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Sept. 3, 2025

Legislative Update: House Energy & Commerce Health Subcommittee Holds Hearing on A.I. in Healthcare

Overview:

With the end of August recess, Members of Congress returned to Washington D.C. this week to tackle government funding and the remaining policy priorities not included in the One Big Beautiful reconciliation Bill (H.R. 1). This includes government oversight of Artificial Intelligence (AI), which was proposed in early drafts of the reconciliation package but removed for compliance concerns. On Sept. 3, the House Energy & Commerce Subcommittee on Health met on for a hearing titled: ***Examining Opportunities to Advance American Health Care through the Use of Artificial Intelligence Technologies.*** Key topics of discussion included real-world applications of AI in the healthcare marketplace today; how AI interventions are improving care delivery for patients, providers, and federal taxpayers; and how AI can be leveraged in the future to transform the American healthcare system and better serve patients across the country.

The hearing covered a half-dozen topics specifically related to the use of AI in managed care pharmacy, including the technology's role in utilization management (UM) and benefit design, considerations for reimbursement, and the technology's ability to assist community pharmacists. While some Committee Members sought suggestions on how to use AI in improving UM, a majority of the legislators strongly urged caution or outright objected to the use of AI in prior authorizations, coverage decisions, and denials. Several Representatives highlighted the new CMS Wasteful and Inappropriate Service Reduction (WISeR) model, which is intended to "help reduce clinically unsupported care by working with companies experienced in using enhanced technologies to expedite and improve the review process for a pre-selected set of services that are vulnerable to fraud, waste and abuse," as a concerning pathway for the proliferation of AI in coverage denials. The theme of ensuring human oversight in AI processes emerged often throughout the hearing.

Many Members, on both sides of the aisle, asked questions regarding the FDA approval process and existing public payer reimbursement guidelines for healthcare-related AI devices and software. Many questioners alluded to the fact that, of the hundreds of FDA-approved, AI-enabled medical devices, few have received coverage from CMS. These questions point to a broader gap between FDA approval of novel technologies and CMS coverage decisions, where access to safe, effective, and innovative products such as AI-enabled devices and Prescription Digital Therapeutics (PDTs) is hindered by a delay in public payer coverage.

Representatives Diana Harsbarger (R-TN) and Earl "Buddy" Carter (R-GA), each practicing community pharmacists, also requested further information on the potential for AI to assist community pharmacists and enhance interoperability with physicians and other providers. Witnesses agreed that AI technology could help bolter pharmacists' position as a crucial component of a patient's care team.

While much of the Republican majority members' questioning revolved around opportunities to ensure that AI health platforms are safe and effective without overburdensome regulation, many Democratic minority members also used their allotted question time to speak to the effects of the anticipated H.R. 1 cuts to state Medicaid programs.

Witnesses:

- **TJ Parker,** Lead Investor, General Medicine – (Opening Statement)
- **Andrew Toy,** Chief Executive Officer, Clover Health – (Opening Statement)
- **Dr. Andrew Ibrahim, MD, MSc,** Chief Clinical Officer, Viz.ai – (Opening Statement)
- **Dr. Michelle Mello, JD, PhD, MPhil,** Professor of Law, Stanford Law School, and Professor of Health Policy, Stanford University School of Medicine – (Opening Statement)
- **Dr. C. Vaile Wright, PhD,** Senior Director, Health Care Innovation, American Psychological Association **–** (Opening Statement)

Committee Leadership:

- **Subcommittee Chairman Morgan Griffith (R-VA)** – (Opening Statement)
- **Subcommittee Ranking Member Diana DeGette (D-CO)** – (Opening Statement)
- **Full Committee Chairman Brett Guthrie (R-KY)**
- **Full Committee Ranking Member Frank Pallone (D-NJ)** – (Opening Statement)

Question + Answer Summary:

Subcommittee Chairman Griffith – You need a healthcare professional to help interpret AI data, correct? How much data must be input into AI before it can be reliable?

Dr. Wright – Yes, that's correct. It's not just the amount of data needed but the "correct" data, you want to train the models on a population of patients that is similar to what you're treating.

Subcommittee Chairman Griffith – A friend of mine had a form of ALS and it took several years for doctors to identify and deliver the proper treatment. Wouldn't the use of AI help shorten this timeline?

Mr. Toy – Absolutely. With AI, we can match symptoms, genotypes, and phenotypes of patients much more accurately to tailor care and drug protocols directly to the disease in question.

Chairman Griffith – What type of upstart software is needed for rural health entities to increase their use of AI? Is it expensive?

Mr. Toy – Our AI infrastructure means we can deliver benefits quickly to rural populations. Local independent pharmacists can be coordinated with family doctors.

Subcommittee Ranking Member DeGette – We've seen tremendous innovation in AI, but the uptake of innovative tools such as AI is low, because of a "trust deficit." How would you characterize the evidence base supporting the use of AI? What institutions are primed to do robust evaluations and thoughtful implementation?

Dr. Mello – The evidence base is thin. We have best practices emerging, but why would anyone adopt them if there's no incentive to use them?

Subcommittee Ranking Member DeGette – H.R. 1 will kick 15 million Americans off their health insurance, which means 15 million fewer to benefit from the AI revolution. We're also facing additional $400 billion in uncompensated care over the next 10 years. I would like to enable FDA to help, like we did through the 21st Century Cures Act, but we're unable to do that now with the current administration.

Committee Chairman Guthrie – Clover and Viz.ai have successful technologies in health care. How can AI tools be leveraged to empower, but not replace, providers?

Mr. Toy – Physicians need to feel like they can do their jobs better than before, with less friction and more empowerment. AI should be a force multiplier; it helps them be faster quicker and easier. Our tool allows docs to diagnose earlier.

Dr. Ibrahim – I have a Tuesday afternoon clinic and spend Monday preparing patient data, so the most valuable contribution of AI in my life is increasing the time I can spend with my family by reducing the administrative burden.

Committee Chairman Guthrie – how should policymakers help more patients and clinicians enjoy ai without overregulation? How do we balance guardrails with getting AI deployed to as many people as possible?

Mr. Toy – By having a human reviewer involved in the process. It's an important guardrail in and of itself.

Dr. Ibrahim – FDA is tasked with reviewing devices under decades old guidelines, so support from Congress to help FDA modernize would be very helpful on delineating "good" vs "bad" AI products.

Committee Chairman Guthrie – The Trump administration has made healthcare price transparency a bipartisan priority. How does price transparency help your patients and how does AI increase transparency into what patients are paying?

Mr. Parker – The work we're doing to show prices upfront would not be possible without transparency mandates and AI. We're using AI to read coverage of benefits and turn it into useful data for patients, and in turn calculate clear out-of-pocket prices. But price data must be publicly available for AI to use it.

Committee Ranking Member Pallone – Do we have the appropriate regulatory framework in place, does FDA's authority allow it to be nimble in reviewing emerging technologies?

Dr. Mello – I think the agency is nimble given what they have to work with, but that's not enough. Modernization would help.

Committee Ranking Member Pallone – The Trump administration has announced the WISeR model, I'm concerned that an AI-powered prior authorization model in Medicare would result in denials of lifesaving care. How can we ensure they aren't used to deny lifesaving care?

Dr. Mello – WISeR raises two question – what do we expect when putting a flawed prior authorization program into traditional Medicare? 2. How does AI help a flawed process? We know PA is flawed in itself, we should be concerned about efforts to expand its use, but it is a necessary cost control. And what happens when ai is brought in? We don't know, there is no public info on how AI affects PA decisions.

Committee Ranking Member Pallone – I have concerns around the intersection of mental health and AI. The American Psychological Association issued a health advisory on AI in June, urging safety features to be implemented to protect mental wellbeing, What are you members seeing in practice that would relate to that?

Dr. Wright – AI development is outpacing research and guardrails, we've heard of patients coming in with ChatGPT advice and are seeing public stories about harms of ai on mental health. We have a broken system, so people are seeking health care wherever they can find it. We need to consider the [psychological science when regulating AI.

Subcommittee Vice Chairwoman Diana Harshbarger (R-TN) – In an effort to expand the OTC drug class, the FDA promoted additional conditions for nonprescription use. How do you see tech and automation as a platform to expand and reinvigorate the practice of community pharmacy?

Mr. Parker – Pharmacists are underutilized compared to their capacity. We've worked to codify intakes for specific medicine, so the clinician, such as a pharmacist, has all the info they need to make a judgement on whether such medicine is appropriate in a given setting.

Mr. Toy – There's not much coordination right now between physician and pharmacist. We want to make sure there is coordination and make it easier for the pharmacist and physician to communicate. AI can tailor data for different providers based on what they need in their review.

Subcommittee Vice Chairwoman Harshbarger – Should Congress to begin to define high risk categories of AI in healthcare? And if so, what safeguards would best protect patients without stifling innovation?

Dr. Ibrahim – Innovation moves at the speed of trust, so anything we try to implement requires buy-in of the hospital first. If we don't establish trust and maintain it, we will lose clients. FDA has precedent for devices, and there likely will be similar tiering as used in devices. Existing device review processes provides a framework for this.

Representative Raul Ruiz (D-CA) – What specific dangers and potential harms can AI in health care have on children and their development?

Dr. Wright – Training models must be representative and be trained on data deemed appropriate. At worst, harms include alleged completed suicide, suicide attempts, and discussions of suicide. There was a case in Texas where a young individual attacked family on the advice of chatbot. Positive use cases also exist, like autistic children using a chatbot to practice social skills. It's about how we use the tool to appropriately safeguard it and test its effectiveness.

Rep. Ruiz - If AI systems can behave unpredictably, what guardrails can ensure they don't worsen crises? What benchmarks must be met before AI can be responsibly scaled as a tool for mental health treatment?

Dr. Wright – We have to ensure tools do not misrepresent themselves as licensed professionals, which gives sense of credibility that doesn't actually exist. Real expertise is on the backend; how the AI models are coded. We can encourage less addictive algorithms, ask for specific audit and reporting requirements for suicide, and require age verification and related restrictions.

Representative Gus Bilirakis (R-FL) – The role of AI in rare disease drug development is a potential use case. Can you share how AI will accelerate the patient diagnoses journey?

Mr. Toy – As a rare disease patient myself, rare diseases are rare individually, but many Americans know someone with one. Most clinicians are not trained on your specific rare disease. What AI can do is help clinicians learn more about specific conditions, or identify nearby practitioners with expertise.

Rep. Bilirakis – I'm concerned that AI chatbots may exacerbate growing loneliness problems. Can you speak to how loneliness and social isolation impacts kids and teens development? What are the long term impacts of kids interacting with chatbots?

Dr. Wright – We are also very concerned. Our recent Stress in America survey said that a majority of all adults don't want to discuss stress with humans for fear of burdening them or fear of being judged, which is spurring loneliness and isolation. Having social connections is the better solution. Parents need to model good use of this technology. We also need to consider how we teach the responsible use of in schools.

Representative Debbie Dingell (D-MI) – AI legislation must consider data privacy, bias, displacement of jobs, misdiagnoses and compassion/empathy. Many providers worry that AI will displace providers. How can we make sure that physicians use AI to enhance care and not replace person to person care?

Dr. Mello – Recent cuts to Medicaid enhance the need for AI to assist rural hospitals and patients. The reduction in the federal workforce also makes FDA oversight of this technology more difficult. Just because a human is in the loop doesn't mean that no other AI oversight is needed. People who work with AI need support at the institutional level.

Rep. Dingell – Many patients have unique needs. What considerations are necessary to preserve the level of patient care for those with complex health conditions?

Dr. Mello – Many of these patients are poorly served by the fragmented health system in the first place, so these are best opportunities for AI to make things better. But patients are not going to be good overseers of the use of AI in respect to their care. We need to be extra careful about monitoring here.

Rep. Dingell – I think there will be an outsized impact on young women and girls. How can the mental health care system be bolstered to respond to AI enabled abuse?

Dr. Wright – It starts with helping providers evaluate tools and incorporate them into any setting and helping clinicians know what questions to ask patients about their AI use. This could be through Continuing Education or training within professional school settings for future providers.

Representative Neal Dunn (R-FL) – Clinicians are drowning in paperwork. This could be low hanging fruit for AI to tackle or improve. Patients know that physicians are irreplaceable, so how can the earliest applications of AI in medicine assist frontline physicians or decrease administrative burden?

Dr. Ibrahim – It would be nice for my family if I read less charts. Many things in hospital require manual reporting, such as billing and documentation. There is enormous potential for clinicians to do the thing they want to do. We need the right checks and safeguards in place.

Rep. Dunn – How might CMS pay for these?

Dr. Ibrahim – CMS already has the new technology add-on payment (NTAP) system which allows for temporary reimbursement for 3-5 years for AI products that assist with EKG or radiology reads. It would be better to have a more permanent pathway to coverage, as we are still in the assistance benefit category.

Representative Robin Kelly (D-IL) – I urge support for the Bipartisan Digital Health Caucus. AI tools are only as good as the data they are built on. We've seen algorithms underserve black patients, or tracking software ignore darker skin. AI can replicate inequities, so what steps should regulators and developers take to make sure AI is tested on diverse populations?

Dr. Mello – We need large datasets that represent *all* subgroups, including those not often tagged with discrimination: like kids or rural patients. Bias and inequities arrive at the point of care, even with a good, unbiased algorithm. Unless we were willing to spend more on outreach and capacity, diverse patients will benefit from AI in theory but not reality.

Rep. Kelly – How can AI get more people to join clinical trials? What ethical guardrails should Congress enact?

Dr. Mello – AI can help with the identification of eligible patients. But a major barrier is that we can't convince patients to participate – this is where the human touch is so important and AI can't replace that.

Representative John Joyce (R-PA) – The number of FDA-approved medical devices that utilize AI has grown from 6 to 600 in just a few years, outpacing CMS' existing coverage framework for software based technologies. Does the lack of a stable reimbursement environment for these devices make it challenging for rural providers to ensure that rural patients have access to the latest innovations?

Dr. Mello – I do think there are many things we can do for direct assistance to rural hospitals – reimbursement is critical. Despite the presence of potentially burdensome regulations, we've gotten AI innovations out to hospitals and patients, albeit mostly via radiological tools.

Dr. Ibrahim – Most of the improvements we've seen in stroke care have recently come from work in rural populations. When hospitals decide to adopt new tech, the ability to be reimbursed is in front of mind. We need to assure hospitals that there will be temporary payment fixes in the meantime.

Rep. Joyce – The use of AI in prior authorization is loosely regulated. Do you feel that AI should be leveraged in prior authorization decision making processes? What guardrails should be added?

Mr. Toy – We do not use AI in our prior authorization decisions, but other companies do. It should not be used to review or deny care in any case. It can be used to reduce burden or accelerate decisions, but a human should be the ultimate decision maker.

Representative Nanette Barragan (D-CA) – Of the nearly 600 FDA-approved AI applications, less than 10 are currently eligible for CMS reimbursement. Is that concerning or a good thing?

Dr. Ibrahim – Historical context is important here. The role of FDA is focused on safety and effectiveness, while reimbursement decisions are deferred to CMS which leads to redundancy. It would be helpful for CMS to defer to the rigorous evaluation conducted by FDA.

Rep. Barragan – What can Congress do to make AI tools more accessible to people?

Dr. Mello – We need to ask a hospital: what will move me to spend more on AI? The trust deficit really matters here. We can close the trust deficit by modifying FDA review, reimbursement, and institutional governance.

Rep. Barragan – Earlier this year, HHS released a MAHA report littered with errors and incomplete references, likely assisted by AI. How can we ensure AI is used responsibly and with full accountability?

Dr. Mello – Only by ensuring that there's a human in the loop.

Representative Troy Balderson (R-OH) – What steps can Congress take to support the wider adoption of AI tools, especially in rural areas?

Mr. Toy – The most important thing is making sure there is connectivity to the internet. We can connect physicians to cloud based AI systems and improve interoperability. We can also give connected devices like iPads to patients.

Rep. Balderson – How can congress accelerate connectivity and data sharing between primary care providers and independent specialists?

Mr. Toy – Connectivity to the internet and within systems is important. We need to make sure that current interoperability rules accommodate this. Need it to be physician mediated, could also be patient mediated so they can also request data off of networks.

Rep. Balderson – We've seen that AI can be integrated to speed up diagnoses. How do you see this benefiting physicians and patients?

Dr. Ibrahim – We have rural patients who notice a concerning sign on their imaging, so we transfer them to big city facility, where they are reassured that nothing is wrong. In the future, we'd want to allow AI technology to share information or make decisions without making people physically travel to different locations.

Rep. Balderson – Is there concern for error in using this technology on patient care?

Dr. Ibrahim – We need to be careful and are always learn something new. It is critical to have humans in the loop to mitigate risk, with additional monitoring safeguards.

Representative Kim Schrier (D-WA) – There are only 6 AI products marketed for pediatric use, out of the hundreds approved by FDA. Given the complexity of pediatric care, what can be done to incentivize the use of ai for pediatric patients?

Dr. Ibrahim – Our product is only used for adults. What's important is the sharing of data. The field of AI has improved in this space as AI can share general data without exchanging individual patient info. We can potentially share weighted averages of algorithms without sharing personal identifying info. A hidden benefit of AI is that it requires the improvement of existing IT infrastructure to accommodate itself.

Representative Mariannette Miller-Meeks (R-IA) – How can Congress accelerate interoperability across federal and private health systems in a way that improves innovation but isn't overburdensome?

Mr. Toy – AI runs on data, so better, more relevant, and more personalized data is more important. It's critical to have built infrastructure for interoperability. It would be helpful to modernize current framework, ex: HIPPA was generated in a pre-internet world, we will need to update to improve interoperability regardless.

Rep. Miller-Meeks – We've seen direct-to-consumer chatbots making deceptive and dangerous claims, where does the boundary lie?

Dr. Wright – It is important that these chatbots don't misinterpret themselves, so we have to build better chatbots. An unanswered question is how we can leverage emergent technologies to reach people where they are at.

Representative Lori Trahan (D-MA) – As we consider AI's role in health care, what safeguards should be in place so that technology doesn't duplicate the procedural enrollment we've seen during Medicaid unwinding?

Dr. Mello – First, we need humans monitoring at a population-level. My hope is there will be private innovation to develop apps to notify enrollees before they are disenrolled.

Rep. Trahan – AI often places additional barriers on overly complex reporting systems. How do we design systems to clear barriers to care, rather than build new ones?

Dr. Mello – Collaborative design between AI developers and patients can help avoid replicating these problems.

Representative Cliff Bentz (R-OR) – Where would you put AI if a doctor involved in a malpractice case should have used AI or used it improperly?

Dr. Mello – Reasonableness of action is always the loadstar in a malpractice case. Physicians are provided with little information from the tool on whether recommendations apply to specific patients. Need shared liability between providers, hospitals, and ai developers,

Rep. Bentz – Shouldn't the law create accountability for AI developers?

Dr. Mello – When this accountability is contracted away during licensing, I don't understand how AI developers can add certain disclaimers that other pharmaceutical manufacturers and product developers can't.

Rep. Bentz – At what point does the human become less analytically able than AI?

Mr. Toy – I don't think human thinking will be replaced by AI any time soon. AI will overtake us on more perfunctory tasks.

Rep. Bentz – Have algorithms replaced the human connection? How do we get it back?

Dr. Wright – I'd argue no, reciprocity makes relationships unique and there is no reciprocity with AI. People like AI because it agrees with them, but it does not create true intimacy. We need to be more intentional on AI literacy in schools and for parents and need public educational campaigns.

Representative Marc Veasey (D-TX) – Why are children and adults in crisis particularly susceptible to the harmful outputs of AI chatbots?

Dr. Wright – Children are at a different developmental stag with limited life experience. Individuals with uncertainty want answers – chatbots are coded to give answers that people want, they tell you what you want to hear. We need to disincentive companies from user-engagement business models.

Representative Nick Langworthy (R-NY) – Medicare Advantage (MA) is at the forefront of using AI tools. How are AI innovations used in Medicare Advantage and Medicare more broadly?

Mr. Toy – The advantage of MA is that we can bring better outcomes, data, and reimbursement to doctors. People in MA plans can go to doctors who use AI safely and know the doctor is being reimbursed by the MA plan for the time being used to consult the AI. We are reimbursing for the extra time taken to use AI.

Rep. Langworthy – How does the use of AI inform benefit design?

Mr. Toy – When we use AI to improve outcomes, all of this results in a better medical loss ratio. We're more efficient per unit dollar, we can also reinvest efficiency back into lowering patient's OOP costs. Our incentive is to reduce financial barriers to care by using AI.

Rep. Langworthy – Does Clover leverage AI in utilization management processes? Is there a human check on this process?

Mr. Toy – All of our prior authorizations are done by a clinician, we are not using AI in UM. There is an opportunity to lower friction with AI, to reduce time spent preparing documents etc.

Representative Lizzie Fletcher (D-TX) – Is current federal law sufficient to regulate the use of AI in prior authorization?

Dr. Mello – No, but CMS did good work on rules regarding the use of prior authorization in Medicare Advantage plans. The WISeR model specifies that there needs to be human review – but what does

this mean? Commercial plans – no protections that MA plans do, with little to no reporting requirements. We need to understand what the commercial market is doing with additional oversight.

Representative Buddy Carter (R-GA) – How can AI health platforms help empower America's pharmacies to serve patients?

Mr. Parker - we can use ai to analyze a patients medical record or care gaps, similar data analysis an be used by pharmacists. Robust access to medical records and intelligence of ai is promising.

Rep. Carter – Insurers have taken on a major role in health costs, the price of a drug often depends on an insurer. Would it be helpful to know the price of a drug before going to the pharmacy?

Mr. Parker – Consumers should be able to see the final list price from insurance vs cash before they get to the pharmacy counter. By showing a clear insurance vs cash price up front, many consumers choose cash when they find it is actually less expensive. It is empowering for the consumer to have this info up front.

Rep. Carter – Will this help with patient compliance?

Mr. Parker – Yes, it's had a tremendous impact on the customer experience from what we've seen at my company.

Rep. Carter – How can AI accelerate innovation in drug development?

Dr. Ibrahim – AI helps in informational challenges; it does good in pattern recognition. There is potential in early discovery phases for AI to make the process more efficient.

Representative Alexandria Ocasio-Cortez – Many insurers use unauthorized AI models to deny prior authorization requests. Mr. Toy, have you see this and why do you disagree?

Mr. Toy – Yes, I've seen it. There should always be a clinician involved in these decisions.

Rep. Ocasio-Cortez – Could an AI-PA denial threaten the life of someone in need of critical care?

Mr. Toy – Yes.

Representative Jay Obernolte (D-CA) – The most promising AI models can bring down administrative costs, but previous demonstrations made it seem that AI would completely reinvent the healthcare landscape. Should people be disappointed in "broken promises" around AI?

Mr. Parker – Our implementation is pragmatic, we're trying to improve the customer experience to the best of our abilities. Helping patients understand what they're purchasing is most important to me.

Rep. Obernolte – Do you think government buy-in/oversight would help with the trust barrier?

Dr. Mello – I think *institutional governance* requirements are the most important. Hospitals/physician practices are best suited to understanding their populations and what can go wrong. The government can't build trust alone but can provide incentives for other organizations/institutions to do so.

Representative Greg Landsman (D-OH) – What are the legal, moral, and health challenges that this WISeR program will create?

Dr. Mello – The reimbursement model for AI puts the idea of shared savings on its head. Now, health care organizations will make more money by denying care under WISeR. They chose initial producers that are denied often already, the question is how far does this model go?

Representative Kat Cammack (R-FL) – Researchers are using digital twins to model patients and settings. How close are we to seeing patient-level digital twin tech guiding real time treatment decisions nationwide? What role do you see digital twins providing for rural or underserved providers?

Dr. Ibrahim – The importance for rural programs is immense. We focus on finding diagnoses that could've been caught sooner. We have the ability to diagnose things faster, in the future we can tailor unique, novel treatments for each condition.

Rep. Cammack – How soon do you expect digital twin tech to be regular and commonplace?

Dr. Ibrahim – For common conditions, plausible within next few years. Longer timeline for rare conditions.

Rep. Cammack – Can synthetic data and digital twins serve as foundation for fair coding and care management? How do we make sure they aren't tools that constrain physician judgement?

Mr. Toy – There are many privacy concerns on digital twins. We haven't solved this yet but there is tech that can help. Will probably lead not to full digital twins, but a collective model of people similar to me.

Representative Erin Houchin (R-IN) – What should policymakers think about to protect children: Limits? Age restrictions? Periodic disruptors?

Dr. Wright – We could have disclosures, parent oversight, but these are all empirical questions. We need independent research to identify the problem and brainstorm solutions.

Representative Julie Fedorchak (R-ND) – Many health care providers are upset with the use of prior authorizations. How can we use AI to provide the right guidelines and parameters to protect against blanket disapprovals and "death panels" how can AI improve prior auth?

Mr. Parker – We can help the consumer navigate and overcome the prior authorization landscape. We're focused on helping the consumer find the appropriate level of care. We can incentivize the use of AI in prior authorizations by using AI to help justify the necessity of procedures based on analysis of your condition and medical records.

Mr. Toy – I regularly advise patients on how to navigate their own prior authorization challenges. At Clover, we're looking to provide that advice in a chatbot form.

Links:

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