set of public commitments clear.

We believe these actions are and will be a significant step toward meaningful transparency for consumers as well as plan sponsors.

The Honorable John Joyce, M.D. (R-PA)

1. **Reference Attachment A:**

   a. **Please provide your policies and procedures your companies follow to adhere to the NSA and how you ensure patients are fully protected as the law intended.**

   b. **Please confirm that your company holds patients harmless and does not balance bill patients for any outstanding eligible or ineligible NSA claims.**

   c. **Do you support applying the same penalties to payers for non-compliance with the law's patient protections that already apply to providers? If not, why not?**

Response: Cigna Healthcare is compliant with the No Suprises Act (NSA) and is committed to holding patients harmless as the law intended. Our processes are designed to ensure accurate patient cost-sharing, clear consumer explanations of benefits (EOBs), and prompt correction of any errors that could affect a patient's financial responsibility.

Cigna Healthcare processes over 99.8% of No Surprises Act (NSA) claims and consumer explanations of benefits (EOBs) accurately, and we strive to ensure patients are protected as the law intended with accurate patient cost-sharing. This is an extremely high level of claims and EOB processing accuracy. By way of comparison, Medicare Advantage plans are held to a

[32] The Cigna Group, *The Cigna Group Launches Actions to Drive Positive Change for Customers and Patients*, Cigna Newsroom (2025).

95% compliance standard when claims processing is audited by CMS. Cigna Healthcare far exceeds this threshold in the context of NSA claims and EOB processing.

The NSA introduces operational complexity that does not exist in most health care payment systems that increases the need for manual intervention and elevates the risk of processing errors across the industry. Even with this higher likelihood of error, Cigna Healthcare still processes 99.8% of claims and consumer EOBs accurately. In the small number of cases – approximately 0.175% of NSA claims – where post-IDR adjustment may temporarily result in an incorrect consumer EOB, we audit 100% of NSA claims and consumer EOBs to identify and promptly correct any errors. We are also implementing system enhancements that will eliminate more than half of these remaining post-audit corrections.

Finally, while we strongly support the NSA's patient protections, the most urgent area for reform is addressing abuse of the IDR system by certain third-party and private equity-backed entities that is significantly harming health care affordability. As documented by investigative reporting and independent policy analysis, this abuse is driving billions of dollars in unnecessary costs that ultimately increase premiums for employers, unions, and patients – without improving patient protections. Addressing these systemic issues is essential to preserving the affordability goals of the NSA while maintaining strong consumer safeguards.[33,34]

The Honorable Troy Balderson (R-OH)

1. **Many commercial insurers have hesitated to cover Prescription Digital Therapeutics (PDTs) given the current patchwork of coding and reimbursement strategies used for these products.**

    a. **Would a defined Medicare and Medicaid benefit category help to alleviate any confusion insurers may have around their ability to cover new and innovative therapies like PDTs?**

Response: Potentially. PDTs do not fit existing statutory benefit categories in Medicare and Medicaid; therefore, Congressional action would be helpful to clarify coverage authority and establish payment and coding pathways. Medicare coverage could catalyze broader adoption by other payers, including commercial plans.

2. **Affordable health care is top of mind for patients and providers nationwide. A July 2025 study on anxiety and depression from the Peterson Health Technology Institute found that PDTs could generate annual net savings for commercial plans of $8.7 million per million members.**

    a. **Do you view PDTs and other digital health technologies as effective opportunities to reduce health care costs?**

Response: Potentially. PDTs are seen as promising tools to help control health care costs, but only if usage is evidence-based, targeted, and appropriate. They work best when used alongside traditional care. Clearer reimbursement pathways and long-term usage data across larger populations are needed to support broader adoption. Cigna Healthcare's standard

[33] *How Scott and Alla LaRoque got rich from disputed medical bills,* STAT (Mar. 18, 2026).
[34] Georgetown University, Center on Health Insurance Reforms, *The Substantial Costs of the No Surprises Act Arbitration Process,* (Sept. 24, 2025).

coverage policy recognizes FDA-approved PDTs as legitimate therapeutic interventions that may be covered when specific clinical and medical necessity criteria are met.

3. **When individuals and families are comparing coverage options, how important is flexibility in plan design to helping them manage financial risk over the course of a year?**

   Response: Flexibility in plan design is critical to helping individuals and families manage financial risk over the course of a year, particularly by reducing uncertainty around premiums and out-of-pocket (OOP) costs.

   The Cigna Group has a proven track record of leveraging our patients' and clients' feedback to introduce bold changes. In 2025, we launched Clearity by Cigna Healthcare.[35] Clearity is a new copay-only health plan that uses artificial intelligence-powered digital tools to bring greater predictability and simplicity to our customers' care experience. The Clearity plan empowers customers to make confident, informed health care decisions with upfront pricing, verified patient reviews, and a user-friendly digital experience.

   Additionally, in 2025, Evernorth Health Services announced a new protection benefit to help reduce OOP costs for more of our customers.[36] To ensure they always pay the lowest price available for both brand-name and generic medications, Evernorth can automatically compare the negotiated-discount price, the cash-discount price, the drug company's direct-to-consumer price (if available), and the customer's copay. Eligible customers will pay the lowest available price at the pharmacy counter. While the Evernorth negotiated price is typically the lowest, other prices may be lower in some cases, especially for people with high-deductible health plans.

   We support maintaining existing plan design flexibility for employers and plan sponsors and measures to improve cost predictability for certain plan designs. For example, greater flexibility in Health Savings Account (HSA) rules could make it easier for patients to save for OOP expenses and for employers to contribute to those accounts. Clear guidance that allows for separate deductibles and OOP maximums (for example, medical and pharmacy) would give employers flexibility to lower cost burdens and make costs more predictable for employees.

4. **Are there technical areas of federal law where minor statutory clarifications could improve consumer options to better align coverage with their financial needs?**

   Response: HSAs offer several benefits to consumers that should be explored by Congress for potential expansion. Benefits include tax-advantaged savings, flexibility, portability across coverage, and consumer control. However, HSAs, as structured today, often come with limitations that make them unattractive to some customers. For example, for Americans with chronic conditions, the high-deductible health plan (HDHP) that is required to be paired with an HSA can be cost prohibitive compared to more expansive first-dollar coverage.

   There are a number of reforms Congress could consider to improve the utility of HSAs for consumers and expand their reach:

[35] Cigna Healthcare, *Clearity by Cigna Healthcare, A New Tech-Enabled Health Plan Offers Customers Transparent, Predictable Prices*, Cigna Healthcare Newsroom (Nov. 18, 2025).
[36] Evernorth Health Services, *Evernorth Announces New Era of Pharmacy Benefit Services to Lower Americans' Medication Costs*, Evernorth Newsroom (Oct. 27, 2025).

- **Allow HSAs to reimburse health insurance premiums**. Currently, this is allowed only in limited circumstances. Allowing HSAs to reimburse premium costs would substantially increase the utility for buying individual market coverage, for example. This flexibility could ease coverage transitions for individuals who move in and out of employer-sponsored coverage.
- **Expand pre-deductible coverage**. HSA/HDHPs would benefit from having additional flexibility to cover high-value items and services pre-deductible, such as telehealth, additional chronic condition treatments, and high-value behavioral health services.
- **Permit separate deductibles (for example, medical and pharmacy) within a plan**. This would provide insurers flexibility to offer lower deductibles for specific items/services (e.g., prescription drugs) while maintaining an overall OOP maximum for the plan year.
- **Permit separate OOP maximums (for example, medical and pharmacy)**. This would allow flexibility to offer lower OOP maximums for specific items and services while maintaining an overall OOP maximum for the plan year.
- **Lower the minimum deductible** (currently $1,700 for self-only coverage and $3,400 for family coverage in 2026) to give employers flexibility to offer lower-cost HSA/HDHPs.
- **Sever HSAs from HDHPs**. The ability to offer HSAs without requiring an HDHP would substantially increase the utility of HSAs. Potential benefits include:
    - Allowing HSAs to be paired with plans that offer lower OOP costs, potentially reducing the "sticker shock" when participants have high-cost claims.
    - Making HSAs more portable because they would not have to be paired with HDHPs.
    - Potentially eliminating the need for other health accounts such as health flexible spending accounts (FSAs) or health reimbursement accounts (HRAs), which would reduce confusion about different account-based offerings.
    - Making HSAs more viable as a savings vehicle for longer-term health care needs.
- **Amend inflation adjustments** so that OOP maximums for HSA/HDHPs and other group health plans are the same.

5. **Thirty percent of adults with a mental health condition say they didn't get care because of problems with their health insurance.**

    a. **When your company makes it hard to find or denies recommended treatment, what happens to those patients--are the costs simply shifted to emergency rooms, public systems, and taxpayers?**

    Response: Evernorth Behavioral Health powers Cigna Healthcare's behavioral health offerings. Evernorth's approach to behavioral health for the clients and customers we serve is centered on early identification, timely engagement, and coordinated care to prevent escalation and avoidable costs. Behavioral health services are covered in accordance with plan terms and parity laws, including MHPAEA.

Over the past four years, Evernorth has significantly expanded access to behavioral health services by more than doubling our behavioral health network, offering a large virtual behavioral network, and building an integrated care model that supports individuals across the full continuum of need. This includes, but is not limited to, early-state support such as coaching, navigation, and family support, as well as therapy, medication management, and higher-acuity services. 24/7/365 crisis support and urgent behavioral care are available to provide immediate support to patients.

Utilization management tools, when used, are designed to support high-quality, evidence-based care. Prior authorization and step therapy requirements are based on nationally recognized clinical guidelines, regularly reviewed by licensed clinicians, and applied with appropriate human oversight. These processes are designed to promote patient safety, improve outcomes, and reduce low-value or duplicative services.

We continuously evaluate our prior authorization and step therapy policies, including behavioral care policies, and remove or modify requirements when clinical evidence evolves, if requests almost always get approved, or if authorization denials often get overturned on appeal. Additionally, our independent, actively practicing P&T Committee always considers important disruptions in care and ensures that prior authorization and step therapy policies allow continuation of therapy for critical treatments, including for antidepressants, antipsychotics, antiseizure medications, and many others.

For example, routine outpatient services and substance use treatment do not require prior authorization, allowing patients to seek care from any in-network provider. Clinicians are also not required to submit a prior authorization request to enroll a patient in an intensive outpatient program. Additionally, we recently removed prior authorization requirements for partial hospitalization (PHP) level of care[37] and transcranial magnetic stimulation (TMS).[38] For the rare services where prior authorization is required, such as inpatient, residential, and intensive autism treatments, a dedicated team of advocates is available 24/7 to review requests.

More broadly, The Cigna Group has publicly committed to improving prior authorization for both patients and providers, in recognition that more can be done to reduce administrative burden while maintaining quality of care.[39] In early 2026, The Cigna Group released the first annual Customer Transparency Report detailing meaningful progress to reduce prior authorizations, enhance electronic communications, improve turnaround times, and provide more customer support and transparency.[40] We have made important progress, but recognize there is still more work to do in this multi-year effort.

The Honorable Kat Cammack (R-FL)

1. **Physicians report that Cigna downcodes evaluation and management services after care has been delivered, often relying on automated systems.**

[37] Evernorth Health Services, *Update to Prior Authorization Requirements for Partial Hospitalization Level of Care Effective January 1, 2025,* Evernorth Newsroom (Jan. 2025).
[38] Evernorth Health Services, *TMS Prior Authorization Requirements to be Removed for Contracted Providers,* Evernorth Newsroom (Mar. 2026).
[39] The Cigna Group, *The Cigna Group Launches Actions to Drive Positive Change for Customers and Patients*, Cigna Newsroom (2025).
[40] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).

a. **Please describe the role automated tools or algorithms play in Cigna's downcoding of evaluation and management services, whether a licensed clinician reviews these determinations prior to payment reduction, and how Cigna addresses the administrative and financial burden on physicians and patients when downcoding decisions are overturned on appeal.**

Response: We understand your concern regarding the use of automated tools and algorithms in claim adjudication. Cigna Healthcare believes that consistent, correct coding and careful review of medical records is important, as it ensures the correct level of reimbursement for the services provided and accurate patient financial responsibility. That is why Cigna Healthcare does not rely on algorithms to make final determinations. Our coding accuracy policies utilize claim-based criteria developed by certified coders and clinicians as an initial screening mechanism to detect potential discrepancies, examining relevant claim data, associated diagnoses, and any additional services rendered during the same encounter. **Since implementing this policy in October 2025, almost 99% of all in-network providers have remained unaffected. This includes more than 97% of providers who bill more comprehensive level 4 and 5 E/M codes.**

Cigna remains committed to ongoing engagement with the provider community to improve transparency, clarify expectations, and ensure that coding accuracy processes support high-quality patient care while minimizing disruption to physician practices.

The Honorable Erin Houchin (R-IN)

1. **Because of shared savings fees, your company has a financial incentive to make physicians out of network. Have you been making new contracts with hospitals that exclude non-employed physicians as part of these new networks?**
    a. **Have you started excluding any physicians that have routinely been part of your networks?**
    b. **How much did your company collect on shared savings and program integrity fees in 2025? How much did you collect on these fees in 2024?**

Response: No. Network participation decisions are based on objective, established criteria such as licensure, credentialing, quality, geographic access, and contractual agreement, not shared savings or program integrity arrangements. These programs are designed to promote appropriate billing accuracy and payment and do not create incentives to place physicians out of network or favor employed over non-employed physicians. We continue to contract broadly with hospitals and physicians across markets to ensure adequate access to care for our members, consistent with network adequacy standards. 90% of claims adjudicated every year are processed on an in-network basis – a figure that has been consistent over time. Generally, for the same service rendered, the net cost for out-of-network providers is substantially higher than the net cost for in-network providers. Therefore, if more out-of-network care transpired, it would deteriorate the overall affordability of our products and we would be less competitive in the market.

We have not implemented any initiative to systematically exclude physicians who have historically participated in our networks. Changes in physician participation occur for standard, well-established reasons, including contract terminations initiated by either party, changes in

practice ownership or affiliation, credentialing status, or the expiration or renegotiation of agreements. These changes are not driven by shared savings or payment integrity initiatives.

Shared savings program fees are earned only when measurable cost savings or recoveries are achieved in accordance with contractual terms and applicable law. These fees represent a small fraction of total medical spending and are intended to offset the operational costs of administering these programs, not to influence network design.

We remain committed to maintaining broad provider networks, ensuring patient access, and complying with all applicable federal and state requirements, including the No Surprises Act and network adequacy standards. Our payment integrity and shared savings programs are designed to promote accuracy, affordability, and fairness, not to influence network participation decisions.

2. **Can you commit that, in peer-to-peer review processes, a provider can speak with a physician in the appropriate specialty to make a medical determination about a patient's care?**

   Response: In peer-to-peer discussions, Cigna Healthcare ensures that the treating physician can speak with a physician of appropriate clinical expertise in managing the specific patient's care or condition, recognizing that more than one specialty may be considered appropriate. All of our medical directors have at least one active, unrestricted medical license to practice within the U.S. and physician reviewers are available across a broad range of specialties.

3. **What are program fees intended for and what are they based on? These fees incentivize your company to inappropriately deny payments to doctors and hospitals for appropriately performed exams and procedures.**

   a. **Why are these fees not part of the routine services covered by the premiums paid to you to administer self-insured health plans?**

   Response: Program fees associated with payment integrity and shared savings arrangements are intended to compensate for identifying, preventing, and recovering inaccurate or improper claim payments, not for denying medically appropriate care. These fees are contingent on demonstrated financial value and are earned only when verified savings or recoveries are achieved through activities such as billing and coding validation, duplicate payment identification, contractual compliance review, and recovery of overpayments. If no savings or recoveries are achieved, no fee is charged.

   Payment integrity programs are a key tool for identifying and addressing waste, fraud, and abuse in the health care system – such as upcoding, unbundling, duplicate billing, and payments that do not align with contractual or documentation requirements. By correcting these inaccuracies, the programs help protect employer and employee health care dollars and reduce unnecessary cost growth without restricting access to medically appropriate care. These programs do not change benefit coverage, alter negotiated provider rates, or apply clinical criteria to deny care. Claims are adjudicated based on plan terms and applicable law, and any payment adjustment reflects correction of an error or overpayment.

   In self-insured (Administrative Services Only (ASO)) arrangements, routine administrative services, such as claims processing, customer service, and network access, are covered by fixed administrative fees. Payment integrity and shared savings programs are optional,

value-based services that require additional specialized resources, including advanced analytics, clinical review expertise, and investigative functions. Because the value of these programs varies by client population and claim mix, they are structured on a performance-based model rather than embedded into standard administrative fees. Embedding these services into routine ASO fees would require all clients to pay for programs regardless of whether they generate value, which many employers have indicated they do not prefer.

These programs are designed to improve payment accuracy and affordability while preserving access to care. Providers retain full appeal rights, and all adjustments are subject to contractual and regulatory requirements. Our approach prioritizes transparency, compliance, and stewardship of employer and employee health care dollars.

4. **Physician insurance payments have not kept pace with inflation and Medicare physician payments have stagnated over the past 20 years. How will your company ensure that rising health care costs will not result in downstream physician reimbursement cuts?**

   Response: We share your concern about the financial pressures facing physician practices. Independent experts, including the Medicare Payment Advisory Commission (MedPAC), have documented that statutory Medicare physician payments have not kept pace with practice cost inflation, even as the cost of delivering care has continued to rise.[41]

   It's important to distinguish between Medicare payment policy, which is set administratively and is subject to congressional requirements, and commercial payment. Commercial payers do not unilaterally set physician reimbursement; rates are negotiated based on market conditions, service mix, and quality or value-based arrangements. In many instances, shortfalls in Medicare payments as well as those from other public programs or non-reimbursed charity care are being offset by commercial payers, adding to the unsustainable cost trajectory.

   Greater competition and paying for value, not volume, is the solution. To support physician practices and greater health care affordability, we work to promote value-based payment arrangements, support site-of-care optimization, improve transparency, and reduce unnecessary administrative burden, all of which help preserve resources for patient care and physician services. Efforts to streamline utilization management and modernize administrative processes are also intended to lower practice overhead and allow physicians to spend more time on clinical care than paperwork.

   System-wide health care affordability requires addressing the largest and fastest-growing cost drivers – hospital pricing and high-cost specialty drugs. Sustainable progress will require aligning incentives across the system so that health care decisions are driven by better outcomes and value rather than higher prices. While the private sector will continue to innovate, targeted public policy reforms must be a part of the solution. We stand ready to work with Congress, the Administration, and our partners throughout the health care sector to build a health care system that prioritizes prevention, rewards value over volume, and leverages competition where it works to reduce costs for patients.

5. **Insurance company contracting with Utilization Management vendors, like Optum, has resulted in an increase in denials for physician services. Payers are increasingly using**

[41] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, Chapter 1 (June 2024).

machine learning models to auto-deny high-cost encounters based only on claims and without any review of clinical documentation. "Downcoding" practices such as this coupled with prior authorization requirements, arbitrary codes, and modifier edits drive up prices, burden physician practices, and threaten small practice viability and access to care for patients.

a. **How will insurers ensure fair medical review of clinician documentation for each patient and appropriate appeals processes and timelines?**

Response: Each request for coverage is reviewed individually, and medical necessity decisions are based on the member's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies, and the terms of the individual's health plan. As stated in Cigna Healthcare's publicly posted coverage policies, medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations.[42]

The Cigna Group – inclusive of Evernorth Health Services and Cigna Healthcare – does not use AI to deny coverage or claims, only to accelerate approvals. Our approach to ethical AI practices is publicly available.[43]

Peer-to-peer conversations are always available at the request of the treating provider to support a two-way clinical discussion with a board-certified physician reviewer at a time selected by the treating provider. These conversations allow providers to share patient-specific clinical details that may not be fully captured in written documentation alone, helping ensure coverage decisions are grounded in the individual facts of the case. When appropriate, this process can resolve questions earlier and reduce the need for formal appeals.

Cigna Healthcare offers customers and their treating providers multiple levels of post-decision reviews, including peer-to-peer discussions, reconsideration, appeal, and a review by an independent third party, to ensure that each patient's case is reviewed carefully and thoroughly and that their physician has multiple opportunities to provide additional clinical information.

With respect to post-service payment reviews to ensure appropriate coding and billing (which are separate and distinct from pre-service medical necessity reviews), Cigna Healthcare believes that consistent, correct coding and careful review of medical records is important, as it ensures the correct level of reimbursement for the services provided and accurate customer financial responsibility. That is why Cigna Healthcare does not rely on algorithms to make final determinations. Our coding accuracy policies utilize claim-based criteria developed by certified coders and clinicians as an initial screening mechanism to detect potential discrepancies, examining relevant claim data, associated diagnoses, and any additional services rendered during the same encounter.

6. **Insurance carrier consolidation leads to fewer insurance plans competing in the marketplace, and the potential for rising premiums. How many competitors exist within your market and what restrictions on insurance company consolidations would you recommend?**

[42] CHCP - Resources - Coverage Policies
[43] The Cigna Group, *The Cigna Group's Approach to Ethical AI Practices*, Cigna Newsroom (2023).

Response: Health insurance markets in the U.S. remain highly competitive and locally structured, with the number of competing insurers varying significantly by geography, market segment, and line of business. In most commercial markets, employers, individuals, and public purchasers typically have multiple competing insurers to choose from, including national carriers, regional carriers, and nonprofit Blue Cross Blue Shield affiliates. Large employers routinely evaluate three to five or more carriers through competitive procurement processes, and switching among insurers is common when price, value, or service expectations are not met.

Importantly, premium growth is driven by underlying drug and medical cost growth, particularly in markets dominated by consolidated hospital and physician systems. Hospital and provider consolidation is strongly associated with higher prices, often without corresponding improvements in quality or outcomes, which pressures premiums and affordability.[44] By contrast, recent research finds that prices are *lower* in markets with greater insurer scale, demonstrating that insurers' scale works to counterbalance hospital market power and reduce prices on behalf of employers and patients, rather than increase them.[45]

We support targeted policy reforms that address the true cost drivers in the system – particularly hospital and provider consolidation, high drug prices set by drug companies, anti-competitive drug company practices, and enforcement gaps that allow high-priced care to persist. We stand ready to work with this Congress, the Administration, and our partners throughout the health care sector to build a health care system that prioritizes prevention, rewards value over volume, and leverages competition where it works to reduce costs for patients.

7. **Insurance network adequacy, lack of specialists and long wait times for appointments are ongoing issues. What is your plan doing to address these concerns?**

Response: Cigna Healthcare addresses network adequacy, specialist access, and appointment wait times through ongoing network monitoring, targeted expansion, and expanded care delivery options. We regularly evaluate provider access and availability using data-driven analyses, including geographic access standards, provider-to-member ratios, and reviews of provider capacity across primary care, specialists, and hospitals. When gaps are identified, we implement corrective action plans and targeted remediation, consistent with state, federal, and accreditation requirements.

To help address workforce shortages, particularly in behavioral health and other high-demand specialties, we have expanded access through virtual care and integrated delivery models. These offerings are designed to connect patients to the right level of care more quickly while preserving in-person capacity for higher-acuity needs.

Cigna Healthcare also works with providers through value-based arrangements and network development strategies to improve access, continuity, and care coordination, particularly in underserved or rural areas. These efforts are complemented by provider support, network

[44] Alexander Borsa, Geronimo Bejarano, Moriah Ellen, & Joseph D. Bruch, *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, BMJ 382, e075244 (July 19, 2023). Anjali Bhatla, Victoria L. Bartlett, Michael Liu et al., *Changes in Patient Care Experience after Private Equity Acquisition of US Hospitals*, JAMA 333;(6):490-497 (2025).
[45] Suhui (Evelyn) Li, David Jones, Eugene Rich & Aimee Lansdale, *How Do Hospitals Exert Market Power? Evidence from Health Systems and Commercial Health Plan Prices*, Health Affairs Scholar 3(1) (2025).

adequacy filings, and ongoing regulatory reporting to ensure compliance with access and availability standards.

8. **As carriers increasingly rely on third party vendors such as Availity, Cotivity, Evicore, and Optum for claims reviews, prior authorizations, coding integrity, how are you monitoring third party vendors to ensure that their determinations are consistent with the plan member's benefits coverage and the physician contracts?**

   Response: Each request for coverage is reviewed individually, and medical necessity decisions are based on the member's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies and the terms of the individual's health plan. All of Cigna Healthcare's third-party vendors are obligated to apply Cigna Healthcare's reimbursement policies, which are made available to providers via the Cigna for Health Care Professionals portal (CignaforHCP.com).

   Cigna Healthcare maintains a comprehensive and effective oversight framework to ensure that delegated entities performing utilization management and appeals activities comply with applicable accreditation standards, regulatory requirements, and contractual obligations. Oversight is conducted through a combination of pre-delegation assessments, annual audits, review of periodic operational and performance reports, and formal approval of delegated program documentation. The oversight framework includes ongoing monitoring activities, such as case file audits and policy and procedure reviews, to verify that delegated functions are performed in accordance with established requirements and that quality of care and service is maintained.

9. **Physicians report that when appealing carrier denials, they are told the third party made the decision based on the vendor's algorithm. Shouldn't insurers have a responsibility much like employers' fiduciary responsibility on the behaviors of their contracted vendors?**

   Response: Each request for coverage is reviewed individually, and medical necessity decisions are based on the member's specific health condition, current medical evidence, Cigna Healthcare's publicly posted clinical coverage policies and the terms of the individual's health plan. All of Cigna Healthcare's third party vendors are obligated to apply Cigna Healthcare's reimbursement policies, which are made available to providers via the Cigna for Health Care Professionals portal (CignaforHCP.com).

   As indicated above, Cigna Healthcare maintains a comprehensive and effective oversight framework to ensure that delegated entities performing utilization management and appeals activities comply with applicable accreditation standards, regulatory requirements, and contractual obligations. Oversight is conducted through a combination of pre-delegation assessments, annual audits, review of periodic operational and performance reports, and formal approval of delegated program documentation. The oversight framework includes ongoing monitoring activities, such as case file audits and policy and procedure reviews, to verify that delegated functions are performed in accordance with established requirements and that quality of care and service is maintained.

10. **Independent physicians are the backbone of our healthcare system. What are your companies doing to help ensure that continues to be true?**

Response: Independent physicians play a critical role in delivering accessible, high-quality care, and Cigna Healthcare's approach is designed to support their continued participation and success across diverse practice settings. We contract broadly with independent primary care and specialty physicians and design our networks to meet state, federal, and accreditation standards for access and availability.

Through Cigna Collaborative Care, independent physicians can voluntarily participate in value-based care arrangements that reward quality, care coordination, and patient outcomes rather than volume. These programs provide independent practices with actionable data, care coordination support, and performance-based incentives, while preserving physician clinical autonomy and medical judgment.

Cigna Healthcare also works to reduce administrative burden and support practice sustainability by streamlining prior authorization processes, honoring existing authorizations during patient plan transitions, and sharing patient-specific insights to help independent physicians manage complex populations more effectively.

Together, these efforts are intended to strengthen independent physician practices, expand patient choice, and ensure that independent physicians remain a foundational part of the health care system.

11. **Administrative burdens from insurers are taking hours and hours from physicians and their staff every day contributing to their moral injury and burnout and taking away precious time that could be used for direct patient care. What are your companies doing to address this?**

    Response: Cigna Healthcare recognizes that administrative burden contributes to physician burnout and reduces time available for patient care, and we have made reducing unnecessary friction a core priority. Our efforts focus on simplifying prior authorization, increasing automation, and improving transparency for providers.

    Over the past year, we have significantly reduced the volume of services subject to prior authorization by removing hundreds of routine tests, procedures, and services from the prior authorization process. Today, the vast majority of claims do not require prior authorization, and when authorization is required, many requests are resolved immediately or near immediately through electronic and automated workflows. We have also expanded electronic prior authorization and introduced digital status tracking to reduce manual work. Lastly, all of Cigna Healthcare's coverage policies are available to providers via Cigna for Health Care Professionals portal (CignaforHCP.com).

    To further reduce disruption to care and administrative workload, Cigna Healthcare honors existing prior authorizations for a transition period when patients change plans, invests in tools that streamline post-care claims resolution, and participates in an industrywide initiative with AHIP and HHS to standardize and simplify prior authorization practices.

    These actions are designed to reduce paperwork, speed decision-making, and allow physicians and their teams to spend more time caring for patients rather than navigating administrative processes.

12. **Which regulations currently in place should be repealed in order to make plans more affordable?**

Response: Health plan affordability is best supported by targeted regulatory reforms that reduce unnecessary administrative costs and market distortion while preserving patient protections. Based on our experience, several existing regulatory frameworks would benefit from reform or recalibration:

- Reforms to the NSA IDR process are needed to address structural flaws that have increased, rather than reduced, health care costs. Public analyses show that abuse of the IDR process by a small number of providers and private equity-backed billing entities has driven billions of dollars in added costs for employers and patients.[46] Regulatory changes to better screen out ineligible claims, strengthen oversight of IDR entities, and realign financial incentives would help restore the law's original intent and improve affordability.
- Drug patent loopholes should be closed to prevent drug companies from delaying access to affordable generics and biosimilars using patent thickets, product hopping, and pay-for-delay schemes. Take Keytruda for example, a leading immunotherapy for cancer that generates $29.5 billion in annual sales and is projected to get biosimilar competition in 2028. The Evernorth Research Institute estimated that if a biosimilar is delayed from the market for five years, it could represent as much as $45 billion in missed savings to the commercial market.[47] This is in addition to federal taxpayer savings from closing loopholes that allow these delays to continue.
- Misleading direct-to-consumer pharmaceutical advertising should be eliminated to reduce inappropriate demand for high-priced drugs over more affordable alternatives and reduce influence on prescribing practices. Pharmaceutical companies spend roughly $14 billion annually on advertising, significantly impacting taxpayer costs through tax deductions, and exceeding spending on R&D for some firms.[48]
- Incentives for local provider and hospital consolidation should be addressed. For example, expanding site-neutral payment reforms and addressing anti-competitive contracting practices could discourage mergers, increase competition in local markets, and result in federal taxpayer savings.
- Duplicative and inconsistent prior authorization requirements across federal and state programs increase administrative burden for providers and plans without improving care. We support continued regulatory alignment to standardize electronic prior authorization and promote real-time approvals. Further regulatory streamlining would allow plans and providers to redirect resources toward patient care.
- The current Transparency in Coverage (TIC) machine-readable file requirements should be reformed to ensure that they provide user-friendly and actionable information to consumers given the considerable and costly compliance burden on both insurers and hospitals. Today, we are concerned these requirements have only yielded millions of

[46] Georgetown University, Center on Health Insurance Reforms, *The Substantial Costs of the No Surprises Act Arbitration Process,* (Sept. 24, 2025).
[47] Evernorth Health Services, *Pharmacy in Focus: The Biosimilar Breakthrough in Adoption and Affordability*, Evernorth Research Institute (2025).
[48] Campaign for Sustainable Rx Pricing, *Big Pharma's Direct-to-Consumer Advertising Costs U.S. Taxpayers Billions of Dollars* (Mar. 18, 2025).

dollars in compliance burdens that add to the cost of coverage in lieu of simpler, private market-driven reforms that would achieve the goal of meaningful price transparency to patients and policymakers.

- Reforms to the current federal and state mental health parity regulations should ensure that nonquantitative treatment limitation (NQTL) standards are administrable, clinically grounded, and consistently enforceable across plans and issuers. We support the Department of Labor reexamining its parity enforcement approach and support reforms prioritizing outcomes-focused access measures, clear safe harbors, and alignment with existing clinical and utilization management practices.
- Regulatory barriers that limit data interoperability and innovation, including fragmented state-by-state requirements and overlapping reporting mandates, raise costs and slow adoption of lower-cost, preventive, and virtual care models. Policies that streamline compliance obligations and support consistent national standards – particularly for digital health and AI-enabled tools – would improve efficiency and affordability while maintaining strong consumer protections.

Taken together, these targeted reforms, rather than broad deregulation, would help reduce waste, administrative friction, and unnecessary cost growth, enabling delivery of more affordable coverage to employers, workers, and families.

The Honorable Tom Kean, Jr. (R-NJ)

1. **Earlier this month, the CDC made changes to the vaccine schedule. I appreciate the September statement made by America's Health Insurance Plans that plans will continue covering all immunizations that were recommended by the ACIP as of September 1, 2025, with no cost-sharing for patients through 2026.**
    a. **Beyond 2026, will you commit that your company will continue to cover all previously ACIP-recommended vaccines that were listed in September 2025?**
    b. **Will you commit to covering these prevention measures without cost-sharing or additional utilization management practices like prior authorization?**

Response: At The Cigna Group, ensuring access to immunizations remains a core public health priority. We recognize the importance of maintaining public confidence in immunization access and remain focused on providing clarity and consistency for the individuals, families, and businesses we serve.

Cigna Healthcare continues to provide comprehensive coverage for all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines without cost-sharing as part of our standard benefit design, and in accordance with the Affordable Care Act, Inflation Reduction Act, and applicable federal regulations. To maintain broad immunization access for our members, coverage for COVID-19 vaccines remains available without cost-sharing, regardless of age group, health condition, or risk factors. Similarly, we continue to offer MMRV, MMR+V, and Hepatitis B vaccines without cost-sharing. It is important to note that self-funded employer plans and certain government-sponsored plans retain the discretion to adopt alternative coverage criteria.

We continue to closely monitor developments related to ACIP and carefully evaluate its recommendations to provide evidence-based guidance to our clients. We remain committed to

aligning our coverage policies with established clinical evidence and regulatory requirements, informed by the consensus of medical experts.

The Honorable Richard Hudson (R-NC)

1. **North Carolina is home to one of the most vibrant life sciences ecosystems in the world. Tens of thousands of North Carolinians work in research, development and advanced manufacturing, ultimately affecting whether the next breakthrough therapy makes it from the lab to the people who need it.**

    a. **How do your coverage practices account for the long-term value of innovative therapies that may reduce hospitalizations or cure diseases?**

    b. **Do unpredictable formulary access and rebate demands discourage investment in new therapies, particularly for rare or complex diseases? In turn, costing more per patient in the long run?**

Response: The Cigna Group's solutions and coverage offerings account for the long-term value of innovative therapies by using evidence-based coverage policies, outcomes- and prevention-oriented care models, and alternative payment approaches that consider both clinical benefit and downstream health system impact. This approach is particularly important as many FDA-approved cell and gene therapies now carry list prices ranging from approximately $375,000 to more than $3.5 million per patient, excluding administration and related costs, creating the risk of significant upfront financial exposure for patients, employers, health plans, and public programs.

For high-cost therapies with the potential to reduce hospitalizations or deliver durable benefit, such as cell and gene therapies, Express Scripts, The Cigna Group's pharmacy benefit services provider, evaluates clinical evidence, durability of response, and real-world outcomes, and may pair coverage with outcomes-based or value-aligned contracting and specialized care coordination rather than short-term utilization controls.

The Cigna Group also uses risk-pooling and financing solutions to enable coverage of therapies with high upfront costs while recognizing their potential to avert future medical spending and improve long-term outcomes. For example, our Embarc Benefit Protection solution is an innovative gene therapy network solution designed to make high-cost and potentially life-saving gene therapy drugs more accessible to patients who need them and the cost more affordable and predictable for employers.[49] Embarc currently covers nearly 7.2 million people and has provided $140 million in value to enrolled plans and patients in less than 5 years.

As additional real-world evidence becomes available, Express Scripts and Cigna Healthcare update clinical coverage policies to reflect demonstrated long-term value, ensuring that access decisions evolve with the science rather than relying solely on short-term cost considerations.

Formulary access and rebate demands do not discourage investments in new therapies. Our coverage and formulary processes are designed to provide clear, clinically grounded decision-making criteria and predictable access pathways, while focusing negotiations on net

[49] Evernorth Health Services, *As More Gene Therapies Come to Market, Payers Need Expanded Options to Protect Their Plans*, Evernorth Newsroom (Aug. 2024).

cost and value rather than rebate size alone, to help ensure sustainable access for patients and plan sponsors. Importantly, The Cigna Group does not set drug prices; drug companies retain full control over pricing and investment decisions.

2. **Research showed that in 2025, more than 1,400 medicines were excluded from at least one of the three largest PBMs' standard commercial formularies.**

    a. **Given this trend, are PBMs driving higher spending for patients and employers by prioritizing products that yield the PBM more profit over those that offer lower net costs?**

    b. **It seems insurance companies frequently cite drug list prices as the cause of affordability issues. Can you state in general what manufacturers actually receive – net of rebates – for your top drugs? How does that compare to patient out-of-pocket costs?**

        i. **If manufacturers are providing larger rebates each year, why do patients continue to see rising out-of-pocket costs at the pharmacy counter?**

        ii. **Do higher rebates sometimes result in higher list prices?**

        iii. **How much of the rebate revenue generated by manufacturers is retained by your PBM rather than used to reduce patient costs?**

Response: Drug companies set list prices for their products and can lower them at any time. The Cigna Group encourages drug companies to proactively price their products affordably without relying on rebates. In the absence of those actions, Express Scripts will continue to seek the lowest possible net prices for its customers and clients. Today, OOP spending represents roughly 10% of total prescription drug spending and about 82% of our pharmacy benefit customers spent less than $250 OOP in 2025 for their long-term prescriptions.[50,51] Using a PBM is a choice – if PBMs were not driving savings for their clients, they would not continue to use them.

Formularies are clinically driven. Express Scripts' standard formularies are developed by an independent Pharmacy & Therapeutics Committee (P&T) of actively practicing physicians and pharmacists who represent a broad range of specialty practice areas. Clinical appropriateness is evaluated before cost considerations, and the Committee has no access to rebate or pricing information. Importantly, Express Scripts' clients determine the formulary that is used in their plans. Clients can develop their own formularies, adopt Express Scripts-developed standard formularies, or make changes to standard formularies to create a custom formulary.

We recognize affordability challenges remain. In response, we developed a new protection benefit to help reduce OOP costs for more of our customers. To ensure they always pay the lowest price available for both brand-name and generic medications, Express Scripts can automatically compare the negotiated-discount price, the cash-discount price, the drug company's direct-to-consumer price (if available), and the customer's copay. Eligible customers will pay the lowest available price at the pharmacy counter. While the Express

[50] Centers for Medicare & Medicaid Services, *National Health Expenditure Accounts: NHE Fact Sheet* (2024).
[51] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).

Scripts-negotiated price is typically the lowest, other prices may be lower in some cases, especially for people with high-deductible health plans.

Looking ahead, Express Scripts is beginning to transition to a new, rebate-free, standard pharmacy benefits model that makes the lowest price of the drug readily available and transparent from the start. This is a fundamental business shift to reinvent the PBM model and help make prescription benefits work better for everyone.

3. **The research institute RTI International found patients must go out of network for mental health care three-and-a-half times more often than for physical health care—showing that providers exist, but they aren't in your networks. RTI also found that, compared to Medicare, insurers pay physical health clinicians 22 percent more than behavioral health providers. When you underpay mental health providers and layer on burdensome insurer requirements, clinicians leave your networks. That leaves your policyholders with too few in-network options and forces families to pay far more out of pocket—or go without care.**
    a. **Why are the reimbursements so much lower for mental health providers resulting in inadequate networks?**
    b. **Would this saddle more out-of-pocket costs for families?**
    c. **Would this shift costs to emergency rooms, public systems and taxpayers?**
    d. **What steps will your companies take to stop these cost shifts?**
    e. **What do you all cover compared to Medicare, Medicaid and TRICARE as it relates to mental health services?**

Response: Access to behavioral health care has lagged behind medical care across health systems, but we do not agree that the challenges identified by RTI can be attributed solely – or even primarily – to insurer reimbursement practices. Behavioral health access constraints are systemic and multifactorial, driven by longstanding workforce shortages, uneven geographic distribution of clinicians, and historically fragmented care delivery models that affect all payers and public programs, including Medicare and Medicaid.

Evernorth Behavioral Health powers Cigna Healthcare's behavioral health offerings and has taken sustained, measurable action to address these barriers. Over the past four years, Evernorth has significantly expanded access to behavioral health services by more than doubling our behavioral health network, including offering a large virtual behavioral network, and building an integrated care model that supports individuals across the full continuum of need. This includes, but is not limited to, early-state supports such as coaching, navigation, and family support, as well as therapy, medication management, and higher-acuity services.

When patients cannot access timely, in-network behavioral health care, they are more likely to delay treatment, seek care out-of-network, or experience crises that result in avoidable emergency department visits. Preventing that outcome is precisely why Evernorth and Cigna Healthcare emphasize early identification, rapid access, and coordinated care, including 24/7/365 crisis support, urgent behavioral health services, and a mobile-first myCigna tool that guides individuals through need-based questions and connects them with appropriate in-network providers. Members have access to applied behavior analysis (ABA)-certified and licensed providers either in-person or virtually to improve continuity of care and meet patients where they are.

Cigna Healthcare, along with other payers, integrates services from Evernorth Behavioral Care Group (EBCG), an Evernorth-contracted outpatient provider group designed to expand access to outpatient therapy through rapid appointment availability and streamlined scheduling and matching. EBCG supports virtual and in-patient access to more than 5,000 licensed, outpatient behavioral health providers nationwide.

EBCG provides access to licensed, contracted behavioral health providers within 72 hours of booking that is grounded in: (1) measurement-based care; and (2) matching patients to the right practitioner and service to meet their needs, including their clinical needs, scheduling preferences, and the personality style with which they connect. From precision recruitment to rapid access for patients to outcomes measurement, every aspect is designed to ensure patients receive evidence-based, compassionate, and effective treatment. Providers benefit from reduced administrative burdens, fair compensation, and clinically appropriate referrals to foster better patient outcomes.

In short, the access challenges identified by RTI are real, but the solution is not reimbursement changes alone. Sustainable improvement requires workforce expansion, administrative simplification, value-based payment, early intervention, and integrated care delivery – all areas where Cigna Healthcare and Evernorth are already making significant, measurable investments to reduce delays, support the link between behavioral and medical care, and make it easier for patients to access evidence-based behavioral health services.

The Honorable August Pfluger (R-TX)

1. **In your testimony, you stated that you acquired Express Scripts specifically to enable "coordination across medical, behavioral, and pharmacy care" and to deliver "coordinated, whole-person, high-quality care that improves outcomes and reduces total costs."**

    a. **Is that accurate?**

    b. **Is that what this integration is designed to deliver?**

Response: When we pursue a coordinated care model approach across the delivery of medical, pharmacy, and behavioral coverage, it has been for one goal: to accelerate the development of solutions that enable more coordinated, whole-person, high-quality care that improves patient outcomes and reduces total costs. According to Cigna Healthcare's 2025 Value of Integration Study, fully integrated medical, pharmacy, and behavioral benefits can save employers $241 per member, per year and up to $28,000 per oncology patient per year.[52] Employers that choose integrated medical, behavioral, and pharmacy benefit services consistently see greater patient engagement, better care coordination, fewer duplicative or unnecessary services, and meaningfully lower total medical costs.[53]

This approach is in direct response to growing market demand from patients, employers, unions, and public health entities for more affordable, coordinated coverage that effectively navigates today's fragmented health care delivery system. Employers, unions, and public

[52] Cigna Healthcare 2025 National Book of Business study of 2024 claims of medical customers who have Cigna Healthcare integrated medical, pharmacy, and Cigna Total Behavioral Health benefits. Savings are for those with a condition diagnosis and engaged in Case Management or a Health Maintenance Activity.
[53] Cigna Healthcare, *The Top Health Care Trends for 2026 and How They Will Impact U.S. Employers,* Cigna Newsroom (2026).

purchasers conduct competitive procurements and change service providers if value is not delivered. Our clients and customers are demanding more affordability, transparency, and value and a simpler consumer experience and The Cigna Group is stepping up to deliver meaningful solutions.

2. **You acknowledged in your testimony that when a hospital system demanded a 30 percent rate increase, you settled for 20 percent because you couldn't walk away. You also acknowledged that commercial rates are roughly 200 percent of Medicare rates.**

    a. **If Cigna cannot say no to 20 percent increases and cannot get close to Medicare rates, what value is your market power providing to employers and consumers?**

Response: At Cigna Healthcare, our objective in every negotiation is to secure competitive rates that protect affordability and preserve access to high-quality care for patients and employers. The reality acknowledged in our testimony does not reflect a lack of insurer value, but the economic realities of an inflated cost environment, highly consolidated hospital markets, the network access requirements of regulators, and expectations of patients and employers. We approach negotiations with a strong focus on data-driven decision making, incentivizing value-based care, and delivering meaningful value to customers and our employer clients.

Across the industry, factors like inflation, technological innovation, labor shortages, government funding of public programs, regulatory requirements and evolving care models all play a role in providers seeking significant rate increases. In these negotiations, hospital systems have a keen awareness and understanding of network adequacy requirements, their regional importance to both patients and employers, and how to leverage the media if an agreement isn't reached. Additionally, providers are extracting unsustainable profits from employers, unions, and commercial insurers for out-of-network services.[54] In network contract negotiations, the providers reaping these profits are citing their NSA IDR win rates as rationale for demanding payment well over in-network median rates.

Compounding this, in numerous regions of the country, hospital systems have consolidated to the point where they are "must-haves" in insurers' networks, limiting the ability of any insurer to walk away without disrupting patient access to care. As the CBO and Rand have observed, commercial insurers' ability to exclude providers from networks is often constrained in highly concentrated hospital markets.[55,56] This consolidation has also fueled the use of anticompetitive contracting practices that limit insurers' ability to construct more value-based networks – an issue being actively addressed by the U.S. Department of Justice in New York and via bicameral federal legislation that is projected to save billions over ten years.[57,58]

Even in that environment, Cigna's market presence provides meaningful, measurable value in four key ways:

First, insurers' negotiating leverage meaningfully constrains price growth.

[54] *How Scott and Alla LaRoque got rich from disputed medical bills,* STAT (Mar. 18, 2026).
[55] Congressional Budget Office, *The Budgetary Effects of Key Provisions in the No Surprises Act* (2021).
[56] Rand Corporation, *Prices Paid to Hospitals by Private Health Plans* (Dec. 10, 2024).
[57] U.S. Department of Justice, *Justice Department Sues New-York Presbyterian Hospital for Anticompetitive Contracts That Increase Health Care Costs* (Mar. 26, 2026).
[58] Congressional Budget Office, *Cost Estimate for H.R. 3120* (Nov. 2024).

Peer-reviewed research shows that hospital prices are higher in more concentrated hospital markets **and lower where insurer bargaining leverage is stronger**.[59] In areas with greater hospital competition, Cigna Healthcare actively leverages competition to secure better rates and accelerate the shift from volume-based to value-based payment models.

Second, Cigna Healthcare consistently secures significant discounts from billed charges.

Hospital charges are an initial list price rather than what the hospital collects. Even when hospitals demand large increases, negotiated rates remain 50% below billed charges for commercial payers, directly reducing costs for employers and consumers relative to an unmanaged market. In our view, there is little incentive for hospitals to compete on price, which dilutes traditional economic principles. Generally, due to market consolidation and patient insulation from underlying hospital costs due to benefit design, hospitals often compete on location, brand/reputation, quality, providers, or amenities rather than unit price or cost.

Third, Cigna Healthcare reduces total cost of care.

Cigna Healthcare's value to employers and consumers also comes from active management of total cost of care, including guiding patients to high-value providers and sites of care, reducing unnecessary admissions and duplicative services, coordinating care for individuals with chronic and complex conditions, and using integrated medical, pharmacy, and behavioral data to improve adherence and health outcomes.

Fourth, Cigna Healthcare prevents fraud, waste, and abuse in the health care system.

Cigna Healthcare's Special Investigations Unit (SIU) protects customers and clients from waste, fraud, abuse, and other questionable billing or provider practices that can lead to higher costs and financial harm. The SIU operates as a core affordability and integrity lever within Cigna Healthcare's broader care and payment ecosystem. In 2025, SIU prevented approximately $1.3 billion in fraudulent claims.

These efforts directly reduce spending growth even when underlying unit prices remain elevated. The underlying challenge is not insurer market power, but the structural imbalance created by provider consolidation and anticompetitive tactics used to elevate costs, which requires targeted policy solutions beyond contract negotiation alone.

a. Does Express Scripts pay affiliated pharmacies higher reimbursement rates than unaffiliated pharmacies? If so, what is the percentage difference?

Response: No. A comprehensive economic analysis conducted by Professor Dennis W. Carlton and co-authors, using data provided to the Federal Trade Commission, concludes Express Scripts does not pay higher reimbursement rates to affiliated pharmacies than to unaffiliated pharmacies on average.[60] The analysis affirms that there is no systematic evidence that Express Scripts, or the other PBMs analyzed, favor affiliated pharmacies through higher reimbursement rates.

[59] Suhui (Evelyn) Li, David Jones, Eugene Rich & Aimee Lansdale, *How Do Hospitals Exert Market Power? Evidence from Health Systems and Commercial Health Plan Prices*, Health Affairs Scholar 3(1) (2025).
[60] Compass Lexecon, *Comprehensive Analysis of PBM-Affiliated Pharmacy Reimbursements Shows FTC Interim Reports Reached Flawed Conclusions Based on a Small, Non-Representative Sample of Drugs* (Apr. 28, 2025).

3. **You are one of the largest purchasers of health care in America with massive data analytics capabilities. Despite your market dominance, your vertical integration, and your claims about negotiating power, costs keep rising faster than the underlying medical expenses.**

    a. **If your business models are designed to reduce costs, why are premium increases running at rates three times faster than hospital cost increases?**

    Response: Health insurance premiums reflect the total cost of care in the underlying health system – including unit prices, utilization/frequency, service mix, and mandated coverage requirements. Premiums do not drive these costs; they mirror them. When system-wide cost pressures accelerate simultaneously across multiple categories, premiums increase even when insurers are actively working to contain spending growth.

    Unit cost pressures

    Hospital prices remain a primary driver of premium growth. Hospital system affiliation, cross-market mergers, and vertical integration with physician practices are associated with significantly higher commercial prices, often without commensurate improvements in quality or outcomes.[61] Peer-reviewed research demonstrates that hospitals with greater market share command materially higher rates and private equity-affiliated provider practices bill higher prices for the same services than independent practices.[62, 63]

    Prescription drug spending is another major unit cost driver. Most new drugs entering the market are high-priced, branded specialty medications. Launch prices have increased dramatically over the past decade, with median U.S. launch prices rising from tens of thousands of dollars in the early 2010s to hundreds of thousands of dollars per year for many new therapies, particularly in oncology and rare diseases.[64,65] These prices significantly increase total medical spend even when utilization remains limited.

    Similar dynamics exist in medical technology, where new imaging, diagnostic, and interventional tools often enter the market at substantially higher prices despite incremental clinical improvement, adding to per-episode and per-patient costs over time.

    Utilization and shifts in the mix of services

    High unit prices are compounded by increased utilization and a shift toward more intensive services. The U.S. population is aging, and chronic and mental health

[61] Jessica Y. Chang & Kathryn Martin, *Commercial Inpatient Hospital Price Growth Driven by System Affiliation and Non-profit Status Hospitals*, Health Affairs Scholar 2(11) (Nov. 2024).
[62] Suhui (Evelyn) Li, David Jones, Eugene Rich & Aimee Lansdale, *How Do Hospitals Exert Market Power? Evidence from Health Systems and Commercial Health Plan Prices*, Health Affairs Scholar 3(1) (2025).
[63] Alexander Borsa, Geronimo Bejarano, Moriah Ellen, & Joseph D. Bruch, *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, BMJ 382, e075244 (July 19, 2023). Anjali Bhatla, Victoria L. Bartlett, Michael Liu et al., *Changes in Patient Care Experience after Private Equity Acquisition of US Hospitals*, JAMA 333;(6):490-497 (2025).
[64] Reuters, *Prices for New US Drugs Doubled in 4 Years as Focus on Rare Disease Grows (*May 22, 2025).
[65] Benjamin Rome, Aaron S. Kesselheim, Alexander C. Egilman, et al., *Trends in launch prices for new brand-name prescription drugs in the United States, 2008–2021,* JAMA 327(21):2145–2147 (2022).

conditions now account for approximately 90% of total health care spending, increasing both the frequency and complexity of care.[66]

Recent years have also seen rapid growth in utilization of high-cost therapies, including GLP-1 medications for diabetes and obesity and advanced oncology treatments, each of which carries substantial per-patient costs even before accounting for downstream utilization.

In addition, coding intensity has increased across outpatient settings, contributing to higher allowed amounts per visit. Independent analyses of national claims data show a marked shift toward higher-complexity evaluation and management (E/M) billing across emergency departments, urgent care centers, and physician offices, raising costs for commercial payers without clear evidence of corresponding increases in clinical severity.[67] A separate analysis concludes that these increases are tied to providers and hospitals increasingly applying generative AI to electronic health records and to the claims billing process.[68]

Federal and state coverage requirements

Premiums also reflect the cost of implementing federal and state coverage mandates and regulatory requirements. While many of these policies are well-intentioned, they frequently increase administrative complexity and benefit costs without producing offsetting system-wide savings. Requirements related to out-of-network billing, transparency, reporting, and compliance, along with expanding benefit mandates, are incorporated into premiums because insurers are required to fund implementation and ongoing compliance.

For example, the NSA was intended to protect patients from balance billing by providers and lower costs. CBO originally estimated it would lower premiums and provide $17 billion in federal savings from reduced coverage costs. However, private equity and third-party abuse of loopholes in the IDR process is significantly increasing costs for American employers and patients. Georgetown health policy researchers recently estimated that the IDR process has added an estimated $5 billion in costs – not savings – to the health care system.[69]

State premium taxes and assessments

Beyond federal and state mandates, state-level taxes and assessments on health insurance premiums present a significant and often overlooked driver of coverage costs for employers and insured individuals. At the national level, the average annual family health insurance premium is approximately $24,540, with an average embedded premium tax rate of 6.64%, adding an estimated $1,630 in taxes to the cost of coverage.[70] State rates vary considerably (ranging from under 2% to over 10%), meaning

[66] Centers for Disease Control and Prevention, *Fast Facts: Health and Economic Costs of Chronic Conditions (*Aug. 2025).
[67] Trilliant Health, *Changes in Coding Intensity Suggest How Upcoding is Happening Across Outpatient Settings* (May 2025).
[68] Blue Cross Blue Shield Association, *Rising Coding Intensity and Its Impact on Health Care Affordability* (Mar. 2026).
[69] Georgetown University, Center on Health Insurance Reforms, *The Substantial Costs of the No Surprises Act Arbitration Process,* (Sept. 24, 2025).
[70] The U.S. Chamber of Commerce, *The Hidden Cost of Premium Taxes on Health Insurance* (Mar. 2026).

the tax burden on a given employer or individual depends significantly on where they are located.

Financing structure of government programs

Each hospital considers their unique payer mix which determines the balance between revenues from government programs, commercial insurers, and charity care. This payer mix is crucial because it influences how hospitals manage cost shifting, often requiring them to rely more heavily on commercial insurers to offset any shortfalls caused by public programs and uncompensated care. Since over half of the U.S. population receives health insurance through commercial payers, the employer community and consumers subsidize shortfalls due to lower government payment rates. As a result, commercial payers bear the brunt of paying higher provider reimbursement rates which in turn drive higher premiums.

Addressing the drivers of health care cost growth

Premium growth that outpaces any single cost category reflects the cumulative effect of multiple, reinforcing cost drivers, not a failure of insurer cost-management models. Addressing affordability requires mechanisms that can help balance these forces and introduce competitive discipline into markets that do not self-correct. We support targeted policy reforms that address the true cost drivers in the system – particularly hospital and provider consolidation, anti-competitive drug company practices, and enforcement gaps that allow high-priced care to persist. We stand ready to work with this Congress, the Administration, and our partners throughout the health care sector to build a health care system that prioritizes prevention, rewards value over volume, and leverages competition where it works to reduce costs for patients.

b. What value are you providing to employers and families paying these premiums?

Response: At The Cigna Group, we:

- Negotiate lower costs for medical services and prescription drugs than individuals or employers could achieve on their own. In fact, we've helped the U.S. achieve some of the lowest prices for generics in the world[71]
- Design networks of doctors, hospitals, and pharmacies and drug formularies to ensure that patients receive high-quality, lower-cost care
- Coordinate care across medical, behavioral, and pharmacy services to reduce fragmentation and avoid duplicate or unnecessary use of resources
- Build incentives promoting a culture of health, engagement, and wellness to support healthier choices and health literacy
- Advance value-based payment models that reward outcomes rather than volume of services

[71] Rand Corporation, *International Prescription Drug Price Comparisons: Estimates Using 2022 Data* (2024).

- Process claims and payments efficiently across a complex supply chain. In fact, of the approximately 155 million medical claims that were processed by Cigna Healthcare in 2025, approximately 95% were approved and paid

These functions are essential in a fragmented system; without them, patients and employers would face even higher costs and inconsistent quality of care.

c. What are the top three things your company does to rein in underlying gross premium increases across the commercial marketplace? Please quantify their impact in any way you can.

Response: Patients, employers, unions, and public sector entities have choice in the market for health benefits coverage and will change service providers if value is not delivered. This competition ensures that we are constantly innovating to meet our customers' and clients' needs and deliver services that enable more affordable, coordinated coverage that effectively navigates today's fragmented health care delivery system. Our financial model is built around one simple idea: when we improve health and lower total health care costs, everyone benefits.

Our combined medical, behavioral, and pharmacy benefit capabilities help us to create solutions that improve predictability, affordability, and transparency. Our focus helps us anticipate needs, accelerate innovation, and provide personalized experiences for customers and patients at scale – ensuring clear alignment with the value we deliver. As a result, today we are privileged to serve millions of employers, public sector entities, customers, and patients.

To rein in underlying gross premium increases, we:

1. **Actively manage total medical costs, including data-driven contracting and site-of-care optimization**

   The largest driver of commercial premiums is hospital spending, particularly in consolidated markets. We create access to the right care at the right time through data-driven contracting with hospitals and provider groups, securing better prices for care than our customers and clients could secure on their own and enabling access to high-performing providers through value-based reimbursement models that align incentives and drive better health outcomes.

   Site-of-care optimization goes farther than just network management; it's actively supporting our customers' decision-making and health by promoting access to safe, medically necessary care in the most effective settings. For example, patients that need regular infusions of specialty medications may benefit from the lower cost and convenience of receiving in-home infusions rather than traveling to get the same treatment at a higher-priced hospital. A recent study found that infusions outside of the hospital setting are associated with fewer reactions, reduced ER visits, fewer hospital admissions, and lower OOP costs.[72]

[72] Daniel Cullen and Aliza S. Gordon, et al., *Infusion Therapy Patient Outcomes are Similar at Reduced Costs in Alternative Sites of Care Compared with Hospital Outpatient Departments: A Matched Cohort Analysis of Infusion Therapy Across Multiple Chronic Conditions*, Journal of Managed Care and Specialty Pharmacy 32(3): 312-322 (Mar. 2026).

2. **Drive care coordination through integrated medical, behavioral, and pharmacy care to help people stay healthier and avoid costly complications**

   The frequency of high-cost episodes for patients has increased significantly since the COVID-19 pandemic. One percent of patients drive roughly 30% of the total cost of care, with the number of patients having over $1 million in medical spending increasing 16% per year on average since the pandemic. Some of the fastest growing areas of health care spending are chronic and complex conditions – such as obesity, diabetes, oncology, and inflammatory disease – that increasingly rely on evidence-based medications, including high-cost specialty medications.

   Effectively managing these conditions requires coordinated medical, behavioral, and pharmacy coverage to support appropriate use, adherence, and long-term outcomes. When an employer chooses this model, we can better support a patient's care – reducing duplicate services, avoiding unnecessary care, and ensuring medications and treatments work hand-in-hand. This approach consistently produces better health outcomes and meaningfully lowers total medical costs for employers and their employees.

   Cigna Healthcare routinely evaluates the impact of medical, pharmacy, and comprehensive behavioral benefit integration on annual total medical costs. When reviewing 2024 claims of medical customers who have Cigna Healthcare integrated medical, pharmacy, and Cigna Total Behavioral Health benefits, the total medical cost savings is $241 per member, per year (PMPY).[73] Savings are much higher across complex conditions or therapies. For example, savings for patients with specialty conditions is $8,255 PMPY and up to $28,000 PMPY for patients with a cancer diagnosis.[74]

3. **Contain drug prices and promote competition, especially generics and biosimilars**

   Prescription drugs – particularly high-cost brand and specialty medicines – remain a significant and fast-growing contributor to premiums. Through Express Scripts and Evernorth, we aggressively promote generic and biosimilar use and lower costs through formulary design, manufacturer negotiation, and innovative benefit management, including developing market-leading solutions to support clinically appropriate access for gene therapies and GLP-1s.

   The generics market demonstrates what effective competition combined with formulary design can achieve: generics account for 90% of prescriptions filled but only 10% of total drug spending. Additionally, the introduction of biosimilars has significantly reduced costs for American businesses and patients in certain drug classes. Data from Evernorth Research Institute shows that the introduction of interchangeable Humira biosimilars resulted in $200 million in savings from January

[73] Cigna Healthcare 2025 National Book of Business study of 2024 claims of medical customers who have Cigna Healthcare integrated medical, pharmacy, and Cigna Total Behavioral Health benefits. Savings are for those with a condition diagnosis and engaged in Case Management or a Health Maintenance Activity.
[74] *Id.*

2024 to March 2025.[75] In 2024 alone, savings from the Humira biosimilars averaged $4,505 per patient, per year.[76] By aggressively promoting generic and biosimilar use, Express Scripts will continue to help insulate patients by maintaining low average OOP costs and delivering meaningful savings to employers, unions, health plans, and public sector entities despite continued growth in brand drug prices.

To address high-cost brand and specialty drugs, The Cigna Group has introduced industry-first programs to support more affordable, predictable access. For example, Embarc Benefit Protection is an innovative gene therapy network solution designed to make high-cost and potentially life-saving gene therapy drugs more accessible to patients who need them and make the cost more affordable and predictable for employers.[77] Embarc currently covers nearly 7.2 million people and has provided $140 million in value to enrolled plans and patients in less than 5 years.

Similarly, our EncircleRx Cardiodiabesity solution offers patients and plan sponsors financial guarantees to provide greater predictability and control of GLP-1 spending, including access to FDA-approved medicines and prioritizing adherence, proper dosing, clinical support, and patient safety. In one year, clients saved more than $400 million and over 11 million people enrolled in the program, demonstrating the value of our solutions to patients and to our clients.

The Cigna Group more broadly has a proven track record of leveraging our patients' and clients' feedback to introduce bold changes that shift incentives from a reactive sick care model to one that emphasizes prevention, engagement, price and health literacy, transparency, and coordination across medical, behavioral, and pharmacy care.

Last year, we committed to a multi-year journey to improve health coverage and confront some of the most pressing challenges in health care. As part of those commitments, we recently published the first annual Customer Transparency Report that provides public information documenting our progress.[78] We have made important advancements, but recognize there is still more work to do in this multi-year effort.

d. How do your companies currently or are planning to deploy technology to increase patient affordability?

Response: The Cigna Group is leveraging health technology across our businesses – Cigna Healthcare and Evernorth Health Services – to improve the patient experience and health outcomes while addressing systemic inefficiencies in the U.S. health care system.

On the member and patient side, we have deployed AI-powered digital tools to simplify benefit navigation, improve access to care, and support better decision-making. In

[75] Evernorth Health Services, *Pharmacy in Focus: The Biosimilar Breakthrough in Adoption and Affordability*, Evernorth Research Institute (2025).
[76] *Id.*
[77] Evernorth Health Services, *As More Gene Therapies Come to Market, Payers Need Expanded Options to Protect Their Plans*, Evernorth Newsroom (Aug. 2024).
[78] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).

2025, Cigna Healthcare launched an industry-leading generative AI virtual assistant within the myCigna portal that helps members understand coverage, estimate costs, track claims, and find in-network providers using clear, conversational language. Early results showed high proactive use and improved comprehension of benefits.

Through Evernorth, we're making significant investments in advanced analytics and predictive modeling to identify and engage patients earlier in their care journey with clinical and wrap-around support, including chronic disease management, virtual care, and earlier intervention – such as MDLIVE's virtual primary and chronic care services and digital programs like Omada Health for diabetes and cardiometabolic conditions – helping improve outcomes while reducing avoidable acute care utilization.

We are also applying technology to reduce waste, fraud, and abuse and lower administrative burden for providers and the health system. AI and rules-based automation are used to streamline claims processing, payment integrity, and utilization review, enabling faster, more accurate decisions while maintaining compliance and clinical oversight. Non-AI coding accuracy policies apply claims-based criteria developed by certified coders and clinicians to address inappropriate upcoding by a limited number of providers to support high-quality patient care and minimize disruption to provider practices.

For providers, Evernorth has invested in digital tools that reduce friction – such as virtual care platforms, asynchronous care capabilities, and data-driven clinical decision support – freeing clinicians from administrative tasks and allowing more time for patient care.

Collectively, our strategy reflects a system-level approach – using technology not as a standalone solution, but as an enabler of simpler experiences, better outcomes, reduced administrative waste, and a more efficient and sustainable U.S. health care system.

4. **What are the specific federal regulations or policies that you believe contribute to rising health care costs?**
    a. **What regulatory changes would you support to improve affordability for consumers?**
        i. **Additionally, some argue the Medical Loss Ratio creates perverse incentives, specifically that capping profit as a percentage means the only way to grow profits is to grow total spending. Do you agree with that criticism? If not, explain how MLR doesn't incentivize premium inflation.**

Response: Health plan affordability is best supported by targeted regulatory reforms that reduce unnecessary administrative costs and market distortion while preserving patient protections. Based on our experience, several existing regulatory frameworks would benefit from reform or recalibration:

- Reforms to the NSA IDR process are needed to address structural flaws that have increased, rather than reduced, health care costs. Public analyses show that abuse of the IDR process by a small number of providers and private equity-backed billing

entities has driven billions of dollars in added costs for employers and patients.[79] Regulatory changes to better screen out ineligible claims, strengthen oversight of IDR entities, and realign financial incentives would help restore the law's original intent and improve affordability.

- Drug patent loopholes should be closed to prevent drug companies from using patent thickets, product hopping, and pay-for-delay schemes to delay access to more affordable generics and biosimilars. Take Keytruda for example, a leading immunotherapy for cancer that generates $29.5 billion in annual sales and is projected to get biosimilar competition in 2028. The Evernorth Research Institute estimated that if a biosimilar is delayed from the market for five years, it could represent as much as $45 billion in missed savings to the commercial market.[80] This is in addition to federal taxpayer savings from closing loopholes that allow these delays to continue.
- Misleading direct-to-consumer pharmaceutical advertising should be eliminated to reduce inappropriate demand for high-priced drugs over more affordable alternatives and reduce influence on prescribing practices. Pharmaceutical companies spend roughly $14 billion annually on advertising, significantly impacting taxpayer costs through tax deductions, and exceeding spending on R&D for some firms.[81]
- Incentives for local provider and hospital consolidation should be addressed. For example, expanding site-neutral payment reforms and addressing anti-competitive contracting practices could discourage mergers, increase competition in local markets, and result in federal taxpayer savings.
- Duplicative and inconsistent prior authorization requirements across federal and state programs increase administrative burden for providers and plans without improving care. We support continued regulatory alignment to standardize electronic prior authorization and promote real-time approvals. Further regulatory streamlining would allow plans and providers to redirect resources toward patient care.
- The current Transparency in Coverage (TIC) machine-readable file requirements should be reformed to ensure that they provide user-friendly and actionable information to consumers given the considerable and costly compliance burden on both insurers and hospitals. Today, we are concerned these requirements have only yielded millions of dollars in compliance burdens that add to the cost of coverage in lieu of simpler, private market-driven reforms that would achieve the goal of meaningful price transparency to patients and policymakers.
- Reforms to the current federal and state mental health parity regulations should ensure that nonquantitative treatment limitation (NQTL) standards are administrable, clinically grounded, and consistently enforceable across plans and issuers. We support the Department of Labor reexamining its parity enforcement approach and support reforms

[79] Georgetown University, Center on Health Insurance Reforms, *The Substantial Costs of the No Surprises Act Arbitration Process,* (Sept. 24, 2025).
[80] Evernorth Health Services, *Pharmacy in Focus: The Biosimilar Breakthrough in Adoption and Affordability*, Evernorth Research Institute (2025).
[81] Campaign for Sustainable Rx Pricing, *Big Pharma's Direct-to-Consumer Advertising Costs U.S. Taxpayers Billions of Dollars* (Mar. 18, 2025).

prioritizing outcomes-focused access measures, clear safe harbors, and alignment with existing clinical and utilization management practices.

- Regulatory barriers that limit data interoperability and innovation, including fragmented state-by-state requirements and overlapping reporting mandates, raise costs and slow adoption of lower-cost, preventive, and virtual care models. Policies that streamline compliance obligations and support consistent national standards – particularly for digital health and AI-enabled tools – would improve efficiency and affordability while maintaining strong consumer protections.

Taken together, these targeted reforms would help reduce waste, administrative friction, and unnecessary cost growth, enabling delivery of more affordable coverage to employers, workers, and families.

Medical Loss Ratio

Medical loss ratio (MLR) requirements have limited applicability to our business as more than 80% of our U.S. medical customers are in the self-insured segment. These are employers and labor unions who bear their own financial risk and are therefore not subject to MLR requirements.

Where applicable for our business model, MLR requirements are not a meaningful driver of health care costs, as both fully insured and Marketplace coverage must compete based on premiums. Empirical analyses of the Affordable Care Act (ACA) individual market demonstrate that premium increases lead to measurable enrollment losses, creating strong competitive pressure that discourages insurers from raising premiums to accommodate higher underlying costs.[82]

Consistent with this dynamic, analysis of Marketplace plan selection shows that consumers disproportionately choose lower-premium options, reinforcing incentives to constrain premiums.[83] This structure, along with regulatory requirements (e.g., rate reviews), serves to constrain premium increases and disincentivize any inflation of underlying costs. Simply put, inflating premiums would make our fully insured and individual market businesses unviable and likely unable to pass significant regulatory scrutiny.

5. **Ground ambulance services are often out-of-network, even though they are the only emergency option for rural patients. Rural hospitals report payment delays and below-cost reimbursement, contributing to closures. Will Cigna commit to:**

    a. **Standardized reimbursement for emergency services that patients cannot shop for?**

    b. **Transparent payment methodologies with denial rate caps and interest on late payments to stabilize rural providers?**

Response: Cigna Healthcare seeks to address patient needs in the face of provider shortages and seeks to contract with ground ambulance providers at sustainable rates – and has successfully done so when providers are affiliated with health systems. Contracting is more

[82] Christine Eibner & Evan Saltzman, *Premiums and Stability in the Individual Health Insurance Market*, RAND Corporation (2014).
[83] Cynthia Cox et al., *Individual Market Insurers Requesting Largest Premium Increases in More Than Five Years*, Kaiser Family Foundation (July 18, 2025).

challenging with independent, township, or county-owned EMS providers that rely primarily on 911 calls, do not depend on network referrals, and therefore have limited incentive to participate in networks.

Because patients cannot choose an ambulance provider in an emergency, some ground ambulance providers remain out-of-network to bill full charges. Ground ambulance services were not included in the federal No Surprises Act, though some states have addressed this gap.

When Cigna Healthcare receives an out-of-network ground ambulance claim, we try to negotiate more sustainable payments to reduce costs for patients and the plan sponsor. If negotiations are unsuccessful, charges may reflect the provider's billed rates, which can cost consumers well over negotiated commercial and Medicare rates.

6. **A 12-employee community bank in my district faced a $100,000 annual premium increase. Small employers across TX-11 report double-digit increases without improved access or outcomes. Many are dropping coverage.**
    a. **What actuarial evidence justifies these increases to small employers?**
        i. **How much reflects actual medical costs versus administrative overhead and profit?**
    b. **What are you doing to ensure that small employers—who lack the negotiating power of large corporations—are not priced out of offering health insurance to their employees?**

        Response: Cigna Healthcare recognizes that health care costs are a serious challenge for small employers. The ACA's community rating rules limit variation in premiums within the small group fully-insured market, but they redistribute costs across the risk pool rather than reducing it. Small employers thus pay a persistent "small group loading" in premiums that large, self-insured employers can avoid through larger risk pools.

        In response to this issue, Cigna Healthcare is using its expertise in the ERISA self-insured market to bring solutions to small businesses. We were the first major carrier to offer level-funded arrangements, which allow small and mid-size employers to offer self-insured plans paired with stop-loss coverage to cap catastrophic exposure. Level-funded plans provide predictable premiums, plan design flexibility, and, with certain plan designs (such as those incentivizing primary and preventive care), may return a surplus to the employer if claims are below projections. These products allow small businesses in many cases to have more affordable health care options, similar to those enjoyed by larger employers.

7. **Does your company require peer-to-peer reviews for prior authorizations? If so:**
    a. **What are the qualifications of the physicians conducting these reviews?**
        i. **Are they required to be board-certified in the same specialty as the treating physician?**
    b. **What is the average length of a peer-to-peer review call?**

i. **Do you track how many of these calls are terminated by the treating physician due to time constraints?**

c. **Do you allow treating physicians to designate a qualified staff member to participate in peer-to-peer reviews on their behalf, or do you require the treating physician to personally participate in peer-to-peer reviews?**

Response: Peer-to-peer conversations are never required but are always available at the request of the treating provider to support a two-way clinical discussion with a board-certified physician reviewer at a time selected by the treating provider. These conversations allow providers to share patient-specific clinical details that may not be fully captured in written documentation alone, helping ensure coverage decisions are grounded in the individual facts of the case. When appropriate, this process can resolve questions earlier and reduce the need for formal appeals.

The peer-to-peer process time length varies based on case complexity, and discussions are intended to be collegial, educational, and focused on the patient's clinical circumstances. Cigna Healthcare's peer-to-peer discussions are designed to connect treating providers with physician reviewers who have appropriate clinical expertise in managing the specific patient's care or condition, recognizing that more than one specialty may be considered appropriate. All physician reviewers hold an active, unrestricted medical license to practice within the U.S. and represent a broad range of clinical specialties.

Treating providers can request and schedule peer-to-peer conversations through the Cigna for Health Care Professionals portal (CignaforHCP.com), with flexible scheduling options and the ability to reschedule when needed. Providers may also designate qualified staff to participate on their behalf, subject to limited exceptions (e.g., third-party vendors).

In parallel, Cigna Healthcare continues to enable simpler, easier, and faster prior authorization processes. Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.

8. **How many and what percentage of total prior authorization requests are denied each year specifically because the treating physician was "unavailable" or "refused to discuss" the case during a peer-to-peer review?**

    a. **What percentage of these denials are later overturned on appeal?**

Response: Peer-to-peer conversations are never required but are always available at the request of the treating provider to support a two-way clinical discussion with a board-certified physician reviewer at a time selected by the treating provider.

Treating providers can request and schedule peer-to-peer conversations through the Cigna for Health Care Professionals portal (CignaforHCP.com), with flexible scheduling options and the ability to reschedule when needed. Providers may also designate qualified staff to participate on their behalf, subject to limited exceptions (e.g., third-party vendors).

As part of The Cigna Group's Commitment to Better, we also published an annual Customer Transparency Report that provides public information on prior authorization approvals,

resolution statistics, and improvements to processing times.[84] We have made important progress, but recognize there is still more work to do in this multi-year effort.

9. **Do you track the time burden your peer-to-peer review process places on treating physicians?**

    a. **Have you studied whether this process delays medically necessary care?**

Response: The peer-to-peer process time length varies based on case complexity, and discussions are intended to be collegial, educational, and focused on the patient's clinical circumstances. The conversations are important from a client or employer and a treating provider standpoint for information exchange, i.e., clinical rationale for specific service or discussion of clinical information that may not be present so the payer can make a coverage determination.

Treating providers can request and schedule peer-to-peer conversations through the Cigna for Health Care Professionals portal (CignaforHCP.com), with flexible scheduling options and the ability to reschedule when needed. Providers may also designate qualified staff to participate on their behalf, subject to limited exceptions (e.g., third-party vendors). When appropriate, this process can resolve questions earlier and reduce the need for formal appeals.

In parallel, Cigna Healthcare continues to enable simpler, easier, and faster prior authorization processes. Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.

As part of The Cigna Group's Commitment to Better, we also published an annual Customer Transparency Report that provides public information on prior authorization approvals, resolution statistics, and improvements to processing times.[85] We have made important progress, but recognize there is still more work to do in this multi-year effort.

10. **When a rural hospital with limited staff submits a prior authorization request for a patient who is medically ready for discharge, how long does that process take on average?**

    a. **Do you track denial rates and processing times by geographic location—specifically, are rural providers treated differently than urban providers?**

Response: We continue to focus on making decisions faster for the benefit of the customers we serve and our provider partners. In 2025, 80% of Cigna Healthcare's U.S. medical prior authorizations were approved in one day or less and more than half of submissions submitted electronically were approved within minutes.[86,87] Turnaround times are driven by clinical complexity and the completeness and method of submission, rather than provider geography.

[84] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).
[85] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).
[86] The percentage of medical prior authorizations approved in one day or less is based on the total approved volume that reached an approval status for the same population and time period described in footnote 26.
[87] The percentage of prior authorizations electronically submitted that were approved within minutes is based on the same population and time period described in footnote 26. It considers prior authorizations that were electronically submitted and reached a final approval decision. Voided requests are excluded from the population. Near real-time decisions are generated without manual review through system-based rules and business logic.

Providers can always escalate requests to ask for same day precertification. Ensuring providers have all of the required clinical information on hand substantially supports the ability to obtain a timely determination.

Cigna Healthcare does not apply different prior authorization standards or timelines based on whether a provider is located in a rural or urban area. To support providers across all settings, we have enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly in both rural and urban areas.

For both patients and providers, we launched a medical prior authorization status tracker in June 2025 that shows timely updates and provides answers to frequently asked questions, as well as information on decisions and next steps.

As part of The Cigna Group's Commitment to Better, we also published an annual Customer Transparency Report that provides public information on prior authorization approvals, resolution statistics, and improvements to processing times.[88] We have made important progress, but recognize there is still more work to do in this multi-year effort.

11. **Will you commit to:**
    a. **Requiring that peer-to-peer reviews be conducted by physicians board-certified in the same specialty as the treating physician?**
    b. **Allowing treating physicians to designate qualified staff to participate in peer-to-peer reviews?**
    c. **Establishing reasonable time limits for peer-to-peer reviews and not penalizing physicians who must end calls to see patients?**
    d. **Publicly reporting prior authorization approval rates and processing times, broken down by rural versus urban providers?**
    e. **Publicly reporting the number of prior authorizations denied due to physician "unavailability" and the overturn rate on appeal?**

Response: Today, Cigna Healthcare's peer-to-peer discussions are designed to connect treating providers with board-certified physician reviewers who have appropriate clinical expertise in managing the specific patient's care or condition, recognizing that more than one specialty may be considered appropriate. All physician reviewers hold an active, unrestricted medical license to practice within the U.S. and represent a broad range of clinical specialties.

Additionally, today, treating providers may designate qualified staff to participate in peer-to-peer reviews on their behalf, subject to limited exceptions (e.g., third-party vendors). Call length varies based on case complexity, and discussions are intended to be collegial, educational, and focused on the patient's clinical circumstances. Treating physicians are never

[88] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).

penalized for ending calls to see patients and can request, schedule, and reschedule peer-to-peer conversations through the Cigna for Health Care Professionals portal (CignaforHCP.com).

As part of The Cigna Group's Commitment to Better, the company published the first annual Customer Transparency Report in 2026 publicly detailing progress against our commitments to improve prior authorization and provide greater visibility into how customer care and coverage decisions are facilitated.[89] This industry-first report provides important information regarding how we facilitate customer care and details about our services, data, and resolution statistics.

We are acutely aware that this report represents only the beginning of a long journey. The data and insights surrounding how we are improving and innovating against our Commitments to Better enable us to improve our operations, enhance our customer service capabilities, and help customers make more informed health care decisions. The Cigna Group has committed to publishing this report annually to lead the way for our industry and renew the commitments made in 2025: easier access to care, better support, better value, accountability, and transparency.

The Honorable Diana DeGette (D-CO)

1. **My constituent was diagnosed with stage IV intrahepatic cholangiocarcinoma in March 2025. Initial treatment with immunotherapy and chemotherapy showed no response. Genetic testing revealed a rare NRG1-Fusion mutation present in approximately 1 percent of tumors. This constituent is currently a member, through his employer, of a California-based plan administered by Cigna, though as a Colorado resident, he is seeking care in Colorado. Cigna denied coverage for the targeted therapy designed to treat this mutation, citing lack of medical necessity. After nearly a month of appeals and considerable out-of-pocket costs, he began treatment. The therapy has been successful in reducing the size of the tumor and made him eligible for liver transplant evaluation. Following extensive evaluation, a multidisciplinary medical team cleared him for liver transplant. Cigna denied the transplant authorization within 48 hours of the request. Without transplant, his prognosis is poor. My constituent appealed to Cigna and tried to reach representatives of the company without avail. He also documented his experience on social media, where videos received over 14 million views. Following this attention, Cigna reversed the transplant denial. However, Cigna has since delayed responding to subsequent preauthorization requests from his oncologist for necessary amendments to his treatment plan, placing his transplant—and life—in jeopardy.**
    a. **What are possible reasons for issuing initial denials of care like that described above?**
    b. **How many prior authorization requests were made to Cigna for oncology care in 2024?**
    c. **Of such requests, how many were initially denied?**
    d. **Of such denials, how many were appealed?**
    e. **Of such appeals, how many ultimately resulted in an approval?**

[89] *Id.*

f. **Since learning of this individual's situation, has Cigna:**

   i. **Conducted an analysis of what it could have done differently to avoid administrative burden for this individual? If so, what did that analysis find?**

   ii. **Initiated any corrective actions to its staff training or processes? If so, what are those corrective actions?**

g. **Does Cigna monitor social media for complaints about denials or other issues with the company?**

h. **Is there a threshold of any metric (e.g. views, likes, comments, reposts) of a complaint post that triggers internal review at Cigna? If so, what are those thresholds?**

i. **How does Cigna assign reviewers to prior authorization cases?**

j. **What mechanisms exist to match reviewers with cases within their area of expertise?**

Response: Cigna Healthcare fully understands that timely access to treatment is critical for individuals seeking organ transplant. Cigna Healthcare covers a broad range of services and treatments, grounded in the latest peer-reviewed clinical evidence and aligned with guidelines from leading organizations, including the National Comprehensive Cancer Network (NCCN), the National Liver Review Board (NLRB), and the United Network for Organ Sharing (UNOS).

While we can't speak to this individual case for privacy reasons, we can say that cases like this one are incredibly complex. Cigna Healthcare reviews each case carefully and urgently to ensure a decision is made as soon as possible to support time-sensitive care delivery.

Cigna Healthcare offers customers and their treating providers multiple levels of post-decision reviews, including peer-to-peer discussions, reconsideration, appeal, and a review by an independent third party, to ensure that each patient's case is reviewed carefully and thoroughly and that their physician has multiple opportunities to provide additional clinical information.

We have teams dedicated to supporting customers who mention our company on social media platforms, but social media content is not treated as clinical information and does not impact our coverage decisions.

Prior authorization is an important checkpoint to verify health coverage for certain procedures, treatments, and complex services. Cigna Healthcare makes its standard coverage policies, including prior authorization and step therapy policies, publicly available. Our approach is grounded in evidence-based clinical policies and standards, with oversight by our more than 3,000 clinical colleagues at The Cigna Group including nurses, pharmacists, social workers, therapists, and physicians.[90] Authorization decisions are grounded in plan-specific benefits, clinical guidelines, and individual facts submitted with each request. Emergency services are not subject to prior authorization.

[90] Based on internal analysis of clinicians (nurses, pharmacists, physicians and social workers) directly involved in medical and behavioral Cigna Healthcare U.S. utilization management and prior authorization processes. Includes contractors and part-time as of December 31, 2025.

In early 2025, The Cigna Group committed to helping our customers by making our processes simpler, easier, and faster. We have made meaningful progress:

- **Reducing Prior Authorizations:** Over the past year, we reduced paperwork and the time providers and patients spend obtaining approvals for more routine services by removing 345 tests, procedures, and services from the Cigna Healthcare U.S. prior authorization process.[91] This change has decreased the volume of medical prior authorizations by approximately 521,000 annually.[92] In 2025, less than 6% of Cigna Healthcare and Express Scripts customers went through our prior authorization process.[93]
- **Streamlining Prior Authorizations:** In addition, in 2025, we were pleased to begin a partnership with AHIP, the U.S. Department of Health and Human Services (HHS), and industry peers to streamline, simplify, and reduce prior authorization by:[94]
    - Standardizing electronic submissions
    - Reducing prior authorization volume
    - Honoring existing approvals during patient changes in insurance to ensure continuity of care
    - Boosting real-time approvals
- **Electronic Communications**: Today, nearly 65% of medical prior authorization requests are submitted electronically to Cigna Healthcare, an increase of 3.7% year-over-year.[95] Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.
- **Improved Turnaround Times**: We continue to focus on making prior authorization decisions faster. In 2025, 80% of Cigna Healthcare U.S. medical prior authorizations

[91] Based on absolute number of prior authorization codes removed during the year ended December 31, 2025, related to Cigna Healthcare U.S. business. Cigna Healthcare publishes a Master Precertification List quarterly. https://www.cigna.com/health-care-providers/coverage-and-claims/precertification

[92] Reflects estimated prior authorizations that would have been avoided in 2024 if the codes removed in 2025 had been removed for the calendar year 2024. Population consists of core medical prior authorizations and excludes pharmacy.

[93] The percentage of customers subject to our prior authorization process is calculated based on the number of unique customers who receive initial prior authorization decision(s) (i.e., approved or denied) and average quarterly membership for the year ending December 31, 2025. Prior authorization data reflects Express Scripts Pharmacy Benefit Services business and Cigna Healthcare U.S. core medical business, including behavioral services paid under a medical policy. Stand-alone behavioral prior authorizations are excluded. Customers with multiple prior authorizations are counted once, which is calculated separately for pharmacy and medical prior authorizations. Average quarterly membership includes customers of Express Scripts Pharmacy Benefit Services and Cigna Healthcare U.S. core medical, regardless of whether a client uses our prior authorization services.

[94] America's Health Insurance Plans (AHIP), *Health Plans Take Action to Simplify Prior Authorization* (2025).

[95] The percentage of medical prior authorization requests submitted electronically reflects the proportion of total prior authorizations for Cigna Healthcare U.S. core medical business including behavioral services paid under a medical policy that were submitted electronically via the Cigna Healthcare web portal. Data is based on the twelve month period from October 1, 2024 through September 30, 2025, updated as of December 31, 2025 to reflect a 90 day run-out period. Stand-alone behavioral prior authorizations are excluded.

were approved in one day or less.[96] More than half of the submissions submitted electronically were approved within minutes.[97]

- **More Customer Support**: Over the past year, we've strengthened our customer support, creating distinct teams to help customers navigate their health care and pharmacy benefits. Our high-touch advocate teams helped approximately 155,000 medical customers with prior authorization and post-care claim processes in 2025, 79% more customers than the year prior.[98]
- **Digital Status Tracker:** In June 2025, we launched a medical prior authorization status tracker for Cigna Healthcare. This new tool shows timely updates and provides answers to frequently asked questions, as well as information on decisions and next steps. It's available to every Cigna Healthcare customer through our myCigna platform, which is used by 79% of customers.[99]

2. **How much of each premium dollar does Cigna spend on preventive services? In your answer, please list the services included in your calculation.**

   Response: The Cigna Group strongly supports evidence-based preventive services and has long viewed prevention as one of the most effective ways to improve health outcomes and reduce avoidable costs over time. Preventive care is foundational to our approach to whole-person health, and we actively promote early detection, screenings, immunizations, and counseling services consistent with nationally recognized clinical guidelines.

   Under current law, Cigna Healthcare covers preventive services in accordance with the ACA, including services that receive an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by ACIP, and women's and children's preventive services supported by the Health Resources and Services Administration (HRSA) – all without cost-sharing for eligible members. These standards are embedded in our administrative policies, provider guidance, and benefit designs across applicable lines of business.

   In addition to these requirements, Cigna Healthcare and Evernorth have worked to expand access to preventive care through integrated primary care, virtual care, and outreach programs that help members understand which screenings they need and why, reinforcing the clinical and economic value of prevention.

3. **What is Cigna's current policy on coverage of vaccines that were recommended by ACIP as of September 1, 2025?**

   a. **Will you commit to maintaining no-cost access to vaccines that were recommended by ACIP as of September 1, 2025 through calendar year 2027?**

[96] The percentage of medical prior authorizations approved in one day or less is based on the total approved volume that reached an approval status for the same population and time period described in footnote 26.
[97] The percentage of prior authorizations electronically submitted that were approved within minutes is based on the same population and time period described in footnote 26. It considers prior authorizations that were electronically submitted and reached a final approval decision. Voided requests are excluded from the population. Near real-time decisions are generated without manual review through system-based rules and business logic.
[98] Based on internal analysis of the number of customers who called the Cigna Healthcare call center and interacted with a member of our high touch advocate teams during the year ended December 31, 2025.
[99] The percentage of customers who are digitally engaged by using the myCigna platform. This reflects Cigna Healthcare U.S. core medical customers over the age of 18 that have registered on the platform.

Response: At The Cigna Group, ensuring access to immunizations remains a core public health priority. We recognize the importance of maintaining public confidence in immunization access and remain focused on providing clarity and consistency for the individuals, families, and businesses we serve.

Cigna Healthcare continues to provide comprehensive coverage for all ACIP-recommended vaccines without cost-sharing as part of our standard benefit design, and in accordance with the Affordable Care Act, Inflation Reduction Act, and applicable federal regulations. To maintain broad immunization access for our members, coverage for COVID-19 vaccines remains available without cost-sharing, regardless of age group, health condition, or risk factors. Similarly, we continue to offer MMRV, MMR+V, and Hepatitis B vaccines without cost-sharing. It is important to note that self-funded employer plans and certain government-sponsored plans retain the discretion to adopt alternative coverage criteria.

We continue to closely monitor developments related to ACIP and carefully evaluate its recommendations to provide evidence-based guidance to our clients. We remain committed to aligning our coverage policies with established clinical evidence and regulatory requirements, informed by the consensus of medical experts.

4. **Absent a recommendation from ACIP, does Cigna have a policy or procedure in place to evaluate coverage of a new vaccine or a vaccine for which new evidence becomes available?**

   Response: Yes. Cigna Healthcare's coverage policies are grounded in clinical first principles and evidence-based decision-making. This includes reviewing the safety, effectiveness, and appropriateness of vaccines based on peer-reviewed clinical literature, FDA labeling, clinical practice guidelines, and expert clinical review.

   Cigna Healthcare's coverage policies are developed and regularly reviewed by teams of highly trained clinicians, including nurses, pharmacists, and physicians, with additional review by internal and external practicing clinicians to ensure real-world applicability. Evernorth's P&T Committee – independent, actively practicing physicians and pharmacists who represent a broad range of specialty practice areas – make the final determination of products included on standard formularies. Because medical knowledge and clinical evidence evolve rapidly, these policies are reviewed and updated as new evidence becomes available.

   Cigna Healthcare closely monitors developments related to ACIP and carefully evaluates its recommendations alongside evolving clinical evidence and regulatory requirements. This ongoing evaluation ensures that coverage policies remain aligned with public health needs and support timely access to appropriate preventive care.

5. **FDA has approved an increasing number of cell and gene therapies in recent years and many more are expected in the coming years. Many of these therapies will treat and potentially cure chronic illnesses for which there was previously no cure. Some of these illnesses, such as type 1 diabetes, may be appropriate for larger patient populations than previous high-cost curative therapies.**

   a. **Please describe your company's current coverage of cell and gene therapies.**

   b. **Please describe any financial mechanism that your company has instituted to manage the risk associated with coverage of cell and gene therapies.**

c. **Please describe how your company is planning for a future environment in which more curative but high-cost cell and gene therapies are available and indicated for a broader population.**

d. **Please discuss whether legislation or any other U.S. Government policy change is needed to address access to cell and gene therapies as more are approved by FDA, and any recommendations you might have for such legislation.**

Response: Cigna Healthcare covers FDA-approved cell and gene therapies when they are medically necessary, primarily through the medical benefit and subject to evidence-based coverage policies and utilization management. Coverage is administered through Cigna Healthcare's dedicated Gene Therapy Program, which directs patients to designated Centers of Excellence and participating providers, supported by high-touch case management and specialty clinical teams. The program is designed to ensure appropriate patient selection, safety, and quality while managing affordability through network design, care coordination, and innovative payment approaches. Patient cost-sharing generally mirrors the underlying medical plan and is not increased solely due to the high cost of these therapies.

More broadly, The Cigna Group manages the financial risk of cell and gene therapies through a combination of innovative financing and risk-pooling mechanisms. Most notably, The Cigna Group offers Embarc Benefit Protection, an integrated solution that spreads the cost of high-cost gene therapies across a broad membership base using a predictable per-member-per-month fee, shielding employers from catastrophic single-claim exposure and excluding those claims from future medical renewals. In addition, Cigna Healthcare's Gene Therapy Program uses outcomes-based and other innovative pharmaceutical contracting arrangements and directs care through designated networks to control costs and eliminate inefficient "buy-and-bill" practices. Together, these approaches are designed to provide affordability and predictability while maintaining access to medically necessary therapies.

The Cigna Group is preparing for a future with more widely indicated, high-cost cell and gene therapies by actively monitoring the expanding pipeline and conducting plan-specific forecasting based on disease prevalence, utilization assumptions, and evolving FDA indications. The company is scaling and adapting programs like Embarc to accommodate a growing number of therapies and larger patient populations while maintaining predictable, pooled financing for employers. Cigna Healthcare is continuously updating clinical coverage policies, provider networks, and care models to ensure therapies are used for appropriate patients and delivered through specialized sites of care. Together, these efforts are intended to support access to curative treatments while preserving affordability and sustainability as gene therapies move beyond ultra-rare conditions into broader clinical use.

We do not believe federal policy changes are necessary at this time. Private-sector, market-based solutions are already enabling access to FDA-approved cell and gene therapies while managing affordability and risk for both the public and private sectors. We caution against one-size-fits-all coverage or government-run financing models because not every approved therapy is appropriate for every patient, and flexibility is essential as medical evidence evolves. Instead, we encourage policymakers to support innovation in private financing arrangements, preserve evidence-based coverage decision-making, and avoid policies that could crowd out effective employer- and plan-sponsored solutions. Strong FDA

standards, post-market evidence development, and data transparency are also extremely important to inform appropriate use as therapies expand to broader populations.

6. **Patients with chronic conditions like type 1 diabetes routinely report delays or denials for clinically necessary treatments such as insulin, continuous glucose monitors, and insulin pumps.**

    a. **Please describe your coverage policies for the following, including any prior authorization, step therapy, or other utilization management requirements:**

        i. **Insulin**

        ii. **Continuous glucose monitors**

        iii. **Insulin pumps**

    b. **Please describe any utilization management requirements that are in place on any item or service to treat or manage diabetes that is recommended as the standard of care in clinical guidelines issued by physician professional societies.**

Response: We recognize the clinical importance of timely access to insulin, continuous glucose monitors (CGMs), and insulin pumps for individuals with diabetes and design coverage to support evidence-based care while promoting affordability and adherence. We have taken a strategic leadership role in developing innovative approaches to address the triple aim of improving the patient care experience, improving the health of populations, and reducing the cost of health care in this important arena. We are addressing the diabetes health crisis specifically through efforts aimed at both prevention and management.

Prevention
We began offering our Diabetes Prevention Program in collaboration with Omada Health in January 2019. This integrated solution is an intensive behavioral counseling program focused on reducing the risk of diabetes for members who have prediabetes or are at risk for developing diabetes. It is a digital, CDC-recognized, outcomes-based program with deep data science for personalized coaching. A study conducted in late 2020 of our participating clients from the first two years of this program showed 19% of participants lost 5% or more of their initial weight by the end of the first year, and 24% lost 5% or more of their initial weight through the second year.

The Diabetes Prevention Program also signals our commitment to creating digital enhancements for our overall health coaching programs, focused on the development of condition-specific, multi-modular online coaching integrated with wearables and other devices.

Management
To address the whole person and not just their disease, Your Health First chronic condition coaching program helps members with lifestyle management coaching on healthy weight, stress, and smoking cessation goals; health and wellness coaching on topics like hypertension, hyperlipidemia, exercise, and healthy eating; and treatment decision support for select health conditions. Additionally, the program allows members the flexibility to engage with a health coach by phone or online in self-guided coaching modules.

Our holistic program also coaches members on comorbidities because we know that 98% of those members with diabetes also suffer from at least one other chronic condition and that their risk of developing depression doubles with a diabetes diagnosis.

Coverage and Affordability
Coverage for insulin, CGMs, insulin pumps, and other diabetes treatments is based on nationally recognized clinical guidelines and evidence-based recommendations. Utilization management tools, where used, are intended to promote safe, appropriate use and are tailored to the specific service or device.

To help improve affordability and adherence, we offer the Patient Assurance Program to ensure that members who use eligible medications to treat chronic conditions (e.g., insulin) pay no more than $25 for a 30-day supply/$75 for a 90-day supply at participating retail and home delivery pharmacies. This program is projected to save patients an average of $15 per month, or 40%, and even more for those with high-deductible health plans.

Leveraging the IRS preventive classification, the Patient Assurance Program provides first-dollar coverage and waives any applicable deductible. By removing cost as a barrier to access, we can improve adherence and drive greater affordability for people taking essential medications to manage chronic conditions. The list of medications that are eligible for the reduced cost-share under the Patient Assurance Program varies based on the client-elected Cigna Healthcare prescription drug list. For example, the program includes all insulin types, including those by Eli Lilly and Company, Novo Nordisk A/S, and Sanofi SA.

7. **Individuals with chronic conditions like type 1 diabetes rely on drugs and medical devices to effectively manage their condition. Many such individuals report unaffordable and increasing cost sharing for items and services that are used to manage their condition.**

    a. **For calendar years 2024 and 2025, what was the total out-of-pocket spend by your plan members on managing a chronic condition? In terms of percentage of total out-of-pocket spending?**

    Response: Generally, medications used to manage chronic disease make up 85-90% of total OOP spending in the commercial and Medicare markets across 2024-2025. Approximately 82% of pharmacy benefit patients spent less than $250 per year OOP for long-term prescriptions in 2025.[100]

    We recognize affordability challenges remain. In response, we developed a new protection benefit to help reduce out-of-pocket costs for more of our customers. To ensure they always pay the lowest price available for both brand-name and generic medications, Express Scripts can automatically compare the negotiated-discount price, the cash-discount price, the drug manufacturer's direct-to-consumer price (if available), and the customer's copay. Eligible customers will pay the lowest available price at the pharmacy counter. While the Express Scripts-negotiated price is typically the lowest, other prices may be lower in some cases, especially for people with high-deductible health plans.

[100] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).

b. **Do individuals who do not adhere to chronic disease management regimens prescribed by their health care providers tend to consume more or fewer health care resources than those who do (i.e., are non-adherent patients more expensive)?**

Response: Evernorth and Cigna Healthcare have examined the relationship between medication adherence and health care utilization among individuals with diabetes, and the evidence consistently shows that non-adherence is associated with higher overall health care costs. Publicly released Cigna Healthcare research, including its *Value of Integration* analyses, demonstrates that individuals with diabetes who receive integrated medical, pharmacy, and behavioral care – core components of adherence support – experience fewer hospital admissions, fewer emergency department visits, and lower total medical costs compared to non-integrated models.[101]

c. **Please describe the process to determine cost-sharing for chronic disease management items and services.**

Response: The Cigna Group's pharmacy benefit services provider, Express Scripts, provides its plan sponsors guidance on prescription drug cost-sharing through consultative benefit design support, data-driven analytics, and transparency tools that help clients understand and manage both premiums and member out-of-pocket costs. Clients receive plan-specific reporting and modeling on how different formulary designs, copay and coinsurance structures, and deductible approaches affect affordability and utilization, supported by Express Scripts' negotiated pricing insights.

Express Scripts also offers enhanced transparency and affordability protections, including tools that compare negotiated prices and cash prices to help ensure members pay the lowest available cost at the pharmacy counter. Together, these resources enable employers and plan sponsors to design pharmacy benefits that balance access, affordability, and predictability for their members.

d. **Please describe any effort by your company to ensure cost-sharing is affordable for items and services prescribed to an individual with a chronic disease for the purposes of managing that disease.**

Response: Express Scripts does not offer a single, mandatory cost-sharing standard exclusively for individuals with chronic diseases. Instead, we work with employers and plan sponsors to design pharmacy benefits that keep cost-sharing affordable while supporting adherence and appropriate use.

As noted in our response to the prior question, clients receive tools to help identify where high cost-sharing may create barriers for members with chronic conditions that allow employers to adjust copays, coinsurance, or deductible structures accordingly. In addition, Cigna Healthcare and Evernorth offer affordability-focused solutions, such as point-of-sale pricing protections, copay-only plan designs, negotiated net pricing, and access to manufacturer and third-party assistance programs, that can be particularly

[101] Cigna Healthcare 2025 National Book of Business study of 2024 claims of medical customers who have Cigna Healthcare integrated medical, pharmacy, and Cigna Total Behavioral Health benefits. Savings are for those with a condition diagnosis and engaged in Case Management or a Health Maintenance Activity.

important for members managing chronic diseases. As a result, affordability for chronic conditions is addressed through benefit design flexibility, transparency, and targeted affordability tools, rather than a separate or uniform cost-sharing requirement.

The Honorable Robin L. Kelly (D-IL)

1. **Investigative reporting by ProPublica, based on interviews with hundreds of behavioral health providers, documents widespread delayed payments, aggressive retrospective audits, and post-payment clawbacks — sometimes years after care was delivered. Providers report that these practices are pushing them out of insurance networks, which shrinks in-network mental health access, and forces patients to pay more out of pocket or go without care.**

    a. **Given the impact on patients' access and affordability, does your company do retrospective audits that claw back payment for services that have already been delivered and paid for?**

        i. **If so, how many mental health and substance use disorder patients had claims that were clawed back last year?**

Response: Evernorth Behavioral Health powers Cigna Healthcare's behavioral health offering. Evernorth's approach to behavioral health for the clients and customers we serve is centered on early identification, timely engagement, and coordinated care to prevent escalation and avoidable costs. Behavioral health services are covered in accordance with plan terms and parity laws, including MHPAEA.

Over the past four years, Evernorth has significantly expanded access to behavioral health services by more than doubling our behavioral health network, including offering a large virtual behavioral network, and building an integrated care model that supports individuals across the full continuum of need. This includes, but is not limited to, early-state support such as coaching, navigation, and family support, as well as therapy, medication management, and higher-acuity services. 24/7/365 crisis support and urgent behavioral care are available to provide immediate support to patients.

Evernorth processes millions of behavioral claims annually and always seeks to process each claim quickly and correctly so that providers are reimbursed promptly. We deliver value to providers by offering a distinct, high-touch, provider-centric service experience and simple contract options, including measurement-based care. Our unique approach to provider partnerships enables lower administrative burden through an enhanced provider experience model, which helps triage and resolve issues related to patient care, claims, or billing. For example:

- Clinicians can reach us 24/7 through their dedicated provider advocate, a provider call center, or through online tools and resources.
- We have dedicated teams in the U.S. and worldwide that support behavioral health providers – all of whom are extensively trained to address questions related to contracting, billing, and other administrative issues.
- We have also streamlined the experience for providers and patients by not requiring prior authorization for routine outpatient care for mental health and substance use

disorders. In addition, prior authorization is no longer needed to enroll patients in intensive outpatient or partial hospitalization programs.

- Our behavioral health provider retention rates are strong. In 2023, less than 2% of providers chose not to remain in our network.

2. ASCO's national surveys show that more than 95 percent of oncology practices report treatment delays due to prior authorization, with many delays measured in weeks.

a. Will you commit, on the record, that no patient with a confirmed cancer diagnosis should experience a delay in evidence-based treatment because of prior authorization—and if not, why?

Response: We're living in an era of incredible medical advancement with breakthroughs occurring nearly every day. Those innovations can only make a difference if patients and providers are connected to them. Today, nearly 4 in 10 patients receive care that doesn't meet the latest medical evidence[102] and more than 90% of providers have reported negative impacts from low-value care (i.e., services that provide little to no benefit to patients, may cause harm and result in unnecessary costs).[103] Utilization management is a process used to help address those challenges. Prior authorization applies evidence-based clinical guidelines to providers' requests to make sure they are in line with current science and medical best practices.

Cigna Healthcare makes its standard coverage policies, including prior authorization and step therapy policies, publicly available. Our approach is grounded in evidence-based clinical policies and standards, with oversight by our more than 3,000 clinical colleagues at The Cigna Group including nurses, pharmacists, social workers, therapists, and physicians.[104] Authorization decisions are grounded in plan-specific benefits, clinical guidelines, and individual facts submitted with each request. Emergency services are not subject to prior authorization.

While prior authorization is an important checkpoint for certain procedures, treatments, and complex services, in early 2025, The Cigna Group committed to helping our customers by making our processes simpler, easier, and faster. We have made meaningful progress:

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[102] Jed Duff, Laura Cullen, et al., *Determinants of an Evidence-Based Practice Environment: An Interpretive Description*, Implement Sci Communications (Oct. 2020).
[103] Ishani Ganguli, Nitya Thakore, et al., *Longitudinal Content Analysis of the Characteristics and Expected Impact of Low-Value Services Identified in US Choosing Wisely Recommendations*, JAMA Internal Medicine (Feb 2022).
[104] Based on internal analysis of clinicians (nurses, pharmacists, physicians and social workers) directly involved in medical and behavioral Cigna Healthcare U.S. utilization management and prior authorization processes. Includes contractors and part-time as of December 31, 2025.
[105] Based on absolute number of prior authorization codes removed during the year ended December 31, 2025, related to Cigna Healthcare U.S. business. Cigna Healthcare publishes a Master Precertification List quarterly. https://www.cigna.com/health-care-providers/coverage-and-claims/precertification

authorizations by approximately 521,000.[106] In 2025, less than 6% of Cigna Healthcare and Express Scripts customers went through our prior authorization process.[107]

- **Streamlining Prior Authorization Processes:** In 2025, we were pleased to begin a partnership with AHIP, the U.S. Department of Health and Human Services (HHS), and industry peers to streamline, simplify, and reduce prior authorization by:[108]
    - Standardizing electronic submissions
    - Cutting prior authorization volume
    - Honoring existing approvals during patient changes in insurance to ensure continuity of care
    - Boosting real-time approvals
- **Electronic Communications**: Today, nearly 65% of medical prior authorization requests are submitted electronically to Cigna Healthcare, an increase of 3.7% year-over-year.[109] Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.
- **Improved Turnaround Times**: We continue to focus on making decisions faster; in 2025, 80% of Cigna Healthcare U.S. medical prior authorizations were approved in one day or less.[110] More than half of the submissions submitted electronically were approved within minutes.[111]
- **More Customer Support**: Over the past year, we've strengthened our customer support, creating distinct teams to help customers navigate their health care and pharmacy benefits. Our high-touch advocate teams helped approximately 155,000 medical customers with prior authorization and post-care claim processes in 2025, 79% more customers than the year prior.[112]

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[108] America's Health Insurance Plans (AHIP), *Health Plans Take Action to Simplify Prior Authorization* (2025).
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[112] Based on internal analysis of the number of customers who called the Cigna Healthcare call center and interacted with a member of our high touch advocate teams during the year ended December 31, 2025.

- **Digital Status Tracker:** In June 2025, we launched a medical prior authorization status tracker for Cigna Healthcare. This new tool shows timely updates and provides answers to frequently asked questions, as well as information on decisions and next steps. It's available to every Cigna Healthcare customer through our myCigna platform that's used by 79% of customers.[113]

The Honorable Nanette D. Barragán (D-CA)

1. **Analyses show that copay accumulators are not keeping premiums low, and eliminating copay accumulators isn't raising drug prices.**
    a. **Given the evidence, what is the justification for continuing copay accumulator programs?**
    b. **If you can't point to patient benefit or premium savings, why should Congress not move to prohibit them, seeing as they cause harm to patients?**
    c. **Would you commit to take steps to remove these policies from your health plans?**

    Response: Accumulator policies primarily affect how costs are allocated between plans and patients. Cigna Healthcare and Evernorth continue to offer copay accumulator programs because they are one of several benefit design tools that some plan sponsors choose to manage overall pharmacy spending and preserve formulary incentives, particularly where manufacturer copay/coupon programs steer utilization toward higher-priced brand drugs when lower-cost, clinically appropriate alternatives are available. Plan sponsors view these programs as a way to control plan liability and maintain predictable benefit costs, especially in the commercial market. Importantly, we do not mandate their use; rather, clients retain discretion to adopt, modify, or prohibit accumulator programs.

    We do not believe Congress should impose a blanket prohibition because copay accumulator programs are one of several *optional* tools that employer plan sponsors may choose to manage overall pharmacy spending. A prohibition would potentially shift costs elsewhere in the benefit design without addressing the underlying drivers of high drug prices, which remain manufacturer pricing and limited competition.

2. **A ProPublica investigation into Cigna found that the company built a system that let its doctors reject claims 'without opening the patient file' — with one former Cigna doctor saying, 'We literally click and submit.' Over just two months, Cigna doctors denied more than 300,000 claims this way, spending about 1.2 seconds on each. Claims are not just numbers; they represent a loved one's treatment for cancer, opioid addiction, autoimmune diseases, and depression. While these practices predate artificial intelligence (AI), AI now allows insurers to deny care at unprecedented speed and scale.**
    a. **Given that reality, would you support 1) a clear ban prohibiting AI from denying care and 2) a requirement that any denial be based on an individualized review by a licensed clinician with appropriate training and experience in that specific type of**

[113] The percentage of customers who are digitally engaged by using the myCigna platform. This reflects Cigna Healthcare U.S. core medical customers over the age of 18 that have registered on the platform.

care—especially when only 16 percent of physicians report that insurer "peer reviewers" have the appropriate qualifications?

Response: The Cigna Group – inclusive of Evernorth Health Services and Cigna Healthcare – does not use AI to deny coverage or claims, only to accelerate approvals. Our approach to ethical AI practices is publicly available.[114]

All reviews for medical necessity involve human oversight. Each medical necessity denial is reviewed by a board-certified physician. Technology, including automation and data-driven tools, is used to accelerate claims processing efficiency and accuracy. Medical necessity determinations are subject to human review and are governed by publicly available clinical coverage policies.

In peer-to-peer discussions, Cigna Healthcare ensures that the treating physician can speak with a physician of appropriate clinical expertise in managing the specific patient's care or condition, recognizing that more than one specialty may be considered appropriate. All of our Medical Directors have at least one active, unrestricted medical license to practice within the U.S. and physician reviewers are available across a broad range of specialties.

Importantly, please note that the Procedure to Diagnosis (PxDX) process referenced in your question is not powered by AI. Rather, it is a simple, software-driven process that helps accelerate payments to clinicians for common, relatively low-cost tests and treatments. This is similar to processes that have been used by CMS and our peers for years. Patients are not denied care through PxDx because the review takes place only after they receive treatment and most do not experience any additional costs even if a claim is denied.

3. **Twelve months ago, the Food and Drug Administration approved the first in class novel non-opioid painkiller for moderate to severe pain in 20 years.**
    a. **Do you believe that, as health insurers, you have a responsibility to work with providers to keep your plan members as healthy as possible and prevent seniors from adverse events associated with opioids, such as falls, dizziness, and addiction?**
    b. **Would avoiding these adverse events save you and the overall Medicare system money?**

Response: The Cigna Group is an industry leader in the fight against the opioid epidemic and does not believe patients should have to choose between effective pain relief and the risk of addiction. We believe in a comprehensive approach to combatting opioid misuse and overuse across all lines of business.

Standard drug formularies offered by both Express Scripts Pharmacy Benefit Services and Cigna Healthcare include access to non-opioid pain treatments, including nonsteroidal anti-inflammatory drugs (NSAIDs), tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors (SNRIs), and anticonvulsants. In many cases, non-opioid alternatives must be considered, attempted, or ruled out before opioid therapies are deemed medically necessary. Express Scripts offers its clients a combination of formulary design, drug utilization

[114] The Cigna Group, *The Cigna Group's Approach to Ethical AI Practices*, Cigna Newsroom (2023).

management, data analytics, case management, and communication strategies to reduce or avoid opioid dependence while providing patients safe access to pain management therapy.

Access to a clinically sound, high-quality pharmacy benefit depends on sophisticated, carefully constructed strategies that place patients and their physicians first. The processes Express Scripts uses to develop formularies have been constructed to ensure that clinical considerations – not cost – are paramount. Our clinically sound formularies are based on the determinations of independent physicians and pharmacists on the National Pharmacy and Therapeutics (P&T) Committee who are not employed by Express Scripts.

The Honorable Kim Schrier (D-WA)

1. **I've heard many stories from providers about how when they go to the Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA), they have to wait through the backlog, and then even when they win and are supposed to be paid within 30 days, insurance companies aren't paying; insurers are sitting on the money, waiting weeks, months, and sometimes over a year, to pay on claims, all while collecting interests and leaving providers on the hook for meeting payroll and rent while they wait. Is your company failing to pay IDR decisions on time?**
    a. **What percentage of IDR decisions against your company have a payment made within the 30-days required by the NSA?**
    b. **Will you commit to ensuring all payments resulting from IDR decisions are paid within 30 days?**

Response: The Cigna Group is committed to prompt payment for NSA-eligible claims. Our commitment applies to both initial payments and IDR determinations where the determinations are actionable.

Overall, we have an approximately 99% timely processing rate for NSA-eligible claims (i.e., initial payments). The high volume of ineligible, inactionable, and/or misfiled NSA IDR claims/disputes initiated by providers, particularly private equity-backed providers, and third-party billing intermediaries contribute to processing delays.

Of the nearly 490,000 NSA IDR adjustments we've completed for 2025 IDR claims to date, the average turnaround time is 25.5 days from IDR determination date to paid date. The NSA requires total payment following IDR determination or successful negotiation within 30 days.

Where post-IDR determination payments take longer than 30 days to process, it is typically due to one or more of the following reasons: incomplete information on the claim(s) at issue in the IDR initiation; incomplete provider information; or misrouting of the original IDR initiation or determination (e.g., wrong email address used).

Certain IDR payment determinations cannot be adjusted because the underlying service/claim was not NSA eligible or there are other key technical defects. The following are some of the reasons why we may not act upon an IDR payment determination:

- Member's Cigna coverage was terminated as of the claim's date of service.
- Medicare was the primary insurance.
- Not a Cigna claim number.

- Initiating party was a participating provider (not out-of-network and therefore NSA does not apply).
- Provider signed a Post Payment Negotiation agreement, so the claim was already adjusted using the negotiated dollar amount.
- Services were performed in a physician's office, not a facility, therefore NSA does not apply.
- CPT code specified in the payment determination was not on the claim.
- Designated bank account for IDR determination payment has been closed.

2. **Through the No Surprises Act, Congress sought to maintain a level playing field between insurance companies and health care providers – giving both sides a reason to pursue in-network contracts, to prevent out-of-network care. I have heard concerns that some providers who offer care covered under the No Surprises Act have had their contracts terminated by insurance companies, increasing the out-of-network care they provide. While patients are protected from certain out-of-network bills under the No Surprises Act, I am concerned that network adequacy may suffer as a result of cancelled contracts. How has your rate of in-network and out-of-network care changed since implementation of the law?**

    a. **What steps are you taking to bring more providers in-network, which would reduce the need for the payment resolution provisions of the No Surprises Act?**

    b. **Given what is known about payment dispute resolution outcomes, is this information being used to inform in-network contract negotiations?**

    Response: Cigna Healthcare monitors and ensures network adequacy throughout our geographic service areas, adhering to time and distance requirements. Though we are meeting network adequacy requirements, we are finding that dysfunction in the NSA IDR process is giving certain providers leverage to demand dramatically higher in-network payment rates given the ability to extract egregiously high payment rates for out-of-network services through NSA IDR.

    For example, in Cigna Healthcare's current contract negotiations with one in-network air ambulance provider for contract renewal, the air ambulance company is demanding 40% rate increases and is refusing to lower their offer given their track record of winning in NSA IDR over 90% of the time and receiving extremely high IDR determination amounts. IDR outcomes are indeed informing in-network contract negotiations, but they are being used by providers as leverage to force commercial insurers to pay exorbitant in-network rates, threatening health care affordability for American patients and businesses. Without improvements in NSA IDR, there will increasingly be little incentive for certain physicians to enter into network contracts with payers.

    The NSA was originally intended to protect patients and lower costs, with the CBO originally estimating it would lower premiums and provide $17 billion in federal savings. IDR was intended to be a fair and limited backstop, not the primary mechanism for setting rates. While the billing protections are working for consumers, private equity and third-party abuse of the IDR process is significantly harming employers and patients by driving increased premiums and

health care costs.[115] Georgetown's health policy researchers estimated the IDR process has added an estimated $5 billion in *costs* – not savings – to the health care system.[116]

Reforms to the NSA IDR process are needed to address structural flaws that have increased, rather than reduced, health care costs. Regulatory changes to better screen out ineligible claims, strengthen oversight of IDR entities, and realign financial incentives would help restore the law's original intent and improve affordability for American patients and businesses.

3. **The U.S. Preventive Services Task Force is a scientifically independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services. The USPSTF has enabled millions of Americans access preventive services without a copay to promote and maintain their health, most without even realizing the USPSTF was to thank. While the Supreme Court has ruled affirmatively on the legitimacy of the recommendations, recently, Secretary Kennedy has slowed the pace of approving new recommendations and created uncertainty and political pressure on the members of the task force and their recommendations.**

    a. **Will insurance companies represented by this panel commit to honoring the recommendations as they exist today if Sec. Kennedy rolls back any of the recommendations?**

Response: The Cigna Group strongly supports evidence-based preventive services and has long viewed prevention as one of the most effective ways to improve health outcomes and reduce avoidable costs over time. Preventive care is foundational to our approach to whole-person health, and we actively promote early detection, screenings, immunizations, and counseling services consistent with nationally recognized clinical guidelines.

Under current law, Cigna Healthcare covers preventive services in accordance with the ACA, including services that receive an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by ACIP, and women's and children's preventive services supported by the Health Resources and Services Administration (HRSA) – all without cost-sharing for eligible members. These standards are embedded in our administrative policies, provider guidance, and benefit designs across applicable lines of business.

In addition to these requirements, Cigna Healthcare and Evernorth have worked to expand access to preventive care through integrated primary care, virtual care, and outreach programs that help members understand which screenings they need and why, reinforcing the clinical and economic value of prevention.

In that context, Cigna Healthcare will continue to:

- Honor preventive care coverage requirements as required by federal and state law, including existing USPSTF A and B recommendations that remain in effect.

[115] *How Scott and Alla LaRoque got rich from disputed medical bills,* STAT (Mar. 18, 2026).
[116] Cigna Healthcare, *Clearity by Cigna Healthcare, A New Tech-Enabled Health Plan Offers Customers Transparent, Predictable Prices*, Cigna Healthcare Newsroom (Nov. 18, 2025).

- Closely monitor any changes to federal guidance or legal requirements affecting preventive services and provide evidence-based recommendations to our clients.
- Ensure our coverage policies remain aligned with public health needs and support timely access to appropriate preventive care.

The Honorable Jake Auchincloss (D-MA)

1. **An investigative report found substantial evidence that group purchasing organizations (GPOs) are a cynical semantic exercise designed to allow Cigna, UnitedHealth Group, and CVS to continue making profits in the face of increasing pressure and regulatory reform directed at pharmacy benefit managers. In essence, the insurers have created these shell companies with few or no employees that charge manufacturers "fees" instead of "rebates" and established them overseas for tax and opacity reasons. This enables the insurers to nominally comply with PBM reforms and contractual obligations, while not impacting their bottom line.**

   The investigation alleges that GPOs operate as "shell companies" with few or no employees. After reviewing LinkedIn profiles, team photos, corporate filings, and job listings to determine the staffing at all three entities, the investigators identified fewer than 150 employees total (as of October 10, 2025) – about 88 at Ascent, 29 at Emisar, and 24 at Zinc. How many people work at Zinc, Emisar, and Ascent?

   a. **Do they work in-person or remotely?**

   b. **Why do Zinc and Emisar not have a website?**

   c. **Is the role played by the GPOs (Zinc, EMISAR, Ascent) disclosed to PBM plan clients?**

      i. **How?**

      ii. **By name?**

      iii. **If not, why not?**

   Response: The "investigative report" from Hunterbrook Capital is neither factually accurate nor representative of the services provided by Ascent Health Services to its clients and American patients. Furthermore, it is not real journalism: it was written by a short-selling hedge fund and likely intended to serve as a vehicle for profit through short-selling and through financing litigation against the GPOs.

   Hunterbrook Capital's "reporting" focuses on revenue – but revenue does not equate to profit. PBMs' profit margins, inclusive of GPO activities, are approximately 4% and have not increased over time.[117]

   Ascent's Transparency
   On behalf of its participants, Ascent negotiates with drug companies to achieve deeper savings to make prescription medicines more affordable. Ascent's participants negotiate for and pay a participation fee as compensation for the services Ascent provides, including rebate

[117] Compass Lexecon, *PBMs and Prescription Drug Distribution: An Economic Consideration of Criticisms Levied Against Pharmacy Benefit Managers* (April 2025).

contracting. In addition, drug companies may negotiate for and pay fees separate from any applicable rebate amount in exchange for services provided by Ascent, such as the processing and reporting of utilization data and analytics services. Ascent is subject to regular audits from participating entities to ensure compliance with contractual arrangements.

Express Scripts also charges fees for its services. Express Scripts' clients decide how to pay for services and each client's financial model is negotiated for and transparent.

The rebate contracting operations performed by Ascent on behalf of Express Scripts will be moved to the U.S. from Switzerland as part of our comprehensive settlement with the Federal Trade Commission. Moreover, per the settlement, Express Scripts is moving to a transformative rebate-free model. The rebate-free model will be widely available to employers and health plan sponsors to lower the cost of all brand medications for their members as Express Scripts' new standard model.

2. **Neither the PBM GPOs nor their parent companies report financial information for these specific entities, but the limited data available suggests these businesses are improbably lucrative. A 2023 report estimates PBMs earned $7.6 billion in fees related to their GPOs in 2022. With fewer than 150 employees across all three entities, these PBM GPOs generate more than $50 million in revenue per employee. What does the GPO (Zinc, EMISAR, Ascent) do differently than what the PBM (CVS Caremark, OptumRx, Express Scripts) does?**
    a. **What proof do you have to demonstrate that PBM GPOs save patients money?**
    b. **What is the number of covered lives that the GPO (Zinc, EMISAR, Ascent) covers?**
        i. **What is the number of covered lives the respective PBMs (CVS Caremark, OptumRx, Express Scripts) serve?**
    c. **Assuming the delta is small, how does the GPO aggregate purchasing power any more than the existing PBM?**
    d. **Job postings raise questions about how independent an operation the GPOs really are. Why did several job postings for the GPO appear on the PBM and parent company websites?**

Response: Hunterbrook Capital's "reporting" focuses on revenue – but revenue does not equate to profit. PBMs' profit margins are approximately 4%, inclusive of GPO activities, and have not increased over time.[118]

Founded in 2019, Ascent was created with a mission to aggregate purchasing volume and negotiate greater discounts from drug companies than any of the participants in Ascent could achieve alone. U.S. drug costs are driven by a combination of high prices and elevated demand – fueled in part by U.S.-only direct-to-consumer advertising, which for many large drug companies rivals or exceeds R&D spending.[119, 120] In this environment, Ascent helps lower

[118] Compass Lexecon, *PBMs and Prescription Drug Distribution: An Economic Consideration of Criticisms Levied Against Pharmacy Benefit Managers* (April 2025).
[119] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. *Comparing U.S. and International Market Size and Average Pricing for Prescription Drugs, 2017-2022* (Dec. 2024).
[120] Campaign for Sustainable Rx Pricing (CSRxP), *Direct-to-Consumer Pharmaceutical Advertising Spending and Its Impact on Prescription Drug Costs* (Mar. 2025).

health care premiums and other costs for more Americans by serving as a critical counterbalance to multinational drug companies that derive most of their profits from the U.S., despite it representing only 5% of the global population.

Express Scripts, Inc. was one of two participants of Ascent when it was founded and is the only participant affiliated with The Cigna Group. Since its inception, additional participants representing a range of diverse interests have joined Ascent, including PBMs and health plans. Today, participants in addition to Express Scripts include Kroger, Prime Therapeutics, and Health Transformation Alliance (a cooperative of 58 self-insured employers), among others.

Importance of Collective Buying Power

The collective buying power of a GPO has a material effect on the level of savings provided to American businesses and patients: it is a critical lever when negotiating with large, multi-national drug companies that set the price of drugs and use tactics to extend their patents and maintain high prices.[121] A GPO negotiating with a drug company can often achieve greater savings because drug companies have greater incentive to offer more competitive prices and much larger concessions to GPOs than individual PBMs, health plans, and employers can achieve on their own.

In short, in a world in which drug companies continue to set increasingly higher list prices, the negotiation of savings by PBMs and GPOs remains the most effective way to combat their list price increases and reduce costs for plan sponsor clients and patients. According to a 2023 report issued by the Department of Labor's Inspector General, the agency exceeded expenditures on prescription drugs by over $300 million within a six-year period because it did not utilize a PBM for its workers' compensation benefits program.[122] The benefits of utilizing a GPO are even greater, as Ascent combines the collective negotiating strength of multiple PBMs and health plans to negotiate with drug companies.

Ascent Increases PBM Industry Competition and Expands Savings to U.S. Patients and Businesses

Smaller PBMs often market themselves to plan sponsors as industry disruptors through differentiated technology and business models, and the savings they realize via Ascent – either directly or via a relationship with another Ascent participant – are likely greater than they would otherwise be able to achieve on their own. This likely helps enable their success and results in more U.S. patients and businesses benefiting from savings than would otherwise occur.

3. **A 2024 Federal Trade Commission (FTC) report states, "…since the PBMs spun off their rebate aggregators, they have extracted from drug manufacturers billions of dollars in additional fees." The investigation notes that the exponential revenue increases flow through a "labyrinth of payment categories" that are carefully engineered to avoid transparency: entity administration fees, prescription data services, data portals, enterprise fees, and other charges that PBMs insist are not rebates and therefore don't require pass-through to health plans. "These revenue streams exist on top of the PBM's typical administrative service fees of about 3 to 5 percent of the wholesale price of each**

[121] Hong D, Tu SS, Beall RF, et al. *Estimating Costs of Market Exclusivity Extensions For 4 Top-Selling Prescription Drugs in the US,* JAMA Health Forum (2025).
[122] U.S. Department of Labor, Office of the Inspector General, *OWCP Did Not Ensure Best Prices and Allowed Inappropriate, Potentially Lethal Prescriptions in The FECA Program*, Report No. 03-23-001-04-431 (March 21, 2023).

drug, further inflating healthcare costs." Why do the GPOs (Zinc, EMISAR, and Ascent) label manufacturer payments as 'fees' rather than 'rebates'?

- **a. What fees earned by PBM GPOs are passed through to health plans?**
- **b. What is the total annual value of the contracts [Emisar/Zinc/Ascent] have negotiated with drugmakers?**
  - **i. How much of that money does each retain, either in the form of fees from the drugmakers or fees/reimbursements from the PBMs?**

Response: On behalf of its participants, Ascent negotiates with drug companies to achieve deeper savings to make prescription medicines more affordable. Ascent's participants negotiate for and pay a participation fee as compensation for the services Ascent provides, including rebate contracting. In addition, drug companies may negotiate for and pay fees separate from any applicable rebate amount in exchange for services provided by Ascent, such as the processing and reporting of utilization data and analytics services. Ascent is subject to regular audits from participating entities to ensure compliance with contractual arrangements.

Express Scripts also charges fees for its services. Express Scripts' clients decide how to pay for services and each client's financial model is negotiated for and transparent.

4. **Two of the three GPOs investigated are headquartered abroad. EMISAR (UnitedHealth) is located in Dublin, Ireland, and Ascent (Cigna) is located in Schaffhausen, Switzerland.**
   - **a. Why are UnitedHealth and Cigna using an offshore entity to collect fees that are never seen by the American patients paying for these drugs?**

Response: The Cigna Group, while domiciled in the U.S., has a large international presence and operates in almost every continent to provide health care benefits and services to millions of people across the globe. Expanding that global footprint to include an organization based in Switzerland that aggregates purchasing volume of diverse interests has several operational benefits, including:

- Meeting drug companies where they are. Switzerland has an exceptionally large life sciences sector and is close in proximity to the E.U., also home to many biotech companies.[123] This proximity allows Ascent to consistently meet with drug companies in person to drive greater contract savings.
- Ensuring firewalls for Ascent's participants. In addition to strict firewall policies in place, establishing Ascent in Switzerland ensures physical separation from The Cigna Group and its subsidiaries.

The Cigna Group is not an outlier. Switzerland's Federal Statistical Office, the national center for official statistics, reported that close to 50% of the roughly 35,000 multinational companies in Switzerland were foreign controlled, with the U.S. being one of the leading sources (nearly 20%).[124] Nevertheless, per our recent settlement with the Federal Trade Commission, Ascent's rebate contracting operations conducted on behalf of Express Scripts will be moved to the U.S.

[123] Swiss Biotech, *Swiss Biotech Report 2025: The power of international alliances* (May 5, 2025). IQVIA, *How Switzerland is Contributing to the Commercial Success of Biotech Companies Worldwide* (May 17, 2023).
[124] Swiss Federal Statistical Office (FSO), *Enterprise Group Statistics (STAGRE)* (November 2022).

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The Honorable Troy A. Carter (D-LA)

1. **Can you share your company's step therapy policy?**

Response: Broadly, step therapy encourages the use of clinically appropriate, lower-cost generic or brand medications before the use of non-preferred brand medications, which eliminates unnecessarily high costs for employers, unions, and public sector entities and lowers OOP costs for patients for clinically similar, alternative treatments. For individuals enrolled in standard Cigna Healthcare coverage policies, Cigna Healthcare publicly publishes its medical, behavioral, and pharmaceutical clinical coverage policies, including information on step therapy requirements.

All step therapy programs are clinically sound, evidence-based, and supported and reviewed by the independently staffed National Pharmacy & Therapeutics (P&T) Committee within our Evernorth Health Services division. Step therapy programs are supported by medical practice guidelines, product labeling, clinical studies, and guidance from the P&T Committee. Programs are developed with the understanding that medical experts consider these medications therapeutically similar and on even clinical footing. The P&T Committee always considers important disruptions in care and ensures that step therapy and prior authorization policies allow continuation of therapy for critical treatments. Each program offers an exception process to address individual patient cases as needed. This includes allowing for expedited requests, which are typically processed in 24 hours.

Additionally, step therapy and prior authorization programs are routinely re-evaluated based on updated clinical evidence, FDA actions, and evolving standards of care, and are retired when they are no longer necessary to support safe, appropriate, evidence-based prescribing.

We are constantly working to automate processes and leverage prescription claims data to lessen the provider and patient burden. Our Real Time Benefit Check tools allow providers to quickly see if a drug requires step therapy and allows providers to address any prior authorization or step therapy in their workflow. Providers can digitally check requirements, submit requests, view status, and add documents. This is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.

When a pharmacy attempts to process a claim for a drug with step therapy, the system automatically looks back 130 days to see if the first line medication has been tried. If there is a history of the first line medication, the claim for the non-preferred medication is automatically approved.

Stepping back, studies have demonstrated that 25-30% of U.S. health care spending is unnecessary or wasteful and does not improve patient outcomes.[125] These dynamics are driven by a combination of fraud and abuse, defensive medicine, low-value or duplicative care, patients using high-priced brand drugs when clinically equivalent generics or biosimilars are available, and the delivery of routine services in high-cost settings rather than lower-cost sites of care. The Cigna Group's role is to help address these inefficiencies and protect patients – by improving price transparency, promoting appropriate site-of-care decisions, increasing adoption of generics and biosimilars, and coordinating care – often against entrenched financial incentives from brand-drug companies and highly consolidated hospital systems that benefit from the status quo.

2. **How are your companies ensuring that coverage decisions for HIV prevention drugs, including long acting agents like lenacapavir, do not undermine the President initiated Ending the HIV Epidemic in the U.S. (EHE) by 2030 goal—particularly for communities that have historically faced barriers to access like Louisiana's 2nd congressional district?**

    a. **If the answer is yes, please explain how your coverage policies will ensure timely, affordable, and equitable access to long acting HIV prevention therapies like lenacapavir.**

    b. **If the answer is no, please explain how that position aligns with the national goal of ending the HIV/AIDS epidemic by 2030.**

    Response: Coverage policies for HIV therapies rely on evidence-based clinical criteria aligned with FDA labeling and nationally recognized HIV treatment guidelines, while avoiding unnecessary administrative barriers. For long-acting HIV therapies such as Sunlenca® (lenacapavir), Cigna Healthcare has established a dedicated coverage policy that supports access when clinically appropriate, with clear prior authorization criteria, defined approval durations, and ongoing reassessment based on treatment response, helping providers and patients avoid delays in care.

    To promote equity, Cigna Healthcare applies uniform, diagnosis-based criteria across populations; does not impose additional restrictions based on race, gender, sexual orientation, or geography; and updates coverage policies as clinical evidence and FDA indications evolve. As new long-acting HIV prevention therapies are approved by FDA, Cigna Healthcare evaluates them promptly to ensure coverage policies reflect the best available science and public health guidance.

3. **Prior authorization and step therapy in behavioral health frequently disrupts ongoing care, wastes critical time, and creates dangerous gaps in treatment. More than 90 percent of physicians have reported that prior authorization negatively impacts patients' health. Removing prior authorization in behavioral health has been shown by numerous studies to increase treatment initiation, reduce relapse rates, and prevent emergency department visits. Given that evidence, does your plan continue to require prior authorization and/or step therapy for behavioral health services—despite knowing it destabilizes patients,**

[125] National Academy of Medicine, *Valuing America's Health: Aligning Financing to Reward Better Health and Well-Being* (2023). Shrank, W.H., Rogstad, T.L., & Parekh, N. *Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings*, JAMA 322(15):1501–1509 (2019).

increases downstream costs, and ultimately shifts those costs to taxpayers through emergency care and public programs?

a. Are you aware that studies show removing prior authorization in behavioral health increases treatment initiation and reduces emergency department visits?

Response: Evernorth Behavioral Health powers Cigna Healthcare's behavioral health offerings. Evernorth's approach to behavioral health for the clients and customers we serve is centered on early identification, timely engagement, and coordinated care to prevent escalation and avoidable costs. Behavioral health benefits are covered in accordance with plan terms and parity laws, including MHPAEA.

Over the past four years, Evernorth has significantly expanded access to behavioral health services by more than doubling our behavioral health network, including offering a large virtual behavioral network, and building an integrated care model that supports individuals across the full continuum of need. This includes, but is not limited to, early-state support such as coaching, navigation, and family support, as well as therapy, medication management, and higher-acuity services. 24/7/365 crisis support and urgent behavioral care are available to provide immediate support to patients.

Utilization management tools, when used, are designed to support high-quality, evidence-based care. Today, nearly four in 10 patients receive care that doesn't meet the latest medical evidence and more than 90% of providers have reported negative impacts from low-value care (i.e., services that provide little to no benefit to patients, may cause harm, and result in unnecessary costs).[126, 127] Prior authorization and step therapy requirements are based on nationally recognized clinical guidelines, regularly reviewed by licensed clinicians, and applied with appropriate human oversight. These processes are designed to promote patient safety, improve outcomes, and reduce low-value or duplicative services.

We continuously evaluate our prior authorization and step therapy policies, including behavioral care policies, and remove or modify requirements when clinical evidence evolves, if requests almost always get approved, or if authorization denials often get overturned on appeal. Additionally, our independent, actively practicing P&T Committee always considers important disruptions in care and ensures that step therapy and prior authorization policies allow continuation of therapy for critical treatments, including for antidepressants, antipsychotics, antiseizure medications, and many others.

For example, routine outpatient services and substance use treatment do not require prior authorization, allowing patients to seek care from any in-network provider. Clinicians are also not required to submit a prior authorization request to enroll a patient in an intensive outpatient program. Additionally, we recently removed prior authorization requirements for partial hospitalization (PHP) level of care[128] and transcranial magnetic stimulation (TMS).[129] For the

[126] Jed Duff, Laura Cullen, et al., *Determinants of an Evidence-Based Practice Environment: An Interpretive Description*, Implement Sci Communications (Oct. 2020).
[127] Ishani Ganguli, Nitya Thakore, et al., *Longitudinal Content Analysis of the Characteristics and Expected Impact of Low-Value Services Identified in US Choosing Wisely Recommendations*, JAMA Internal Medicine (Feb 2022).
[128] Evernorth Health Services, *Update to Prior Authorization Requirements for Partial Hospitalization Level of Care Effective January 1, 2025,* Evernorth Newsroom (Jan. 2025).
[129] Evernorth Health Services, *TMS Prior Authorization Requirements to be Removed for Contracted Providers,* Evernorth Newsroom (Mar. 2026).

rare services where prior authorization is required, such as inpatient, residential, and intensive autism treatments, a dedicated team of advocates is available 24/7 to review requests.

More broadly, The Cigna Group has publicly committed to improving prior authorization for both patients and providers, in recognition that more can be done to reduce administrative burden while maintaining quality of care.[130] In early 2026, The Cigna Group released the first annual Customer Transparency Report detailing meaningful progress to reduce prior authorizations, enhance electronic communications, improve turnaround times, and provide more customer support and transparency.[131] We have made important progress, but recognize there is still more work to do in this multi-year effort.

[130] The Cigna Group, *The Cigna Group Launches Actions to Drive Positive Change for Customers and Patients*, Cigna Newsroom (2025).
[131] The Cigna Group, *Customer Transparency Report*, Cigna Newsroom (2026).