Written Testimony of
David Cordani
Chairman and Chief Executive Officer, The Cigna Group
Before the House Committee on Energy and Commerce Health Subcommittee
U.S. House of Representatives
January 22, 2026

Chairman Guthrie, Chairman Griffith, Ranking Members Pallone and DeGette, and members of the Health Subcommittee, thank you for the opportunity to testify today on one of the most pressing challenges facing American families, employers, and policymakers: the cost of health care.

My name is David Cordani, and I serve as Chairman and Chief Executive Officer of The Cigna Group. We are a health care company serving millions of Americans through employer- and union-based coverage and the health services we deliver are designed to make care more accessible, affordable, and easier to navigate.

And while we are proud of that work, we know there is more to be done.

At a high level, there are three steps the country can take to improve how care is delivered to patients:

- First, we must focus on the needs of the patient by expanding early access to care – especially programs that prevent chronic disease and support long-term health.
- Second, we need to advance payment arrangements that reward providers for health outcomes, not simply volume.
- And third, we must leverage competition where it has been proven to lower costs and improve care for patients in America.

I joined Cigna more than thirty years ago, and in that time I have seen extraordinary medical advances. I have also seen health care costs rise far faster than inflation. Prescription drug prices alone have increased roughly three times the overall inflation rate. Many Americans feel that pressure every day, which is why this discussion is so important.

Access to health care is only meaningful if it is affordable. An affordable system requires health plans, hospitals, drug manufacturers, physicians, and policymakers working together with the patient at the center.

At Cigna, we are focused on expanding access to preventive care, coordinating services around patient needs, and increasing transparency so people understand how health care dollars are spent. But today, our system overwhelmingly pays for care after people become sick. Prevention and sustained engagement are still the exception – not the rule.

We know a better approach works. For people living with chronic conditions, we have redesigned coverage and care models to support prevention and treatment adherence. That means lowering or eliminating out-of-pocket costs for life-saving medications. It means coordinating medical, pharmacy, and behavioral care. And it means giving patients real support to stay healthy and avoid costly complications.

But expanding these solutions requires confronting the underlying cost drivers in the system.

Since 2000, the cost of a hospital stay has increased more than 220%.[1] In 2024, the median price of a new prescription drug was $370,000 – up from about $2,000 less than twenty years ago.[2,3] That's nearly a 12,000% increase. Prices at that level put many treatments out of reach for families and employers, especially when competition is delayed or blocked.

We also need to recognize broader forces at work. Our population is aging and more Americans are living with chronic conditions. Five percent of the population drives half of total health care spending.[4] That increase builds pressure across the system and ultimately shows up in premiums – just as an increase in fuel prices would drive up the cost of goods across the economy.

At Cigna, we work tirelessly to be a counterweight to those pressures. Our ability to drive competition among generic drugs has led to some of the lowest drug prices in the world for Americans. Where we can effectively harness competition for brand drugs, we are delivering meaningful savings for patients. We capped insulin costs at $25, we provide biosimilars at no cost to many patients, and we are modernizing prescription benefits to deliver lower costs at the counter through greater transparency.

This focus on solutions matters most when people are at their most vulnerable. A cancer diagnosis, for example, is devastating for patients and families. We have built care models that reduce – or in some cases eliminate – out-of-pocket costs and connect patients quickly to top specialists, supported by our focus on rewarding value over volume. The goal is simple: the right care, at the right time – without adding financial stress.

No single company, and no single sector, can solve these challenges alone. 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 to reduce costs for patients.

Today my testimony will focus on three core points:

- Why health care affordability continues to deteriorate despite decades of debate,
- What role health insurers and pharmacy benefit managers play in counterbalancing the system's most powerful cost drivers, and
- How private-sector innovation and targeted public policy can work together to restore affordability, access, and value.

Who We Are

The Cigna Group operates through two complementary platforms: Cigna Healthcare and Evernorth Health Services.

[1] Baker Institute for Public Policy. *Hospital Price Increases Since 2000 Outpaced Inflation by More Than Double, Baker Institute Report Says* Rice University's Baker Institute for Public Policy, 2024.
[2] Reuters. *Prices for New US Drugs Doubled in 4 Years as Focus on Rare Disease Grows* May 22, 2025.
[3] Benjamin N. Rome, Aaron S. Kesselheim, Andrew C. Egilman, et al., *Trends in Launch Prices for New Brand-Name Prescription Drugs in the United States, 2008–2021* JAMA. 2022;327;(21):2145-2147. doi:10.1001/jama.2022.5542.
[4] Ana Hernandez-Viver and Emily M. Mitchell, *Concentration of Healthcare Expenditures and Selected Characteristics of People with High Expenses, United States Civilian Noninstitutionalized Population, 2018–2022* (Statistical Brief No. 560), Agency for Healthcare Research and Quality, 2025.

Through **Cigna Healthcare**, we primarily serve employers, unions, and other private purchasers by delivering comprehensive health coverage and benefit solutions. While we participate in the individual market in select geographies, we do not currently offer comprehensive medical coverage in Medicare or Medicaid. Our focus in the employer-sponsored market – where more than half of Americans receive their coverage – reflects where we can deliver the greatest value and where innovation has historically been strongest.

Evernorth Health Services is our health services platform. Through Evernorth – and Express Scripts – we provide pharmacy benefit management, specialty pharmacy services, and targeted care delivery solutions across the health care ecosystem. This integrated model allows us to address affordability not at a single point in the system, but across the full continuum of care.

Framing the Affordability Problem

Demand for health care in the United States is growing rapidly. The population is aging, chronic conditions are increasing, and today chronic disease and mental health conditions account for roughly 90% of total health care spending in the United States.[5] Conditions like heart disease, diabetes, and Alzheimer's are among the most expensive, with Alzheimer's care alone projected to reach $1 trillion annually by 2050.[6] Together, these forces drive heightened demand for health care services.

The organizations and professionals that deliver and produce care – hospitals, physicians, pharmaceutical manufacturers, and medical device and technology companies – are driving significant innovation. However, many of these advances come at extraordinarily high cost, often without a corresponding evaluation of whether they meaningfully improve outcomes or extend longevity.

- Hospital service prices have surged more than 220% between 2000 and 2022.[7] Data from the Bureau of Labor Statistics show hospital prices rising faster than insurance premiums from 2006 through 2023.[8]
- These pressures are compounded by consolidation. Hospital acquisitions and private equity ownership of provider practices have repeatedly been shown to increase prices, often without corresponding improvements in quality or outcomes.[9,10] Payment models frequently reward volume over value, meaning additional capacity leads to higher utilization rather than lower costs.
- Most new drugs coming to market today are high-priced, branded specialty medications. Last year, the median list price of newly launched drugs was approximately $370,000 – up from $2,000 in 2008 – placing them well out of reach

[5] Centers for Disease Control and Prevention. *Fast Facts: Health and Economic Costs of Chronic Conditions* Updated August 2025.
[6] Alzheimer's Association. *2025 Alzheimer's Disease Facts and Figures: Executive Summary* Alzheimer's Association, 2025.
[7] Baker Institute for Public Policy. *Hospital Price Increases Since 2000 Outpaced Inflation by More Than Double, Baker Institute Report Says* Rice University's Baker Institute for Public Policy, 2024.
[8] Health Affairs Scholar. *The Role of Employer-Sponsored Insurance in U S Health Care* Volume 2, Issue 6, Article qxae078. Oxford Academic, 2024.
[9] Borsa, A., Bejarano, G., Ellen, M., & Bruch, J. D. (2023). *Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: Systematic review*. BMJ, 382, e075244. July 19, 2023.
[10] Bhatla, A., Bartlett, V. L., Liu, M., et al. *Changes in patient care experience after private equity acquisition of U S hospitals*. JAMA. 2025;333;(6):490-497. doi:10.1001/jama.2024.23450.

for most Americans without effective counterbalances.[11,12] At the same time, drug manufacturers frequently take steps to delay generic and biosimilar competition, preventing the market forces that would otherwise drive prices down.
- Similar dynamics exist in medical technology, where new imaging and diagnostic tools enter the market with incremental clinical improvement but materially higher prices.

The result is what we see today: persistent growth in health care spending. Health insurance premiums reflect these underlying costs and unsustainable dynamics; they do not drive them.

Our current reimbursement system is not structured to effectively contain these prices, as payment models are too often designed to compensate health care providers based on the volume of services they provide rather than delivering better health outcomes for their patients. Increases in capacity often lead to higher overall costs, not lower ones. Additional specialist capacity generates additional utilization – more appointments, more diagnostics, more procedures. Providers increasingly use sophisticated tools, including AI, to maximize billing opportunity and intensity, driving spending upward even when the underlying care does not change.

A high-cost environment combined with less profitable Medicare and Medicaid payments means hospitals rely on commercial rates. Commercial insurance rates are on average 200% higher than Medicare rates and significantly higher than Medicaid rates.[13] This cross-subsidization is also exacerbated by consolidation. Research shows that when hospitals consolidate, prices for inpatient care can increase by 20-50%, without corresponding improvements in quality or patient outcomes.[14] Large regional delivery systems that millions of patients depend on have the leverage to demand significant rate increases. For example, a large, regionally important hospital system recently requested a 30% increase over two years and, instead of moving the hospital system out of network, we settled at 20% to preserve patient access and limit disruption. This is the environment many insurers are facing: how to effectively shift our system from volume to value, preserve patient access, and improve affordability amidst unsustainable price increases from important hospital systems.

Drug and device manufacturers play a major role in driving high costs. Drugs and devices launch with high prices and then prices are exacerbated over time by limited competition. Manufacturers use patent thickets to block generic and biosimilar competitors and keep specialty and traditional brand drug prices elevated. Direct pharmaceutical ads to patients encourage unnecessary medicalization of normal conditions, fueling demand for expensive treatments that may not be appropriate. Medical device manufacturers continuously introduce new, high-priced diagnostics and imaging technologies, which health systems then seek to recoup through increased use.

[11] Reuters. *Prices for New US Drugs Doubled in 4 Years as Focus on Rare Disease Grows* May 22, 2025.
[12] Rome BN, Kesselheim AS, Egilman AC, et al. *Trends in launch prices for new brand-name prescription drugs in the United States, 2008–2021* JAMA. 2022;327(21):2145–2147. doi:10.1001/jama.2022.5542.
[13] Marshall, Spencer, Danjie Zhou, and Charlie Mills. *Commercial Reimbursement Benchmarking 2025: Commercial Payment Rates for Medical Services as a Percentage of Medicare Fee-for-Service Rates* Milliman, July 24, 2025.
[14] Gudiksen, Katherine L., Alexandra D. Montague, and Jaime S. King. *Mitigating the Price Impacts of Health Care Provider Consolidation* New York: Milbank Memorial Fund, September 2021.

As a result, these markets have attracted significant private equity (PE) interests. PE ownership and consolidation can increase prices without corresponding improvements in quality, and in some cases may worsen outcomes. PE-affiliated primary care physicians charge 8% higher prices for office visits compared to independent practices and similar studies have documented worsening outcomes for patients following PE-driven acquisitions.[15,16] In addition, exploitation of the *No Surprises Act's* Independent Dispute Resolution (IDR) process has turned a consumer protection into a cost-inflation mechanism. PE-driven abuse of the IDR process is driving the caseload 100x above CMS estimates and median provider payments are 450% above in-network rates for services.[17,18]

Federal and state laws and regulations, while well intentioned, can also exacerbate the problem. Digital health records were introduced without meaningful interoperability, incentivizing proprietary systems and a patchwork of expensive, incompatible platforms. Our legal system lends itself to excessive costs from malpractice premiums and defensive medicine. State-level restrictions on market entry and scope of practice (e.g., certificate of need laws) reduce competition and create increased market power for incumbents.

The result is high prices and high utilization reinforcing one another rather than generating value. This dynamic often fuels unproductive finger-pointing – when the real issue is the misalignment of incentives and relentless expansion of high-priced supply.

Addressing affordability requires mechanisms that can help balance these forces and introduce discipline into markets that do not self-correct.

Existing Forces Offsetting Cost Drivers

Protecting Patients from Unchecked Pricing Power
In a system that does not self-correct, entities are required to protect patients from unchecked pricing power. That is the role we play at The Cigna Group through Cigna Healthcare and Evernorth Health Services.

Specifically, we:

- Negotiate lower costs for medical services and prescription drugs than individuals or employers could achieve on their own.
- Design provider and pharmacy networks and drug formularies to ensure patients receive high-quality, lower-cost care.
- Coordinate care across medical, behavioral, and pharmacy services to reduce fragmentation and avoid duplicative or unnecessary utilization.
- Incentivize 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.
- Process claims and payments efficiently across a complex supply chain.

[15] Yashaswini Singh, Nandita Radhakrishnan, Loren Adler, and Christopher Whaley. *Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications* JAMA Health Forum. 2025;6;(1):e244935. doi:10.1001/jamahealthforum.2024.4935.
[16] Kannan S, Bruch JD, Song Z *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition* JAMA. 2023;330;(24):2365-2375. doi:10.1001/jama.2023.23147.
[17] Centers for Medicare & Medicaid Services (HHS/DOL/Treasury), *Fact Sheet: Clearing the Independent Dispute Resolution Backlog* Sept. 19, 2025.
[18] Center on Health Insurance Reforms (CHIR), Georgetown University. *The Substantial Costs of the No Surprises Act Arbitration Process* Georgetown University Health Policy Institute, 2025.

- Introduce guardrails to reduce waste, fraud, and abuse while preserving access to care.

These functions are sometimes the targets of criticism, but they are essential in a fragmented system characterized by concentrated pricing power and limited competition. Without them, patients and employers would face even higher costs in markets that lack natural constraints.

Health coverage is among the most heavily regulated industries in the country. Insurers are subject to Medical Loss Ratio requirements that cap administrative costs and profits, ensuring that 80-85% of premium dollars are spent directly on medical care. **In 2025, despite premium growth, insurer profit margins declined to approximately 1.8%.**[19] By contrast, profit margins for pharmaceutical manufacturers and medical technology companies remain significantly higher: drug companies consistently report margins between 20-40% and medical technology companies average margins near 30%.[20]

A Bright Spot: The Power of Effective Market Competition
Despite these system-wide pressures, there is one area where the United States consistently demonstrates that competition can meaningfully improve affordability: generic and biosimilar medicines. When lower-cost competitors are allowed to enter the market without obstruction, the results are unmistakable. Today, generics account for approximately 90% of all prescriptions filled in the United States yet make up only 10% of total prescription drug spending. As a result, the United States has some of the lowest generic prices and highest uptake in the world, reflecting what happens when robust competition is permitted to function as intended.

This stands in stark contrast to branded pharmaceutical medicines, where just 10% of prescriptions drive nearly 90% of drug spending. In these markets, drug companies frequently employ patent extensions, exclusivity strategies, and litigation to block or delay generic and biosimilar competition. As long as these tactics persist, high-cost brands will continue to overpower the competitive forces that have made generics one of the few true affordability success stories in American health care. This is precisely the kind of competition insurers and pharmacy benefit managers are designed to support when market forces are allowed to function as intended.

Looking to the next 10 years, the United States has an important opportunity to capitalize on an estimated $100 billion in savings from biosimilar competition. Allowing the current tactics to persist that delay generic and biosimilar access will maintain high prices and harm American patients and businesses. 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. If an interchangeable biosimilar is delayed for five years, it could represent as much as $45.3 billion in added costs for just one specialty drug, which will directly translate into increased costs for American patients.[21]

[19] National Association of Insurance Commissioners (NAIC). *2025 Mid-Year Health Insurance Industries Analysis Report* NAIC, 2025.
[20] Campaign for Sustainable Rx Pricing (CSRxP). *Pharma Profit Margin Analysis* November 2024.
[21] Evernorth. *2025 Pharmacy in Focus: Biosimilars Report* 2025.

The lesson is clear: **competition works when it is allowed to work**. Strengthening, not weakening, the mechanisms that support generic and biosimilar adoption is essential to improving affordability for patients, families, employers, and taxpayers.

Coverage Offered by Employers is An Innovation Engine
As the largest source of health coverage in the United States, employer-sponsored coverage remains a cornerstone of our health care system. Employers are more than just payers, they are integral in supporting their workers' access to care and have a vested interest in keeping their employees healthy, productive, and present. Health benefits for employees and their families are customized to maximize personal health engagement and outcomes, manage costs, support employee retention, and foster productivity. To do this, employers often actively innovate ways to improve coverage, engage employees in their health, and drive value for this investment in their workforce.

Employers are afforded more flexibility to design plans that best fit their needs and the needs of their workforces, unlike traditional Medicare and Medicaid coverage. This makes them natural partners to accelerate innovation to improve care delivery and affordability. Our partnership has enabled us to develop and deploy new solutions that improve health outcomes or lower health risks, shift physicians to value-based care arrangements, and offer new benefits to address changing employee needs. As health care costs continue to rise across the system, employers are realizing an estimated 120% return on investment in 2025, increasing to 137% in 2029.[22] This is due to lower direct medical costs, higher employee productivity, reduced recruitment and turnover costs, lower short- and long-term disability expenses, and tax advantages. Employer sponsored coverage is also of tremendous value to the federal government: every dollar reduction in tax revenue generates an estimated $4 in health care for Americans.[23]

Leading on Change

We know our industry must lead on solutions. We have a proven track record of leveraging our patients' and clients' feedback to introduce bold changes. Last year, we committed to a multi-year journey to improve health coverage and confront some of the most pressing challenges in health care. These commitments include:

- **Easier Access to Care:** Helping customers quickly resolve administrative issues with prior authorization, enabling clear communication through digital status updates, and encouraging electronic communication with providers.
- **Better Support:** Expanding our Care Advocates team for Cigna Healthcare customers facing the most challenging and/or complex conditions and helping them navigate every stage of their treatment journey.
- **Better Value:** Ensuring the savings generated to lower prescription drug costs for our clients translates into even lower prices at the pharmacy counter for patients and providing a personalized year-end statement detailing prescription drug savings.
- **Accountability:** Tying more of our leaders' compensation to improving the satisfaction of our customers.
- **Transparency:** Establishing an annual Customer Transparency Report detailing progress on these commitments, the first of its kind for our industry.

[22] Avalere Health. *Return on Investment for Offering Employer-Provided Insurance* December 15, 2025.
[23] U.S. Chamber of Commerce. *Employer-Sponsored Health Insurance Produces 47% Return on Investment for American Businesses* June 29, 2022.

We are already making progress. We doubled the number of Cigna Healthcare employees who help patients navigate every stage of complex health conditions like cancer, stroke, or heart attack. We're accelerating and simplifying the process for physicians to submit claims and prior authorization requests. **More than half of prior authorizations submitted electronically get decisions within minutes and more than 80% are approved in one day or less.**

To further advance prior authorization reforms system-wide, we partnered with the Trump Administration and industry stakeholders on measurable steps – standardizing electronic submissions, reducing volume, ensuring care continuity during plan transitions, boosting real-time approvals by 2027, and ensuring appropriate medical reviews for denials. We have made considerable progress on these commitments, many of which are in place as of the beginning of this year.

Leading on these types of solutions is not new. We have provided American patients with personalized price transparency for common health services and prescription drugs for the last 15 years. We pioneered high-value provider and pharmacy networks and drug formularies that incentivize more affordable, high-value services. We advanced value-based reimbursement models with providers that align incentives based on evidence-based standards and drive better health outcomes. We introduced innovative financing models to help small businesses better manage health coverage. More broadly, we have worked to 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.

Consider a cancer patient navigating diagnoses, treatment, behavioral health, and specialty medications – often through disconnected systems instead of an integrated treatment plan. Coordination across medical, behavioral, and pharmacy care is essential to achieve the gold standard of affordability and clinical outcomes. It is why we acquired Express Scripts: to accelerate the shift toward coordinated, whole-person, high-quality care that improves outcomes and reduces total costs.

Today, that integration is delivering a comprehensive oncology model that integrates pharmacy, medical, and behavioral treatment across patients' entire cancer journey – from prevention and early detection through diagnosis, treatment, and survivorship. These solutions not only improve outcomes but also reduce or eliminate patient out-of-pocket costs and generate substantial savings for our clients.

More broadly, since the acquisition, we launched Evernorth Health Services, allowing us to develop and deploy more integrated, personalized solutions. We were the first to cap patient out-of-pocket costs for insulin and other chronic conditions at $25; we introduced industry-first programs to support more affordable, predictable access to GLP-1s and gene therapies; and we consistently drive high generic utilization rates and significant savings on branded prescription drugs for our patients and clients.

Earlier this year, we announced a fundamental business shift to introduce a simpler and more transparent pharmacy benefit model as an alternative to the more complex, post-purchase rebate process. The combined capabilities of Evernorth and Cigna Healthcare positioned the company to proactively take this bold action to lower patient costs, increase

transparency for patients and clients, and compensate local pharmacies for their important work.

The value of integration is not theoretical. It is experienced by patients every day. In 2000, after years of unexplained symptoms, high fevers, and fatigue, a patient was diagnosed with an immune deficiency disease called CVID. It is not curable, but with consistent support, he could live a normal life by visiting a hospital every month for infusion therapy. However, that means hours away from his family, time he could not visit his clients or do his job, and time away from a host of the things that matter most. That is where we can help. Our specialty pharmacy and at-home nurse trained him on administering the medication at home while he is catching up on email, watching a game, or being with his family. I am proud of the work we do to deliver solutions to not only improve quality of life, but support more affordable, high-value care through our integrated services.

Individuals thrive when care is simpler, affordable, and more personalized but too many Americans remain trapped in a system where high-priced supply overwhelm affordability. Achieving universal access to affordable health care coverage is not possible without fundamentally restructuring incentives embedded across the financing, delivery, and consumption of health care, particularly within certain segments of the U.S. health care market. These challenges require sustained partnership between policymakers and the private market to enable system-wide changes – no single sector can solve these challenges alone. We all must work together.

Partnering on Public Policy Solutions

While the private sector will continue to innovate, targeted public policy reforms must be a part of the solution to address health care cost drivers and enable greater affordability. These reforms have historically been difficult to advance, but we welcome the opportunity to partner with policymakers to enable more sustainable coverage and greater affordability.

Three National Imperatives

1. ***Improve Americans' health*:** Starting with a recognition of the environmental factors impacting health care. Improve access to healthy foods and physical activity through school- and community-based nutrition programs and physical education initiatives. Encourage employer-sponsored wellness benefits that support families, such as healthy meal stipends and mental health resources.

2. ***Accelerate the shift to value:*** Continue to harness the power of HHS and CMS to align payment with quality, not volume. Iterate and improve value-based payment models like bundled payments and Accountable Care Organizations. Streamline prior authorization by expanding electronic access and improving interoperability. Eliminate anti-competitive tactics that reduce competition and maintain high prices. Support employer-driven innovations like precision networks, site-of-care optimization, and Centers of Excellence.

3. ***Embrace and incentivize employer-supported coverage*:** Innovative coverage continues to be developed for millions and supports the stability of Medicare and Medicaid. Encourage flexible benefit designs, including telehealth, behavioral health integration, and wellness programs. Recognize employer coverage as a critical pillar that offsets underpayments in public programs and sustains provider networks.

Targeted Public Policy Solutions

- ***Prevent gaming of drug patents*:** Close loopholes that allow pharmaceutical companies to extend exclusivity and delay access to affordable generics and biosimilars.
- ***Expand access to interchangeable biosimilars*:** Ensure that interchangeable biosimilars come to market on time and that pharmacists can substitute higher cost brands with interchangeable biosimilars at the pharmacy counter.
- ***Limit misleading direct-to-consumer pharmaceutical advertising*:** Eliminate consumer drug ads to reduce inappropriate demand for high priced drugs over more affordable generics and reduce influence on prescribing practices.
- ***Reduce private-equity and provider gaming of the No Surprises Act*:** Strengthen enforcement to prevent exploitative billing practices that are driving up costs for American patients and businesses.
- ***Reduce incentives for provider consolidation*:** Implement site-neutral payment reforms to discourage mergers driven by Medicare reimbursement disparities.
- ***Monitor private-equity acquisitions*:** Increase regulatory scrutiny and transparency to protect American patients from price gouging.
- ***Expand the utility of health savings accounts*:** Codify expansions of pre-deductible coverage to include chronic care and wellness services, permit separate deductibles and OOP maximums, and lower the minimum deductible.
- ***Expand telehealth access*:** Make permanent regulatory flexibilities that improve access to virtual care.

* * *

Health care affordability is one of the defining challenges of our time. It cannot be solved by shifting costs or assigning blame to a single sector. Progress requires confronting the structural drivers of high prices, aligning incentives across the system, and sustaining partnership between Congress, the Administration, and private-sector leaders.

At The Cigna Group, we are committed to doing our part. We stand ready to work with this Committee to address the root causes of rising costs and to build a health care system that delivers better value, better outcomes, and better experiences for the American people.

Thank you, and I look forward to your questions.