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EXAMINING OPPORTUNITIES TO ADVANCE AMERICAN HEALTH CARE THROUGH THE USE OF ARTIFICIAL INTELLIGENCE TECHNOLOGIES

WEDNESDAY, SEPTEMBER 3, 2025,

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2123, Rayburn House Office Building, Hon. H. Morgan Griffith [chairman of the subcommittee] presiding.

Present: Representatives Griffith, Harshbarger, Bilirakis, Carter of Georgia, Dunn, Joyce, Balderson, Miller-Meeks, Cammack, Obernolte, Bentz, Houchin, Langworthy, Kean, Rulli, Guthrie (ex officio), DeGette, Ruiz, Dingell, Kelly, Barragan, Schrier, Trahan, Veasey, Fletcher, Ocasio-Cortez, Auchincloss, Carter of Louisiana, Landsman, and Pallone (ex officio).

Also Present: Representative Fedorchak.

Staff present: Christian Calvert, Press Assistant; Jessica Donlon, General Counsel; Kristin Fritsch, Professional Staff Member; Seth Gold, Professional Staff Member; Sydney Greene, Director of Finance and Logistics; Jay Gulshen, Chief Counsel; Annabelle Huffman, Clerk; Calvin Huggins, Clerk; Sophie Khanahmadi, Deputy Staff Director; Molly Lolli (Brimmer), Counsel; Sarah Meier, Counsel and

Parliamentarian; Joel Miller, Chief Counsel; Jake Riith, Staff Assistant; Dylan Rogers, Professional Staff Member; Chris Sarley, Member Services/Stakeholder Director; James Stursberg; Professional Staff Member; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Jane Vickers, Press Assistant; Katie West, Press Secretary; Nick Wooldridge, Professional Staff Member; Lydia Abma, Minority Policy Analyst; Shana Beavin, Minority Professional Staff Member; Jennifer Black, Minority Professional Staff Member; Keegan Cardman, Minority Staff Assistant; Wavery Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Saha Khaterzai, Minority Professional Staff Member; Una Lee, Minority Chief Counsel; Matt Moore, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Hannah Treger, Minority Staff Assistant; Shae Reinberg, Minority Intern; and Jackson Hall, Minority Intern.

Mr. Griffith. All right. If everybody will take their seats. The subcommittee will come to order. The chair now recognizes himself for 5 minutes for an opening statement.

Today's hearing gives us the opportunity to continue the Energy and Commerce Committee's leadership on artificial intelligence, or AI, by examining current applications of AI across the healthcare sector.

Last Congress this subcommittee held a similar hearing on AI and machine learning. It is critical that we continue these types of educational hearings to understand the evolving health AI landscape, and ensure that Congress keeps up with the many advances in this space.

Applications of AI and machine learning have increased across the healthcare sector in recent years, and will only play a more pronounced role in the daily lives of all Americans moving forward.

In the healthcare space today, AI is being deployed by innovators to empower patients along their personal healthcare journey, support healthcare providers and reduce unnecessary administrative burdens. I look forward to learning more about these real-world applications from our panel of experts today.

I also believe as AI applications advance it is critical that Congress continues to examine this landscape to ensure proper safety and proper oversight. These AI applications can be hugely beneficial to patients and providers, but they are to assist -- they are to assist and not to replace the clinical workforce today.

I want to briefly highlight a few examples of how AI is being used to improve patient experiences and outcomes in the market today. Pharmaceutical companies are using AI to help improve core scientific research functions and develop lifesaving treatments and cures, as well as using AI to expedite clinical trials to bring safe and effective medicines to market quicker.

Insurance companies are using AI to process claims in order to get care to patients quicker, but this is an area where oversight is needed to make sure that the AI is not being used in an inappropriate way. And we have seen that on occasion, so we have got to be careful.

Physicians in hospitals who have been dealing with documentation burdens are using AI to assist in writing up and consolidating post-visit records, which has helped reduce documentation time by roughly one-third in some cases, and allowed for doctors to spend more time, that is right, they get to spend more time with their patients. What a novel idea.

Companies who develop medical devices are using machine learning to better understand certain diseases and help advance innovations to deliver more clinically appropriate and effective care interventions.

The Trump administration has also been forward leaning on advancing AI in the health space and streamlining regulations to increase its application. I applaud the work of the current administration to incorporate AI in a responsible manner that can help improve care.

To date, the CMS Innovation Center is working to utilize AI and machine learning to identify waste, fraud, and abuse in Federal healthcare systems, and to root out improper taxpayer spending.

The FDA has incorporated the use of AI to drastically shorten the time needed to complete some tasks in their review process.

Researchers at NIH have developed an AI algorithm that modernizes the process of matching potential clinical trial volunteers to suitable trials, cutting down administrative time by 40 percent while maintaining the same level of placement accuracy. And one would hope that would even get to be a better placement accuracy.

These are only a few examples of many ways the administration is integrating AI and streamlining the way our American healthcare system operates. With all these innovative advancements being leveraged across the American healthcare ecosystem, it is paramount that we ensure proper oversight is being applied, because the application of AI and machine learning is only going to increase. We must ensure that these tools continue to empower and not replace the providers that serve our communities across the Nation.

These tools should help improve the patient experience, and, ultimately, access to care, particularly in rural areas like the one that I represent in Virginia's 9th Congressional District.

I hope we have a constructive conversation today about the opportunities and the risks that come with AI, and how our committee should be thinking about the role we can play in helping shape the future of AI in healthcare.

I am looking forward to hearing more from our witnesses and the members on this subcommittee on the application of AI in healthcare.

With that, I yield back, and I now recognize the subcommittee's ranking member, my friend, Diana DeGette, for her 5 minutes for an opening statement.

Ms. DeGette. Thank you so much, Mr. Chairman, and welcome back. If you judge from this subcommittee's schedule, you would think that nothing pressing has happened in the healthcare arena in the last 5 weeks. And certainly, I think it is important, and all of us think it is important that we look at the role of AI in healthcare. And I hope at some point when we are not in a crisis mode, we can do a thorough investigation, because it is certainly a concern of mine.

But my friends, right now Rome is burning. Rome is burning. More important than this is

the peril that the Trump administration's policies have put my constituents and the constituents of every single person on this panel into. All of our constituents are at risk because of the risky and dangerous and unscientifically based principles of RFK, Jr., and his advisors.

Last week, Mr. Chairman, President Trump and Secretary Kennedy fired Susan Monarez, the new CDC director, who had taken her post just a month before. Her offense was refusing to rubber stamp Secretary Kennedy's evidence-free vaccine policies and fire seasoned respected senior CDC staff.

As CDC doctors and scientists are removed for following science and telling the truth, the rank-and-file people who defend America against disease are no longer going to trust the CDC.

And in addition, ever since Donald Trump became President, an estimated 20,000 people have been fired from HHS. Critical research into cancer, into pediatric diseases, and many other diseases have been put on hold or shelved. My constituents, your constituents, and everyday Americans across the country are going to suffer.

Secretary Kennedy's dereliction of duty and incompetence are underscored by over 1,000 and growing HHS employees who signed a letter demanding his resignation today.

Mr. Chairman, I would ask unanimous consent to put that letter into the record.

Mr. Griffith. Without objection, so ordered.

[The information follows:]

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Ms. DeGette. I agree with those 1,000 professional researchers. Secretary Kennedy must resign immediately. And if he does not, President Trump should fire him for doing such damage to the institutions that have up and until now, been the paragons of research in the world, and have kept Americans healthy and safe.

And Mr. Chairman, we need to do our jobs. This subcommittee must bring RFK, Jr., Dr. Monarez, and others in to shed light on this administration's unprecedented interference in public health and science.

Mr. Chairman, I looked at the calendar, I think we have time in this subcommittee next week, and I would urge that we bring this up. Let's use it to get the answers that our constituents deserve.

The Democrats on this panel and I have been asking for months for this committee to do its job and provide rigorous oversight of HHS under this administration. We have been asking to move critical legislation that we all agreed on at the end of the last year, a number of extensions of critical programs that are bipartisan. Elon Musk killed those programs with a tweet when we were doing the continuing resolution, and those bills still have not come up to this day.

And we have been asking for this committee to rediscover its sense of duty and initiative. Congress, us, we are not a co-branch -- equal branch of government. We are the first branch of government.

Article 1, the American people's most direct expression of their will, and where the Constitution that vast by far the most power up until now, and we are languishing.

Between asking the President for permission to take the smallest action, and refusing to ensure that the executive is faithfully executing the laws passed by this Congress, everybody in this room on both sides of the aisle should be embarrassed about Congress's work. I know I am.

And we have only had just one hearing, a budget hearing with a presidential appointee of this administration during this entire Congress. Inaction in the face of incompetence and malice, that is

complicity, and we have got to stop that. We have got to investigate the misdeeds of this administration. We have got to follow the investigations where they lead. We have to insulate scientific judgment from politics and ideology. And as the health subcommittee of Energy and Commerce, we must base our decisions on science.

Mr. Chairman, I hope we can start doing that as of today. As you can tell, this issue is important to the American people and our constituents, and we are not going to stop talking about it until we restore these important protections for our constituents' health. I yield back.

Mr. Griffith. The gentlelady yields back. I now recognize the chairman of the full committee, Mr. Guthrie, for his 5 minutes.

The Chair. Thank you. Thank you, Chairman Griffith. And thanks to all of our witnesses for being here today.

We are here today to continue the discussions surrounding artificial intelligence, and specifically, the meaningful impacts this innovative technology has had on the American healthcare system, as well as AI as a whole.

This committee has been a leading voice in the discussion on how to leverage AI across all of our subcommittees focused on unleashing innovation while safeguarding consumers to improve the health of all Americans while ensuring it is used safely and responsibly.

I would also like to commend the administration for their leadership on these issues. We support the administration's national AI action plan that would accelerate AI innovation, build American AI infrastructure, and bolster U.S. leadership in AI development and deployment.

I have also been encouraged by progress across HHS to maximize these new technologies, and I look forward to continuing to work with CMS, FDA, and everyone else as that work continues to evolve.

Today we are here -- just a few examples of our AI technologies that are being applied across the healthcare system. I want to emphasize that AI, in no way, is intended to overtake the jobs of

hardworking Americans. It is, instead, an opportunity to enhance the work conducted by humans across our healthcare system, improving the quality and efficiency of care, reducing time-consuming and costly administrative tasks and burdens, enhancing the provider-patient relationship, and expediting the discovery of new treatments and cures.

Recent news stories have also highlighted potential safety concerns with improper personal use of AI, and the committee is working towards stronger guardrails to prevent tragic events from occurring in the future, especially in healthcare.

It is important to understand where AI technologies are creating significant positive impacts on efficiency and research and development of health products along with the overall delivery of care, but not to forget the importance of appropriate safety precautions.

The committee remains steadfast in its efforts to improve the use of AI technologies while ensuring AI is used in a human-centric, responsible, and safe manner.

I thank all of our witnesses for being here today and for your participation in today's hearing, and I look forward to how we can all work together to have the most optimal use of AI in the healthcare field. Thank you, Mr. Chair, and I yield back.

Mr. Griffith. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for his 5-minute opening statement.

Mr. Pallone. Thank you so much. Today, the committee Republicans are holding this hearing on AI technologies in healthcare, but unfortunately this is happening at the same time that the Trump administration and Health and Human Services' Secretary Robert Kennedy, Jr., are dismantling the Department of Health and Human Services and raging a war on public health.

For 9 months now the Trump administration and Secretary Kennedy have created chaos in our Nation's healthcare system. Last week it hit a breaking point when the administration fired the director of the Center for Disease Control and Prevention, and three key scientific leaders resigned after refusing to sign off on watered down and misleading and unscientific recommendations on

vaccines.

The Trump administration's reckless actions lead the CDC with a critical leadership vacuum as we head into the fall and the flu season, coupled with the mass layoffs of over 25 percent of the CDC's workforce, this administration's path of destruction threatens America's health.

The CDC must be guided by leaders who govern above politics and remain focused on the agency's core purpose, which is safeguarding and improving the health of our communities, preventing infectious and chronic diseases, and protecting all Americans.

I would like to submit for the record the powerful resignation letter of Dr. Daskalakis, the former director of the CDC's National Center for Immunization and Respiratory Diseases, which details the widespread deception at HHS over changes to the vaccination schedule.

[The information follows:]

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Mr. Pallone. Last week's actions follow the Trump administration's decision to restrict access to COVID-19 vaccines for millions of Americans. This unprecedented action by the FDA means that healthy adults under 64 will no longer be able to receive the COVID vaccine. Americans will die as a result of Secretary Kennedy's actions, and that is why it is well past time for this committee to finally begin demanding answers.

In April, we called on Chairman Guthrie to schedule a hearing with Secretary Kennedy, specifically on his illegal layoffs and reorganization. Then in June, I called for Chair Guthrie to join me in conducting a bipartisan investigation of Secretary Kennedy's actions to restrict access to vaccines.

I have also called for this committee to examine the administration's devastating cuts to the NIH, and the administration's dangerously inadequate response to the growing measles epidemic. These requests have been met with silence. Republicans would rather sit on the sidelines as Kennedy moves ahead with advancing his dangerous pseudoscience agenda.

Secretary Kennedy must testify before this committee to answer questions and be held accountable for threatening public health by abusing his authority, propagating disinformation and politicizing science. It is time that Republicans take these threats seriously and join us in holding Secretary Kennedy accountable.

Turning to today's hearing, AI has the potential, if used appropriately, to provide innovative approaches and efficiencies in healthcare. The goal in using these technologies should be to provide better direct patient care and health outcomes, but I am concerned that the expanded use of AI in healthcare has generated significant risks that we simply cannot ignore.

Congress must recognize and address the complex, ethical, legal, economic and social concerns raised by using AI in our healthcare system. Without adequate oversight, these new technologies can lead to devastating consequences for patients, medical care could be delayed, and insurance coverage denied, preventing Americans from getting the care they need to live.

There is also the threat of personal health information and data privacy breaches. While AI tools can support healthcare providers, their advice and recommendations should not serve as a substitute for the nuance judgment of healthcare professionals, and should not come at the expense of patient safety.

And I am very concerned about the impact of AI on mental health. The tragic stories of teens interacting with AI chatbots that encouraged them to take their own lives is devastating.

The speed at which AI technologies have been incorporated into healthcare has so far outpaced the regulation and oversight. That is why it is concerning that the Trump administration rescinded a 2023 executive order aiming to strength AI governance at high-risk domains, and issued a separate executive order to remove barriers and revoke policies that they view as hindering AI innovation.

I am also extremely concerned by the administration's announcement to implement a pilot program in New Jersey and five other States that will allow for nonprofit companies to utilize AI to review prior authorization requests for seniors in medicare.

I also believe it is critical that safeguards are in place to protect the privacy and security of patient data. AI cannot function without large quantities of data, and we must ensure that the increased data, which AI relies on, does not come at the expense of consumers' right to privacy.

Again, this is a very important hearing, but we have to think about the consequences of what is going on with AI, which can be positive, but often can be negative without proper regulation. Thank you, Mr. Chairman. I yield back.

Mr. Griffith. The gentleman yields back. That concludes member opening statements. The chair would like to remind members that pursuant to the committee rules, all members' opening statements will be made a part of the record.

We want to thank our witnesses for taking their time to testify before the subcommittee today. Although it is not the practice of this subcommittee to swear in witnesses, I would remind

our witnesses that knowingly and willfully making materially false statements to the legislative branch is against the law under Title 18, Section 1001 of the United States Code. You will have the opportunity to give an opening statement followed by questions from members.

Our witnesses for today are Mr. TJ Parker, Lead Investor in General Medicine; Andrew Toy, Chief Executive Officer of Clover Health; Dr. Ibrahim, Chief Clinical Officer at Viz.ai, if I said -- Viz.ai. I guess I am getting that right.

Dr. Michelle Mello, Professor of Law at Stanford Law School, and Professor of Health Policy at Stanford University School of Medicine, and Dr. C. Vaile Wright, Senior Director, Health Care Innovation, American Psychological Association.

Per committee custom, each witness will have the opportunity for a 5-minute opening statement followed by a round of questions from members. The light on the timer in front of you will turn from green to yellow when you have 1 minute left.

And I will now recognize Mr. TJ Parker for 5 minutes to give his opening statement.

STATEMENTS OF TJ PARKER, LEAD INVESTOR, GENERAL MEDICINE; ANDREW TOY, CHIEF EXECUTIVE OFFICER, CLOVER HEALTH; DR. ANDREW IBRAHIM, CHIEF CLINICAL OFFICER, VIZ.AI; DR. MICHELLE MELLO, PROFESSOR OF LAW, PROFESSOR OF MEDICINE, STANFORD UNIVERSITY; AND DR. VAILE WRIGHT, SENIOR DIRECTOR, HEALTH CARE INNOVATION, AMERICAN PSYCHOLOGICAL ASSOCIATION;

STATEMENT OF TJ PARKER

Mr. Parker. Thank you, Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, Ranking Member DeGette, and distinguished members of this subcommittee. I am TJ Parker, a second-generation pharmacist and the founder of General Medicine, which is a brand-new healthcare store, and a partner at Matrix, a 50-year-old venture capital firm.

It is an honor to be here today to discuss the important role AI is playing in General Medicine's ability to offer price transparency and a better customer experience.

Previously, I was the founder of PillPack, a pharmacy that made it easy for customers to get and take medications as prescribed. I sold that company to Amazon in 2018 and spent 4 years building Amazon Pharmacy and Amazon Clinic and putting Amazon on the path to expand broadly into healthcare.

As an investor, I see myriad new healthcare AI startups. Most, including some I am involved in, are building administrative tools, AI scribes, prior authorization automation, AI phone calls, and other administrative tasks. It is important work that will have a downstream impact on customers.

However, today, I want to talk about improving the customer experience in healthcare. Americans are frustrated. They want healthcare to be easier. At General Medicine, we are using AI to directly improve the customer experience across all care, from basic needs to complex cases.

General Medicine is a healthcare store, a one-stop-shop for telemedicine, prescriptions, imaging, labs, specialists, or anything you need. We have made it as easy to shop for healthcare as it is to shop for anything else. This means a clear choice of providers, upfront price, with or without insurance, and a simple way to actually book the care they need right on our platform. We take insurance, or customers can pay with cash. This approach eliminates the opacity and quagmire of complexity customers experience while trying and often failing to access healthcare today. Our mission is to get every customer the best care for their needs. So far, customers love it, and it would have been impossible without AI.

Let me give you two examples of how we have used AI to reinvent the experience. The first is pricing. In healthcare, people rarely know what care will cost in the end. They can't possibly shop without a clear price. We set out to change that.

Behind the scenes of General Medicine we analyze the customer's insurance information, including the 80- to 100-page coverage of benefits. We use large language models to turn these

PDFs into structured data, and combine that with open pricing files and other sources to give customers a clear upfront price for any service, including procedures, labs, imaging, referrals, and pharmacy at any location. This is the first time comprehensive pricing has actually been available in U.S. healthcare.

Another example, proactive care plans. When you go to a doctor today it is almost always for an isolated reason. You leave with a prescription or one follow-up task. It is all our current system is set up to handle. Today, General Medicine is using AI so that patients after they visit have a comprehensive, personalized actionable plan covering not just what brought them in, but all their conditions and any overdue preventive care.

With patient permission, we use AI to pull together their medical history, labs and prescriptions, then flag what is missing, maybe a colonoscopy, a cholesterol check, or a follow-up lab for blood sugar. The doctor reviews it and the customer sees it all in one place where they can easily take action on each step via General Medicine. It is the equivalent of adding to cart and checking out, truly making healthcare as intelligent and easy to shop as everything else.

Looking ahead, we are building the ability for patients to directly request these insights themselves. People can ask questions back and forth with the AI to clarify the recommendations, based on their needs and preferences, then seamlessly book with a provider to discuss and take action. This innovation allows patients in collaboration with providers to take informed control of their health.

At PillPack and Amazon, we learned that when customers feel in control and actually enjoy using a service, they are more likely to take the right steps for their health. The same pattern is proving true at General Medicine.

In closing, I also want to sincerely thank the members and staffers who have worked diligently over the past decade plus, to enable broadly available price transparency files, improve provider directories, and enable data interoperability between providers. Without these efforts, very little of

what we do today will be possible.

By combining this infrastructure with AI we can offer a vastly better healthcare experience for every American regardless of location, insurance, or background.

Thank you all for the opportunity to share the story of General Medicine, and I welcome any questions you may have.

[The prepared statement of Mr. Parker follows:]

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Mr. Griffith. I appreciate your testimony. Thank you so much. And we will now go to Mr. Toy for his 5 minutes.

STATEMENT OF ANDREW TOY

Mr. Toy. Thank you. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to testify today.

My name is Andrew Toy, and I am the CEO of Clover Health. We are an AI technology company offering Medicare Advantage plans, and helping doctors take better care of seniors. We serve over 100,000 seniors, many of whom live on fixed incomes, or in underserved communities.

I am not your typical health plan CEO. I have both a bachelor's and master's degree in computer science from Stanford University. I built a startup that was acquired by Google, and I later worked on Android and Google Cloud.

I am also a patient with Marfan syndrome, a rare genetic condition that took my father's life as he was diagnosed too late for his condition to be managed. His death may have been prevented if his doctors had the right data and coordinated care. That drives my mission, using technology so no patient slips through the cracks the way he did.

So how can AI help? Doctors today are asked to do the impossible, care for patients while juggling mountains of data across disconnected systems. This is where AI can make a difference. It can pull together information from labs, pharmacies, hospitals, and electronic records, then highlight what matters most right at the point of care and in the doctor's existing workflow. Our tool, Clover Assistant, does exactly that.

Now, let me be clear, AI should never be used to deny care or replace physicians. It should be used to empower physicians, helping doctors identify diseases earlier, personalize treatments, and spend more time with their patients.

I see three big healthcare AI opportunities. Number one, bringing sophisticated care to every community; number two, making care truly personal; and number three, reducing inefficiencies and costs.

So starting with bringing care everywhere. For too long, advanced data systems have only been available inside large hospital networks. Independent doctors, especially in rural and underserved areas, haven't had access. That has real consequences, misdiagnoses and opportunities for care, duplicate or incorrect tests and dangerous delays. It is what happened with my father.

With the AI power capabilities in Clover Assistant, a solo physician in Iowa, or a small clinic in urban New Jersey has the same data-driven insights as a major academic center. By integrating records from national networks, geography and practice size no longer determine care quality.

Turning to personalizing care. Every patient is unique. As someone with a rare condition, I know I am not a statistic. I am an end of one.

AI helps doctors move beyond generic population management to truly personalizing care, and the results are real. For example, doctors using Clover Assistant start diabetes patients on treatment 3 years earlier on average. They identify kidney disease 1-1/2 years earlier. Preventive screenings also go up, 11 percent more colorectal cancer screenings, and nearly 5 percent more breast cancer screenings.

Among heart failure patients, Clover's AI enabled care has been tied to 18 percent fewer hospital stays, and 25 percent fewer readmissions. And because of this, doctors using Clover Assistant have significantly lower cost ratios, over 10 percent better. We use those superior economics to help patients afford care and lower out-of-pocket costs with $0 premiums, the lowest copays for specialists' visits, and $0 copay access to both in-network and out-of-network primary care.

AI is powerful, but must be used responsibly. Three things matter most, I think. Number

one, empowering providers. AI should empower, not replace, clinicians. It should make their jobs easier and their time with patients more meaningful.

Number two, ensuring interoperability. AI is most effective when patient data is accessible and secure. We must protect patient privacy without creating burdensome mandates.

And number three, accelerating care. AI should make it easier and faster for patients to be diagnosed, receive personalized treatment and get that care paid for.

AI is here, it is helping doctors identify diseases earlier, deliver more personalized care and lower costs. Used responsibly, AI can give every senior in America the personalized and effective healthcare they deserve.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Toy follows:]

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Mr. Griffith. I appreciate the gentleman yielding back. I now recognize Dr. Ibrahim for his 5 minutes.

STATEMENT OF DR. ANDREW IBRAHIM

Dr. Ibrahim. Chairman Griffith, Ranking Member DeGette, members of the committee, thank you for the opportunity to testify.

My name is Andrew Ibrahim. I am the Chief Clinical Officer at Viz.ai, a practicing general surgeon at the University of Michigan, and a research scientists with over 200 publications focused on how we improve the delivery of care.

Over nearly two decades, I have seen firsthand how workforce shortages, rising costs and mounting complexity are pushing our healthcare system to the breaking point. Doctors are asked to see more patients in less time with information scattered across multiple systems and logins. Patients may need to make three or four calls just to schedule a single appointment, only to sometimes be sent to the wrong clinic, or lost to follow-up altogether. And the heavy documentation burden takes away from doctors what matters most, caring for their patients.

Artificial intelligence offers one of the most viable paths forward to save U.S. healthcare and reverse these trends. There are many types of artificial intelligence, including machine learning, deep learning, and large language models, but the technical distinctions are not what matter most. In healthcare, what matters most is not the algorithm in isolation, but how these tools are integrated into real clinical workflows to solve real high-stakes problem.

At Viz.ai, that has been our approach. Viz.ai is a healthcare technology company that uses artificial intelligence to empower clinicians with actionable information within seconds so they can make timely decisions to provide high-quality care. By getting the right information to the right doctor at the right time, Viz.ai helps hospitals treat patients faster, save lives, and reduce costs.

Importantly, it offloads burdens from busy clinicians and improves diagnostic accuracy.

We began tackling one of the most devastating conditions in medicine, stroke. These events are often caused by a blood clot to the brain. Every minute untreated costs a patient nearly 2 million neurons. Without immediate action a stroke can leave patients permanently disabled, or even lead to death. Approximately 800,000 Americans from all walks of life, urban and rural, suffer a stroke each year.

This reality is personal to me. When I was in medical training, my father, a university professor, called me from his office and he was experiencing vision changes and trouble finding words. I immediately recognized it may be a stroke, and I called campus security on him. They went to his office and facilitated getting him to the hospital. And while he was in route I called ahead to the emergency room. I also called in personal favors to make sure that the neurologist and interventionalist were available. Because of these extraordinary steps he got timely treatment, and days later walked out on his own feet able to speak and see clearly.

But not everybody has a medically trained son ready to coordinate their emergency care. We need systems that ensure patients get the right treatment without relying on luck or personal connections.

That is why I joined Viz.ai. Our AI platform helps coordinate timely care for patients just like my dad. It automatically analyzes CTs to identify those with life-threatening conditions, alerts the stroke team in real time, and assembles the relevant clinical information to support urgent decisions. Independent studies show that this reduces treatment time by more than 30 minutes and shortens hospital stays by as much as 3 days. The result is simple, but profound. Patients walk out of the hospital who otherwise may never return home.

Our platform is scaled to more than 1,800 hospitals nationwide. Every 5 seconds, a patient's care in this country is supported by our platform. From leading academic centers like the Cleveland Clinic, to critical access hospitals in rural America, where AI helps identify who needs to be

transferred quickly for emergency care.

And stroke is just one example. We have applied the same model to other serious conditions, such as hypertrophic cardiomyopathy, a disease where the heart muscle becomes abnormally thick and makes it harder to pump blood. Left undiagnosed it can lead to sudden cardiac death, particularly in younger adults. It affects 1 in 500 Americans, yet most don't know they have it. A Cleveland Clinic study showed that our AI tool cut time to diagnose this from years to just 3 months. Pulmonary embolism is another time-sensitive condition where a blood clot can go to the lung resulting in straining to the heart. It affects 900,000 Americans each year and is responsible for over 100,000 death annually. At TriHealth study, use of our platform, reduced time-to-treatment from hours to just 6 minutes with a measurable reduction in in-hospital deaths.

Finally, brain aneurysms affect nearly 1 in 50 Americans, which would be at least one or two people in this room, but most don't know they have it. Left untreated, it also can lead to life-threatening consequences.

We have expanded these approaches to other areas including oncology, cardiology, vascular medicine and trauma. I mention all of these to underscore that the real-world potential of AI in healthcare is not hype or theoretical. For us it has been a decade of hard work that has translated into FDA-cleared, CMS-reimbursed tools embedded in frontline care today.

But the road has not been easy, and we face barriers common to many innovators, including regulatory challenges, reimbursement and data accessibility.

I am deeply optimistic about what AI can do for American patients and clinicians, and I believe the United States can lead the world in this space. With the right policies, incentives and commitment, we can ensure that every patient, whether in San Francisco or rural Montana, receives timely life-saving care, and we can restore doctors to what they entered medicine to do, care for patients. Thank you.

[The prepared statement of Dr. Ibrahim follows:]

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Mr. Griffith. The gentleman yields back. I now recognize Dr. Mello for her 5 minutes of questioning -- excuse me. A statement.

STATEMENT OF DR. MICHELLE MELLO

Dr. Mello. Thank you, Mr. Chairman. I appreciate the opportunity, Chairman Griffith, Ranking Member DeGette, and others in the subcommittee to speak with you today.

I am part of a group of data scientists, physicians and ethicists at Stanford University that helps govern how AI tools are used in healthcare at our Stanford facilities. And I would like to share some of the learnings that we have had at Stanford, and my own professional experiences over two decades studying patient safety and health policies.

I am enthusiastic about healthcare AI. There are so many intractable problems that it will help solve. But AI presents both a historic opportunity and a serious risk. And although properly -- improperly designed regulation my hinder innovation, there is a critical role for the government in ensuring the conditions for innovation to translate into AI adoption.

The key problem isn't that there is a lack of innovation in the AI space. As you have heard today, there is much to be proud of. But the uptake of these innovations is relatively low. And the major reason for that is what experts call a foundational trust deficit.

There are four areas where I think experts agree that policy interventions could help build trust in healthcare AI and spread innovation and adoption systemwide.

First, policymakers can help ensure that the entities that develop and use AI adequately assess, disclose and mitigate the risks of these tools. Surprisingly, most healthcare organizations and insurers really don't do that much vetting of AI tools before they use them, or monitor them after they deploy them. Nothing requires them to do more.

AI developers aren't required to make any particular disclosures to customers when they

pitch their products. And the law also permits them to disclaim liabilities and warranties. As a result, developers have little incentive to reveal weaknesses of their AI tools, and little consequence when things go wrong.

This rule-free space has left hospitals, clinicians and patients apprehensive about the risks of AI, and that fear is chilling adoption.

It is no coincidence that the largest area of AI implementation today isn't the amazing, exciting life-saving tools that are being developed. It is tools that perform simple administrative tasks, like taking notes during clinic visits. We need a supportive infrastructure to build trust in AI tools.

For starters, healthcare organizations and insurers should be required to show they have a governance process in place that meet certain standards.

Fortunately, there are many good models for institutional governance to draw on. At Stanford, for instance, a C-suite level committee decides which tools will be deployed in the hospitals drawing on an evaluation of the tools' clinical utility, its financial sustainability, its fairness, and ethical considerations. That is done by an interdisciplinary team. And we have found that with just a modest of investment of effort, we can spot and address risks, mismatched assumptions, and unfounded expectations.

The Federal Government already requires research organizations to prove that they monitor human subjects research and participants using institutional review boards. Such a concept could be exported to the AI realm, requiring that participants in Federal health program have a process for vetting any AI tool that affects patient care and a plan for deploying and monitoring it.

The joint commission, which accredits hospitals for Medicare is already developing voluntary certification standards for facilities' use of AI.

But institutional governance is only effective if developers feed information into it, and that is why developers should be required to disclose information about AI design and performance. Work

on model cards is a great place to draw from here.

A second step the government can take is to support independent research on how AI tools perform in practice. That can provide critical information about benefits and risks of the tools once they are in the hands of clinicians and insurance companies, and it can ensure that that information disseminates out to the public.

Third, healthcare reimbursement policy should support adoption and monitoring of effective AI solution. Many AI tools don't enhance revenue or healthcare organizations, and won't generate significant cost savings, and they are costly to monitor. Adapting Medicare and Medicaid reimbursement to help cover costs would bring the benefits of these tools to a wider spectrum of hospitals, including those in underserved communities.

Finally, the FDA should be empowered to be a more constructive partner in AI development and deployment. There is only so much the agency can do with the substructure that dates to the Ford administration. Many tools aren't subject to FDA jurisdiction at all, and many of those that are faced with cumbersome processes that weren't designed for software evaluation.

Modernizing the FDA authority could help build confidence in AI, while fixing areas where current regulation makes it hard to bring products to market.

With these steps, Congress can help close the trust deficit that hinders innovation from reaching the bedside. Thank you.

[The prepared statement of Dr. Mello follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you very much. I now recognize Dr. Wright for her 5 minutes.

STATEMENT OF DR. VAILE WRIGHT

Dr. Wright. Good morning, Chairman Griffith, Ranking Member DeGette, and distinguished members of the subcommittee. My name is Dr. Vaile Wright. I am a licensed psychologist, and I serve as the Senior Director for Healthcare Innovation at the American Psychological Association. On behalf of the APA, and our 173,000 members, thank you for the opportunity to testify today.

I am here to discuss the critical role of psychological science and researchers in shaping the oversight of artificial intelligence in healthcare, and the role psychology can play in the ethical and safe development and deployment of AI technologies.

AI is not just a technology. It is a tool built by humans to be used in human systems. Therefore, a deep understanding of human cognition, behavior, and emotion must be central to its deployment to ensure it serves people effectively, ethically, and equitably.

The APA recognizes AI's immense potential to revolutionize healthcare. For consumers and patients, it can enhance diagnostic position and expand access to treatment and preventative care, especially in behavioral health where we know that there is a huge workforce shortage. For providers, AI can alleviate administrative burdens that can lead to burnout. For example, AI-powered ambient scribes as we have heard today are already being used to automate progress notes, which frees up clinicians to focus on direct patient care.

We are also seeing the rise of digital therapeutics, software-based interventions that deliver evidence-based psychological treatments under the oversight of a licensed provider. These regulated tools represent a responsible pathway for innovations to address the mental health crises. However, this promise is matched by significant uncertainty. Public's trust is fragile with polls reporting that the majority of Americans are uncomfortable with AI being used in their own

healthcare.

Currently this discomfort is not unfounded. First, AI risks amplify existing health and equities. For example, one deployed algorithm determines a patient's level of illness based in part on their total healthcare cost. But we know that certain patient populations have historically spent less on healthcare as a result of systemic issues. So what this leads to is unfairly concluding that they were healthier, making them less likely to be identified for high-risk, care-management programs. This problem can impact patients based on their gender, age, race, ethnicity, and socioeconomic status.

Second, the direct consumer market is flooded with unregulated chatbots making deceptive and dangerous claims. One entertainment chatbot presenting itself as a psychologist engaged in millions of chats. And in another documented case, the chatbot appeared to validate a user's violent thoughts toward his family members. This is unacceptable. The APA has formally requested investigations by the FTC, and the Consumer Product Safety Commission to address these potentially harmful products.

To realize AI's promise, while protecting patients, the APA urges the subcommittee to advance legislation and oversight built on the foundation of ethics, equity and evidence. The core mission of healthcare to help and do no harm must be our guiding principle.

We recommend five key actions: The first, establish clear regulatory guardrails. We need a robust Federal framework that prohibits the misrepresentation of AI as licensed professionals, and mandates transparency and human oversight over clinical decisions.

Second, we need to prioritize equitable access to care and mitigate harm. We must require that AI models undergo rigorous independent testing for harms across diverse populations before they are deployed in the marketplace.

Third, we must protect vulnerable populations, especially our youth. Adolescents are in a critical developmental period. As outlined in APA's recent health advisory, we must require

age-appropriate safeguards, and robust data protections to support their healthy development.

Fourth, we need to invest in research and AI literacy. AI development is far outpacing the research. We need a significant Federal investment and independent research with psychological scientists and developers in the same room to understand AI's impacts, paired with comprehensive AI literary education for the public and for providers.

Last, we must enact comprehensive data privacy legislation. A strong Federal privacy law is essential. We must establish a right to mental privacy by safeguarding biometric and neuro information, like data from wearables, that can be used to infer an individual's mental state without their consent.

Ultimately, we must ensure that a human remains in the loop. AI should be seen as a tool to augment, not replace, the clinical judgment and therapeutic relationship that are the benchmark of quality healthcare. The APA believes AI holds the potential to create a more accessible and equitable healthcare system, but only if we intentionally embed psychological science into its entire lifecycle.

We are eager to collaborate with the subcommittee to develop and enact legislation that advances these principles.

Thank you so much, and I look forward to your questions.

[The prepared statement of Dr. Wright follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you very much. Per committee custom, each witness will have -- hang on. You did your opening statement. We will now move onto questions. And I will ask members not to begin a new question to our witnesses as their 5 minutes expires, and would encourage members to submit written questions for the record.

I now recognize myself for 5 minutes of questions.

Let's go back to you, Dr. Wright. I thought you made some really good points, and so, let's make this clear for everybody at home. You need to have somebody in whatever you are looking at, whatever you think your disease might be, or condition, if you are just online or you are using AI online, you need a healthcare professional to help you interpret that to make sure that you haven't gotten a hold of some rogue untested AI. Is that basically part of what you said? I know it is not the whole 5 minutes, but you took about a minute on that; is that correct?

Dr. Wright. Yes, that is correct.

Mr. Griffith. And so, we need to make sure that we have the clinicians involved because, and originally, I was going to ask Dr. Ibrahim this, but I have an article I read a couple years ago coming out of The London Times related to an AI diagnosis of lung disease from x-rays, and the radiologist actually did better than the AI because there were so many different factors that had to be looked at. And in a different study, part of the problem that was identified was they had gotten a lot of the input data from Sub-Saharan, Africa, where the conditions were very different than the conditions in Europe and they were given a lot of false positives.

And so what we have to do is we have to figure out how much data has to go in before it is effective, and if you can tell us, and I know there is no magic bullet, but roughly, I mean, how much data has to go in? And I guess the more complicated it is, the more data you need. But you need a fair amount of data in order to make the AI work correctly. Isn't that a fair statement?

Dr. Ibrahim. Thank you, Chairman Griffith. I agree with your point, and maybe would add to it that it is not just the amount of data, but it is the correct data. And ideally to get these models

to function correctly, you want to train them on a population that is similar to the one you are treating.

In our experience with stroke, a lot of our initial data came from the Southeast United States because that is where the stroke belt was, and so training our models there was relevant. And that has been a learning curve of the field, to know to do that. So I appreciate you raising that point. It is incredibly important.

Mr. Griffith. I appreciate that. I am excited about the potential of AI.

Mr. Toy, you raised the issue, and Marfan, if I said it correctly, and I hope I did, but I have two cases at home that I know about. One was a friend of mine who had a form of ALS, but apparently there are four or five different types, and to get the proper treatment it took them several years to figure out exactly what version of the disease he had. And wouldn't AI, I mean, I grant you have got to get a lot of data in, but wouldn't AI help shorten the time period to eliminate, or to identify which type that he might have had? He since passed away. The treatments just weren't there, and by the time they diagnosed it, it was not possible to get him what he needed. But wouldn't AI help with making that identification shorter?

Mr. Toy. Absolutely. Thank you. Definitely. Also, we look after a lot of ALS people in our population, and within Marfan, I have Type 4, and there is like many, many, many different types, exactly as you just said, which understanding protocols of care are treated actually very similarly.

I think with AI you can match systems, you can match genotypes, you can match phenotypes must more precisely in that end of one personalization I was talking about so that you can then match care protocols, drug protocols directly to the kind of disease that your friend unfortunately had.

Mr. Griffith. Yeah. And this can also help in the population that doesn't have a family history. I know of a case where an individual who was adopted had no clue that they might suffer from Huntington's. It turns out that is what they had, but they spent a year or more looking at MS

and other muscle diseases before they said, wait a minute, maybe it is something we haven't looked at. And AI might help identify based on the systems, it might help quicker identify, and that is not to say the doctors were doing anything wrong, it is just that they got hundreds of options, and AI can help cut through those options, can it not?

Mr. Toy. I think absolutely. When we talk about earlier identification, this is a huge area that we are seeing already happening with AI where a doctor will be doing the right thing and looking at this set of symptoms, but then not thinking as much about something that is a little bit rarer or not obvious, and AI can notice something there in the system set and bring it to the doctor's attention and the doctor then says, oh, yes, I should consider that. And that is a big, big area we see that doctors are saying it is helpful to have from AI.

Mr. Griffith. Yeah. All right. Last, but not least, my district is very rural and economically stressed, most of my hospitals and community health centers run on very thin margins. What type of upstart software is needed for rural health entities to use to advance to AI and machine learning and is it expensive?

Mr. Toy. That is a great question. I think that what is really exciting is that the infrastructure we are building on AI, and the infrastructure of the country on Cloud means that we can deliver these capabilities very quickly to more rural areas, to smaller towns, and they can enjoy the same benefits that a larger, more dense urban center would have, and the same coordinated care as well between different sites of care. So that local independent pharmacist in that small town would be coordinated with the local family doctor in a way that they have never been able to before.

Mr. Griffith. I appreciate it very much. I yield back. I now recognize Ms. DeGette, the ranking member, for her 5 minutes of questions.

Ms. DeGette. Thank you so much, Mr. Chairman, and thanks to all of our witnesses for their very illuminating testimony.

There has been tremendous innovation in the machine learning and generative AI spaces in recent years, and the healthcare sector really can see the potential benefit of this innovation. And all of you gave excellent examples of how this can happen.

One thing that struck me, Mr. Toy said that AI should assist doctors, not substitute for them. And I think -- all of you are nodding, so I think none of you disagrees with this statement, and we all agree with that.

So Dr. Mello, I want to ask you, you testified that the uptake of the innovative tools is low, in part because of its foundational trust deficit. Is that right?

Dr. Mello. Yes, Congressman.

Ms. DeGette. So in general, how would you characterize the evidence-based supporting the use of novel AI tools?

Dr. Mello. It is thin, you know, and what we have predominantly comes from the people selling the technology.

Ms. DeGette. And I also suspect there are not well-established industrywide best practices for the use of AI tools in the house space.

Dr. Mello. We have best practices emerging. The difficulty is why adopt them if there is no incentive or reason to do that.

Ms. DeGette. And at present, which types of institutions are able to measure the impact of AI tools and to optimize their use?

Dr. Mello. The ones in the best position to do that are the ones with the most money and the most scientific expertise.

Ms. DeGette. Right. So is it likely that institutions with fewer resources are going to be able to pull off that sort of robust evaluation and thoughtful implementation in the current environment?

Dr. Mello. I don't believe so. Certainly not with help from the reimbursement

improvements that would enable them to staff up and gain that capacity.

Ms. DeGette. Right. So those organizations with the fewer resources that we are talking about, like rural hospitals, community health centers, and other healthcare providers, they all serve our constituents, they are facing tighter and tighter resources to do their jobs. And as all of you know, and, of course, my colleagues here know, earlier this summer H.R. 1, which I call the big bad bill, was signed into law. What that bill will do, it will kick 15 million people off of their insurance. So that is 15 million fewer people who are going to benefit from an AI revolution in healthcare.

And hospitals who need resources to care for our constituents and to work on improving care, including with new AI tools, are facing an additional $400 billion in uncompensated care over the next 10 years. So all told, H.R. 1 is slashing over $1 trillion from our constituents' care.

I have got to say, this is what I meant when I said in my opening statement that we are fiddling while Rome burns. All of us agree, AI can really work, it should be used, we should use best practices, but when we are taking away the money to treat our constituents, then the idea that somehow they are going to find a way to do a robust and appropriate AI system is a dream, at best.

Impoverishing the healthcare system is just not going to help these improvements, and there is no, as we all agree, there is no AI solution that can replace the doctors and nurses that hospitals, which will serve the poorest Americans, can no longer afford to employ.

And I want to say, this committee just simply has to stop acting like it is business as usual and ignoring the real problems that are facing our healthcare system and our constituents. If we really want to use AI as a good tool, we are going to have to reverse the cuts to Medicaid before they take effect and devastate millions of Americans. And we are going to have to stop the administration's damage to our public health system before the emergency lays open our vulnerabilities.

I mean, this is really serious. I would like to be able to find a way to do some innovation at the FDA. I did that in 2016 with Congressman Fred Upton, then Congressman from Michigan, we did 21st Century Cures, which restructured a lot of things we do at the FDA, and the NIH, and the

CDC, and it enabled us to have Operation Warp Speed, which I guess now the President doesn't like, but which saved millions of lives with the COVID vaccine.

So I would like to be able to help spearhead a bipartisan effort to put the protocols in place, and the funding in place at the FDA to do artificial intelligence. Folks, that is not where we are right now, and people better know that. I yield back.

Mr. Griffith. The gentlelady yields back. I now recognize the chairman of the full committee, Mr. Guthrie of Kentucky, for his 5 minutes.

The Chair. Thank you. And I thank you all for being here today.

So, for Mr. Toy and Dr. Ibrahim, Clover and Viz.ai have both launched successful AI technologies in healthcare. Speaking from your company's own experience -- so I will start with Mr. Toy and then -- speaking from your company's experience, how can AI tools be leveraged to empower and not replace providers in ways that can help them better manage and deliver care?

Mr. Toy. Thank you for the question. I think the key here is, as we have all said, that the physicians in question need to be able to feel like that they are able to do their jobs better than they were before, that the friction is being lowered, and that they are feeling effectively empowered to do a better job. It should be a force multiplier that comes from AI.

So what they were going to do perhaps anyway they can do faster, quicker and easier, including getting reimbursed for that treatment. So I think that AI, we are showing in our own plan, is already doing that with our tool Clover Assistant, we are putting that in the hands of primary care physicians who are diagnosing diabetes earlier, who are managing chronic disease earlier, and that is by synthesizing that data and putting it at their fingertips.

The Chair. Thank you. Dr. Ibrahim.

Dr. Ibrahim. And I will just add to that, and maybe just give perspective from my own practice. I have a clinic every Tuesday afternoon where I may see a dozen new patients, and Monday night I spend 2 or 3 hours to read about them because to get the 3 or 4 data points that I

need to make a decision about their care. I log into three or four different places, I read through scan PDFs from an outside hospital to try to piece the whole story together. And I know many of my colleagues do the same thing, including for time-sensitive things in the hospital.

To harness our technology, and it is one of the things we have done in our company, to help find that information quicker so that the physician can get to what they want to do is make a treatment plan for that patient, may be one of the most valuable contributions of AI.

The Chair. Okay. So, follow-up for the two of you as well. How should policymakers think about ensuring more of these innovations can reach patients and clinicians without overburdensome regulations getting in the way and we balance the need -- how do we balance the need between the appropriate guardrails and patient safety and getting these deployed?

Mr. Toy. I will take that first. Thank you, for that question as well. I think that the way we consider it is, by having that clinician looking -- being accelerated by the AI, knowing that that clinician is available to review its recommendations, that serves as an important guardrail in and of itself. And so we are accelerating what is in their own mind, we are relying on the training that they have, we are just making their job easier. So any time we are making that -- expanding the possibilities of how we do that with a clinician, a physician, we feel like we are in a pretty good place from a guardrail perspective.

Dr. Ibrahim. Thank you, Chairman. And I may be connect my answer to the Ranking Member DeGette's previous comment, I have a lot of empathy and sympathy for the FDA at the moment where they are being asked to evaluate a new technology that they are not really designed to evaluate right now. They are using laws that are decades old, or statutes or authorities or frameworks that don't really fit the pace or the way that AI is being used.

So support from Congress that would help FDA modernize, whether it is another version of 21st Century Cures, or something similar, would be helpful so that the FDA can efficiently figure out which of these products are snake oil and should not be approved, and which of these are approved,

and once they are approved they can then be supported through reimbursement. So I think there is some tangible policy there that would be incredibly helpful.

RPTR ZAMORA

EDTR ROSEN

[11:16 a.m.]

The Chair. Okay. Thank you.

And so, Mr. Parker, this committee and the Trump administration has made healthcare price transparency a top priority. It is bipartisan. How are price transparency and reporting policies enabling your company to empower American patients in their healthcare journey, and can you discuss the role AI plays enabling general medicine to do this work?

Mr. Parker. Yeah. I should state very clearly that the work we are doing to show consumers prices upfront for procedures, labs, imaging, anything that they need would not be possible without all of that work. We are using the open pricing files to figure out the sort of reimbursement, and there is specific pricing for the consumer. But the -- it really also wouldn't be possible without AI.

You know, the example I shared in the testimony is we are literally taking down your full 100-page coverage of benefits and using AI to read those coverage of benefits and turn it into useful data, and then munging that together with the open pricing files to give patients a clear, out-of-pocket price. So, it really is a byproduct of all the work that has been done over the last decade to require providers to disclose these pricing files.

The Chair. And so the providers, insurance companies, whatever, PBMs, you have to have the price data publicly available for AI to be able to call out and give people the best answer?

Mr. Parker. That is correct, yep.

The Chair. Because if it is hidden data, then AI is not going to find it.

Mr. Parker. Yep, right.

The Chair. Thank you. And I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the ranking member of the full committee, Mr. Pallone, for his 5 minutes of questions.

Mr. Pallone. Thank you, Mr. Chairman. I am trying to get in two questions to Dr. Mello and one to Dr. Wright, so bear with me here.

Dr. Mello, we are witnessing a significant increase in AI-driven medical product development. Given their rapidly expanding technologies, we must ensure that we also better understand and evaluate how these AI-enabled devices function so they don't put patients at risk. So my question, or first question, to achieve this, do we have the appropriate regulatory framework in place, and does the FDA's current statutory authority allow the Agency to be nimble in its oversight of AI-enabled devices, if you will?

Dr. Mello. Thank you for the question. I will answer the second part first. I think the Agency has been remarkably nimble given what they have to work with, but what they have to work with does not allow a great deal of maneuvering room. So, absolutely, there needs to be modernization to solve two problems: One is that they can't do enough; and one is that the statutory framework requires them to do too much or the wrong things given the type of technology that they have confronted now, as Dr. Ibrahim has said.

Mr. Pallone. Okay. And I am also concerned that there are insufficient guardrails in place to protect patients from bias in AI and coverage denials for necessary care. In July, the Trump administration announced the Wasteful and Inappropriate Service Reduction Model, which would impose prior authorization in traditional Medicare and allow for profit companies to use AI to perform prior authorization reviews. And I am concerned that this AI model will result in denials of lifesaving care and incentivize companies to restrict care. So my question is, how can we ensure that these algorithms are not being misused to delay and deny lifesaving care for patients, if you will?

Dr. Mello. Right. So the WISeR program really raises two questions: One is, when we take a process that is fundamentally and for a long period of time flawed and put it into traditional

Medicare, what would we expect to happen? And then the second is, when you take that process, prior authorization, and amp it up with AI, what will change?

I think we have pretty good evidence that prior authorization as a process itself is fraught, that there are high rates of wrongful denials, low rates of appeal, high rates of overturn on appeal. So we should have some concern about any effort to expand its use, while at the same time, recognizing that in some areas, including, I will say, the areas that WISeR currently targets, it is a necessary cost control, and the question is how you do it.

And then the second issue is, what happens when you bring AI into the game? And there, we don't know. We don't know because there are no publicly available information that would enable somebody like me to be able to tell you does using AI make prior authorization better for patients or worse, because I think both outcomes are very possible.

Mr. Pallone. All right.

Let me go to Dr. Wright. Another area of concern is the intersection of mental health and AI.

If I could, Mr. Chairman, I would request that the Washington Post article titled, "What Is AI Psychosis, and How Can ChatGPT Affect Your Mental Health?" be submitted in the record, if you will, Mr. Chairman.

Mr. Griffith. Do you have the date on that?

Mr. Pallone. What is that?

Mr. Griffith. Have we been submitted that? The date.

Mr. Pallone. I think you have it, but if not, I will give it to you.

Mr. Griffith. Oh, we have it. Okay.

Without objection --

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pallone. All right. Thank you.

Mr. Griffith. -- so ordered.

Mr. Pallone. So, Dr. Wright, the question is, the American Psychological Association issued a health advisory on AI and adolescent well-being in June calling for robust protections for young people interacting with AI, urging developers to implement safety features and for educators and parents to foster comprehensive AI literacy. So can you share information on what prompted APA to issue this advisory, and what your members are seeing in their practices that would relate to that?

Dr. Wright. Thank you for the question. Yeah, APA really felt a sense of urgency to look at what the psychological science has to say in this space, because, as we have said, AI development is just outpacing the research and the guardrails. And we have been hearing from both clinicians who are seeing patients that are coming in with their ChatGPT advice, and we have heard the public stories like The Washington Post story you just mentioned about the harms that seemingly are happening, in part because, to Ms. DeGette's point, we have a broken mental health system, and so people are seeking out help wherever they can find it. And that, while very human, might not be a best idea.

And so I see a future where, you know, we will have mental health options that are more appropriate, that do utilize AI, but that is just not what is on the commercial market right now. And so helping parents, teachers, educators, technologists, understand what does the psychological science say about how to do this well and what are the considerations that need to be factored in is a huge part of why we put out that advisory, and why we are also standing up a second advisory more specific to the use of these wellness chatbots and these general chatbots.

Mr. Pallone. Thank you.

Thank you, Mr. Chairman.

Mr. Griffith. The gentleman yields back.

I now recognize the vice chair of the subcommittee,

Mrs. Harshbarger.

Mrs. Harshbarger. Thank you, Mr. Chairman.

And thank you to the witnesses for being here today. I am excited about this line of questions, and I hope you are too.

I will start with Mr. Parker. You know, I am excited about the fact you have got a one-stop-shop for telehealth, basically, telemedicine. You can do the labs, the prescription, give them the price and do all that, and bill insurance or let them do a cash model, kind of like a concierge service, you know, when you walk into a brick-and-mortar.

I guess enhancing the role of the clinician is a key win for technology and is part of the expansion of the over-the-counter drug class. The FDA promoted something called additional conditions for nonprescription use, and what this essentially means is consumers can answer some questions on a phone app or another technology platform to determine if a drug is right for them and then access a prescription drug therapy.

So how do you see technology and automation as a platform to expand and reinvigorate the practice of community pharmacy -- since that is what I am, a compounding pharmacist and I have a community pharmacy?

Mr. Parker. Yeah, it is a great question. And I think as we all acknowledge, pharmacists are underutilized compared to their --

Mrs. Harshbarger. Absolutely.

Mr. Parker. -- capacity. And I do think, if you take some of the work that we have done at general medicine where we have worked really hard to codify these intakes for specific medications, so it is very -- the clinician, which in this case, could be a pharmacist, has all the information they need to make a judgment on whether it is appropriate for the patient in that moment would apply very well in that setting. I think it wouldn't just be constrained to a traditional clinical setting. And so, I think a lot of the logic infrastructure and work we are doing would be a great opportunity for

pharmacists to participate more in that.

Mrs. Harshbarger. Absolutely. Thank you for that. We need to practice at the top of our license, which is something I am working on, too.

Mr. Parker. Agree.

Mrs. Harshbarger. Mr. Toy, you mentioned that as far as utilizing your community provider in rural areas and your pharmacists, can you -- what do you think about this?

Mr. Toy. Absolutely. I think that -- and you probably see this in your own practice, but there is not a lot of coordination right now between the actual pharmacist and the physician. Oftentimes the physician uses their mind. They think about things. They write a script, and then they are like, okay, where would you like that filled, right?

Mrs. Harshbarger. Yeah.

Mr. Toy. That is the question they ask the patient. And so what we want to make sure is that there is coordination there, make it very easy for the pharmacist to have the same information that was available. And the thing that AI can do also is take that same information and customize it not just to the patient, but customize it to the clinician in question. So it will show a certain version of that to the PCP, and it will show a more pharmacist-relevant version of that to the pharmacist. But they are seeing the same data, but two different facets of that same data, so they can then apply that critical training.

Mrs. Harshbarger. Well, you work with collaborative agreements between a physician and a pharmacist is how you would do that, and every State is different. So, you know, that is why I am looking at an ECAPS bill and some other things associated with that, so, yes, sir. I got it. I am glad you are on my team. Thank you.

Mr. Toy. Absolutely.

Mrs. Harshbarger. Dr. Ibrahim, while some applications of AI in healthcare, such as basic chatbots, may appear relatively low risk, others carry higher stakes, including tools targeting mental

health, minors, or care and coverage of determinations. Should Congress begin to define high-risk categories of generative AI in healthcare? And if so, what safeguards like -- such as independent validation of clinical claims or patient safety protocols for sensitive-use cases made the labeling and the disclosures for consumers, and what would best protect that patient without stifling that innovation?

Dr. Ibrahim. Thank you, Congresswoman. Innovation moves at the speed of trust. That is something we have all sort of been trained and brought up in. In our practice, anything that we have tried to bring to patients requires a partnership with hospitals first where we map out what do we have the capabilities to do, what are their needs. We pilot things several times in historic data before even trying it in real clinical practice, and then have rigorous milestones to meet before it actually gets scaled to any other settings. And that has been our practice, in part, because that is necessary for our business. If we do not establish that trust and maintain it, we will lose our clients, so it is required for us to do that fundamentally.

The FDA has some precedent for devices, which is what much of this has been mirrored on. And there likely is a similar tiering of class one, two, three devices that would mirror an AI technology. I think that would be welcome guidance to help create some roadmaps, so we understand where we need to spend a lot of time and be methodical and rigorous, and where are things that we can accelerate faster.

Mrs. Harshbarger. Yeah. Output is only as good as the input, and it better be correct, right? Okay.

Dr. Ibrahim. That is right.

Mrs. Harshbarger. Thank you, sir.

And, Mr. Chairman, I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from California, Dr. Ruiz, for his time of questioning.

Mr. Ruiz. Thank you, Mr. Chairman.

Artificial intelligence has potential for expanding access to healthcare and improving patient care. However, as with any new or developing technology, we need to make sure that we are evaluating any potential harms and ensuring appropriate safeguards as the technology continues to expand. It is crucial to directly address the risks, including mental health risks that AI tools may pose for our children.

Dr. Wright, in your testimony, you discuss the need to protect vulnerable populations like youth. You stated that, quote, "AI systems designed for adults are not necessarily appropriate for youth." Could you please explain what specific dangers and potential harms AI technology used for healthcare can have on children in their development?

Dr. Wright. Thank you so much for the question. So I think, when we think about the model, right, it is really about representativeness. And ensuring that whatever training model we are employing has been trained on the data that is appropriate is critical, because you do end up seeing these harms when you have got systems that were developed for adults. And children are not just little adults. They have very different developmental trajectories. What is helpful for one child may not be helpful to somebody else, not just based on their age, but based on their temperament and how they have been raised.

So, you know, at worst, some of the harms we are seeing have been, you know, alleged completed suicides, and also suicide attempts and much of -- and suicidology discussions with different types of chatbots. You have seen, as I mentioned in my testimony, there is a case in Texas where a young individual following the validation and advice from a chatbot attacked his family and had to be hospitalized. So the harms are real.

We also have positive-use cases on top of it, right. So I hear stories of children who use a chatbot to practice their social skills so that they can make a new friend at school. It is not an all-good or an all-bad thing. It is about how we use the tool appropriately, how we safeguard it,

how we test its effectiveness to ensure that children who are going to continue to use these AI tools -- because they are not going away -- will be protected.

Mr. Ruiz. You know, I, too, am alarmed at stories of individuals turning to AI chatbots as a source for therapy, including the tragic story of teenager -- California teenager Adam Raine. ChatGPT provided mental health resources when Adam shared his suicidal ideations, maybe a popup or something, which is inappropriate in a clinical setting. Imagine you are admitting your suicidal thoughts, and the clinician just holds up a poster board with a hotline number and then continues with more deep conversations about how to actually complete suicide. So it is completely not clinically appropriate or that helpful.

Dr. Wright, if AI systems can behave unpredictably, what enforceable guardrails are needed to ensure that they do not worsen crises or harm individuals, especially those seeking mental health resources? And what benchmarks must be met before AI can be responsibly scaled as a tool for mental health support, especially for youth?

Dr. Wright. Well, I think at first, we have to ensure that these tools do not misrepresent themselves as licensed professionals, that they cannot call themselves psychologists or psychiatrists or social workers, because that gives a sense of credibility that doesn't exist. I think on the back -- the real expertise for these products are on the back end. They are how they are being coded. And we could encourage companies to make them less addictive in their coding tactics and make it so that user engagement isn't the sole outcome that they are trying to achieve.

I think some of those things would also help. And we could also ask for specific audit and reporting requirements where these companies had to actually disclose anytime they detected suicidology or attempted or completed suicides. We could have better age verifications and age restrictions. I think there are some pretty low-level things that we could do that would actually ensure that these tools are used better. We also just need better tools.

Mr. Ruiz. And what can we do to educate clinicians on how to use these?

Dr. Wright. Well, I think for sure, clinicians need a lot of education on how to use these. I think part of why you haven't seen adoption is the anxiety and the fear that these tools bring and the lack of understanding of how they work. So I think helping providers know what works, what the limitations of these tools are, is first step towards helping them decide whether or not they want to choose to implement them in their practices.

Mr. Ruiz. Thank you.

I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes.

Mr. Bilirakis. Thank you. I appreciate it, Mr. Chairman. This is a great hearing, and I thank the witnesses.

One area that I am interested in is the role of AI in drug development, particularly in the rare disease space. Scientists have developed AI models to identify drug candidates from existing medicines that could be applied for rare diseases with unmet needs. The innovation is just the beginning, and we should continue to explore similar applications to improve our healthcare system. Most people agree with that.

The question is from Mr. -- this is for Mr. Toy. Your testimony discusses your personal experience as a rare disease patient. Thank you so much for sharing your story. It really means a lot to the community. Can you share further how AI will continue to accelerate the patient diagnosis journey, please.

Mr. Toy. Absolutely. And thank you for talking about rare disease here with the committee. So speaking as someone there, I also serve on the board of the Marfan Foundation. It is a rare disease. It is a genetic-based disease. And so something I would point out to you is, rare diseases are rare individually, but across like the entire country, many people have a family member who has at least one form of rare disease, so they are not rare in collection.

Mr. Bilirakis. That is right.

Mr. Toy. The other thing I would say, and we have discussed it here, and we are talking about clinicians, I think the key thing is, most clinicians are in their training. The chance of having a clinician who has the training, the CME, the continuing medical education, on your rare disease is actually quite low, because they can't take training on everything there. What AI can do is help them learn more about the condition, also help them identify practitioners in the area who have more expertise in those and collaborate with those practitioners and get a given patient closer to sight of excellence for that rare disease.

Mr. Bilirakis. Very good. Excellent. Appreciate that information.

Dr. Wright -- and, again, I am just following up with Dr. Ruiz on this particular subject.

Dr. Wright, as chair of the Commerce, Manufacturing, and Trade Subcommittee, I am very interested in protecting children and teens online, as we all are. In that space, there is a lot of talk about how children and teens using online services may face greater risk of suicide, self-harm, and other dangers. One discomforting new trend is the rise of AI chatbots, which we have been discussing, which I am concerned may exacerbate existing problems of loneliness and social isolation among young people.

While still early days, the prospect of children and teens socializing primarily with chatbots and building supposed relationships and even romantic relationships with these new online services is troubling to many parents. Can you speak to how loneliness and social isolation impacts children and teens' development, and what could the long-term impacts be of children and teens interacting primarily with AI chatbots instead of their peers?

Dr. Wright. Thank you for the question. Yeah, obviously, we are very concerned as well on the role that all emerging technologies will have on our children and adolescents.

In our recent Stress in America survey, the majority of all adults -- that included children -- said that they feel like they can't talk to people about their stress because they don't want

to burden them. We also have a study that says that adolescents would prefer to speak with an ambient source -- like a chatbot -- than a person because they fear being judged. This is a real challenge in our culture. And, yes, it is spurring increased loneliness and isolation.

So what do we need to do as a culture to help people understand that coming together and having empathy and having social connections is actually the better solution than turning to these technologies as a replacement for people? They can be a huge tool as long as you use them and then go back to the people that you are trying to connect with.

And so if we as parents need to model good use of these technologies for kids, we need to help them understand what the risks of them are, what the business models are, and how that influences how they interact with them. And part of that is going to have to be how we teach this in schools to kids, because, again, this AI is not going away. But how do we help people remember that it is personal connection that makes us the people that we are?

Mr. Bilirakis. Absolutely. Thank you very much. I appreciate it.

I yield back, Mr. Chairman.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Michigan, Mrs. Dingell, for her 5 minutes.

Mrs. Dingell. Thank you, Mr. Chair. And thank you and our ranking for holding this hearing on the use of artificial intelligence in healthcare systems.

Look, AI is transforming every sector, and we have seen that this emerging technology has the potential to transform lives and improve healthcare incomes. But let's be honest, with rapid advancements comes serious challenges as well. Any potential AI-related legislation must consider potential data privacy -- which I worry about deeply -- bias, displacement of jobs, and in the case of healthcare, misdiagnoses, and as our witness also said, the humanness of patients, and you need compassion and empathy.

It is also important to highlight the context in which we are having this conversation. My

Republican colleagues in Congress and the Trump administration have already enacted and seek to advance further reductions in staff and funding of our healthcare system. Adequate resources are critical to ensuring that the usage of AI technology in the healthcare space is subject to guardrails that protect the safety of the providers, the patients, and their loved ones.

So Dr. Mello, as providers grapple with the increasing presence of AI in their workplace, many worry that this technology jeopardizes patients' right to high-quality care and displaces our talented doctors and nurses. How can we ensure that AI serves as a tool that physicians use to enhance care, not one that replaces person-to-person care?

Dr. Mello. It is an important question. And the context that you specifically raise of cuts in Medicaid reimbursement intensifies both the need for AI to augment capacity in rural and low-income hospitals, and also the constraints around their ability to monitor it properly. I think there is a lot of promise in use of AI to address the needs of populations in those facilities, especially those with complex needs, but they will need help.

And assuming, as many organizations do, that simply because there is a human in the loop, we don't need to provide support, training, and institutional-level monitoring is a grave mistake. Let's not forget the whole reason that organizations are implementing many of these technologies, like scribes and note summarizations, is the burnout that afflicts those facilities. So these people in the loop, this is not Superman. They need support, and it has to be at the institutional level.

Mrs. Dingell. So let me take that one more step down. Many patients, particularly seniors and individuals with disabilities, and children, as we are talking about, have unique needs that require knowledge and care of a human provider. What specific considerations are necessary to preserve the level of patient care for those with complex health conditions as AI plays a larger role in their care?

Dr. Mello. Well, as I think about that question, I have to start from where we are now, which is that those patients are in many ways really poorly served by the system we have in its

extreme fragmentation of both care and information. So I actually think, to some of the testimony that other witnesses have given here, that those are some of the best opportunities for AI to make these better.

But there are reservations that I have as well, in part because patients in that position are not themselves positioned to be good overseers of the AI that is being used in their care. For example, whereas I might be inclined to review an after-visit summary that I know an ambient scribe generated, somebody who is dealing with multiple complex conditions will not. And so we need to be extra careful about monitoring for them.

Mrs. Dingell. I have some thoughts, but I will put them in another question. I want to have time for one more. I want to turn to the potential mental health impacts of AI, particularly on women and girls. We know that the victims of abusive AI-generated content such as deepfakes feel isolated and distrustful around them. We have already talked about depression, anxiety, suicide, et cetera. I was one of the proud leads of the Take It Down Act.

But Dr. Wright, because I am almost out of time, how can our mental healthcare system be bolstered to better respond to the impact of AI-enabled abuse?

Dr. Wright. Well, thank you for the question. I think in part, it starts with helping providers, clinicians, and others really know how to evaluate the tools and what they should be looking for if they are going to incorporate these tools into any kind of setting that they are doing. And I think it is about helping clinicians and providers know what questions to ask of their patients about their AI use.

I think a lot of providers have no idea where to even start to ask that question, and so, you can't even sift out whether abuse is happening if you don't know the right question to ask. And so, it is these sorts of things, whether there are continuing education trainings that providers get, or we think about how do we train individuals within the school setting, our future providers, because they are the ones who are really going to be up against it.

Mrs. Dingell. Thank you.

Mr. Chair, I am out of time, so I will yield back.

Mr. Griffith. Yes, ma'am. The gentlelady yields back.

I now recognize the gentleman from Florida, Dr. Dunn, for his 5 minutes.

Mr. Dunn. Thank you very much, Mr. Chairman.

And I thank the witnesses for being with us here today.

As a medical doctor, I am certainly excited to see the advances that AI can make possible in healthcare, from improving efficiency at the administrative level to assisting providers in clinical practice. I am sure it is going to be great for all of us. You know, we clinicians are drowning in paperwork, and I think that that could be the low-hanging fruit for AI, frankly.

It is essential that the United States remain at the forefront of AI, and I firmly believe the FDA should be continuing to work with pioneering companies to ensure that patients benefit from a full scope of AI technologies. It can also be, you know, valuable in complementing the work done by physicians to provide better healthcare outcomes. But by reducing administrative burdens and costs, I think it can give us far more time to focus on our patients and save money. And by assisting clinical physicians, AI can bolster the human expertise in medicine.

Dr. Ibrahim, patients know that physicians are essentially irreplaceable in the system at this point. We are the lynchpin of human responsibility. You and I are both physicians. We know we can be more efficient. How do you see the earliest applications of AI in clinical medicine as increasing the efficiency of frontline clinicians or replacing your administrative burdens?

Dr. Ibrahim. Thank you, Doctor and Congressman. I appreciate your question, and that strikes personally close to home to me. I think, if I could go home to my family and say instead of reading charts Monday night for 2 hours, all that information would be ready for me in clinic and I could just spend time with my family, I think that would be great.

There are a number of things that we need to do in the hospital that require a significant

amount of manual abstraction, whether it is quality reporting, whether it is documentation or billing. Many of those things require very highly trained people to spend hours of time literally sometimes checking boxes for information that we could readily extract. So I think there is enormous potential to get people actually doing the things that they want to do and doing less of the things that we could probably automate now. It certainly would require, as mentioned by the panel, that we have the right safeguards in place and the right checks to make sure it is being done appropriately, but I think there is a lot of potential there.

Mr. Dunn. I couldn't agree with you more. To that end, Dr. Ibrahim, can you envision a world where most imaging studies, pathology slides, radiology, pattern recognitions, whatnot, are pre-read by software?

Dr. Ibrahim. Thank you, again, for that question. I think pre-read is challenging. I think the idea that it could triage and identify high-risk conditions, to say this imaging likely shows high-risk stroke, or this shows a life-threatening heart condition, still needs a human to really solidify that. From our own data, we know it is not near perfect yet, but it helps identify the highest risk ones. I don't know -- it would be too hard to speculate if we would get to a time in my career where that could be entirely automated.

Mr. Dunn. Well, I agree with you, by the way, on that, but I think that there -- we may need some updates on the CMS payments model to make that world possible. Can you see how that might happen?

Dr. Ibrahim. CMS currently does have an opportunity through NTAP where new technologies are able to be temporarily reimbursed for 3 to 5 years that assist with either EKG reads or radiology reads. I think it would be great to have that, a more permanent pathway to reimbursement, but that would still be in the assistance category.

Mr. Dunn. Thank you. Thank you very much for your thoughtful answers.

And I look forward to working with my colleagues to ensure that AI in health care is utilized to

its maximum potential and ensuring patients' safety remains at the forefront. And with that, Mr. Chairman, I yield back.

Mrs. Harshbarger. [Presiding.] The gentleman yields back.

And now I recognize Representative Kelly for her 5 minutes of questions.

Ms. Kelly. Thank you, Madam Chair and Ranking Member DeGette, for holding today's hearing.

And thank you to all the witnesses.

It is important that we do not ignore how in this last week, Secretary Robert F. Kennedy, Jr., and others in the Trump administration continue to undermine Congress and the public health system's ability to function cohesively with the firing of senior staff and experts. Secretary Kennedy is putting Americans' health and well-being at risk by actively dismantling HHS. Unfortunately, too many of my colleagues remain silent on this devastating public health issue and other harmful policies caused by the "Big Ugly Bill."

But our work continues, and that is why I am proud to cochair the bipartisan Digital Health Caucus with my colleague Rep. Troy Balderson. I encourage my colleagues on both sides to join us as we aim to educate and learn more about these issues.

Integration of AI in the healthcare system offers the potential to be a transformative solution to address longstanding disparities and access issues, as you guys have talked about. Many in both the healthcare and technology fields have promoted AI to create a more accessible and equitable healthcare landscape, particularly in minority, underserved, and rural communities. However, we must remain vigilant of the promises as well as the limitations.

Dr. Mello, AI tools are only as good as the data they are built on. When the data is incomplete or skewed, the results may lead to inaccurate suppositions. We have already seen examples where algorithms underestimated the needs of Black patients, because healthcare costs were used as a stand-in for health status, and where dermatology tools trained mostly on lighter skin

tones misdiagnosis conditions on darker skin. These cases show how quickly AI can replicate inequities already in our healthcare system.

What steps should developers, health systems, and Federal regulators take to make sure AI tools are tested on and validated for diverse populations before they are deployed?

Dr. Mello. It is such an important question, and I know you have heard already about the need for large data sets that include sufficient representation from a variety of subgroups, including, I will add, subgroups that are not usually on the map for anti-discrimination worries, like kids, people in rural areas, people with rare conditions.

And FDA, of course, should be doing more in the area of performance testing. But let me add a wrinkle that I think doesn't get talked about enough, and that is that even when you have a well-performing algorithm that performs well for all of those subgroups, bias and inequities arise at the point of care because of the way that it is deployed.

And I will give a simple example. We have got tons of algorithms at Stanford that screen our patients using information in their medical record to identify people who would benefit from additional services, but our ability to get those patients in the door is dramatically different depending on what those patients look like and where they live. So unless we are willing to spend more money doing outreach and creating more capacity in our clinics for those patients, they can benefit in theory but not in reality.

Ms. Kelly. Interesting you say that. As chair of the Digital Health Caucus, a cochair, one of the things I am looking to better understand is how AI and data science can help with efforts such as clinical trial recruitment and retention. I am also chair of the Congressional Black Caucus. What are some ways AI can be used to get more people into clinical trials, and what ethical or policy guardrails should Congress consider as we support this responsible use?

Dr. Mello. Well, I think the main area where AI can help is in the identification of potentially eligible patients. We heard already about the NIH initiative. At Stanford we have a new tool being

deployed across our system now that enables a researcher to query the medical record to find all patients who have a particular health condition and meet other inclusion criteria for the trial, and that could be hugely helpful.

I will say, though, that the major -- a major reason why we don't have representation in clinical trials is not that we can't identify the patients; it is that we can't convince them to enroll. And AI is never going to get us there. That is where we really need the human touch, reaching out to those communities, and explaining the benefits of trial participation along with the risks.

Ms. Kelly. And my office has been doing a lot of work around that, because we know all the past issues that people have and the lack of trust, but we know there is still a lot more work to do.

I thank all of you so much, and I yield back.

Mrs. Harshbarger. The gentlewoman yields back.

And I will now recognize my friend, Dr. John Joyce, for 5 minutes of questions.

Mr. Joyce. Thank you, Madam Chair.

Much like other industries, the growth rate that we are seeing in AI within healthcare over the last few years has dramatically expanded offering the potential to fundamentally alter how care is developed and delivered. A key area of this growth is in the FDA-approved AI-enabled medical devices. Just over a decade ago, there were just six approvals by the FDA for AI-enabled medical devices. Today, that number exceeds 600.

CMS has begun to offer some level of coverage for software-based technologies to support clinicians and is currently seeking input as part of the proposed CY 2026 physician fee schedule and outpatient payment roles. However, I believe that more can be done here to provide a sustainable and consistent pathway for these devices under Medicare. This is why I have been working with Senators Rounds and Heinrich on introducing a House version of the Health Tech Investment Act, which would do just that.

Dr. Mello, and then Dr. Ibrahim, do you feel that the lack of a stable environment for

reimbursement for these new devices makes it much more challenging for rural and small hospitals, like those that I represent in Pennsylvania's 13th Congressional District, to invest and ensure that rural patients and communities have access to the latest innovation? First, Dr. Mello.

Dr. Mello. I do. There is no question that when you are trying to just get through the day thinking about innovation and staying on the cutting edge of future care is not possible in the thought space and resources that you have. So there are many things we can do to provide direct assistance to rural hospitals, both in the academic sector but also in the policy sector, and the reimbursement piece, as you said, is critical.

I think, you know, the FDA example that you began with is really illustrative because that is an area where despite regulation, despite clearance processes, we have gotten a lot of those innovations out broadly to hospitals. These are overwhelmingly radiological tools. Of the nearly 1,000 applications approved by the FDA, overwhelmingly these are radiology tools, and we have done a good job of getting them out into practice, but --

Mr. Joyce. And you see that mostly those are in major metropolitan areas and not in rural areas?

Dr. Mello. You know, again, it depends on whether there is a mechanism for billing for that extra. And it is really critical to remember, the extra is not just the cost of buying the thing. The extra is the cost of training radiologists on how to use it, and making sure that it is working well for everybody, and that is where a rural hospital might be willing to adopt but not do the work of keeping people as safe as they could be.

Mr. Joyce. Dr. Ibrahim, could you please comment.

Dr. Ibrahim. Thank you so much for the thoughtful question, Doctor, and I appreciate you bringing up rural health. Some of the most impressive improvements we have seen in stroke care from our technology have been in rural work, that one of the references in interventional neuroradiology in my testimony was from Texas, sharing that, in deep rural Texas, we were able to

improve some of the time of treatment by 80 minutes in stroke patients.

You are correct to identify the tension there, that when hospitals make a decision about whether or not to adopt the technology, the ability to get reimbursed for it is front of mind. If we are able to identify ways to reassure hospitals that there will not only be temporary payment, but sustained payment for technologies that have already gone through the rigor of the FDA and gotten approved as safe and effective, that would do a lot to help improve the adoption of these technologies.

Mr. Joyce. Thank you.

In my remaining time, I want to pivot to Dr. Toy. We recognize the opportunities that AI has provided. It is loosely regulated usage in prior authorization that is my concern. In fact, in March of 2025, the AMA uncovered that over 60 percent of physicians are concerned that the expanded use of AI in prior auth is exacerbating the rate of incorrect care denials, over 60 percent of doctors. Given this concern from physicians, do you feel that AI should be leveraged in the AI prior authorization decision-making process? And if that answer is yes, what guardrails should be put up?

Mr. Toy. Thank you for the question there. So definitely in the case of prior auth, I think that right now, at Clover ourselves, we do not use AI in any form within the prior authorization process.

Mr. Joyce. But are you aware that many --

Mr. Toy. Very aware.

Mr. Joyce. -- Medicare advantage plans utilize and Medicaid manage care plans do as well?

Mr. Toy. Absolutely. And I think that, from our position, they should not be use in any kind -- AI should not be used to review to deny in any case. Like, that is not a good use of AI. I do not think AI is ready to do that right now, which I think is the problem you are addressing. There are use cases where it can reduce burden, accelerate getting to yes faster. Those are good places

you can use AI, but not to deny care. That should not --

Mr. Joyce. Do you feel that if AI does cause a denial or refusal of care that there should be a person-to-person, a physician-to-physician evaluation?

Mr. Toy. Absolutely. A peer-to-peer is always appropriate, and that should be in all cases, maybe not even in denial. If requested or if appropriate, a human clinician should always be the one making those decisions.

Mr. Joyce. Thank you for your comments.

Madam Chair, my time has expired, and I yield back.

Mrs. Harshbarger. The gentleman yields back.

And I recognize Representative Barragan from California for her 5 minutes of questions.

Ms. Barragan. Thank you, Madam Chair.

This is a great conversation to be having. Although, to do it in a context of what is going on in this country is to turn a blind eye. You know, the Trump administration has caused chaos at the Centers for Disease Control. Under Secretary Kennedy's leadership, thousands of dedicated public health workers have been fired. Scientific experts, like former CDC director, have been forced out, and hundreds of millions of dollars in critical research funds have been canceled.

This week, eight former CDC directors, who served under Presidents from Jimmy Carter to Donald Trump, took the extraordinary step of sounding the alarm in an op-ed. Now, this is it. The title says it all. It says, "We Ran the CDC: Kennedy Is Endangering Every American's Health." Think about that for a moment, that the Secretary of HHS is endangering the health of every American.

They write that what the administration has done is, quote, "unlike anything we have ever seen at the Agency and unlike anything our country had ever experienced," end quote. They warned that Americans are now less protected from cancer, heart disease, and infectious disease. They note the CDC is being directed to downplay vaccines and pursue unproven treatments.

I want to ask for unanimous consent to enter the former CDC director's op-ed into the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Harshbarger. Without objection, so ordered.

Ms. Barragan. I think we should be taking up legislation to protect workers at the CDC. My colleague, Representative McClellan, has a bill to prevent mass firings at HHS. And I recently introduced a bill that would protect our Public Health Workforce Act to bring back the CDC staff that Trump has fired. Instead of oversight hearings or legislative action to hold this administration accountable, Republicans continue to pretend that nothing has happened, and so you can't go on without saying something at this hearing.

Dr. Ibrahim, I want to turn your attention to AI and the topic at hand today. AI has shown real promise in healthcare, such as helping doctors catch devastating diseases like cancer earlier. But as of last year, over 600 AI applications approved by the FDA -- out of over 600 applications approved by the FDA, less than 10 were eligible for reimbursement from the Centers for Medicare & Medicaid Services. That is less than 2 percent. Does that number concern you, or is that a good thing?

Dr. Ibrahim. Thank you so much for raising that point, and it has some historical context that the role of the FDA in the way it has been statutorily designed has disproportionately focused on safety and effectiveness and deferred the decision of reimbursement to CMS, which unfortunately creates almost reinventing the wheel, because a lot of the material they have to review and evaluate ends up being redundant. There have been some efforts to address that in parallel path reviews. Ultimately, I think what would be more efficient is if we focused the rigorous evaluation upfront by the FDA, and if it got FDA approval, that it would then be reimbursed by CMS.

Ms. Barragan. Well, thank you. You know, first when you look at the number you think like, oh, geez, people are not getting access to these AI tools that could be, you know, life-saving. But, of course, we have heard today about other concerns about trust and regulation and whether it is helpful or whether you need to have a plan in place.

So, Dr. Mello, what can Congress do to make sure AI healthcare tools are accessible to more

people?

Dr. Mello. Yeah. So both of the things that you just said are true at once, right, that we are concerned that there is not enough access and that there are real, you know, policy barriers to getting there. Again, where I land is, if I am a hospital, I am doing radiological scans, what is going to move me to spend more on AI if there is no reimbursement? Maybe it is a substantial improvement in quality of care, but that sometimes is not documented. Maybe my radiologists are clamoring for it, but they know they are on the hook if anything goes wrong. So this trust deficit really matters. And the steps that I have outlined, including both modifications of FDA review, modifications to reimbursement, but also institutional governments, that is the pathway forward.

Ms. Barragan. Thank you.

Dr. Mello, the use of AI can reduce workloads and improve efficiency in our healthcare system, but it can also make mistakes. Earlier this year, HHS Secretary Kennedy released a report that was based on incorrect information and made-up sources because of AI. How can we ensure that AI is used responsibly and with full accountability in the healthcare system, especially when it affects people's trust in science and their health?

Dr. Mello. I think it only begins by saying there is a human in the loop that is supposed to be reading that stuff. You have to create the conditions to make it possible for him or her to do that job in the setting where they are working. And right now, hospitals are not doing that.

Ms. Barragan. Right. Thank you all. And with that, I yield back.

Mrs. Harshbarger. The gentlewoman yields back.

And I now recognize my friend from Ohio, Representative Balderson, for his 5 minutes of questions.

Mr. Balderson. Thank you, Madam Chair.

And thank you all, for being here today.

My first question today is to Mr. Toy. In your testimony you mentioned that AI platforms

like Clover Assistant can very quickly bring together fragmented patient data and integrate it into existing clinical workflows, even in practices that are still paper based. From your experience, what steps do you believe Congress can take to support a wider adoption of AI-enabled tools like yours, especially in rural areas where providers may lack access to modern her systems?

Mr. Toy. Thank you for the question there. I think that most important thing -- I know this is discussed in Congress -- is making sure that there is connectivity to the internet within any practice within America. Like, I know that is a focus already, but once we can connect physicians to the internet, we can then connect them to cloud-based AI, and then we can also connect them to the vast amounts of data that we will bring online by our interoperability.

So I think those things all chained together, and it will solve the connectivity problem today by giving out devices to people, like connected iPads. We will help them work with their local telcos to connect. But if that could be solved, we can pretty much get rid -- fix the rest.

Mr. Balderson. Thank you. A follow-up, Mr. Toy. In your testimony, you also provided a good example as to how a lack of coordinated care can lead to missed warning signs. Much of my district is rural Ohio, and so many of my constituents have complained about fragmented care. How can Congress help accelerate connectivity and data sharing, especially between independent specialists and primary care providers so that AI tools can deliver the full picture of patient's health in real time, regardless of where care is delivered?

Mr. Toy. Yes. Thank you for that. I think that a huge part of what we can do here is that connectivity to the internet, and then within the healthcare ecosystem making sure that the interoperability rules that are being passed right now and future rules are all being accelerated and enforced. We want more EHRs talking to each other. We want to collect the lab system to that data stream. We want the pharmacies connected to that data stream, and all of that can come together. And once we have that -- and I think we are very close to that -- we want to make that to be physician-mediated, which is it is right now. But I also encourage us to consider making it

member -- patients mediated as well. A lot of the networks right now offer physicians to request data, and we also should allow patients to request their own data off those same networks.

Mr. Balderson. Agree. Thank you very much.

My next question is for Dr. Ibrahim. Thank you for being here today. Dr. Ibrahim, Viz AI platform integrates AI to speed up diagnosis and enhance care coordination across specialties and physicians. Given your background in both clinical practice and healthcare delivery, how do you see those benefiting both physicians and patients, especially in rural and critical access hospitals?

Dr. Ibrahim. Thank you for the question. One of our important studies around improvement in care for rural patients comes from TriHealth in the Cincinnati area, in Ohio. One thing I have noticed in my own practice, we often have rural patients that may have a concerning sign on one of their imaging studies, and they get transferred 3 to 4 hours to a big academic center. We may not have the imaging. We end up re-scanning them. Or if we have the imaging, we can look at it and say -- actually reassure them and tell them it is okay.

It is hard to estimate the number of patients who have been transferred only to give them reassurance and have them drive back home at no small burden. So the ability for us to leverage this technology to share information, readily get expertise eyes on some of this imaging before asking a patient to take on the travel burden would be significant. There are also many conditions where the care can stay local, but if the expertise can be disseminated by sharing information, it could also help maintain the volume of care that stays local in rural communities.

Mr. Balderson. Thank you. Is there any concern for error in using these technologies for patient care?

Dr. Ibrahim. I think we need to be incredibly humble that all of us here, including the people on the frontline of doing this, are always learning something new about it, and that as good as our models get, as we get more experience, they get better and we learn. We try to put several safeguards in place to try to mitigate and anticipate that. You heard multiple times today about

having humans in the loop.

We also have additional monitoring safeguards that also alert us that if there is some signal change in how many things we are detecting, we start to go back to the providers and say, Is there something different about the patients you are screening? Is there something different about the information you are giving us, because the signal started to look different acutely? So we try to put multiple safeguards in place to prevent that.

Mr. Balderson. Okay. Thank you all very much.

Mr. Parker, I apologize. I was going to have you next, but I am out of time.

So, Madam Chair, I yield back.

Mrs. Harshbarger. Okay. The gentleman yields back.

And I recognize Dr. Schrier from Washington for her 5 minutes of questions.

Ms. Schrier. Thank you, Madam Chair.

As a pediatrician, I have always relied on trusted experts at FDA and CDC to help me make the best decisions possible when I am taking care of my patients, and they are being purged. Madam Chair, that is why I am joining all my Democratic colleagues in calling on this committee to hold an oversight hearing to investigate the firing of CDC Director Monarez and the subsequent departure of several CDC officials who were unwilling to abandon science and bend a knee to our conspiracy theory-driven HHS Secretary RFK, Jr.

We have in this committee oversight jurisdiction, and we cannot stand by while Secretary Kennedy discards decades of American medical advancement and jeopardizes all of our health for the sake of his own fringe, anti-vaccine agenda and a very profitable anti-vaccine industry. Our children deserve better, we deserve better, and we have jurisdiction and a responsibility for oversight.

Speaking of children, I would like to discuss AI tools that are currently used on children. According to the American College of Radiology, over 200 FDA-approved AI tools are used for medical

imaging, but only six are actually marketed for pediatric use after review by the FDA. That is a staggering disparity in innovation between adult and pediatric care. And partly, that is because it is much easier to develop AI imaging software for adults. It is trickier to do it for kids because they are not just little adults, as you said. Bone, heart, thymus images look different in infants, children, teens, and adults, and normal lab results are also different ranges when you look at different ages. So we need just a lot more data to generate the volume of age-specific data that we will need to generate this.

Dr. Mello, you know that Packard Children's, where I trained, is connected by a hallway to Stanford Medical Center, and that kids and adults go to the exact same emergency department. And I just believe that children in that ER should not get the short end of the stick. And we not only need more tools for pediatric use, but we also need the existing tools to be clearly labeled so that providers know if the software they are using is actually intended and safe for kids.

Dr. Ibrahim, given the variability in complexities of pediatric care but also acknowledging that we need this cutting-edge technology that makes doctors better and the doctors make AI better, what can be done to incentivize and increase the development of AI tools for pediatric patients?

Dr. Ibrahim. Thank you so much, Doctor and Congresswoman, for your question and highlighting the differences between pediatric and adult patients. Our current product has been only on adult patients recognizing that it is an entirely different specialty to be able to apply those tools. Underscoring much of it is the sharing of data.

I am encouraged that the field of AI development has progressed in this space where we are able to share not the actual individual data, but the waiting of our algorithms from our data across institutions in a way that we can benefit from sharing the data without actually exchanging the individual patient's data.

Pediatrics, that is particularly important, because just the sample size is much smaller. So incentives and even national efforts that would help institutions aggregate this information that they

could share it in a way that maintains privacy without the individual records being dispersed, but being able to share the weights of the algorithms would be incredibly helpful -- for adults, in fact, as well.

Ms. Schrier. And do you have ways of not only incorporating the pediatric radiologists at children's hospitals, but also specifically pediatric radiologists at outside hospitals so that everybody is involved?

Dr. Ibrahim. That is a great point. I think one of the hidden benefits of AI is that the IT infrastructure has had to improve significantly to enable AI technology to do what it does. One of the things has just been the exchange of radiologic images. So we have had a number of hospitals say, Thanks for being able to just share the images. We are not sure if we will need your AI tool, but you at least got us to that part, so --

Ms. Schrier. Thank you.

I am going to just quickly -- I don't have time to ask you the question, Dr. Mello, but I just want to bring up the issue of physician liability, that when you have AI giving one answer and a physician giving another answer and something goes wrong, I think we need to think hard about where the liability is, is it on the AI company or is it on the physician, and the toll that that takes on physicians also to be a checkpoint and also to just be a reviewer of loads of data.

Thank you all for your testimony. I yield back.

Mrs. Harshbarger. Thank you. The gentlewoman yields back.

And I now recognize my dear friend from Iowa, Dr. Miller-Meeks.

Mrs. Miller-Meeks. Thank you, Madam Chair.

And I want to thank the witnesses for testifying before the subcommittee today.

Three years ago, we were asked as a conference to be on certain task force, and so, there was a Healthy Future Task Force, and I chaired the Subcommittee on Modernization and with the chair of the current Subcommittee on Health, and we focused on AI data, interoperability, devices,

technology, and how it can help with both access to care, affordability, prevention, and better outcomes. So I am delighted for this hearing today and for your testimonies.

And earlier this summer, I hosted a bipartisan briefing to spotlight how artificial intelligence is transforming clinical practice and patient care.

And thank you, Dr. Toy, for assisting the provider, augmenting the provider rather than replacing providers or physicians.

During the briefing, we heard from Dr. Michael Abramoff from the University of Iowa about how his company, Digital Diagnostics, is using AI to tackle diabetic retinopathy. In fact, it is, I think, the first autonomous AI device to be approved by the FDA -- Dr. Ibrahim -- and his diagnostic device is now used in numerous healthcare systems around the country, and it underscores that AI-powered diagnostic platforms can be deployed safely while improving patient outcomes in healthcare productivity.

So, Dr. Toy, your testimony mentions the importance of interoperability and standardized data access for effective AI performance. How can Congress help accelerate interoperability across Federal and private healthcare systems in a way that encourages innovation, but avoids imposing rigid, one-size-fits-all technical mandates?

RPTR HNATT

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[12:16 p.m.]

Mr. Toy. Yes. Thank you for the question there. I think the key on interoperability is AI runs on data, and the better, more relevant, the volume of data, and, also, like the more personalized that data is, the better the AI is going to be able to run. So it is critical, it is critical that we have built infrastructure around healthcare interoperability.

The current rules that we have on the books right now, I think that it would be wonderful if we could focus on modernizing those particular areas. I would point everyone to, for example, HIPAA. HIPAA does, you know, good work, the intention of it is very good, but it was originally developed in an almost pre-internet world, let alone pre-AI world. And so, the intentions of portability, and the intention of accountability in HIPAA must remain, but we must update some of those regulations, I think, otherwise they will start to hinder interoperability.

Mrs. Miller-Meeks. Although I think that AI has tremendous potential in healthcare, as I have previously mentioned, I am going to discuss some of the dangers of AI.

We know that older individuals have less trust, but that younger individuals who have grown up in a world connected remotely, or by the internet, have greater trust in these systems. And we know that they are looking towards, at the same time, the internet and social media platforms to address loneliness and isolation and connectivity exacerbated by the pandemic, but they, also, it is a source of bullying and threats to them.

Mrs. Miller-Meeks. I would like to enter into the record an article, August 26th, by The New York Times, A Teen Was Suicidal. ChatGPT Was The Friend He Confided In. The tragic story of Adam Raine as reported by The New York Times has ignited a difficult, but urgent conversation about the role of AI and mental health support. I am not going to list everything because my time is running out, but his parents are now suing OpenAI alleging that the chatbot became his closest

confident and ultimately a contributor to his death.

And Dr. Wright, in your testimony, and we have very little time, direct consumer chatbots are making deceptive and dangerous claims, with one presenting itself as a psychologist that validated a user's violent thoughts, and where should the boundary lie, if you could be brief in your comments?

Dr. Wright. Well, again, I think that the boundary really lies in ensuring that the these types of chatbots, A, don't misrepresent themselves, that they are not allowed to call themselves a licensed anything. We wouldn't want them to call themselves a licensed lawyer. I mean, we just -- we would not want that because it gives a sense of credibility that doesn't exist.

I think that we also have to build better chatbots. I mean, I think everybody deserves therapy, everyone deserves human one-on-one therapy. That might not be what everybody needs, so we need to think about how can we actually leverage emerging technologies, personalize them in a way that actually reaches people where they are at.

We have a system that we still people in crisis. What if we can get to them first.

Mrs. Miller-Meeks. I am running out of time. But you have mentioned the human connectivity, and everybody -- that interaction and parental oversight. And I just want to emphasize that groups, programs, schools that are pushing to exclude parents, prohibit informing parents of children's activities when at school, it actually undermines the very human connectivity and support from those groups and those parents and those families that our youth desperately need. Thank you, and I yield back.

Mrs. Harshbarger. The gentlewoman yields back. And I recognize Representative Trahan from Massachusetts for her 5 minutes of questions.

Mrs. Trahan. I want to thank the chair, and certainly the witnesses here today.

In normal times, a hearing on artificial intelligence can be -- used to advance healthcare access would be a welcome and an important conversation. And in those times, I would be asking how we can harness AI for powerful uses, like improving medical imaging to detect diseases earlier

and more accurately, but these aren't normal times.

Just weeks ago, this Congress passed the largest healthcare cut in our country's history, and our Federal public health agencies are in chaos with mass resignations, dismantled programs and an exodus of scientists that leave us less prepared for outbreaks, less secure as a country, and an erosion of public trust in government and medical guidance.

And as all of this unfolds, you know, the Secretary of Health and Human Services is busy posting videos of himself drinking raw milk and competing in push-up contests.

Against this backdrop, my questions today will be about AI in the clinical setting, but just pointing out, some patients won't even make it there because they are going to lose their coverage. If we want technology to improve health, we must start by ensuring that people are covered. And history shows technology can either wrongfully take that coverage away, or help keep people eligible and enrolled.

By February 1st, 2024, more than 16 million Americans had lost Medicaid coverage as States sunset the continuous enrollment protections that were in place during COVID-19. Nearly 70 percent of these losses were procedural. Not due to changes in eligibility, but to missed paperwork or State software glitches. These cases are a stark reminder that technology can either amplify or improve systemic problems, and it is up to policymakers to direct responsible uses of technology, design appropriate safeguards and conduct oversight when necessary.

Now with States required to implement burdensome Medicaid paperwork requirements, thanks to the Republican big ugly bill, it is critical that technology is used to protect access to care for as many folks as possible.

We know that these new requirements have led to the removal of tens of thousands of Americans who are eligible for coverage in the past, and that is when these requirements were implemented for only a short time and for a small number of people. But Republicans just took that model of burdening people with unnecessary paperwork to keep their health coverage, and they

expanded it nationwide. States must use every tool to keep eligible people covered and ensure that automation safeguards coverage rather than triggers wrongful terminations.

In Tennessee and other States, automated eligibility systems have wrongfully cut Medicaid for thousands who were still eligible. TennCare Connect, which cost over $400 million, was meant to use income and health data to determine eligibility, but instead, often misloaded data, assigned people to wrong households, and made incorrect determinations according to a Federal court ruling.

Dr. Mello, as we consider AI's role in health programs, what safeguards should be in place so that technology doesn't duplicate the procedural disenrollments we saw during the Medicaid unwinding?

Dr. Mello. Thank you for the question. The kind of situation that you described is, frankly, inexcusable. That there would be failure on that large a scale really raises fundamental questions about the amount of testing that was done before that system was rolled out, and who was watching? So job one, I think, is if we are going to use automation to enforce these disenrollments, that there are humans monitoring, not particularly individual disenrollments alone, but, also, what is happening at the population scale.

But as you say, AI could be used to improve some of these problems, and so, my hope is that there will be innovation in the private sector that develops apps that enable enrollees to be put on alert before they are disenrolled. I think AI has a lot of promise for making sure people don't miss filing deadlines, and are aware when the paperwork that they have submitted is not going to be sufficient.

Mrs. Trahan. I appreciate that. In building on that, we have also seen that even when technology is working as intended, it is often placed on top of an overly complex reporting system, it can still cause harm.

Automation is often sold as a silver bullet for eligibility determinations, but in practice, when it is layered on top of complicated reporting rules, it can speed up coverage losses for people who

still qualify. So I appreciate the alerts.

I am wondering if you could expound on how we design systems so that they clear barriers out of the way instead of building new ones for those who need care the most.

Dr. Mello. I think where the incentives, their collaborative design is the key there. If you involve advocates who understand what the major pitfalls and errors are that keep people wrongly off of Medicaid rolls, people who are eligible under the rules that we have set up, that goes a long way to building AI that is designed to avoid replicating those problems.

Mrs. Trahan. I appreciate your answers. Thank you. I yield back.

Mrs. Harshbarger. The gentlewoman yields back. And I recognize Representative Bentz from Oregon for his 5 minutes of questions.

Mr. Bentz. Thank you, Madam Chair. Thank you all for being here. This is extraordinarily interesting to me. As a lawyer for a hospital for many years, I obviously became extremely familiar with the standard of care for doctors.

So Dr. Mello, where would you put AI were you on the witness stand and we were asking you if the doctor involved in the malpractice case should have, could have, did, used AI, and go both directions on it, they did use it and it turned out wrong, or they didn't use it and it turned out wrong, tell me where you think it fits.

Dr. Mello. Thank you. It is an important question. And although I am not a medical doctor, I am a scholar of medical malpractice law, and we know that in malpractice law, reasonableness of action is always the lodestar, even more so than custom, what your colleagues --

Mr. Bentz. I thought it was who the lawyers were was generally the -- never mind. Go ahead.

Dr. Mello. So the question is when is it reasonable for a physician to depart. And the problem with being able to answer that question in the courtroom is that physicians are provided with so little information by the tool that enables them to understand whether its recommendation,

which makes sense at a group level, applies well to this particular patient. So that is why I think there needs to be shared liability between physicians, hospitals, and developers because sometimes the errors that doctors make as a result of output could not reasonably have been foreseen by them and, therefore, are not unreasonable for the physician --

Mr. Bentz. Let's take it back to a point that was made earlier in the testimony you folks have given today, and that was the lack of accountability, or the promise by those who are providing AI, that it is going to work, or that it meets certain standards, don't you think that the law of -- that you and I are now discussing, these standards, don't you think that creates some sort of accountability for those who are creating these AI systems?

Dr. Mello. Well, the difficulty will be, as you will understand as a hospital attorney, that when you contract away that responsibility at the licensing stage, it eliminates a lot of avenues for recovery. And many of these licensing agreements that hospitals are now executing with developers have disclaimers up and down that hospitals have to accept in many cases to have bargaining power --

Mr. Bentz. So are you suggesting that we do something about that here at the congressional level that we say that is not something that they should be able to do?

Dr. Mello. I don't understand why AI is treated differently from other products where we don't allow makers to disclaim ordinary warranties. Why should that be? And if the answer is there isn't a good reason for treating it differently, then we ought to treat it the same.

Mr. Bentz. Thank you. I want to shift to Mr. Toy. And you indicated, or someone, forgive me, because it has been a long time since I have been waiting to ask my questions, I may have confused who it was that said what, but at what point do you think that the human becomes less analytically able than AI? Do you see that in the next 2 years? 10 years? When?

Mr. Toy. I think that it depends on what kind of reasoning and what kind of information. Like I think humans are already -- the AI is probably already better at searching a large corpus of data

and finding something, like, relevant to show to a human being. So searching through data, I think AI is very, very good at that.

I think you are asking about reasoning, in particular. I do not think that most human thinking will be replaced by AI any time soon. I think that what will be replaced will be more perfunctory kind of tasks, and that is where we should be focused right now.

Mr. Bentz. Thank you. Dr. Wright, you said a phrase I thought was very interesting, personal connections make us who we are. I have all these younger adults coming into my office and I ask them how many hours they are spending on their cell phones, and it runs, frankly, the average is about 12 hours a day. It is frightening.

I would just ask you if you think algorithms have now replaced the human connection, and if so, isn't this kind of about wish that we go back to some previous time, which I see unlikely, so where do you think this human connection, this personal connection is going to come from now that -- haven't we given it away?

Dr. Wright. It is a really interesting question. I would argue, no, that we have not given it away. I think that what makes relationships unique are the reciprocity of it. There is no reciprocity when it comes to AI. That is partly why people like it, because they don't have to care about the AI and give back, but that is not a genuine relationship. And it does not build true intimacy. AI knows things, but it doesn't understand. It doesn't understand you or why --

Mr. Bentz. I agree with all of that. What are we going to do about it?

Dr. Wright. I think we need to be much more intentional about AI literacy and technology literacy within schools. I think we need to train parents. I think that we need to incorporate AI literacy and the impact it can have developmentally within healthcare. I think we need to have public campaigns helping people understand how to use these tools appropriately and when to walk away.

Mr. Bentz. And I very much appreciate your testimony, and the entire panel's. Very

interesting. I yield back.

Mrs. Harshbarger. The gentleman yields back. And I recognize Representative Veasey from Texas for his 5 minutes of questions.

Mr. Veasey. Thank you, Madam Chair. And before I get into the AI, I want to begin by saying that I am deeply disappointed and frankly fearful about the reckless direction that HHS is taking under Secretary RFK, Jr.'s failed leadership and the decision to include pulling the rug from under cancer vaccine research and putting America's lives directly at risk, in particular. And illnesses like cancer, quite frankly, don't care about what political party you may happen to belong to. It is something that has touched literally everyone in this committee, and probably in this body, and yet the Secretary is abandoning the millions of Americans who will face cancer in the years to come. And we are entering a very dark chapter in American history, and I hope that this committee will devote some serious time to demanding some answers.

But today, the hearing is also a matter of life and death. And we have seen some very disturbing reports, and when people talk about what they see as an existential threat and talk about things that scare them, AI scares me more than anything else, quite frankly. We have seen disturbing reports about AI chatbots leading to real harm, and some stories are so shocking they can honestly be hard to believe.

I would like to enter into the record a Washington Post article titled, Instagram's Chatbot Helped Teen Accounts Plan Suicides and Parents Can't Disable It. This article discusses Instagram's chatbot Meta AI that actually walked teens through how to kill themselves. And kids are turning to AI when they feel they have no one else to talk to, and they are being told that these bots are companions. And instead of guiding them towards parents, teachers or doctors who could help them, the chatbot is actually helping them go through with the suicide, and we have to stop this. This is not rare, and it is not just children, it is vulnerable adults who are at risk.

And chatbots have reinforced paranoid delusions, validated dangerous thoughts, and in some

cases contributed to self-harm, or even violence. And we know that these tools, that there are millions of Americans already using them.

On the other hand, as Dr. Wright described in her opening testimony, there are AI programs deceptively marketed as mental health providers, and some even masquerade as licensed psychologists and they are racking up millions of conversations with people while handing out reckless harmful advice to people in crisis.

Again, this is deceptive and it is a danger, and it is a threat to public safety, and yet, every single Republican on this committee voted just a few months ago to prevent States from regulating these danger bots, including the companion bots that kids can access, and programs marketed to adults suffering from mental illness. And so we have to do something. We should not be discouraging States from saving kids' lives.

And Dr. Wright, in your testimony you spoke about the danger of unregulated products giving harmful advice to people searching for help, and in some cases, treatment for their mental health. Why are children and adults in crisis, particularly those that are susceptible to harmful outputs of -- why are children and adults in crisis particularly susceptible to the harmful outputs of AI chatbots?

Dr. Wright. Thank you for the question. I think they are particularly vulnerable for a couple of reasons. One, adolescents and children are at a very different developmental stage. They do not have the life experiences to be able to listen to their gut and know when something seems off. Individuals in a vulnerable position who are in uncertainty want to seek out answers, and these chatbots are coded in a way to give them the answer that they want. They are unconditionally validating and reinforcing even harmful or unhealthy behaviors. And they tell you exactly what you want to hear, over and over and over again. And so when people engage in these prolonged chats, so not a one-off chat, but hours and hours and hours, we know that the algorithms, A, lose accuracy and become less safe.

So what we need to do is somehow disincentivize these companies from a user engagement business model where they are incentivized to continue to program in an addictive way. They don't have to do that. There are ways to not code these things addictively so that they could be more helpful. But unless there is some regulation that is encouraging them to do that, I don't see them doing it on their own.

Mr. Veasey. Well, thank you very much. Thank you, Madam Chair, I yield back.

Mrs. Harshbarger. We will enter your document to the record without objection.

[The information follows:]

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Mrs. Harshbarger. Thank you. Okay. I now recognize Mr. Langworthy from New York for his 5 minutes of questions.

Mr. Langworthy. Thank you, Madam Chair. AI is no longer a theory about the future. It is already transforming the way we deliver care and how we diagnosis disease and how we use data to improve outcomes.

In my district in western New York, in the rural southern tier, families are counting on a healthcare system that is more efficient, more affordable, and more responsive. AI-driven tech, innovation and technology can help us meet those expectations by reducing administrative burdens, strengthening clinical decisionmaking, and unlocking discoveries that once took years in a matter of months.

And with that, Mr. Toy, as you know, Medicare Advantage has been at the forefront of developing AI tools to streamline beneficiary enrollment, manage costs of care, and reduce administrative burdens. And as Medicare Advantage continues to grows, both in New York and nationwide, more than half of New York's Medicare beneficiaries, about 2 million people, have chosen Medicare Advantage over Fee-For-Service Medicare. And for them, Medicare Advantage is Medicare.

Mr. Toy, can you speak to how these innovations in AI are being used in Medicare Advantage, and even Medicare more broadly by reducing administrative paperwork for providers and improving outcomes for patients?

Mr. Toy. Absolutely. Thank you for the question. I think the advantage of the, no pun intended, the advantage of the Medicare Advantage model is that we can bring a lot of better outcomes, we can provide better data to doctors, we can actually provide better reimbursement to doctors as well. So a lot of the things we are discussing here at the committee are things that we can actually put into production right away, and we have put into production right away.

So people in Medicare Advantage can go to a doctor, they can have a doctor use an AI tool

safely, be trained on that AI tool, know that that AI tool is helping them with not sort of like -- with the diseases that they actually have in their own personal life, on the main diseases of aging, such as pulmonary disease, such as kidney disease, such as diabetes, and know that their doctor is being reimbursed by that MA plan for the time that they are using to use that AI tool because that is something we can do. We must reimburse on the CMS schedule. We can also reimburse above the CMS schedule.

And so, we are already reimbursing primary care physicians above the regular Medicare rate for the extra time that they are taking to use an AI tool. So their doctors are using it, getting better outcomes, and being reimbursed better.

Mr. Langworthy. Mr. Toy, how does Clover's use of AI inform your thinking on network design and delivering the best product that you can to seniors choosing to enroll in a Medicare Advantage plan.

Mr. Toy. Thank you for that as well. So as I said before, when we improve outcomes, and when we are improving -- accelerating diabetes identification, and accelerating diabetes management, when we are keeping kidney function at a higher level because management begins earlier, all of that results in a better medical loss ratio, which means that we are actually more efficient per unit dollar when we allocate dollars out to the medical network.

What that also means is we can reinvest those -- that efficiency back into lowering out-of-pocket costs for patients. So our intense focus is to reduce those financial barriers to care, making care more accessible, more available, and that is powered by AI improving the care that is being delivered to the membership as well.

Mr. Langworthy. Thank you. There has also been a lot of critiques over the past year or so about Medicare Advantage plans leveraging AI to make prior authorization determinations. Does Clover leverage AI in their utilization management process, and if so, is there a clinician or a human that is a check in that process?

Mr. Toy. So all of our prior authorization is being done by a clinician who is working with providers in our network in order to make those determinations. We are not using AI to make any kind of utilization management, or prior authorization determinations.

I do think there is an opportunity to do that, but to accelerate getting to yes faster, to lower friction for our provider network, to make it easier, as you were mentioning, to reduce the amount of time they are spending preparing documentation to apply for prior authorization, I think AI is going to have great use cases there, and that is where we should be heading.

Mr. Langworthy. Well, thank you. AI is not a replacement for doctors, nurses, or caregivers, but a tool to help them deliver better care for more people. If we embrace it responsibly and have the right framework in place, we can strengthen our healthcare system, and ensure those across the country see the full benefits of this innovation in this great country. And with that, I yield back, Madam Chair.

Mrs. Harshbarger. The gentleman yields back. And I recognize Representative Fletcher from Texas for her 5 minutes of questions.

Ms. Fletcher. Well, thank you. Thank you, Madam Chair, and thank you to all the witnesses for testifying today.

I do think that the opportunities, as well as the concerns about AI are important for our committee and the subcommittee to consider, and for the Congress to act on, and appreciate your testimony today.

But like my colleagues, I am deeply concerned about the context in which we are having this hearing. And this conversation, we really do have to have in the context of 2025, both the rapid advancements in AI, and the massive reductions in access to healthcare that the Trump administration has set in motion with a rubber stamp from this Congress.

Since January, the administration has dismantled our government agencies and public health infrastructure, and this Congress hasn't just ignored it, although it has, it has enabled it. This

committee is included in that problem.

From the mass layoffs, to the firing of the vaccine advisory board, to the Twitter firing, non-firing of the CDC director, and the mass resignations of the CDC just last week, to the gutting of substance abuse and mental health agency, this administration has weakened our public health agencies. And at the same time, it has demanded that Congress reduce access to care and efforts to make care affordable for all Americans.

And this committee has done so. We have sat though those markups and those votes. This committee has done no oversight on the issues I just identified. And has held hearings and markups reauthorizing programs that the administration is gutting.

And so, while there is an important opportunity here, and I really appreciate your testimony and your being here to help inform us in this work, it is really important to know that it is happening in this environment, and that this committee and this Congress need to get serious about the things that you all are sharing with us.

And with that said, with kind of the time that I have, Dr. Mello, I do want to follow up on your exchange with Ranking Member Pallone about prior authorization, and on some of the issues we just heard about as well with Mr. Toy in the last questions.

I represent a lot of physicians in Houston, Texas, and they and their patients tell me that prior authorization slows down access to appropriate care by forcing physicians to spend time, as we have heard about, and also, just leading to wasted time, worst health outcomes. It is documented, and for years there has been bipartisan agreement, I think in Congress, that Medicare Advantage prior authorization practices need to be reformed, we also heard about that from Dr. Joyce, and particularly when it comes to the use of AI to deny claims.

And despite the consensus, as you all know, the Trump administration announced the CMS pilot program, the wasteful and inappropriate service reduction, WISeR model, that implements prior authorization for a list of services for people enrolled in traditional Medicare in six States, including

my home State of Texas, as well as Arizona, New Jersey, Ohio, Oklahoma, and Washington. And the way CMS plans on carrying out this pilot is to contract with companies that will use AI to determine whether a procedure will be covered.

CMS has said that the ultimate decisionmaking authority will be a clinician, but it has also included financial incentives for these AI companies to reduce spending. And one way they can reduce spending is by denying care. And so they are going to receive a percentage of the savings from denying care to patients.

And so instead of improving these prior authorization policies in Medicare Advantage that have been under scrutiny for years for denying critical medical care, the administration is really doubling down, as far as I can tell, in creating the same problems for the traditional Medicare program.

And so, Dr. Mello, in your view, is current Federal law sufficient to regulate the use of AI in prior authorization?

Dr. Mello. No, it is not.

Ms. Fletcher. Do you want to expand on that a little bit on how and what specific things that we could do on this committee and in Congress with Federal legislation to address and ensure that AI used in coverage determinations doesn't deny or delay medically necessary care.

Dr. Mello. Well, I want to acknowledge that CMS did some very good work on the regs in the final rule for use of PA in Medicare Advantage plans. Much better.

There are two gaps. One is that it specifies that there needs to be human review before a denial is issued. No one argues about that. Everybody does that. But the question, what does that mean? There are no standards for what that means. And in my opinion, when you present a human with a packaged-up predetermined denial nicely curated with all the reasons, that human approaches the decision in a very different way than they would with a fresh pair of eyes in a non-curated file. So it should mean that human isn't primed by a computer to validate the AI

decision.

And the second gap is commercial plans. So aside -- people who are in employer-sponsored plans, commercial insurance plans who are non-Medicare don't have any of these protections that Medicare Advantage plans do, and those plans have no, little or no reporting obligations, particularly for ERISA plans.

So finding ways to penetrate the commercial market and understand what they are doing, where AI is being used to get to yes faster, and where it is problematic, that requires additional action.

Ms. Fletcher. Well, thank you so much. I have gone over my time. I have one more question for you I will submit for the record. And with that, I will yield back.

Mrs. Harshbarger. Thank you. The gentlewoman yields back. And I recognize my good friend, another pharmacist in Congress, Representative Carter from Georgia for his 5 minutes of questions.

Mr. Carter of Georgia. Well, thank you. And thank all of you for being here. A very interesting discussion. In case you are wondering why I am at the top of the dais and in the bottom of the questions, I was 40 seconds late. So that explains that. But, nevertheless, that is the rules and we have to abide by them.

Mr. Parker, thank you for being here. I haven't heard a lot from you, but I have got a lot of questions for you as a fellow pharmacist, and certainly want to know how AI can help us, particularly when it comes to patient compliance, and particularly when it comes to helping patients and making it easier for them, the process. Can you tell me how AI healthcare platforms can empower American's vast pharmacy providers, particularly our independent pharmacies to serve patients?

Mr. Parker. Sure. I mean, I think it may be helpful to talk through the patient journey at General Medicine in that context where, you know, prior to a visit with a patient we are able to collect their full historical medical record, use AI to analyze that and figure out where they might

have care gaps and recommendations a clinician can provide, but there is no reason that information couldn't also be presented to a pharmacist to help them identify similar levels of care gaps, vaccinations, other opportunities to help the patient improve their health. And I think, you know, with General Medicine, the ambition is that we are able to empower providers, not just our providers, but providers in the community to provide that level of care, and I think it is a combination of robust access to medical records based on all the work that has been done here, coupled with the intelligence of AI.

Mr. Carter of Georgia. So obviously, we would have to have the patient's permission to use those medical records, and that would go without saying. But can you see it, you know, one of the things that I have seen over my years of practice in pharmacy is how insurance companies and third-party payers have really taken part. I can remember, and I am telling my age here, but I can remember when, you know, everything was cash, and you just got the lowest price you could get if you were a consumer. But now so much of it depends on your insurance and what is covered and what is not covered. So I can see it helping in the sense that before you even go you would -- before you even visit the pharmacy you ought to know whether this is covered or not by your insurance company.

Mr. Parker. That is exactly how we think about it. So in reality you should be able to see all of that information before you ever get to the pharmacy counter, both the insurance price, the lowest cash price, whether it requires a prior authorization so as a consumer you are not sitting there trying to wrestle through this at the pharmacy counter.

I think one interesting anecdote from my previous experience building out the pharmacy business at Amazon is that by just showing them a clear insurance and cash price upfront, half the time the consumer was choosing to use cash because it ended up being cheaper than their benefit. And I think you see a very similar dynamic across the medical benefit. I don't know the ratio specific to each category yet, but it really is empowering to the consumer to have that information upfront

and to be able to make an informed decision.

Mr. Carter of Georgia. And that is going to improve patient compliance.

Mr. Parker. Yep

Mr. Carter of Georgia. You know, I can think of so many situations. One of my pharmacies, I had three pharmacies, but one of them was kind of in a rural area where people had to travel a long distance, and whenever they would bring me a prescription and they would want it to get it filled and I have to tell them, I am sorry, I have to call your doctor because I have to get a prior approval, a lot of times they would never come back, never come back and get the medication. And so patient compliance I would think would increase tremendously with this as well.

Mr. Parker. Yep. I totally agree. I mean, I think you -- there are oftentimes in the Amazon experience where something was $14 and it required a prior authorization, like the amount of wasted energy that was going into that far exceeded the $14 cost that they could just pay out of pocket, and so I think just pulling this forward into the customer experience has a tremendous impact.

Mr. Carter of Georgia. Absolutely. Well, I am glad to hear this because this is something obviously that I have experienced over my career and my professional career, and ways to improve it and make it more streamlined, if you will, I think will really help, will really result in better healthcare for Americans.

Real quickly, Dr. Ibrahim, I wanted to ask you, how can AI accelerate innovation in drug development?

Dr. Ibrahim. Thank you so much. I think one of the themes that you have heard today is AI helps in a lot of the informational challenges. So much of the drug development historically has been empiric, like we have almost been lucky, we just try hundreds or thousands of things to get the one that is right. AI does a good job in pattern recognition, and to be able to predict of the thousand things we were going to try, these ones may be more likely. So there is enormous

potential in the early discovery phase to make it more efficient.

Mr. Carter of Georgia. Good. Well, I certainly hope, and I am looking forward to this particularly with AI because, you know, in my years of practicing pharmacy I have seen nothing short of miracles as a result of research and development and drug development, and I hope that that is going to be the case with AI.

Very good. Very good panel. This has been very interesting. Thank you all for being here, and I yield back.

Mrs. Harshbarger. The gentleman yields back. And I recognize Ms. Ocasio-Cortez from New York for her 5 minutes of questioning.

Ms. Ocasio-Cortez. Thank you so much, Madam Chairwoman. And thank you to our witnesses for being here today.

And I want to kind of dig into a topic that has come up several times over the course of this hearing, which is this area of prior authorization. Now, generally I like to take a step back so that folks at home can kind of understand what it is exactly that we are talking about here. And I think most people hear the term prior authorization and understandably our eyes start glazing over in this bureaucratic language. But in the way this affects our lives is that if someone is diagnosed with a condition, an illness, a disease, they require medication, treatment of some kind, they will -- their doctor may recommend it to them, and that doctor has to very often, depending on their insurance, ask their insurance for permission so that their insurance can say we will cover this treatment, or we will not cover this treatment, and that is the process known as prior authorization. Is that a fair description of it, Dr. Mello?

Dr. Mello. It is, and I would just add that it also applies to procedures and surgeries.

Ms. Ocasio-Cortez. Yes. And prior authorization oftentimes can be a really big headache and pain point for patients and doctors, and especially if you have interacted with a for-profit health insurance company, although all sorts of health insurance companies use prior authorization, you

have likely dealt with this. And there have been famously, I think, videos that have circulated on social media of doctors trying to haggle with an insurance company, of everyday people trying to get -- navigate their chemotherapy, or any sort other condition with the prior authorization system.

And if you have a Medicare Advantage plan, which is the for-profit version of Medicare, you have definitely dealt with prior authorization. In fact, in 2023, Medicare Advantage for-profit health insurers filed over 100 times more prior authorization requests than traditional Medicare. And Medicare Advantage plans also deny care to patients at significantly higher rates than normal. Medicare Advantage plans deny as much as 16 times the normal rate. Does this sound consistent with some of what you have seen, Dr. Mello.

Dr. Mello. Yes, I believe that is what numerous reports have indicated.

Ms. Ocasio-Cortez. And this is all to restrict patient care because we have a profit margin to maintain. And many of those for-profit insurers use unregulated and unsupervised AI models to review prior authorization requests. And I think it is very important that people understand that this is happening, that AI is being rolled out in the industry so that when a doctor who has gone through 4 years of medical school, in addition to their additional training, say that a patient needs something and they submit a prior authorization request, many times an AI model may deny them that care to a human being who has gone through extensive medical training.

Now, Mr. Toy, you said earlier in this hearing that you are the CEO of Clover Health, but you have said in this hearing that Clover Health does not use AI in your company to implement prior authorizations, correct?

Mr. Toy. Correct.

Ms. Ocasio-Cortez. But you have seen this happen in your industry?

Mr. Toy. That is correct.

Ms. Ocasio-Cortez. And you disagree with this usage why?

Mr. Toy. I disagree with it because it should always be a clinician who is making this

decision. So I myself, as I said, I am also a patient, I have had my own scans be denied through prior authorization. And I fortunately have the sophistication to navigate my own appeal, as you said, to get there, but that is not a reasonable thing for it to happen.

Ms. Ocasio-Cortez. And for a person that is diagnosed with a condition in which time is of the essence, and an AI model has denied a trained clinician the ability to provide them care, this could potentially threaten a person's life, correct?

Mr. Toy. Absolutely. Time-to-care is critical in many cases.

Ms. Ocasio-Cortez. And so we are seeing certain healthcare companies, and on top of that, the Trump administration has planned to launch a new program to expand the use of AI in prior authorizations, known as WISeR, beyond Medicare Advantage and into regular Medicare recipients.

Mr. Toy, it is not your company's plans to participate in the WISeR program, correct?

Mr. Toy. That is correct, we are not participating.

Ms. Ocasio-Cortez. And you have no plans to?

Mr. Toy. And we have no plans to.

Ms. Ocasio-Cortez. Thank you very much, and I yield back my time.

Mrs. Harshbarger. Thank you. The gentlewoman yields back. And I recognize my good friend from California, Representative Obernolte, for his 5 minutes of questions.

Mr. Obernolte. Thank you very much, Madam Chair, and thank you to our panelists. I have really enjoyed this panel on one of my favorite topics.

Mr. Parker, I want to start with you. I really enjoyed your testimony about the impact that AI is going to have on healthcare delivery, and indeed, it mirrors the findings that we made in the AI task force that I had the honor of chairing last year. When we issued our report in December, we had a whole chapter on healthcare because honestly there isn't a segment of the economy in the United States that is going to be dramatically impacted by AI than healthcare.

One thing I wanted to ask about, though, is that you testified that as you see these startups

come through, that the most promising of them right now are the ones that use the application of AI to bring down administrative costs. And that actually mirrors what we found in our task force report as well on healthcare, that is seemingly the low-hanging fruit that AI is going to bring first.

But you have to admit that if you are a -- the average American, that is a little disappointing. Right. You know, we have been telling people for years how healthcare is going to -- how AI is going to aide in drug discovery, how it is going to aide in diagnosis, predictive diagnoses where there is pattern recognition and talking about risks you didn't even know existed, tailored drug therapies that are tailored to your genome. You know, all these things are what we have been promising people that AI is going to do and we are coming now to them with, it is going to reduce your administrative costs and that is what we are doing with it right now. Should people be disappointed about that, or is this just the first of many things to come?

Mr. Parker. Thank you for the question. And I think that is why, you know, we are spending all of our energy on improving the customer experience and using AI in ways that create real tangible value to the end patient. And I think I am optimistic that those new experiences will help people be healthier, help them save money, and it is why our implementations are so pragmatic. Right. I think everyone has always talked about how you can't get a price for anything in healthcare, so solving that, using AI is a very useful utility for the consumer.

I think similar with the care plans, enabling consumers to be able to manage their health, understand what they should be doing as next steps is to me what gets me up in the morning is helping patients realize the value of AI in their everyday life. It is not to diminish the value that would be created on the administrative side. I think that is low-hanging fruit, there is a lot of opportunity there, but I am personally most excited about the potential to impact the end patient.

Mr. Obernolte. Well, let's not lose sight of that optimistic vision because I fear that when we start talking about how we are using AI today, to automate note taking, to automate billing, you know, that that is going to distract away from what AI could do.

Dr. Mello, I was really interested in your testimony. You were talking about how do we get Americans to trust the use of AI, especially in a domain as important to them as their healthcare. And you talked about a foundational trust deficit, which I very much agree with. That was one of our key findings, not just in healthcare, but over and over and over again as we did our task force hearings last year was the fact that Americans really don't trust this new technology. And in some ways, they are right not to trust it because it is new.

But another thing that you said that I am not sure I agree with is that the solution to this is government certification, standard settings, disclosure requirements, and I am not sure -- I mean, my understanding of why that trust deficit exists is because Americans don't have a very realistic view of what AI is and what it isn't, what it does and what it doesn't do, the way it works and what the real risks of AI are. And I don't think that, short of educating them on those issues, that just telling them that, well, the government says it is safe and so you ought to trust it is going to do the trick. Would you agree with that, or would you disagree?

Dr. Mello. I would. But to be clear, what I am suggesting is that there be requirements that institutions do governance because hospitals and physician practices, they are the ones that are best situated to understand their patients, their staff, and what can go wrong.

I spend a lot of time interviewing patients as part of my work at Stanford, including patients who are very sophisticated about AI, they are part of a learning community, and the message I consistently get from them is we expect you to be looking at this stuff, especially when policymakers turn to things like consent and disclosure requirements in lieu of requiring things that will actually keep them safe. Can the government do this directly? No. But does it need to provide additional incentives and nudges for organizations to do it? Yes.

Mr. Obernolte. I just want to make sure we don't conflate the two because I think absent that education, I think that foundational trust issue is going to continue to exist and it is going to be an impediment to deploying AI, not just in healthcare, but in a lot of different productive domains. I

can talk about this all day. Thank you very much to our panelists. I really enjoyed the hearing. I yield back.

Mrs. Harshbarger. The gentleman yields back. And I recognize my good friend from Ohio, Representative Greg Landsman, for his 5 minutes of questions.

Mr. Landsman. Thank you, Madam Chairwoman and Ranking Member DeGette for today's hearing on the use of AI in our healthcare system. Obviously, as we have heard, there are so many opportunities to improve care and to lower costs. There are also enormous dangers associated with this. And I want to talk about the Medicare piece and this potential new program that the administration has announced because Ohio is one of the States. So this is urgent for us, and I want to make sure that this committee, which I think will appreciate the need for some bipartisan pushback and guardrails here, will act because it is going to be our seniors in Ohio and in Texas and in the other States that may get hurt, and we don't want that to happen.

But as you all know, for decades, tens of millions of Americans have -- seniors have paid for and relied on Medicare for their healthcare needs. The administration announced this new effort that will require preauthorization, pre-approval, for procedures under Medicare, and it has been referred to as the AI death panel in that you are taking what private health insurance companies do now in terms of denying care, care that ultimately leads to the loss of life, and you are handing it over, as I understand it, to a tech company that is going to use an AI model that has not been vetted. And to make matters worse, the incentive is there to deny the claim. You get more money if you are that AI tech company if you are able to deny more and more claims. That is going to lead to people getting hurt. And I do, again, think there is a bipartisan desire to ensure this doesn't happen.

The doctor and the patient should determine what care is needed, and we all agree on that. And while AI could provide some additional insight, I think, Dr. Mello, you talked a little bit about what needs to happen, but I wanted to get your thoughts on the legal, moral and health challenges

that this new program creates.

Dr. Mello. As you pointed out, the reimbursement model for these tech companies really stands the concept of shared savings on its head. You know, shared savings evolved in the Medicare program to give healthcare organizations incentives to take better care of people, and then when they got better, if they saved money on expensive procedures, the healthcare organization got to save that money.

This has flipped. Now they are going to make more money by denying care. And, yes, there are safeguards there, procedural safeguards to prevent the worst abuses, but that is a very weird reimbursement model for what they are trying to do here.

The other thing I would point out is there is some political genius in the architecture of this program in that they have chosen to begin with a small set of procedures that most people who do what I do for a living and assess health services would say we are providing too much of, they are expensive and there is very thin to no evidence base. The question is where does this program go in the future? And the problem is going to be that we don't have national coverage determinations to expand it in ways that can protect beneficiaries.

Mr. Landsman. Yeah. Until we have those answers, until we have those assurances, I think that the pilot should be stopped, and hopefully, there will be support to stop it because you mentioned, I want to just do this very quickly, and others have agreed or reiterated, that there should be disclosure of the product, full disclosure of the products being used, seems smart enough, that there is full vetting of those products, that an independent review board, and maybe the joint commission, as you mentioned, can serve as that review board, deal with the liability questions and ensure that this doesn't touch, quite frankly, anything that could harm patients. And until we have that, I think the program should be shut down, should be -- and I will help lead on that. I am sorry. My time ran out. I yield back.

Mrs. Harshbarger. The gentleman yields back. And I recognize my good friend from

Florida, Representative Cammack, for her 5 minutes of questions. And a new mama, by the way. Congratulations.

Mrs. Cammack. Thank you. A new mama who actually has to go pump, so I will make this quick. So thank you, madam chairwoman, and thank you to my wonderful colleague for letting me jump the line, and to our witnesses for being here. This is really important as we are grappling with all the new technology and all the opportunities, but also some of the challenges along with it.

So we know that healthcare and AI have incredible opportunities and potential. We are seeing it speed up drug development, cutting down on paperwork, and giving the doctors and patients more time, which is really the upside, the good side that has been talked about at length here today. I really do appreciate a lot of the commentary on data privacy as well.

So when we are talking about these potentials, we need to also examine the downsides, which a few have been highlighted here today. We all agree that AI should never replace a doctor's judgment, and it shouldn't become another way for bureaucrats, or swamp creatures, as I call them, or big corporations to pull strings. Patients deserve to know that their data is safe, their privacy is respected, and that their care is being guided by people, not just algorithms.

So in my district, the University of Florida, a/k/a, the everything school, we are testing some of the most exciting applications of AI, from digital twins of ICU units, to patient-level models that help predict the most effective treatments and outcomes in tough cases like cancer, we are showing what is possible.

So I want to highlight that, but also talk to you guys about some data privacy issues that we are wrestling with.

So I am going to start with you, Dr. Ibrahim. As I mentioned, my district, University of Florida, Gator Nation, I keep having to say that, you know, lots of national titles, five in the country, just putting that out there for my fellow FCC friends here on the committee, researchers are using digital twins to not just replicate hospital units like the ICU and operating rooms, but also to model

individual patient trajectories in complex cases like cancer or intensive care.

How close are we to seeing this type of patient-level digital twin technology guiding real-time treatment decisions nationwide, and beyond direct care, what role do you see digital twins playing in education and training, particularly for providers in smaller or rural hospitals who don't have access to some of this cutting-edge technology?

Dr. Ibrahim. Thank you so much for that question. And I will keep my Big Ten thoughts to myself.

The importance of this technology in rural communities is incredibly important. And in our own program, we have done discounted rates to help ensure that rural hospitals can participate. About 25 percent of our hospitals are in rural communities, and they are often partnering with large communities, large hospitals so they can have some coordination of care in triaging and sharing of expertise.

Your question about our ability to identify better treatment plans for patients is super important. One of the things we have spent a lot of time on is finding diagnoses that potentially could have been caught sooner, or weren't identified initially. One example is hypertrophic cardiomyopathy where we have looked back in old EKGs and re-run our models and found that for many patients we could have diagnosed years earlier.

So I think in the current state we have the ability to diagnose things faster. I think the future state you described, that we could actually tailor a unique novel treatment, I think that is in its infancy. It is certainly in the pipeline and horizon, but I think today we can point to that we are able to diagnose people faster. How well we can curtail the treatment is still nascent, but coming very quickly.

Mrs. Cammack. How soon do you expect the digital twin technology, utilizing someone's medical history, their chart, their DNA, biometrics, how soon do you see that being regular and commonplace?

Dr. Ibrahim. I think for common conditions, because the hitch of these models is having enough patients to train on, so for common conditions, I think that is very plausible within the next year or two, and there is probably some pilots that already exist. For more rare conditions, nuance, novel cancers and things, I think we are more than a couple years away.

Mrs. Cammack. Okay. I appreciate that. Thank you. I am going to go to you, Mr. Toy. As we talked about, UF is pioneering immune system digital twins to personalize treatment and developing synthetic data that allows AI to train without risking patient privacy.

From your perspective, can synthetic data and patient-level digital twins serve as a foundation for fair coding and care management across pairs, and also, what safeguards are needed to ensure that they don't become tools that privatize patient data or constrain physician judgment?

Mr. Toy. Yes. Absolutely. So a very interesting question. So, number one, doing the second part first, I think there are a lot of privacy implications around digital twin technology. There are a lot of upside, but literally, if you are making a digital twin of yourself, you would probably want to know how that is going to be used.

Mrs. Cammack. A little scary.

Mr. Toy. Right. So it can be a little scary. So I think the answer is we haven't solved all of that yet, but there are technologies that will help with this. So I think that what is probably going to end up happening is you are not making a full twin as in it is literally my thing moving around and being used, that is going to have too many privacy implications, but it is going to be sort of like a collective model of people who are kind of like me that can then be analyzed and processed so I don't have -- I have fewer privacy concerns.

Mrs. Cammack. Okay. And I know my time has expired, but I will submit for the record some questions about de-anonymization of data and some of the honest broker questions that surround that. But thank you all so much for your time, and thank you to my colleagues, again, for your understanding. Thank you. I yield back.

Mrs. Harshbarger. The gentlewoman yields back. And I now recognize my friend from Indiana, Representative Houchin, for her 5 minutes of questions.

Mrs. Houchin. Thank you, Madam Chair. I appreciate all the panelists testimony today. This has been a great hearing, and I think one that is much needed. I am particularly interested in hearing from Dr. Wright, and I want to just expound upon the written testimony that you have provided.

You said AI is a tool built by humans for human systems, therefore, a deep understanding of human cognition and behavior must be central to its deployment to ensure effective, ethical and equitable use of the technology. I couldn't agree more. I think the American Psychological Association probably will be playing a big role, hopefully, in ensuring that. And I appreciate that you have asked the FTC for -- and the CPSC for an investigation into unregulated products making claims of being a psychologist. That is particularly dangerous, and I join your call for information from the FTC.

On the health disparities that you mention in your comments, I do think, and I think Mr. Landsman alluded to this, too, that it does create concerns for rationing care, and it resurrects fears of death panels and other things if AI is in the mix, and I think we have to be particularly concerned about that.

But my focus of my comments is really on the impact on youth and children, teens and children. You know, we know the reports, and we have heard them today, the New York Times, the Wall Street Journal, raising concerns about how children have been engaging with AI chatbots and companions. And while I am encouraged that companies like OpenAI and Meta have updated their policies, I think we have to be thoughtful in understanding how these technologies are being used, what risks they pose to children and teens, and to our vulnerable Americans, and what we should be thinking about as policymakers for those protections that need to be in place, the risks, the benefits, how families can be equipped with necessary tools.

So you mentioned in your comments that we should require age-appropriate safeguards and robust data protections to support healthy development. When we passed the Kids Online Privacy Protection Act in 1998, enacted in 2000, we couldn't possibly have imagined the threats to children and teens that we see today through social media interactions and others, and I think that this issue is exacerbated by access to chatbots as we have recently seen.

So I guess several questions that I have for you, and then I will let you expound on this, it is, What should we be thinking about as policymakers to protect children from harm? Should we consider limits, such as age restrictions, on access to AI chatbots from children and teens? Should we consider disrupters, periodic interruptions within the chatbot that reminds the user that it is not a human and that it is not a licensed mental health professional? What things are we not thinking about to further protect children from harm? COPA 1.0 basically set an online standard that a 13-year-old is an adult online, and we know now that the highest rate of teen suicide is among 15-year-old males, so I think we have a lot of work to do in this arena, and I welcome your input.

RPTR ZAMORA

EDTR ROSEN

{1:16 p.m.]

Dr. Wright. Thank you so much for that incredibly important question. I think that there are probably several things we could try. We could try age restriction. We could try cutting people off the platform when they are on for a prolonged period of time. We could roll out, you know, parent programs where they link to the kids. We could, you know, as I mentioned earlier, have disclosures around detected suicidality.

And really, the thing is, though, these are all empirical questions. What we actually need is independent research looking at what the problem is and what the solutions ought to be, and those should be empirically driven, not just us kind of throwing spaghetti at the wall because it makes sense at the time.

And so, I think that really requires a greater investment in research of these products, and, in particular, research that happens before they go to the marketplace.

Mrs. Houchin. Yeah. I thank you so much for your note about that, because I do agree that we have to require independent testing on the harms, almost like sandboxing some of these technologies before they go live to make sure that we are adequately protecting the public. I also agree with you that we need to be distributing educational materials to parents, and maybe through our school systems about the dangers of AI chatbots.

Thank you, all, for your testimony. I yield back.

Mrs. Harshbarger. The gentlewoman yields back.

And I will now recognize my friend from North Dakota, Representative Fedorchak, for her 5 minutes of questions.

Mrs. Fedorchak. Thank you, Madam Chair.

Whoops, a chatbot is talking to me right now. Sorry about that.

Thank you, all, for your participation today. It has been a great panel. There has been a lot of talk about context. I want to take an even bigger context than what has been referenced today and look more broadly. There has been a 50 percent increase in total national health expenditures since 2019. By 2028, projections call for healthcare spending to consume nearly 20 percent of our Nation's GDP. Health insurance premiums are skyrocketing. And for all this additional money that we are spending, our actual health outcomes are not improving at all. In fact, many indicators suggest we are getting less healthy.

So, and what I have learned -- I have only been here for 8 months -- is when you talk to the different players in the healthcare industry, it is a lot of this. Somebody else is to blame. So enter AI, which I think has very serious, you know, downfalls and potential risks, but also incredible upsides, which many of you have highlighted today. So I want to drill into some of those.

In your conversation with Mr. Landsman, he correctly outlined some concerns about the pre-auth. When I go home and talk to healthcare providers, this is their biggest issue is how much time and expense and delays it takes to get through the pre-auth process. So how can we use AI -- and not to say AI is bad. It has to be -- you know, it has to only be human beings. How can we use AI and provide the right guidelines and parameters to protect against the death panels and these blanket, you know, disapprovals, but use the best of it to help us improve the pre-auth situation so that patients get their care faster?

And I will turn that over to you, Mr. Parker and Mr. Toy.

Mr. Parker. That is a great question. Thank you for the question. I mean, I think we have heard a lot of conversation today about prior authorization and automating both sides of that transaction, but we have heard little conversation about how to actually help the consumer navigate that problem, and very little sort of investment and energy into that. And so our frame of reference here is how do we enable the consumer to both understand what their options are, understand what the price is, and in the world where a prior auth is required, help them both navigate that prior auth

and ultimately get it approved if it is appropriate.

And I think if we can reorient a bunch of this energy into that experience -- and oftentimes, that might mean that there is a lower level of acuity, a lower level of care that is more appropriate, and the consumer might be happy to utilize that level of care. They just don't have any of that information. They don't really understand how to navigate any of this. And so, we are super focused on how do you help the consumer figure out the right level of care, and in a world where that does require a prior auth help them get that prior auth approved.

Mrs. Fedorchak. Okay. And I am going to come back to you with a follow-up question after Mr. Toy speaks, but the question will be, what do we need in terms of rules, guidelines, or incentives to make that happen?

So, Mr. Toy?

Mr. Toy. Yes, ma'am. Thank you for the question. So something that I think can definitely help is that, something I use my experience at Clover for, since we run a plan, is I actually advise on the Marfan Foundation for the rare disease, I advise our expert clinicians, and I advise patients on how to navigate their own prior auth. So you can think about that as using expertise to say, this is how you talk to an insurance company to get them to cover your care.

And so something we are looking at doing on the Clover side is providing actually that in a chatbot form, so that people can say, Hey, this is what I am trying to get covered, What is the right way to get that covered? And then we will cite the data, we will roll out the documentation for you, package it up, phrase it in a way that makes it easy for the insurance company to say yes to, and I think that will greatly help.

Mrs. Fedorchak. Cool.

Mr. Parker, how do we incentivize this?

Mr. Parker. I largely agree with that. I think we are building a very similar experience where we can take your full medical record, use AI to analyze it, help justify what procedure or

medication you might need based on your clinical record, and then, to Mr. Toy's point, package that up in a way that the insurance company can approve that. And I think this is a place where the AI is very capable and the data is now available enough to make that experience really possible. And I do think it is a place where, if you can execute that customer experience, it will both be more convenient, more sort of understandable, and ultimately help them get these things approved.

Mrs. Fedorchak. Okay. I have 20 seconds left. Does anyone else have short thoughts to offer?

Dr. Ibrahim. I will just say, there is enormous opportunity that we are trying to explore that the things that you need for prior authorization are predictable, they are public information, they are online. Wouldn't it be great to know that when a patient is in front of you I just have to ask them these two more things, and that will meet the 10 things that I need to do. So we are exploring are there real-time ways to notify physicians of what else is left on that checklist, so that before the patient goes home and then you have to bring them back and require new things. So, in the works.

Mrs. Fedorchak. Very good. Thank you, all. Appreciate your insights today.

Mrs. Harshbarger. Okay. The gentlewoman yields back.

I ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

And without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Harshbarger. And I would like to thank all of the witnesses for being here today. We have talked about how good this panel has been. And Members may have additional written questions for you all. And I will remind Members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to questions promptly. Members should submit their questions by the close of business on Wednesday, September 17.

And without objection, the subcommittee is adjourned.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]