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Signature Event

David Cordani

Speaker

David Cordani
Chairman and Chief Executive Officer
The Cigna Group

Interviewer

David M. Rubenstein
Chairman
The Economic Club of Washington, D.C.

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DAVID M. RUBENSTEIN: Our special guest today is Dave Cardani, who is the CEO and chairman of Cigna. And since he's been the CEO, the stock and the market capitalization are up roughly 800 percent, which isn't bad, right? [Applause.] So, can you do that the next couple years, another 800 percent?

DAVID CORDANI: I'll put it on my to-do list, David.

MR. RUBENSTEIN: OK, good. So, for those people that aren't familiar with Cigna, tell us what it actually does. And why – it's a big health insurer, but why isn't the name health – why isn't the word "health" in in the word Cigna, or title?

MR. CORDANI: So just a moment of background. The Cigna group is a result of two large companies a long time ago that came together, in 1982. One company was founded back in the late 1700s, the other company was founded in the 1860 timeframe. One company was INA, the other company was Connecticut General. Somebody scrambled up the letters and made the word "Cigna." So today we're the Cigna Group. And then we have, by way of health, Cigna Healthcare, which is our more integrated benefits provider. There's a U.S. operation for that and then there's a global, multinational operation. And then there's a health service portfolio that we have as well, with our Evernorth Health Service portfolio, within the overall Cigna group, David.

MR. RUBENSTEIN: And the company is headquartered, where?

MR. CORDANI: We're headquartered in Connecticut.

MR. RUBENSTEIN: OK. And you have been the CEO since?

MR. CORDANI: 2009.

MR. RUBENSTEIN: 2009. OK. That's a long time to be CEO. So you're not tired of it? You like it?

MR. CORDANI: I've been very fortunate.

MR. RUBENSTEIN: OK, good.

MR. CORDANI: I've been with the company a little over 30 years as well.

MR. RUBENSTEIN: So today, in the United States, are you the second-largest health insurer?

MR. CORDANI: Depends on how you measure it, but by and large second or third, based on most measures. We have a global reach to consider. U.S. is by far our biggest business. And we serve about 180 million customer relationships around the world.

MR. RUBENSTEIN: And your revenue annually is roughly, what?

MR. CORDANI: About $250 billion.

MR. RUBENSTEIN: And your market cap is?

MR. CORDANI: About $90 billion.

MR. RUBENSTEIN: Ninety billion, OK. So today, some people would say health insurers are not that popular. And obviously we saw the tragic situation with an officer at the United Health. Why is it that health insurers, who insure everybody here and many people in the country for their health insurance and their medical needs, why are they not that popular?

MR. CORDANI: So, it depends, David, how you – I think there's a lot in there. First, you mentioned United Healthcare. So, Brian Thompson is the individual. He was killed or assassinated on December 4, just a pause moment that transpired. And no matter what one's point of view is around any service or any industry, that's an unacceptable event. It's just fundamentally an unacceptable event. You carry forward and you think about the broader U.S., health care marketplace, individuals' access to health care through a variety of services – Medicare, Medicaid, the public marketplace, or through employer-sponsored coverage.

In employer-sponsored coverage, which is a lot of what we do, there's a lot of highly satisfied individuals. But there are some who are not. And so coming back to your question, what we need to do, both as a company, first and foremost, and as an industry, is to make sure that we are listening as intensely as possible to the needs of individuals. And if there's delay in accessing care, or an inability to access care, or financial responsibility that someone has that is a surprise, we need to innovate new products, programs, and services to help with that. So I can look at the averages and say our averages are quite high. But if it's one person, if it's 10 people, if it's a hundred people, there's too much dislocation. So, we lean in with new innovations, that we could talk about, to help people –

MR. RUBENSTEIN: All right, so on average, though, people who don't get their costs reimbursed, what percentage of the claim is not reimbursed typically? Is it 5 percent is not reimbursed? In other words, what percentage of people get denials? And is that a large percentage of what you do?

MR. CORDANI: You're using the frame "claim." So, if we think about volumes for a moment, context, answer directly for us, it's about 5 percent. So 95 percent do. Five percent don't. And back to – you could look at 95 on most exams you took. roughout your life and say that's good. For the 5 percent who do not, it is not a positive outcome. Contextually, for, say, an example, Medicaid, about 25 percent of all Medicaid claims get returned for more information. In the employer or the commercial marketplace, it's about 5 percent. And in most cases, it's either incomplete information from the medical professional that we need to work with, or a noncovered service.

MR. RUBENSTEIN: So, people – let's say – let's suppose I get a medical procedure and the bill is whatever it is, and then they send it to my company, I guess, and then it goes to the insurer. And I have to picture some person sitting in an office somewhere in the Midwest, or maybe not even in the United States, sitting there looking at the claim and saying, well, maybe denied,

maybe not, I don't know. And then they – who makes these decisions of whether it's denied or not denied or not fully reimbursed? Who is that person?

MR. CORDANI: So, we're talking about two different topics here – access to care. Does somebody get access to the care? And then payment for the care. In majority of cases, once the determination is made that the access is appropriate, that back at 95 percent, the claim is going to be paid. The claim will, in the vast majority of cases, be paid. So that's why the authorization for those services that need to be authorized are most important.

Your question of who makes the decision on access to care, it's a medical professional. It's a medical professional that will look at the information. On the claim payment, it's based on the coverage for the employer or for the governmental organization, and then the relationship with the hospital, or the doctor, or the other organization.

MR. RUBENSTEIN: OK. So, the image I have, which maybe is wrong, is that some nice person sitting somewhere in an office with no windows is sitting there. They're getting all these claims coming in. And they say denied, not denied. And they have a formula, I guess, but how does it really work?

MR. CORDANI: So now we're up to claim payment. If you think about, the vast majority of claims are what's called auto adjudicated – systemically adjudicated, as we would expect. So, a great percentage of claims come in. They're electronically transferred, which is preferred. When they're electronically transferred, the data sets are complete. For most of your businesses you can think about that. And then the claim is electronically completed and electronically settled. That's the preferred path.

When they come in manually or with incomplete information, that's when some of the individuals in offices, with windows and with colleagues around them, and with tool sets and assistance, are actually going through and trying to determine it. What we want to have is the vast majority of them be auto adjudicated or systemically, because it's easier, it's quicker, it's simpler. And it's more efficient for everybody – the individual, the medical professional or delivery organization as well.

MR. RUBENSTEIN: Let's suppose a claim is denied. Let's suppose I need an MRI and for whatever reason it costs $5,000 or something like that. And for some reason they say we're only going to reimburse for $4,000. So it's denied. I get $4,000 reimbursed, not $1,000 that I have to pay for that. But if I want to appeal my $1,000 denial, how do you do that? And what percentage of appeals actually work?

MR. CORDANI: So, based on that part, is you as an individual, more likely than not, most of it was paid for by your employer. But if you want to appeal something, you would, in old school, look at the back of your ID card, in a modern way you look at your digital ID card. There's a number there. And you could place a phone call to facilitate that appeal. If you think that your doctor has – or your medical professional has some information, you could ask your doctor or your medical professional do so. But most people will just look at the number or go online and submit more information for an appeal.

MR. RUBENSTEIN: Right. But is there a benefit to appealing? Because what percentage of people appealing get some relief?

MR. CORDANI: So, you're dealing with a small percentage of the total, for starters. We talked about the 95 percent. So, you're down to single-digit percentages. A portion of those will get overturned, typically with more information. More information causes that to be overturned.

And in the employer marketplace, so for commercial employers, it's a lower percentage – single digit, David – low single digit. In some of the government plans, like Medicaid, it's a higher percentage because of incomplete – largely – the largest impediment to this is incomplete information. So what do we do about it? We try to work with advanced tools to allow, when the information comes in to us, to be more complete, electronic and digitally, because it's more efficient, it's complete, and it allows us to be timely.

MR. RUBENSTEIN: Now, have you ever had a claim denied?

MR. CORDANI: I've had a procedure denied.

MR. RUBENSTEIN: Procedure denied.

MR. CORDANI: Yeah.

MR. RUBENSTEIN: You didn't have the procedure? They wouldn't reimburse?

MR. CORDANI: I needed an MRI. I had herniated discs in my back. I needed an MRI, and it was denied.

MR. RUBENSTEIN: So, you put in the request and they said, you can't have it.

MR. CORDANI: Yeah.

MR. RUBENSTEIN: Did that person get fired who –

MR. CORDANI: No. [Laughter.] No. No. No, David. Remember, they had windows too. They were looking out the window. It turned out, in this case – and, you know, I was a frustrated consumer in that moment, as I was a human being. I had three bulged, herniated discs, and a lot of pain and discomfort. I needed the MRI for the conclusion. Incomplete information that went from my doctor to, in this case, Cigna Healthcare. I was able to understand that. The doctor provided the more complete information. It was, fortunately, approved. And I went and got my procedure done in a freestanding facility –

MR. RUBENSTEIN: OK. You didn't say, I want to go to United Healthcare, or something?

MR. CORDANI: No. And there's nothing wrong with United. But we're happily served by Cigna Healthcare.

MR. RUBENSTEIN: Right. So, when you do underwriting for, let's say – let's say Carlyle has health insurance. And I think we have – do we use Cigna? We do.

MR. CORDANI: You do, yes.

MR. RUBENSTEIN: Right. OK. So, we use Cigna. I didn't really know that till this morning. He actually told me. I didn't know. But OK. Let's suppose we – when you pick – we pay a certain fee, I guess, to you, or charge, for providing this service. You try to make what kind of profit margin on that? Are you making 25 percent profit margin on Carlyle, or whoever you're insuring? What kind of profit margin do you want to do what you want to do?

MR. CORDANI: So, a couple – a contextual answer. For the Cigna Group in total we make 4 percent, about $250 billion of revenue, about $10 billion of before-tax income. That's essentially our business model, is about a 4 percent margin. To the specific question you asked, in the health care space if we take the risk for your service we're capped at what our margin could be. Post the Affordable Care Act, there's a medical loss ratio. For a larger group, which is what you are, it's 85 percent. So 85 percent of all of the money has to be spent on health care and health services. The residual is 15 percent to pay for all the administrative operations on the margin, which brings you back down to about 5 percent.

MR. RUBENSTEIN: Let's suppose I'm starting a new – I'm starting a company, and – or, I'm buying a new company. And it's got employees and so forth. And I want to pick a health insurer. What's the argument you make why you should be picked over, let's say, United Healthcare, or somebody else?

MR. CORDANI: Well, I'll pick why us. I won't say why not somebody else, right, out of respect for my competitors. But the why us –

MR. RUBENSTEIN: I don't mind if you want to say something bad about them. That's OK. [Laughter.]

MR. CORDANI: This is about to get fun. So our organization, when we work with an employer our objective is, how do we work with an employer to understand their culture, their strategy, the health burden of their employees, the use of incentives or use of disincentives, and how they want to communicate and put a series of programs in place? Because what we're trying to do, David, is help you, as an employer, have healthy, productive, highly engaged coworkers, because then your business could thrive. And we want to do it in an affordable way. So, we are a solution provider. I'm not an insurer. We're a business partner.

And in the vast majority of cases, 85 percent of all of our relationships are what's called self-funded, which means fully transparent. We work transparently with the spending all year long to try to get the best possible clinical quality and service and affordability. So, if you want a solution provider, oftentimes we're at the top. If you want a product off the shelf that's commoditized, we're probably not your number-one pick, because we're more consultative in terms of putting a solution suite forward.

MR. RUBENSTEIN: You should get people to pick alphabetically. You'd be at the top. OK. So let's suppose most insurance companies –

MR. CORDANI: I'm going to take that strategy under advisement.

MR. RUBENSTEIN: Most insurance companies, they make money two ways. With underwriting – and you're underwriting to get a 4 percent profit margin, more or less. But they make money investing the money, the premiums that come in. Is that a big profit source for you?

MR. CORDANI: So, you're correct. Most insurance companies have both levers. When you think about health insurance versus property and casualty or life, the investment returns are a much smaller contribution because most of your premiums, what you take in, and your claims, what you pay out, settle in a very short period of time. So your investments have to be short-term in nature. So, the spread that you're going to make, on an aggressively managed investment portfolio versus not, is going to be measured in basis points. Now, on the scale of our business, it's meaningful. But that is all included in my 4 percent that I made reference to.

MR. RUBENSTEIN: I see. So, you're not investing in private equity.

MR. CORDANI: No, sir.

MR. RUBENSTEIN: Have you ever thought about that? It might be good thing to get higher rates of return?

MR. CORDANI: I'll leave that to the experts.

MR. RUBENSTEIN: OK. All right. So, OK. So, let's talk about your own background. How did you get into this business? Did you grow up and say, I want to be a health insurer professional, or something like that?

MR. CORDANI: Oh, no. So –

MR. RUBENSTEIN: You grew up, where?

MR. CORDANI: Grew up Waterbury, Connecticut, which is a manufacturing town. It was a brass and copper manufacturing town. And I'm one of three boys, middle boy. And we were all convinced that we were either going to work in the factories that all of our cousins worked in or, when my father left the factory to become a police officer, to be a police officer. So answer, no. My parents insist that we, all three of us, go to college. Much to our chagrin, because we anticipated we would do one or the other. And I went to college at Texas A&M. And I got a double major in accounting and finance.

MR. RUBENSTEIN: Texas A&M is a great school. I know you have to stand up at the football games and things like that.

MR. CORDANI: They're healthy for you.

MR. RUBENSTEIN: Right. But usually you don't get that many people at Texas A&M who grew up in Connecticut. Maybe I'm wrong. But how did you go to Texas A&M when you were growing up in Connecticut?

MR. CORDANI: Yeah. So little inside baseball there. Mentioned I grew up in Waterbury. My father decided we were going to move to Houston during my high school years. So, he left the police force and he took a risk and went into business with his cousin down in Houston, who was living in Houston at the time. My dad put a three-year window on it. And so I did sophomore through senior of high school in Houston, and then we moved back to Connecticut because my dad wanted to come back home where all his cousins were, and aunts and uncles, et cetera. So, I graduated from a Texas high school. I qualified for in-state tuition in Texas and in-state tuition in Connecticut. I applied back then to two schools – things are a little different nowadays – UConn and Texas A&M, because in-state tuition was all I could afford. And much to my parents' chagrin, and I chose A&M, because of the history of the school.

MR. RUBENSTEIN: OK. So, your father wanted to move backward where your relatives were. I wanted to move away from my relatives. He wanted to move towards them. OK. Different family, I guess. OK. So, all right. So, you go to Texas A&M. And were you a football player or something, an athlete there? No, you weren't?

MR. CORDANI: With this physique?

MR. RUBENSTEIN: Were you a track runner or a track star?

MR. CORDANI: No. I ran, but in running clubs. I played basketball, but intramural and in basketball clubs. It's when I actually became very active in sports, though.

MR. RUBENSTEIN: All right. So, when you graduated, where did you go?

MR. CORDANI: I went back to Connecticut.

MR. RUBENSTEIN: And you went to Cigna?

MR. CORDANI: I went to Coopers & Lybrand first, which is legacy part of PricewaterhouseCoopers. And my client portfolio, which I loved, I was very fortunate, was largely financial services and health care.

MR. RUBENSTEIN: OK. So eventually you got hired by one of your clients, in effect, or?

MR. CORDANI: Actually, Cigna was not a client of –

MR. RUBENSTEIN: So how did you get to Cigna?

MR. CORDANI: They were launching a leadership development program for CPAs. And ultimately, CPAs and MBAs. And I was one of the first two outside hires into that program in 1991.

MR. RUBENSTEIN: Well, you like Cs – Connecticut, Coopers & Lybrand, Cigna. You ever notice that Cs are –

MR. CORDANI: Cordani.

MR. RUBENSTEIN: Right? Cordani, right? Is that a little secret of Cs –

MR. CORDANI: I've never made the connection before. [Laughter.] I appreciate it.

MR. RUBENSTEIN: So, you get there and you work your way to the top. What did you do that enabled you to go from the very bottom to the very top? You must be good at – were you selling insurance to people? Were you assessing their health care risk? What were you doing that made you get to the top?

MR. CORDANI: So, I think in any career it's a combination of a variety of things, but luck's always a part of it. So, I feel very fortunate, number one. Two, the leadership development program made me reference to – well, part . what brought me to Cigna was they had a big health care business. It had a history of being a highly ethical, well-governed company, and had a leadership program. Which meant it moved people around the company to different experiences.

So, I worked in financial roles. I worked in actuarial roles, as not an actuary. I worked in human resources for two years, running leadership development programs. I worked in our investment division back when it was much larger, when we had property and casualty and retirement services, supporting large, complex deal structures. I worked in field assignments. I worked in technology assignments. I worked in operational assignments. So, diversity is message one. I had very diverse experiences that the company enabled.

And in hindsight, I took a fair number of risks. I took positions that folks advised me not to take because people were not successful in those roles. They were high-risk roles. And in hindsight, those were some of the more formative roles and more complex roles.

MR. RUBENSTEIN: So, when does somebody like you get to realize you're on a track to be the CEO? Do they tell you two, or three, or four, or five years in advance?

MR. CORDANI: I'm not sure if they formally tell you. So, I became CEO in 2009. I became COO and president, I think, in 2008, early '08. And I was the president of the health care business prior to that, which was the largest business. So as that window unfolded, when I was given the opportunity to run the health care business, that indicated that there was a possibility. That's when the possibility started to become a reality. Before that –

MR. RUBENSTEIN: Right. So, you became the CEO on January 1 of 2010, more or less, something like that?

MR. CORDANI: It was announced mid-'09, but fair enough. On the back of the financial meltdown.

MR. RUBENSTEIN: Right. But you weren't the chairman. Now you're the chairman. Why did they take, like, 14 years to make you the chairman as well? I mean, you were doing a great job. They should have made you chairman sooner. Why did they not do that?

MR. CORDANI: I'm a slow learner. No, so when I became CEO the board decided to split the role between chair and CEO. And we had a great –

MR. RUBENSTEIN: You didn't take that personally?

MR. CORDANI: No. Actually, the board talked about the importance of that. And Ike Harris was our long-serving independent chairman at the board. When Ike retired about three years ago, I lose track of time, I was given the opportunity. For those 12 years it was a great partnership. And to me, it's all about a team sport. So, the team worked really well in that configuration. And when he retired, it was an opportunity for a new configuration.

MR. RUBENSTEIN: Now, with my powers of observation I have observed you're in very good shape. A lot better shape than me. So, do you work out, like I do, five minutes a day, or something like that? [Laughter.] Or how much workout time do you do?

MR. CORDANI: I commit to an hour a day, at a minimum.

MR. RUBENSTEIN: An hour?

MR. CORDANI: An hour a day.

MR. RUBENSTEIN: When you do that? Do you have time, an hour a day, and you're the CEO of this big company?

MR. CORDANI: Every morning. So regardless where I am or what I'm doing, I convince myself that setting the alarm to give me an hour to work out is better.

MR. RUBENSTEIN: Do you have an instructor that helps you or something?

MR. CORDANI: No.

MR. RUBENSTEIN: You just – and you just go to your gym equipment in your house and do it?

MR. CORDANI: So either in my house, in the basement. There's enough of equipment to be able to do so. Or, like many of you, I'm on the road a lot. So, you take advantage of a hotel gym.

And once in a blue moon I've been known to turn hotel stairs into a Stairmaster when the gym is either too small or doesn't function, because – if the weather's not nice outside. But I found that exercising every day, for me, is not only helpful from a physical standpoint, it's helpful from this standpoint. Clears the mind, manages stress.

MR. RUBENSTEIN: So, when I work out as soon as I feel I'm sweating, I stop. [Laughter.] Is that your technique too?

MR. CORDANI: That's an alternative strategy. I go the other way.

MR. RUBENSTEIN: The other way, OK.

MR. CORDANI: But that's an alternative strategy.

MR. RUBENSTEIN: You do that for an hour in the morning, all right. But you actually are a triathlete, is that right? You do triathlons.

MR. CORDANI: I did triathlons for about 30 years.

MR. RUBENSTEIN: Thirty years. And remind people, who – many people here are probably not triathletes. I don't know, maybe some people are. But to do that, you have to – what do you do? You first you –

MR. CORDANI: It's swim, bike, run. It's always done in that order of danger.

MR. RUBENSTEIN: You swim how much, 100 yards?

MR. CORDANI: No. There's classes of triathlons. Many people think about the Iron Man as the symbol. The most common class in an Olympic distance triathlon, measured in kilometers. We'll round it to miles for all of us. It's about a mile swim, 25 mile bike, and it's a 10K or 6.2 mile run. So that's the most common distance. There's half that distance called the sprint. There's the full Iron Man. That's 2.4 mile swim, 112 mile bike, and a full marathon. And then there's a half Iron Man, which we could do the math and cut that in half, that are now called Iron Mans. So, there's four classes.

MR. RUBENSTEIN: Is there, like, a one-hundredth Iron Man? Like, one-hundredth of an Iron Man? What is that one? I would do that. [Laughter.] But all right. So, to do a triathlon, how many triathlons have you done?

MR. CORDANI: I stopped counting after 125.

MR. RUBENSTEIN: And you're not worried you might have a heart attack while you're doing one of them?

MR. CORDANI: I worry more about the joints. You kind of wear the body. So, the cross-training is really important. So back to my herniated discs. I raced for 30 years. I went back

and did the first race that I did in 1991, 30 years later. That was my kind of anniversary going back to. And as irony would have it, it was four months later that my back blew up. So, I stopped running, cold turkey. Had more heavy cross training. I was able to avoid surgery. A lot of the cross-training and physical activity. And now I'm just starting to run again. So, I haven't raced competitively for three years, as part of that recovery, but I've exercised throughout that –

MR. RUBENSTEIN: Well, in any of these triathlons, did you actually win any of them, or?

MR. CORDANI: So, if you think about it, Connecticut-based races? Yes. Regional races? Some. Placed in my age group regularly. Qualified for nationals as an amateur. I qualified for the Hawaiian Iron Man a long time ago. Was able to complete that. And I qualified for the European Iron Man a long time ago.

MR. RUBENSTEIN: Well, like, a Fortune 100 CEO triathlon, you'd win that one, right?

MR. CORDANI: Maybe Fortune 100, maybe. Maybe. Yeah.

MR. RUBENSTEIN: I think you probably would. But OK.

MR. CORDANI: I'm not sure where this is going, because I don't get – [laughter] – I don't get a lot of revenue or market cap off that, David.

MR. RUBENSTEIN: All right. So, if you're in the health insurance business, do you want people to be healthy, or you don't really care? Because you've got a – you're insuring a lot of people. Some will be healthy, some are not healthy. Does it really make a difference to you, as a health insurance insurer, if people you're insuring are healthier?

MR. CORDANI: So, again, you used the word "insurer." The breadth of our services are more health services. And I'm going to answer your question, but at its core we're guided by our mission. Our mission is to improve the health and vitality of those we serve. We truly believe it. We've put a lot of discretionary energy toward that. We believe that, as an employer, the Carlyle Group is more vibrant if you have healthy, highly engaged coworkers. As a community, the city of D.C. is more vibrant and competitive if it has a healthy community. If we have healthy employers and healthy communities, we have a healthy, vibrant society. So, we believe in that.

So, we can't tell people to be healthier. We have to support them. Which is why we like working through employer-sponsored programs, because you could build that into the – off the employer's culture. So, it fits into that. We don't make more money if there's less medical costs consumed, by and large. In a year, it could be a percent one way or the other. And on our revenue base, that's a lot. But the vast majority of our businesses are services-based, where employers pay us services or fees or performance outcomes.

MR. RUBENSTEIN: OK. So, to be healthy and to live a long life, healthy life, presumably an objective of everybody, what is the best thing to do? Is to have great genes and just not take any risk and not do skydiving or something? What's the best way to live a long and healthy life?

MR. CORDANI: So, I'll go back to what some of the data tells us. The data tells us that in the United States – we'll stick with this country for a moment – if we measure it through traditional health measures, not full-on vitality but through traditional health measures, about 80 percent of all health care costs tie to lifestyles and behaviors. And there's four that drive about 80 percent of the costs. Smoking. That's binary, yes or no. Alcohol consumption, yes, no. People get anxious. If yes, in moderation, yes, no. The science typically says, and it's being revisited again, one drink per day for a woman, one to two for a man. And, no, you can't save it all up for the weekend because that screws up the body's chemistry.

So smoking, drinking. Physical activity. Are you physically active or not? Cardiovascular fitness is important. It means 30 minutes or more of brisk exercise four to five days a week. That's an accelerated walk. And then food intake. Is it healthy and moderate or not? It doesn't mean be on a diet. Just means is it healthy and moderate, or not. Those four are foundational for health. Then you add the vitality dimensions around sense of community, sense of purpose, sense of belonging, spiritual health that correlate to longevity. Without the physical health, longevity is not possible. Without the other dimensions and just physical health, longevity is usually impeded as well. That's why we measure that through vitality.

MR. RUBENSTEIN: OK. So, let's suppose you don't drink alcohol. And let's suppose you don't – you never smoked. So, you have a reasonable chance then. But then when eating, is it your view that red meat is good, to consume a lot of red meat?

MR. CORDANI: I'm not the doctor or the nutritionist. My basic view, personally, everything in moderation.

MR. RUBENSTEIN: OK.

MR. CORDANI: So, in our house there's every kind of chip, we'll see every kind of sweet, snack, and otherwise. Sometimes you have red meat. That's more of a treat. Oftentimes you'll eat chicken or fish. And then you moderate. When you're on vacation you're probably going to indulge a little bit more than not. But the extremes tend to throw bodies off a little bit, as opposed to otherwise.

MR. RUBENSTEIN: I see. OK. Suppose you engage in activities like skydiving. Would you recommend that?

MR. CORDANI: I'm afraid of heights, so I'm going to leave that to somebody else.

MR. RUBENSTEIN: OK. All right. So, on the whole, Americans are getting to be, it seems, less healthy rather than more healthy. Is that fair? Seventy percent of Americans are overweight or obese – 70 percent. So, what accounts for that?

MR. CORDANI: I mean, come back to lifestyles, right? Lack of physical activity and food intake, is at its core. And you're correct. We have about 70 percent – a tad more now – that are overweight or obese. Forty percent of all cancers have a high correlation to obesity. So, coronary disease has a high correlation to obesity. Musculoskeletal strain has a high correlation

too. And in the United States one thing that we should be actually quite proud of, but there's a challenge in, we actually operate the most sophisticated, I would suggest, sick care intervention system in the world. Our system is built to fix you when you're broken. And we typically fix you with advanced surgery, a medical device implant, or, increasingly, a medication.

If you think about where we spend money and our time, we spend less of that on the front-end trying to keep us healthy in the first place. And that's kind of how our system is designed. It's not anybody's fault. We've designed it that way. And we've evolved into a society that is less physically active and consumes food through a more convenient intake. That combination, we're seeing it just – it layers on. It was 40 percent, then 50 percent, then 60 percent. We can look at countries around the globe. We're a global servicer. I could look at 12-year-old in a rural, urban, and suburban configuration.

Take China as an example. You would think the 12-year-old in Beijing would be healthier than the 12-year-old in a rural location. Actually, not the case. The 12-year-old in Beijing has an average eroding health status because there's a more Westernized diet and a more sedentary lifestyle. So back too, the good news is a lot of this is within our influence and control, both as individuals, as organizations, and as society. The challenge is that our momentum is around fixing after things are broken.

You know, what we try to do as a company is to get the best of both, because our health care delivery system, in a lot of ways, is the envy of the world. People from all over the world come here for sophisticated health care. But we need to add to that, as an "and" not an "or," we need to add to it how are we helping to improve health in the first place, or maintain health on a more aggressive basis in the first place?

MR. RUBENSTEIN: OK, so the best things to do – leaving genes aside. You might have inherited not-great genes. But if you don't smoke, you don't drink excessively or very much, just eat well and exercise, basically. What about taking a statin? You think that's a good idea?

MR. CORDANI: For those who actually have the need, it's actually a great idea, when you look at the clinical outcomes. Some could go on to statins to arrest the problem and then modify the need with lifestyle and behavior, and either taper down off the statins or remove the statins. But that's an example where it's a – it's a wonderfully powerful intervention that has worked for many people over time.

MR. RUBENSTEIN: Right. OK. So today, what about my program? I buy a lot of gym equipment and, by osmosis, I hope by walking past it, it might help me. Does that work a lot or not so much?

MR. CORDANI: No. And you're not alone, because, again, we as a society – and especially you all, may have observed this once or twice, or you may know somebody – you know, around the end of the calendar year there's a lot of gym memberships that are purchased, and there's a lot of the equipment that David made reference to. Because the new year's resolutions happen, and by about the end of the month of January they're not being used very much. But what we do

see is we see that when there's kind of more commonality built, for example, with groups – take a group, you and I chatted about a little bit.

Achilles International is an organization that I'm quite passionate about in our company, is they help individuals with disabilities, both veterans and non-veterans, come together, largely around physical activity, and pursue goals like races and otherwise. The sense of community causes a level of engagement and commitment to one another. So, on the day that you don't feel like waking up and going out and going on your walk or your run or your cross training, you do it with somebody else. So that's a really powerful dimension. But just buying the equipment without the motivation and the reinforcement obviously is not helpful.

MR. RUBENSTEIN: It doesn't work so well, unfortunately. OK. What about this? COVID – when COVID came, how did that affect your business? Did people get lot sicker more rapidly? And people unfortunately died. Or did it change your business in any way?

MR. CORDANI: I mean, COVID seems like a long time ago for a lot of us. But COVID changed everything for a short period of time. For our business, a couple things. One, what we felt as though we needed to do – and I'm speaking to the Cigna Group specifically – we felt as though it was very important, guided by our mission, to make a public commitment to all of our clients and customers that we were going to pay for all their COVID services, regardless of their coverage or otherwise, because of the intense uncertainty. Because back in that moment nobody knew how long that dark tunnel was or where it ended. So, it caused us to kind of reorient ourselves.

Secondly, if we remember the first year of COVID, we had this polarization of health care consumption. We saw on TV every day hospitals overwhelmed with the respiratory challenges. On the other side, you had doctors' offices that no one was going to. You had dentist offices that no one was going to. So, for us as an organization, we had handshake agreements with employers that 80 cents, 90 cents on the dollar was going to be paying for health care. But only 50 cents on the dollar was. Should we profit from that? No. So, we actually came up with sophisticated ways to return that to physicians, employers, and individuals. So, it changed – it changed the business a lot for a short period of time.

MR. RUBENSTEIN: So how did the Affordable Care Act help you or hurt you?

MR. CORDANI: Hard pivot. So, Affordable Care Act, we go back about 15 years ago. A lot of hard pivots up here. I don't know if you noticed. It does make it enjoyable. So ACA. The ACA for the country, it expanded health care coverage, full stop. It did it in two ways, primarily. One, it expanded Medicaid. Two, it expanded the employer market, which most people don't recall, by extending coverage to children up to age 26. We looked at the individual marketplace, the so-called exchanges. There was an individual market of about 15-17 million lives that went away. There's an individual exchange marketplace about 15-17 million lives. So point one, the ACA expanded access to care through Medicaid and the employer-sponsored system.

Two, the ACA put in place a floor for all insurers, using your word, to essentially say, if you're covering a small employer you have to pay out at least 80 percent of the premiums for

medical. If it's a larger employer, at least 85 percent of the premiums. So those standards were put in place. And that was good. It didn't go forward enough into some of what we chatted about before, around the health improvement or the incentive alignment. So, it expanded access to care, and it provided a step of transparency around profitability or how the money is spent.

MR. RUBENSTEIN: So, what country in the world do you think has the best health care treatment for its citizens? In other words, let's suppose you wanted to just pick the best country for health care treatment and so forth. Where would you live?

MR. CORDANI: I would choose to live where I live today, in the United States, all in. But to answer maybe a couple specifics in your question, we're a global company. We take care of expats all over the world. We take care of IGOs, intergovernmental organization employees all over the world, and NGO employees broadly all over the world. And then we're in-country in about another dozen countries, quite deep, taking care of folks. So, I use that just for a moment as having a vantage point.

So, when I became COO, I had the ability to visit a lot of countries across the globe, in looking for your answer. I call out two bright spots, and the symbol of the bright spots. Singapore and Denmark. So two different countries. Both less than 10 million individuals. Two points of commonality I'll highlight, just to try to be succinct. Data interoperability, transparency, and consumer engagement of data. I remember the first time I was in Singapore 20 years ago sitting in the back seat of a taxicab, asking the taxicab driver around health care. He showed me on his phone at that point in time his medical information and how he bought pharmaceuticals with full consumer transparency. Denmark invested in full interoperability of their data.

Those are two outlier countries. There are no countries of the scale of what we are. Back to sick care intervention, we have the most sophisticated sick care intervention in the world. Which is why people who are in their – when they're in their most challenged medical state, if they have any ability to come to the United States, will frequently seek to come to the United States for that care.

MR. RUBENSTEIN: So, you obviously know a lot about health care, and medication, and so forth. If the president of the United States said, I'd like you to be secretary of HHS someday – not that we don't have a very knowledgeable person already. But if we wanted somebody – when this person might retire or something – would you ever be interested in that job, or something else in the federal government?

MR. CORDANI: I'm fully focused on my work at this –

MR. RUBENSTEIN: Not interested? OK. All right. So today if you could change the health care system we have in the United States, president said to you how can you improve it, and you could change it, what would you do?

MR. CORDANI: If you only had one – so I try to – try to ask myself this question all the time. Because we care deeply about improving the health care system not just for us, for the next

generation, right? We have to make things better for the next generation, not worse. I believe if we only had one thing you could do, changing the incentive structure in our health care system to pay based on outcomes versus consumption is more likely the single-most powerful tool we have. And if you think about it, we're a $4.5 trillion ecosystem, the U.S. health care system. The vast majority of the $4.5 trillion pays based on consumption of a service. It doesn't pay based on outcome.

And if you think about your personal lives, in most cases large, important things that you consume for people you care about, you're going to pay, or attempt to pay, based upon the quality, not just the consumption. And if you consume something and it doesn't have the desired effect you're probably going to go back and ask for it to be fixed without paying for it again. So, if I only had one tool, it would be – it would be that.

MR. RUBENSTEIN: OK. All right. So, one time I thought I had a headache. And I had a headache for a day or so. I thought I was getting a glioblastoma, and so I said, I need an MRI on my brain. And they approved it. Is that common, where people get MRIs on their brain if they have a headache or something, and you approve those? I'm happy you did, but?

MR. CORDANI: It's less common. We put that into a category, David, of the worried well. So, there's another dimension of what exists with our electronics. And I left my electronic outside the room. But with our electronics, we can self-diagnose pretty quickly. And as you might have found in other aspects of our lives, if we want to find validation of what we think, we can find validation of what we think pretty quickly online. So, in a lot of cases, David, our medical professionals are overwhelmed with folks like you or me coming in and telling a doctor what we have and what intervention we need. And that's challenging.

That's really challenging. And we amplify that even as a society in – and I'm going to use this as an illustration. We lead the world, and we're the only developed country in the world, that allows direct-to-consumer advertising of pharmaceuticals. I'm going to repeat that. We're the only developed country in the world that allows it. Technically, there's one other. It's New Zealand. But New Zealand allows it only for PSA purposes. So back to, in doing so what you do is you now have an individual that goes into the doctor's office and asks for a specific prescription, and a specific brand of a drug, putting the doctor and the patient in a little bit of an awkward situation at times as well.

MR. RUBENSTEIN: All right. Now, speaking of pharmaceuticals, you have a business which buys pharmaceuticals. Then you have a business which, I guess, negotiates – sells pharmaceuticals. So President Trump and his people have said that's a conflict, those things, to some extent. In other words, you have a company, or part of your company, negotiates prices with large drug companies to buy pharmaceuticals. And another part actually sells the pharmaceuticals. Is that a problem in that conflict? Or is that – is something going to happen there?

MR. CORDANI: So, a bunch of questions within there. First, by the way of context, we're one of the largest pharmacy benefit services companies in the United States, full stop. And we're quite passionate about that, because the vast majority of all health care innovation for the future

is going to be pharmacological in some way, shape, or form. We're a large leader in the specialty pharmaceuticals. So, what we historically would have known as an infusible, what you will now know as gene therapies and otherwise. And in many cases, our nurses are invited into people's homes to deliver those services. So two different dimensions – base pharmacy and then specialty pharmacy.

Back to – David, to your question. Within our pharmacy services business, we operate a mail-order pharmacy. So, for people who are on maintenance medication, mailing to their home a 90-day supply of a prescription. That's about 4 percent of all the prescriptions that are consumed by those we serve. It's a choice based on convenience and affordability. By the way, the clinical outcomes are better because people are more likely to use their medications if it's present all the time, and you're less apt to have a break in the medication if it's delivered. But if our mail-order pharmacy was structurally removed from us, our business would not change dramatically.

I think, lastly, legislatively removing choice is not a good thing. Making sure there's transparency, but more choice is better. Transparency is better. But that 4 percent of the pharmaceutical volumes wouldn't change our business.

MR. RUBENSTEIN: OK. What about vaccines? Some people are not big fans of vaccines. Do you think vaccines are generally things people should take? And you go to drugstore these days, they have signs saying, take your flu vaccine and your other vaccines. And is that a good thing to do?

MR. CORDANI: So, that's where it'd be better if one of the medical leaders in our organization was answering. But broadly speaking, where the medical science says yes, yes. So, I got a flu vaccine this year. I believe, it's right to get the flu vaccine. And the data would show that if you get a flu vaccine you're better off, and society is better off. I'm not going to wade into –

MR. RUBENSTEIN: All right. What about – my doctor always gives me other vaccines he wants me to take. I'll never take them all. But shingles, is that a good vaccine to take?

MR. CORDANI: Shingles is becoming a more commonly used vaccine for people over the age of 50. I'm not going to guess your age, but if you doctor made the recommendation –

MR. RUBENSTEIN: It's barely over 50, yes. But, yes.

MR. CORDANI: Yeah.

MR. RUBENSTEIN: So, what about – is it RVS [sic; RSV]?

MR. CORDANI: RVS [sic; RSV].

MR. RUBENSTEIN: RVS [sic; RSV], what about that?

MR. CORDANI: I don't have a point of view on that.

MR. RUBENSTEIN: Hepatitis vaccine?

MR. CORDANI: For some. That's a risk-based vaccine. There's a pretty spirited debate on that. It's based on one risk profile whether or not the hepatitis vaccine should be given versus not. So back to – I think this comes back to a little bit of that patient-physician relationship, right? The patient-physician relationship in the United States, we have a shortage of primary care physicians, OB-GYNs, pediatricians, and geriatricians. That consultative relationship – because what's right for you – if I was the same age as you, and we had the same clinical profile, we may have the same answer. But we don't. Your doctor and you need to talk through what's best for you. The flu vaccine is one where the clinical data, by and large, screens annually binary yes, no; yes, do the flu vaccine.

MR. RUBENSTEIN: The most popular drug in America, next to aspirin, seems to be GLP-1 drugs. Everybody seems to be on them. Do you reimburse 100 percent for those?

MR. CORDANI: So, GLP-1s. GLP-1s, the clinical data externally validate would say GLP-1s – that's the class of drugs for obesity. You'll know them as Wegovy, Ozempic, Zepbound, et cetera. The clinical data would say, and mostly every organization, federal government, states, cities, commercial employers, et cetera, cover it for insulin-dependent diabetics. The data says cover. For the complications versus the benefits, they cover.

The second class is for weight management. Data point, we're the only country, again, back to developed countries around the world, that have this debate around covering it for weight management. If individuals in other countries want it for weight management, that's an out-of-pocket, individual decision. We as an organization, we cover it for insulin-dependent diabetics. We bring it as a choice to employers. About 50 percent of large employers have chosen to cover it for weight management. As you go down, a smaller percentage of small employers do. And then lastly –

MR. RUBENSTEIN: So, it's the employer, you're saying. If the employer wants to pay for it, you're happy to reimburse for it.

MR. CORDANI: And then lastly, we designed the first-of-its-kind service, which is about a year old now – I lose track of time. I apologize. Could be 10 months, could be 11 months. It's called EncircleRX. It takes coverage and support for the weight management drugs we just talked about. It marries them with lifestyle and behavior change programs and active care coordination. We have about 9.4 million people already that are using that program, that employers could decide opt in. And in that case, what you're doing is you're helping an individual get activated. They get access to the GLP-1s, but to get lifestyle management and behavior change to go forward. And ideally, for many people, they'll titrate down on lower doses over time, and potentially stay on a lower dose, or titrate off the doses over time.

MR. RUBENSTEIN: Why not – do you encourage employers to get this GLP-1 reimbursement insurance, because presumably it makes their people thinner and healthier?

MR. CORDANI: So, to be clear, we would make more money if 100 percent of our employers covered 100 percent of their employees for GLP-1s. So now go the other way. We don't encourage 100 percent of our employers to cover it.

MR. RUBENSTEIN: Why?

MR. CORDANI: It's a choice based on the clinical evidence and how they want to come forward. That's why we brought forward EncircleRX, to provide a program that could actively manage it. So, David, that's an example, to come back to getting the incentives aligned. We need to align the incentives more so based on the outcome. And I'll give you the GLP-1 fact, as why we don't say, yes, you should cover for everybody. There's up to 50 percent of individuals who go on to GLP-1s for weight management who stop taking the drug within 12 to 14 months, for a variety of reasons – side effects, gastrointestinal, behavioral, or otherwise. That's a bad outcome.

If you think about it, put the finances aside. If it's $1,000, or $800, or $700 a dose net of everything, on one side. Someone goes on the drug, someone goes off the drug. While they're on the drug, if they lose weight they lose muscle mass and fat. If they've changed nothing and go off the drug, they regain weight. They're going to regain fat, no muscle mass. The person 14 months later is less healthy, 14 months later, than they were when they started the journey. So that's why – that's why it's not yes or no. It needs to be done with the medical professional.

MR. RUBENSTEIN: My biggest risk is probably not over exercise. But Jim Fixx, who was a person who led the jogging and running phenomenon years ago, he dropped dead while he was jogging. Is that a thing I should worry about?

MR. CORDANI: Based on the fact that you don't jog – [laughter] –

MR. RUBENSTEIN: Right.

MR. CORDANI: I actually think you're OK. But there some serious examples in here for sure, right? This is back why even the most – people who appear to be the most fit may not be. That's why an annual physical is helpful. It's why understanding your coronary health is helpful. Somebody who appears to be somewhat overweight may be, in aggregate, healthier than somebody who appears to be more healthy because they're at a better weight, right? So understanding the coronary system in terms of what transpires for an individual.

MR. RUBENSTEIN: So my doctor has a new piece of equipment. You stand on it and it tells you your body weight, or mass, or something.

MR. CORDANI: Body mass index.

MR. RUBENSTEIN: And I don't like that, because it depresses you. Have you thought about the fact that depression that comes about by seeing how bad it is might actually hurt your health? Is anybody worried about that? It worried me. [Laughter.] OK, let me ask you. You have been involved in a philanthropic activity, it's very noble, which is to get veterans who have had

amputations to run marathons. And I didn't know that that was a big thing. But can you explain what you do to get veterans, and why are you so interested in veterans who've had amputations? What led you to that? And how often do you get involved in their running marathons?

MR. CORDANI: So, the organization, thanks, David, is Achilles International. Achilles, I referenced it before, was founded by an individual in the '70s to help folks with, at that time, physical disabilities prepare for and compete in running events. That was its origin. It's blossomed and brought into a global organization. It helps people with disabilities of all types, both physical and psychological, to do the same thing, though. To come together, to form a community, I call them micro-communities, for my learning, have commonality, set goals, prepare to pursue those goals, take on those goals, objectives with support. And what it proves is that – and I'll tie it to the veterans in a moment – what it proves is that when those individuals achieve the goals, they go on to set their next goal and objective, and their next goal and objective. And the reinforcement mechanism is powerful because it's mind and physical.

Within Achilles, there's the Freedom Team. Those are veterans with the overwhelming number of veterans who came back from both Iraq and Afghanistan – not solely, but Iraq and Afghanistan heavily. Single, double, triple, quadruple amputees who are supported by Achilles, in this case, and part of chapters to compete in and pursue mainstream activities. Some individuals are going to be running on prosthetics. Some who cannot are going to be doing hand crank bikes or push rim. All with the same objective of goal setting, preparation, and accomplishing it. And I've had the good fortune for the past decade-plus of being a running guide for veterans, both in half marathons and full marathons.

MR. RUBENSTEIN: In the health care world there's a new – not new; it's ancient but it's been revived – phenomenon called longevity, which is to say getting people to live really, really long – 100-120. Is that realistic, that people are going to live to 100 on a normal basis, or 120? And you think we should encourage people to try to live to that long, or an age, or it's unrealistic that you're going to live in a healthy manner if you live to 100-120?

MR. CORDANI: So, I don't – I don't know, David, the complete answer to the longevity piece, by all means. But there's plenty examples around the world of some subpopulations – so there's some areas in Japan, there's some areas in the Mediterranean, there's some areas in the Nordic – that have much higher average age and outlier ages. And when you measure back to – through our vitality index, when you're looking at both physical health and kind of spiritual health and mental health, have a higher vitality index that comes along with it. So that combination of physical health, and then sense of belonging and purpose and engagement, is quite positive.

Oftentimes it comes back to looking at quality years in between. So some people, genetically, may not be able to get there. Some people may be. In my home state, they were just celebrating a woman just turned 107. And she's about as vibrant as all get out. All the mental faculties are there, and then some, and will run people through their paces.

MR. RUBENSTEIN: When you get older sometimes your brain doesn't work as well. What is the best way to keep your brain active, doing interviews or something like that? What would you say?

MR. CORDANI: So, there's actually a lot to appreciate, and there's ample science around this. But the way I simplify it – because I like to simplify the complex for my own my own thought process. The brain's a muscle. The way I internalize it, the brain's a muscle. If a muscle – we all know that if you don't exercise a muscle – I have a friend who's just going through – the person's left shoulder was immobilized for a while, right, for recovery. And the person, who's probably upper forties, maybe 50, was observing the muscle atrophy already.

So, think through what we all know about muscle atrophy, apply it to the brain. If the brain is not utilized, the erosion will transpire much more aggressively. So, yes, interviews, Sudoku, having friends to play cards with, going on walks, right, learning new things. That's really important for brain health.

MR. RUBENSTEIN: How many people here are going to feel – do something that makes them healthier as a result of this interview? Anybody? OK. How many people have had a claim denied? [Laughter.] Anybody ever had a claim denied? OK.

MR. CORDANI: If you had a claim denied, come see me. For those who put up your hand, that makes my day.

MR. RUBENSTEIN: OK. So, look, you obviously know this area pretty well, and congratulations on your success. Thank you for educating us. And appreciate it. I've got a little prize for you.

MR. CORDANI: Thank you. [Applause.]

MR. RUBENSTEIN: Thank you for your service. A map of the District of Columbia. I'll send this to your office, OK? Thanks a lot.

David Cordani
Chairman and Chief Executive Officer
The Cigna Group

David Cordani was appointed Chairman of the Board in January 2022. He has served as Chief Executive Officer of The Cigna GroupSM since 2009 and President since 2008. Since joining the company in 1991, Mr. Cordani has served in a number of senior leadership roles, including Chief Operating Officer; President, Cigna HealthcareSM; and Senior Vice President, Customer Segments and Marketing. During his tenure, The Cigna Group has grown into a global health company with more than 180 million customer relationships and more than 70,000 co-workers around the world.

Mr. Cordani brings a deep understanding of customer engagement as well as of the critical role data analytics and digital capabilities play in improving the health care system and outcomes for individuals. He offers unique perspective and insight into the health services industry and the innovation of health care delivery models. Mr. Cordani leads the company in advancing its Environmental, Social and Governance (ESG) areas of focus, including expanding and accelerating efforts in support of sustainable health care, health equity and enterprise diversity, equity, inclusion and equality. The progress of The Cigna Group has been recognized by a number of prominent organizations, including the Dow Jones Sustainability Indices for seven consecutive years. He is also the co-author of the best-selling book The Courage to Go Forward: The Power of Micro Communities.

Mr. Cordani is active with a number of nonprofit organizations and currently serves in various capacities with the Achilles International Freedom Team of Wounded Veterans and The Cigna Group Foundation among others, and the David and Sherry Cordani Family Foundation. Mr. Cordani is an Executive Committee member of America's Health Insurance Plans (AHIP) and previously was appointed and served as Chair of the Board. With a commitment to international business relations, Mr. Cordani also served as Chairman of the U.S. Chamber of Commerce's U.S.-Korea Business Council and on the U.S.-India Business Council Board of Directors.