



October 31, 2025
Cigna Healthcare

2025 Annual Health Care Cost Trends Hearing

I, Anthony Cali, am legally authorized and empowered to represent Cigna Health and Life Insurance Company for the purposes of this testimony. This testimony is signed under the pains and penalties of perjury.



Anthony Cali
Provider Contracting Senior Director

2025 Pre-Filed Testimony

PAYERS



As part of the
Annual Health Care
Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the [2024 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2024, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact relevant staff at the information below.

HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at
HPC-Testimony@mass.gov or
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AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov
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THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on members and purchasers, coverage and access to care, providers, in addition to premiums and out-of-pocket costs? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

The Cigna Group is a global health company committed to improving health and vitality. Our Cigna Healthcare and Evernorth Health Services divisions are providers of medical, pharmacy, dental, behavioral health, and related products and services. Our health services business, Evernorth Health Services, includes a broad range of coordinated and point solution health services and capabilities, in pharmacy benefits, home delivery pharmacy, specialty pharmacy, distribution, and care delivery and management solutions, which are provided to health plans, employers, government organizations, and health care providers. Across all segments we serve, The Cigna Group is focused on working to deliver health care that is affordable, predictable, and simple – so people can live healthier, more vibrant lives.

To help deliver on our commitment to improving the health and vitality of those we serve, we advocate for the advancement of policies that drive choice and affordability, foster innovation, demand quality, and improve access. When federal health policy proposals would have unintended consequences that negatively impact access or affordability, Cigna works to mitigate those impacts while complying with state and federal law. In alignment with federal and state cost containment goals, Cigna has employed the following strategies:

Cigna has implemented comprehensive measures to comply with the federal No Surprises Act (NSA) and protect patients from unexpected out-of-network charges or surprise bills. These include:

- Ensuring patients pay only in-network cost-sharing for emergency care and out-of-network care received at an in-network facility.
- Engaging in structured negotiation and arbitration processes with out-of-network providers to resolve billing disputes fairly.
- Supporting cost predictability for purchasers and patients, helping stabilize premiums and out-of-pocket costs.

The Cigna Group is also strongly advocating for the Centers for Medicare and Medicaid Services (CMS) to address weak regulatory safeguards that have allowed private equity-backed providers to collect payments significantly above qualifying amounts for ineligible or otherwise defective claims, undermining the NSA's intent and shifting costs back to plan sponsors and, in turn, consumers. In the last half of 2024, providers prevailed in 85% of NSA independent dispute resolution (IDR) disputes. According to the Georgetown Center for Health Insurance Reforms, providers won upwards of 500% of the qualifying payment amounts over 2023-2024.¹ Reforms should include improving the arbitration process to screen for ineligible claims, addressing biased arbitration entities, strengthening oversight through regular audits, and holding initiating parties accountable for false representations made during the IDR process.

We also help individuals navigate to the highest-quality, cost-effective providers and appropriate sites of care and connect to digital health tools quickly to have support to better manage their care and eliminate gaps in care. Cigna has invested in robust price transparency tools including:

- Personalized cost estimates for patients via myCigna.com.
- Machine-readable files published publicly in compliance with federal rules.
- Integration of provider quality metrics and verified patient reviews to guide high-value care choices.

Cigna supports the goal of providing transparency to consumers through the sharing of meaningful, actionable information that encourages informed health care choices and competition. While we are committed to compliance with federal regulations, we are concerned that public disclosure of negotiated rates and historical pricing data in machine-readable files will not further the goal of consumer-facing transparency. Policymakers seeking to enable consumer-facing transparency should focus on sharing relevant information to plan enrollees for a common set of shoppable services.

Furthermore, Cigna is streamlining prior authorization processes to reduce delays and administrative burden using the following solutions:

- Over 1,100 services removed from prior authorization requirements since 2020, with further reductions planned.
- Enhanced electronic prior authorization systems and real-time responses to improve efficiency and provider experience.

- Beginning January 1, 2026, Cigna will honor prior authorizations from a customer's previous carrier for the same service, under the same type of benefit in network for up to 90 days post-enrollment – supporting smoother transitions and uninterrupted care.
- Continuity of care protections ensure treatment is not disrupted when patients change plans.

Cigna also has been actively engaged in efforts to address and eliminate health disparities and addressing the social determinants of health (SDOH). We support health equity through a comprehensive, multi-level strategy that addresses systemic barriers to care. Cigna is dedicated to embedding health equity programs and practices into the core of our business and invests in community-based programs through its Health Equity Impact Fund. Some examples include:

- Our Pregnancy Support Pilot promotes healthy birth outcomes and maternal care for women by collaborating with health care providers to identify expectant mothers at-risk and offer personalized pre- and postnatal care.
- The Community Health Worker Pilot matches diabetic customers with community health workers in higher-risk SDOH communities who understand customers' cultural nuances and connect them to benefits, services, and SDOH resources/support for better health outcomes.
- Our IndependentRx Initiative expands rural health care access through independent pharmacy partnerships across the U.S. for certain routine, preventive, and chronic care services beyond prescriptions.
- LGBTQ+ Health Programs address health disparities faced by the LGBTQ+ community.

We believe that collaboration across sectors, data-driven oversight, and sustained advocacy are essential to safeguarding the health care system for all residents of Massachusetts.

¹ [The Substantial Costs of The No Surprises Act Arbitration Process | Center on Health Insurance Reforms](#)

2. Many Massachusetts health care providers continue to face significant workforce challenges. What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce in Massachusetts?

Employers play a vital role in the health care system, and we strive to be a model for others by prioritizing the health and vitality of employees within our own company. Vitality is the capacity to pursue life with health, strength and energy. By better understanding vitality and the factors that impact it, employers can more deeply understand the unique needs of their

workforce, act on that knowledge to inform meaningful investment decisions and grow. There are eight dimensions of vitality: physical, emotional, occupational, spiritual, intellectual, environmental, financial and social. A person's perceived ability to make choices and engage willingly, develop skills and capabilities, and connect to others across these life domains impacts their vitality. Our third annual 2024 Vitality in America research, based on a survey of 7,500 adults in the United States provides thought leadership for employers to leverage to address the vitality needs of their employees. The key takeaways include:

1. While Gen Z adults continue to have the lowest overall vitality, they are acquiring the skills for a healthy life, feeling more in control in stressful periods, and becoming more optimistic.
2. There is a positive boomerang effect between vitality and work, and although there are generational and gender differences, workers with high vitality have higher job satisfaction and better job performance.
3. Workday stress, manager relationships, and activity levels strongly influence health and vitality, offering a glimpse into the opportunities employers have to support the vitality of their workforce.

We are passionate about improving the health, well-being, and vitality of those we serve. It drives us in every way. One way we deliver on this is by helping create a culture of well-being in organizations that inspires employees to participate more fully in their health journeys. By connecting members with health engagement opportunities, employers can make it easier for them to improve their total well-being while offering a more seamless health care experience.

Additionally, Cigna is continually looking to improve work processes and alleviate administrative burdens with our provider partners. Our response to Question #3 below comes from some of those examples.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What are the most meaningful steps you are taking to reduce administrative complexity that provides little value to patient care? What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs and the administrative costs of providing care borne by providers and others?

Earlier this year, Cigna announced a new multi-year effort aimed at meaningfully transforming the experiences of the millions of people it serves. The Cigna Group has established five key areas of focus, and several initial specific actions, to improve the health of its customers and the value it provides:

Easier access to care: The company will address the challenges customers face by making its processes simpler, easier and faster.

Better support: The company will provide customers with more support and resources to navigate the healthcare system.

Better value: The company will drive better value for its customers.

Accountability: The company will implement governance processes at the highest levels to successfully ensure positive changes.

Transparency: The company will openly share how it is continuously improving.

Specifically, Cigna Healthcare announced the following actions:

- Expanding its team of Cigna Healthcare advocates who support customers and patients with the most challenging or complex conditions, such as cancer, these highly trained advocates will help more patients navigate every stage of their care and treatment journey
- Investing resources to help more customers and patients quickly resolve administrative needs with prior authorization and post-care claims
- Introducing an enhanced digital status tracker that patients can use for prior authorization updates
- Encouraging physicians to communicate electronically about prior authorizations and claims through Cigna Healthcare's digital provider portal to expedite approvals and reduce errors.

Additionally, starting in 2026, Cigna will publish an annual Customer Transparency Report detailing progress on affordability, care facilitation, and customer satisfaction. Executive compensation will be tied to these outcomes.

Prior Authorization: While prior authorization remains an important checkpoint to protect patient safety and evidence-based care for certain services, The Cigna Group recently made definitive commitments to make the process for patients and providers simpler, easier, and faster. This includes faster resolution of administrative issues, an enhanced digital status tracker, and encouraging provider use of ePA to expedite approvals and reduce errors. More broadly, our industry is partnering with HHS and CMS on voluntary actions to streamline, simplify, and reduce prior authorization by committing to six major actions:

- Standardizing electronic prior authorization
- Reducing the scope of claims subject to PA
- Ensuring continuing to care when patients change plans
- Enhancing communication and transparency on determinations
- Expanding real-time responses
- Ensuring medical review of non-approved requests.

We are making great progress on the voluntary commitments and are on track to meet established goals and timelines. Cigna Healthcare continuously evaluates codes (for services that require prior authorization) based on their usage, the latest evidence-based standards of

care, and feedback from our stakeholders. To help reduce the paperwork and time providers (and patients) spend seeking approvals for more routine services, Cigna Healthcare removed 96 codes from the list of services that require prior authorization for dates of service on and after May 31, 2025. These codes include commonly requested cardiology, otolaryngology (ENT), and other routine services. These removals allow clinicians to dedicate more time to patient care and enable customers to access services sooner, without compromising the benefits that prior authorization offers for more complex services.

Additionally, Cigna has expanded its **My Personal Champion**® program to help patients with serious conditions like cancer or heart disease navigate care and administrative processes. We also offer **Concierge teams** to assist with prior authorizations and claims and **Digital tools** for tracking authorization status and managing care.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. What specific actions or investments is your organization pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your members? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

Cigna promotes the value of primary care through a multi-faceted strategy that emphasizes preventive care, behavioral health integration, value-based care models, and health equity initiatives.

- Cigna highlights the importance of preventive services—like screenings, vaccinations, and routine check-ups—as essential components of primary care. These services are often covered at 100%, and Cigna promotes their use to detect health issues early, reduce emergency room visits and lower overall health care costs.
- Cigna’s Collaborative Care programs aim to integrate behavioral health into primary care settings. This approach improves management of chronic conditions, reduces health care costs and enhances overall patient outcomes. Our collaborative care programs can help increase behavioral health integration in the primary care setting and ensure that patients receive whole-person care at the right time and in the right setting.
- Cigna’s Collaborative Care model promotes value-based reimbursement, where providers are paid based on the quality and efficiency of care. This model aligns incentives with providers, shares actionable data to support clinical decisions and encourages coordinated, cost-effective care.
- Additionally, Cigna addresses social determinants of health and works to close gaps in care by focusing on improving access in underserved areas, supporting mothers and children and tackling chronic conditions like cardiometabolic disease.

We're constantly striving to improve the health care experience to make things simple and reliable in everyday moments- like finding a doctor or pricing medication. We're delivering clinical and service excellence in extraordinary moments- like navigating a cancer diagnosis or managing a lifelong condition like diabetes. And we're embedding industry-leading behavioral and pharmacy into everything we do. And of course, we work hard to improve affordability and transparency for our clients and customers and negotiate competitive rates with providers, so members benefit from those savings.

Our extensive network allows us to offer a wide range of high-quality services at lower costs and we're helping all patients benefit from drug price negotiations (see additional details in our response to question #5 below)

Digital innovations are making it easier for people to focus on their care, not paperwork. Some of the new features already available include:

- Faster, Easier Prior Authorizations that offer near real-time status updates, mobile self-service options, and a centralized support team to help customers get answers and feel confident in their next steps.
- An expanded the My Personal Champion program to all customers offering one-on-one support with a dedicated advocate to coordinate care, resolve issues, and provide expert guidance to focus more on care and recovery.
- By the end of year, our members will have access to an AI-Powered Virtual Assistant that provides 24/7 guidance on benefits, claims, and care options – backed by AI, with seamless transitions to a customer service advocate when needed.

These enhancements blend digital features with real human support to guide all our customers through their everyday and extraordinary healthcare moments.

Data Analytics: Our transformative, differentiated approach to addressing member needs through data and analytics stands on three pillars at the forefront of health: integrated data, prescriptive analytics, and augmented intelligence. Our breadth of data is integrated, linked, and curated across medical, prescription and specialty drug, clinical, behavioral health, and social determinants of health to provide a holistic view of our members and address whole-person health needs. Our analytics go beyond the predictive to the prescriptive, anticipating potential member needs and providing recommendations on appropriate actions with actionable intelligence. Finally, our machine learning and deep learning capabilities augment and enhance, rather than replace, the decision-making of health care professionals. Our goal is to identify and engage at-risk people as early as possible—when our services can have the greatest impact.

We have access to a breadth of data from our millions of customer and patient relationships globally, and billions of pharmacy customer touchpoints annually. We developed a suite of predictive models across breast, colorectal, and lung cancer, to identify members newly diagnosed with cancer either before or shortly after their diagnosis. The goal of early identification is to reach out to members at a time when our support can be of greatest help in navigating their coverage and benefits, providing treatment decision support options, and offering evidence-based practice recommendations around screening and treatment. It also provides the opportunity to

screen members for potential behavioral health and wellness–related needs. Our breast, lung, and colorectal cancer models identify customers 27, 20, and 34 days sooner than standard triggers, respectively.

In addition, patients who are identified by the breast cancer predictive model and engaged in our oncology case management program see the following results compared to those who are engaged later in their breast cancer journey:

- 1.36x more likely to engage in behavioral care
- 17% higher engagement with our oncology case managers
- About \$5,600 medical savings in first 6 months post diagnosis

The avoidable inpatient predictive model was developed to identify customers at risk for an avoidable inpatient stay in the next 12 months. Customers identified by this model are referred to medical case management. Upon engagement, results show 31% reduction in avoidable admissions.

Our behavioral predictive models enable us to identify customers at-risk of developing behavioral conditions or acute health episodes because of existing behavioral conditions. Our cardio-behavioral model predicts cardiac customers with known risk factors for a behavioral condition to provide early intervention. Our high-risk substance use disorder suite of models, eating disorder model, and autism model predict customers who are likely to have acute events in the future. Our Autism Early ID model identifies customers on average 5.5 months prior to their diagnosis. Rather than waiting until the authorization for Applied Behavior Analysis, we proactively engage with customers as they're making care decisions. Low acuity depression/anxiety/ADHD model identifies lower acuity customers who could benefit from digital resiliency, digital cognitive behavioral therapy (CBT), or behavioral outpatient care.

5. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents. Please describe the current and anticipated pharmaceutical trends (and detail the potential impact on health care spending) in the next three to five years, including but not limited to information about anticipated trends in utilization, new medications and therapies, and price increases for brand name and generic drugs. What specific actions is your organization taking to address these trends and to balance patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and members?

The Cigna Group recently announced a first-of-its-kind reinvention of the pharmacy benefit. We're proud of our decades-long legacy of innovation and driving affordability, but more can be done.

Stakeholders have raised questions about the transparency and complexity of pharmacy benefits. We believe this breakthrough new model will help renew trust while addressing market demand. Our new rebate-free pharmacy benefit model will lower costs for patients, deliver greater transparency for employers, and increase reimbursements to community pharmacies. This new Express Scripts pharmacy benefit services model is rooted in three core components: lower costs and better experience for consumers, transparent pharmacy benefit services for employers, and support for local pharmacies.

Express Scripts, The Cigna Group's pharmacy benefit manager (PBM), will transition toward a new model where discounts negotiated with drug companies will be available upfront to patients buying their medications and transparent to employers providing the benefit. This new approach cuts out the complex post-purchase rebate process by making the discounted price of the drug readily available and transparent from the start.

- For patients, this means lower costs, particularly for brand-name drugs, as they will directly benefit from the discounts we secure.
- For businesses and other health plans, this means actionable, real-time visibility into their drug costs, improving their ability to support their population and forecast their budgets.

Cigna Healthcare will adopt this model for its fully insured clients beginning in 2027.

Specialty medications are driving the future of pharmaceutical innovation, accounting for nearly 75% of new drug approvals over the past five years. These medically transformative drugs, which are used to treat chronic, complex, and rare conditions, represent a growing and disproportionate share of U.S. drug spend. In 2024, specialty medications represented about 2% of all claims and accounted for nearly 20% of total health care spending in a commercially insured population of 9.7 million, according to an analysis by the Evernorth Research Institute. The concentration of spending in a few high-cost drug categories with limited price competition – such as oncology, rare disease, and multiple sclerosis – remains a major driver of costs for all payers.

Cigna Pathwell Specialty is aimed at reducing the cost of specialty drugs for employers and employees while ensuring patients receive clinically appropriate treatment from in-network providers and supporting patients with complex medical conditions who require specialty medications. With Pathwell Solutions we support more than 11 million people when they need us most.

Biosimilars have emerged as a key enabler to expand patient choice and lower specialty medication costs, delivering meaningful savings to employers, public programs, and patients. Biologics – which include biosimilars – are derived from living organisms and often require special handling, storage, and administration. Each biosimilar is highly similar to and has no clinically meaningful differences from the U.S. Food and Drug Administration (FDA)-approved biologic, known as the reference or originator product. The growing biosimilar pipeline offers a critical lever to expand treatment options, lower costs, and improve outcomes for patients and communities.

Enabling biosimilars and generics for high-cost products to enter the market as soon as FDA exclusivity and primary patents expire is essential to lowering prescription drug prices.

GLP-1s: Evernorth, the health services division of The Cigna Group announced a first-of-its-kind pharmacy benefit offering that makes weight loss medications WEGOVY® and ZEPBOUND® more available to patients. Through direct negotiations with the medications' manufacturers, Evernorth has ensured that patients' monthly cost will not exceed \$200. Evernorth has the most extensive suite of GLP-1 solutions available with this new addition, which also includes:

- EncircleRx, a financial model with more than 9 million enrolled lives that has saved health plans \$200 million dollars since 2024.
- EnReachRx, a high-touch patient support clinical model for dispensing GLP-1 prescription medications.

It is unclear at this time what the exact impact of the federal Inflation Reduction Act will be on commercial pharmacy trends. It does provide some opportunities for lower drug list prices in the commercial market depending on manufacturer choices and likely varies by year with different drugs impacted.

Additionally, we'd note that health plans are often up against legislation that limits the ability to manage trend and drive out waste. For example, we see proposals that limit formulary changes, step therapy, and prior authorization, all key tools used to improve patient safety and reign in unnecessary health care costs. And a multitude of every increasing coverage mandates and health plan assessments continue to compound premium costs that ultimately impact policy holders and Massachusetts residents.

6. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

Cigna is actively working to make healthcare more affordable through a variety of initiatives that target cost reduction, access improvement, and patient support. Some examples include:

Cigna Pathwell Bone & Joint® is a condition-specific care program designed to improve outcomes and reduce costs for individuals dealing with musculoskeletal (MSK) conditions—specifically those affecting the spine, hip, knee, and shoulder. The program uses predictive analytics to identify individuals at risk for surgery up to a year in advance, allowing for proactive outreach and support and members work one-on-one with licensed nurses or physical therapists (acting as Care

Advocates) who guide them through treatment options, help navigate benefits, and provide personalized support.

MD Live by Evernorth is dedicated to improving the health and well-being of those we serve through high-quality, physician-led, virtual care solutions. Our virtual care platform gives members more convenient access to appropriate and affordable care and ensures more seamless referrals to high-performing providers. The best-in-class virtual care offerings they provide nationally include virtual primary care, urgent care, behavioral health, and dermatology.

Evernorth Care Solutions delivers medical, clinical pharmacy programs, and care management services that connect and coordinate capabilities across Evernorth. Our innovative care models apply a data-driven and clinician-informed approach to predict emerging health needs, close gaps in care, and drive cost savings all while delivering simpler, more connected experiences that empower whole-person and whole-family health. Evernorth Care Solutions is comprised of nearly 4K employees, including nurses, advocates, coaches, case managers, and registered dietitians, serving millions of customers every day.

Evernorth Behavioral Health is one of the largest and fastest-growing behavioral health plans in the industry. Over the last four years, Evernorth Behavioral Health has doubled the size of its provider network to more than 490K providers, including a 48% increase in providers who specialize in cultural and ethnic issues since 2022. In addition, Evernorth Behavioral Health continues to push the industry to prove the value of behavioral health in total cost of care, publishing a first-of-its-kind study in JAMA Network Open that shows routine outpatient behavioral care saves up to \$2,565 after the first year of the diagnosis.

Gene Therapy: **Embarc Benefit Protection** brings together health services, medical management, and specialty pharmacy expertise to make breakthrough medicines more affordable and ensure access for those who need it. We built Embarc to be flexible and grow over time as the gene therapy market is expected to increase substantially in the coming years. This solution addresses the critical need facing everyone from payers to patients by delivering better care, affordability and access. As therapies emerge to target relatively common conditions, potential patient populations are expected to grow exponentially. Under Embarc, patients qualifying for an included gene therapy receive personalized, expert care and have no out-of-pocket costs beyond their normal deductibles. Plans pay a predictable, flat monthly fee to enroll and are eligible for annual reimbursements based on claims. Embarc currently protects nearly 7.5 million people and has provided \$197 million in value to enrolled plans and patients in less than five years. Patients with a wider range of conditions are now eligible for gene therapy support with Embarc. Therapies include Casgevy and Lyfgenia, both one-time treatments for patients with sickle cell disease, and Lenmeldy, which treats patients with metachromatic leukodystrophy. Kebilidi, which treats AADC Deficiency, was added in July 2025.

Robust Provider Networks: On average, over 99.6 of hospitals remain in our medical network year-over-year, ensuring a stable and reliable network of providers for our customers. We help individuals navigate to the highest-quality, cost-effective providers and appropriate sites of care and connect to digital health tools to quickly get ahead of a disease and eliminate gaps in care. This helps to ensure that customers are receiving quality, cost-effective care.

Additionally, **advanced analytics** and machine learning methods power our ability to identify providers who are providing quality, cost-effective care, and guide customers to that care via One Guide. We've developed specific clinical solutions to drive a better experience and improved health outcomes for individuals within five categories: Orthopedic, Oncology, Cardiac, OB-GYN, and Gastro. And Innovative holistic care solutions treat both the mind and body, lower the total cost of care for people, and meet customers' most pressing health care needs.

We also offer tailored, integrated benefits combining medical, pharmacy, and behavioral care to approach each individual as a whole person and drive better health outcomes. These include identifying medical and behavioral risks earlier through real-time data connectivity and predictive modeling; offering health coaching, case management specialists, pharmacists and expanded behavioral health; and designing accountable care model programs to close gaps in care and deliver affordable options. We put the patient at the center of everything we do to ensure predictive, personalized, and connected experiences.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2021 to 2024 according to the format and parameters provided as **HPC Payer Exhibit** (attached) with all applicable fields completed. Please explain the portion of actual observed allowed claims trends that are due to (a) changing demographics of your population; (b) benefit buy down; and/or (c) change in health status/risk scores of your population for each year. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

The trends captured in the columns denoted Change in Risk and Benefit Buydown are components of the total trend and would impact several of the other categories. Change in risk would have more impact to utilization trend and service mix, while benefit buydown would have more impact to unit cost trend, though neither trend category is entirely encapsulated in any one of the components of the total trend.

2. Reflecting on current medical expenditure trends your organization has been observing in 2025 to date, which trend or contributing factor is most concerning or challenging?

Key factors impacting trend in 2025 are: Elevated unit costs resulting from inflationary pressure on the health system and macroeconomic impacts on provider negotiations. Providers continue adopting new tools and leveraging AI to optimize medical coding and reimbursement.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

- Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available “price transparency tool.” In the table below, please provide available data regarding the number of individuals who sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2023-2025			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2023	Q1	3,585	3,026
	Q2	1,913	2,327
	Q3	1,862	2,444
	Q4	1,956	2,706
CY2024	Q1	3,389	3,321
	Q2	2,240	2,149
	Q3	1,888	2,349
	Q4	1,772	1,982
CY2025	Q1	3,040	2,205
	Q2	2,402	1,742
TOTAL:		24,194	24,251

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total	Change in Risk	Benefit Buydown
CY 2021	2.70%	23.60%	0.20%	-9.43%	15.20%	-0.10%	-0.90%
CY 2022	3.10%	-6.10%	0.50%	6.58%	3.70%	0.00%	-0.90%
CY 2023	2.90%	1.20%	-1.90%	5.82%	8.10%	0.40%	-1.20%
CY 2024	4.10%	4.30%	-1.25%	2.23%	9.61%	0.40%	-0.52%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.