# LOWERING THE COST OF HEALTHCARE: TECHNOLOGY'S ROLE IN DRIVING AFFORDABILITY

## JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GROWTH, ENERGY POLICY, AND REGULATORY AFFAIRS

AND THE

SUBCOMMITTEE ON HEALTH CARE AND FINANCIAL SERVICES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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# C O N T E N T S

## OPENING STATEMENTS



## WITNESSES



*Written opening statements and bios are available on the U.S. House of Representatives Document Repository at: docs.house.gov.*

INDEX OF DOCUMENTS

* Article, *Juniper Research Group*, "No, Obamacare Premiums are NOT Doubling in 2026"; submitted by Rep. Burlison.

* Article, *Center on Budget and Policy Priorities*, "By the Numbers Harmful Republican Megabill"; submitted by Rep. Frost.

* Article, *The Hill*, "Medicaid Cuts Will Harm Rural Republican Communities the Most"; submitted by Rep. Frost.

* Fact Sheet, Keep Americans Covered, "Preserve Health Care Tax Credits"; submitted by Rep. Frost.

* Report, Commonwealth Fund, "Expiring ACA Premium Tax Credits Could Lead to Nearly 340,000 Jobs Lost"; submitted by Rep. Frost.

* Article, *Unleash Prosperity*, "How Much Does That MRI Cost"; submitted by Rep. Grothman.

* Article, *AMA*, "Trends in Health Care Spending"; submitted by Rep. Grothman.

* Fact Sheet, CMS, "National Health Expenditures"; submitted by Rep. Grothman.

* Article, Jaisri Lingappa, "How WISeR Will Enable Companies to Profit From Pain—A Retired Physician's Story"; submitted by Rep. Randall.

*The documents listed above are available at: docs.house.gov.*

# LOWERING THE COST OF HEALTHCARE: TECHNOLOGY'S ROLE IN DRIVING AFFORDABILITY

**WEDNESDAY, DECEMBER 10, 2025**

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON ECONOMIC GROWTH, ENERGY POLICY, AND REGULATORY AFFAIRS
SUBCOMMITTEE ON HEALTH CARE AND FINANCIAL SERVICES
*Washington, D.C.*

The Subcommittees met, pursuant to notice, at 10:04 a.m., in room HVC–210, Capitol Visitor Center, Hon. Eric Burlison [Chairman of the Subcommittee on Economic Growth, Energy Policy, and Regulatory Affairs] presiding.

Present: Representatives Burlison, Grothman, Higgins, Donalds, Perry, McGuire, Gill, Comer, Frost, Krishnamoorthi, Randall, Bell, and Simon.

Mr. BURLISON. This joint hearing of the Subcommittee on Economic Growth, Energy Policy, and Regulatory Affairs and the Subcommittee on Health Care and Financial Services will come to order.

Welcome, everybody.

Without objection, the Chair may declare a recess at any time.

I recognize myself for the purpose of making an opening statement.

## OPENING STATEMENT OF CHAIRMAN ERIC BURLISON
## REPRESENTATIVE FROM MISSOURI

Welcome to this joint hearing of the Subcommittee on Economic Growth, Energy Policy, and Regulatory Affairs and the Subcommittee on Health Care and Financial Services. Today, we are here to explore how innovative technology in the healthcare sector can help lower Americans' healthcare costs.

Healthcare costs in the United States have long been on the rise, but recent Democrat policies and the radical Biden Administration's regulatory agenda have made healthcare costs in America even worse.

The Inflation Reduction Act, or the IRA, signed into law by the Biden Administration in 2022, was passed under the guise of lowering healthcare costs for working Americans.

These two Subcommittees recently held a joint hearing on the ballooning costs and the market-distorting policies included in the IRA. Today, we have another opportunity to take a hard look at the consequences of policies that not only failed to accomplish their intended goals but place an undue regulatory burden on Americans.

Business owners in our country put their livelihoods on the line to develop breakthrough technologies to reinvent the healthcare industry but are forced constantly to navigate the regulatory obstacles put in place by Democrat administrations.

The money spent on legal fees and administrative procedures could be reinvested to further improve technologies that doctors and other medical providers can use to improve patient experiences, save lives, and bring families together.

Congress must give private sector innovators the space and the resources that they need to develop these technologies.

We have already begun to see the tremendous capabilities of artificial intelligence to help lower costs in our everyday lives. If that power were harnessed in the healthcare sector, resources could be more effectively deployed to help patients get better.

In addition, lower costs would save the Federal Government and the taxpayers a lot of money in any of our Federal healthcare programs.

For example, patients can use wearable technology to monitor their health. These devices assist doctors and researchers with realistic data on their patients day to day in real time.

3D printing can create personalized medical devices for individual patients. Investment in this printing technology has led to the development of customized prosthetics, implants, and surgical tools.

Telehealth improves the efficiency of healthcare by allowing medical providers to serve patients in a live virtual call. Telehealth saves time and helps patients connect to their doctors, especially in rural areas where there are few medical facilities.

These kinds of technologies are revolutionary, but if innovators cannot afford to develop more of them because of the expensive barriers put in place by the previous administration and the Inflation Reduction Act, the American people will miss out on cutting-edge medical care that could improve patient outcomes.

Earlier this year, President Trump signed the One Big Beautiful Bill into law. That bill gives over $50 billion to rural hospitals to ensure their continued operation and development of medical technology.

Since entering office, President Trump has taken decisive action aimed at reversing innovation-stifling Biden-era policies in artificial intelligence, promoting transparent drug pricing, and eliminating the "Biden Pill Penalty."

Our expert panel of witnesses, including a fellow Missourian and a medical technology business owner, will provide testimony on this important issue.

I thank all of the witnesses for being here today, and I look forward to our discussion.

And with that, I yield to Ranking Member Frost for his opening statement.

**OPENING STATEMENT OF MAXWELL FROST**

**REPRESENTATIVE FROM FLORIDA**

Mr. FROST. Thank you, Chairman Burlison and Chairman Grothman, and thank you to the witnesses for being here this afternoon.

I have got to be honest, I was a little shocked to see this hearing called on healthcare affordability this week as we continue to see congressional Republicans block extension of the tax credits that will help people obtain affordable healthcare.

We, as in this moment, are in a crisis. In just five weeks, the Affordable Care Act, ACA, enrollment period ends, and 189,000 people in my district alone will be paying anywhere between 50 and 300 percent more in premiums, and many will opt out of coverage altogether.

So, we can hold a hearing about whether technology for new software and medical tools can decrease costs. It is very interesting. I would appreciate that conversation and support innovation in the way that we deliver healthcare.

But to hold this hearing now while ignoring the massive upcoming cliff in front of us right now is, quite frankly, an insult to the 25 million Americans that will see their healthcare costs go up if Congress does not do its job.

Healthcare costs are going to skyrocket for American families if people cannot afford their premiums, and using technology to make certain procedures or processes slightly more efficient will not change that.

We cannot allow the costs of treating cancer, diabetes, heart disease, and any other condition to people we know and people we love that are battling every day to bankrupt hardworking Americans.

I cannot imagine trying to convince my constituents who are about to be paying an additional $2,000 a month in healthcare premiums that giving money to tech companies will knock off a few dollars here and there and that it is the best their leaders can do for them.

It is not just my district. Millions of people across the country are unsure whether they can afford healthcare coverage as premiums and deductibles rise.

One in four Americans who currently rely on the Affordable Care Act for health insurance are at risk of losing coverage if congressional Republicans succeed in letting these tax credits expire.

Most Americans who are enrolled in the Affordable Care Act will see their healthcare insurance premiums increase anywhere from 50 to 300 percent. And at the same time, congressional Republicans have taken a sledgehammer to our healthcare system and set us on a path to undo all the gains that made healthcare more affordable under Democratic leadership.

President Trump's One Big Beautiful Bill Act takes healthcare coverage away from a whopping 15 million Americans. The single biggest legislative achievement of congressional Republicans and President Trump this year has been to rip Medicaid away from almost eight million people by 2034. Congressional Republicans and Donald Trump, seems like, do not care whether or not you can af-

ford your healthcare or medical care, and we have got to be clear this issue is fixable.

The healthcare crisis that congressional Republicans and Donald Trump have created have real and devastating consequences for Americans. Patients will go without the preventative and primary care that they need. One in three young Americans are at risk of losing their health insurance in the next few years.

The number of Americans without health insurance coverage in every state and every congressional district will rise. And thanks to the work of Donald Trump and congressional Republicans' new draconian work requirements for Medicaid eligibility, 2.1 million American women may no longer have health insurance when they are pregnant or caring for young children.

And many people, like my Governor, Ron DeSantis, come out and say that young people, quite frankly, might not need health insurance if they are under the age of 40.

People who get health insurance through Medicaid or the Affordable Care Act marketplaces are the same hardworking Americans that we live and work with every single day. The Affordable Care Act premium tax credits allow farmers, ranchers, and small business owners to stay self-employed, invest in their businesses, and employ others. All these things strengthen our communities and economy.

Let us not forget that 77 percent of the Affordable Care Act Marketplace enrollees live in states that President Trump won in 2024. How quickly has he abandoned them. congressional Democrats are fighting to make healthcare more affordable. We are fighting to lower prescription drug prices, and we are fighting to make sure that all Americans have access to quality healthcare.

We know we have a broken healthcare system. There is a lot I personally want to talk about as it relates to this healthcare system. I personally believe in single payer.

But the fact of the matter is right in front of us we have a cliff that we are barreling toward, and if we do not do our job, this whole topic of affordability, I mean, it is something that 25 million Americans are facing as we speak.

As we learn about innovations in healthcare technology today, it is important that my congressional Republican colleagues face the reality that healthcare innovation is not a substitute for affordable healthcare coverage, and it is not enough to reduce cost on its own. Innovation cannot reverse the damage Donald Trump and congressional Republicans have done with their devastating healthcare cuts.

I urge all of us to keep everyday working families in mind that are struggling to afford healthcare. Let us ensure that we pass these premium tax credits. Let us ensure that we do not hike healthcare costs for 25 million Americans from anywhere from 50 to 300 percent. And then let us get together and figure out what we can do in terms of innovation to bring down costs for all Americans.

Thank you, and I yield back.

Mr. BURLISON. I now recognize Chairman Grothman for the purpose of making an opening statement.

**OPENING STATEMENT OF CHAIRMAN GLENN GROTHMAN**

**REPRESENTATIVE FROM WISCONSIN**

Mr. GROTHMAN. Yes, thanks. Just to respond to that a little bit.

I think it is becoming more and more over time apparent that the major beneficiary of Obamacare, or the ACA, are the insurance companies. And we are at a cliff here where we are going to find out—where we find out what happens when we let the insurance companies write such a plan.

We are at a point in which we have got to spend $34 billion a year or more to prop up a failed plan or come up with some sort of alternative.

So, welcome to this joint hearing of the Subcommittee on Economic Growth, Energy Policy, and Regulatory Affairs and the Subcommittee on Health Care and Financial Services. This is an exciting opportunity for us to address one of the most pressing issues for Americans: the continued rising cost of healthcare.

Healthcare costs have been steadily increasing since 1970. The total healthcare spending in the United States was just shy of $5 trillion a year. That is $14,500 per person. That is almost 18 percent of GDP. In 1970, healthcare spending accounted for only seven percent. So, it has increased by 150 percent over the last 50 years.

The United States spends twice as much per person on healthcare as other peer nations. I do not have statistics on how much our insurance companies make compared to other nations.

It makes sense that the overall healthcare costs have increased in the past 50 years. Our country's population has grown from 200 million to 350 million.

The problem is not that we are not spending money on healthcare. The problem is that the money that we are spending is being wasted and does not improve patient health.

Recent studies show that nearly one-third of healthcare spending in the United States is wasteful because it does not lead to better patient outcomes. In 2023, that would mean $1.6 trillion spent on healthcare was wasted.

To put $1.6 trillion in perspective, the Federal Government spent that same amount on total health insurance in 2024, including Medicare, Medicaid, Children's Health Insurance Program (CHIP)s, and the Affordable Care Act marketplace subsidies.

More than half of this wasteful spending can be directly attributed to administrative expenses. That is why when you go into a hospital or a clinic you see a huge number of people working there who really have nothing directly to do with healthcare.

Over the past several decades the growth in administrative staff has far outpaced the growth in doctors and nurses. Hospitals, insurance companies, and health systems now employ layers of administrators focusing on billing, compliance, reporting, coding, and navigating complex regulations rather than delivering care.

In many hospitals today there are multiple administrative employees for every practicing physician. These costs are passed directly to patients through higher prices, higher premiums, and reduced access to care.

At the same time, patients are left completely in the dark about prices. Someone scheduling a routine procedure frequently has no

idea what it will cost or how prices compare across hospitals, clinics, or providers.

In almost no other sector of our economy do consumers face this level of price secretiveness.

Just imagine how much different our entire healthcare system would be if more dollars were directed toward patient care and less toward administration.

This is where technology has the potential to make a real difference, which is why we felt it was timely to bring in experts in technology in the healthcare sector and see what they had to say.

Empowering patients with price transparency can drive competition, lower costs, and improve access to affordable care.

Today's expert panel of witnesses will provide their perspective on how the current healthcare system costs too much, the leading cause of those rising costs, and how innovative technology in the healthcare sector will make healthcare more affordable. We look forward to this testimony.

And with that, I yield to Ranking Member Krishnamoorthi for his opening statement.

**OPENING STATEMENT OF RAJA KRISHNAMOORTHI**

**REPRESENTATIVE FROM ILLINOIS**

Mr. KRISHNAMOORTHI. Thank you, Chair Grothman.

Thank you, Chair Burlison, Ranking Member Frost.

I associate myself with the comments of Ranking Member Frost, and I just want to point a few things out.

If we do not extend these tax credits that are going to expire at the end of the year, in Illinois alone half a million people who receive these tax credits will see, on average, their premiums go from $260 a month to $464 a month, almost an 80 percent increase.

Looking closer at these numbers, those living in urban areas will see an almost 90 percent increase in premiums; whereas, people in rural areas would see premiums rise by a stunning 107 percent on average. So, doubling their premiums.

Let us be clear. People will not stop needing medical care. Safety net and rural hospitals will pay the price. Patients will still show up in emergency rooms but only after manageable conditions have become catastrophic, driving the cost of care through the roof for everyone no matter their insurance status.

Listen, this is not theoretical. In safety net hospitals across Illinois, frontline providers have warned me directly: The Republicans' Big Beautiful Bill—or what I call the Large Lousy Law—includes Medicaid and ACA cuts that will drive up costs, slash essential services, and put struggling communities into healthcare deserts.

At Loretto Hospital in the Austin neighborhood of Chicago, 83 percent of patients rely on Medicaid. In the face of Republican cuts, hospital officials told me they may have to close programs to ensure they do not have to fully shutter the hospital.

In Benton, Illinois, which is in southern Illinois, I visited Franklin Hospital where a fifth of the hospital's budget comes from Medicaid reimbursements. Republican Medicaid cuts will require them to provide care "on a smaller scale" so they can continue serving their rural community.

On top of that, leadership at Franklin Hospital told me that if the Medicaid cuts are significant enough, they would have to reduce staffing and reevaluate the services they can provide, and this will affect the entire rural economy.

Republican healthcare cuts are going to close essential hospitals, and this is a map of 11 hospitals in Illinois that are set to shutter.

It is going to hurt everyone because it does not matter what healthcare status you belong to, health insurance status you belong to, if you use any of these hospitals and if they close, you will be negatively impacted.

And so, that is why we need to be concerned about this expiration of tax credits at the end of the year, but also the implementation of the Large Lousy Law, because it will lead to a crisis in healthcare that is eminently preventable today.

If we can just marshal our energies and collective resources, we can pass an extension of the ACA tax credits and prevent what would otherwise be a catastrophic situation for millions of Americans.

Thank you, and I yield back.

Mr. BURLISON. Thank you, Chairman Grothman, Ranking Member Frost, and Ranking Member Krishnamoorthi.

I am pleased to welcome our expert panel of witnesses.

First, we have Brian Whorley, who is the Chief Executive Officer of Paytient Technologies, Inc.

Next to him, we have Dr. Darius Lakdawalla, Quintiles Chair in Pharmaceutical Development and Regulatory Innovation and Chief Scientific Officer, Schaeffer Center for Health Policy and Economics at the University of Southern California.

Next, we have Dr. Ziad Obermeyer, who is with Blue Cross of California, Distinguished Associate Professor, Health Policy and Management, at the University of California-Berkeley.

And next we have Mr. Chris Jacobs, who is the Founder of the Juniper Research Group.

And finally, we have Ms. Sophia Tripoli, Senior Director of Health Policy at Families USA.

Thank you to each and every one of you for being here today. I am looking forward to your testimony.

Pursuant to Committee Rule 9(g), the witnesses will please stand and raise their right hand.

Do you solemnly swear or affirm that the testimony that you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record show that the witnesses answered in the affirmative.

Thank you, and you may take your seats.

We appreciate you being here.

And let me remind the witnesses that we have read your written statements, and they will appear in full in the hearing record. So, please limit your comments to 5 minutes.

The light system is pretty self-evident. Green is go, yellow is wrap it up, and red is stop.

I now recognize Brian Whorley for his opening statement.

**STATEMENT OF MR. BRIAN WHORLEY**

**CHIEF EXECUTIVE OFFICER, PAYTIENT TECHNOLOGIES, INC.**

Mr. WHORLEY. Thank you. My name is Brian Whorley. I am the CEO and founder of Paytient.

I founded Paytient because I believe the most powerful way to remake the healthcare market and lower the prices we pay is by increasing and returning purchasing power to the one stakeholder in the system most sensitive to and capable of discerning value, and that is the patient.

Our goal is to improve the ability of employers and patients to simply purchase and pay for care. Ideally, paying not just transparent but transactable cash prices directly to providers whenever possible. We do that with help from pioneers like HealthEquity and Mark Cuban Cost Plus Drugs today.

Today, we serve 6,000 employers who want the capital efficiency of lower-cost health plans while ensuring that the 96 percent of their employees who never reach their out-of-pocket maximum have an easier way to pay for care.

We do not do this work alone. We are grateful for partners such as Elevance, Blue Cross Blue Shield of Arkansas, Cigna, Centene, Gravie, Sidecar Health, Humana, and many others who have been investing with us for years to improve the affordability of the out-of-pocket experience for ACA, governmental, and employer health plan members and providers.

I am proud to say that Paytient also provides the software that powers the Medicare Prescription Payment Plan for nearly 22 million Medicaid beneficiaries.

The Medicare Prescription Payment Plan is a bipartisan healthcare payment innovation that gives 54 million seniors the option for their insurer to pay their out-of-pocket costs up front at the pharmacy counter.

Seniors receive a statement at month's end to review for accuracy and then pay in full, like most do, or simply smooth their payment plan over the plan year to better fit their household budget.

This innovation gives 54 million American seniors financial security and the ability to personalize payment in a way that works for their budget. It is a pragmatic approach to make healthcare more accessible and affordable and recognizes the ability to pay a $600 out-of-pocket expense is not the same for every senior.

Importantly, this concept of cost smoothing, it improves affordability without removing responsibility.

This bipartisan idea is catalyzing change in the employer insurance market where brokers, employers, and insurers are realizing that health plans that include cost smoothing create the ability to have lower-cost health plans coupled with better financial experiences for patients and providers.

The market is moving toward these hybrid healthcare plans that have the efficiency of simply paying cash in full or over time for low-cost routine care, coupled with the security and peace of mind of insurance coverage and payment rails for rare care.

Please consider four suggestions to expand the use of this existing in-market technology to immediately improve healthcare affordability.

One, ensure seniors are automatically protected from unaffordable out-of-pocket costs by auto-enrolling them in the Medicare Prescription Payment Plan.

Every insurer in the country has successfully launched and operationalized M3P. Seniors like the financial protection, convenience, and ability to review their monthly statements for accuracy before they send in a check and pay for care. Plans can and should automatically enroll seniors in 2027 in M3P instead of laboriously requiring sick seniors to call, opt in, and potentially delay care.

Two, encourage insurers to expand payments to include medical costs. Why should seniors only be able to smooth their pharmacy claims over time? Why not their larger, more costly, and unpredictable medical expenses?

Second, expand payment smoothing into ACA and employer plans, providing real relief to 180 million people today. To help this innovation, uncompensated care from payment smoothing should be clearly characterized as the equivalent to a medical loss encountered below the line.

Three, allow seniors to access the benefit in real time. Seniors should be able to opt in in real time when they need help the most, when they are standing in a moment of uncertainty at a pharmacy counter, instead of waiting 24 hours and making a return trip to the pharmacy—or not.

The technology exists to allow seniors to opt in in real time or near time, allowing them to simply get their meds when they need to.

And last, return the economic power to the people by allowing employees to receive and control more of their own healthcare dollars. Give employers and employees the voluntary option to receive the full cash value of what their employer would have spent on their health plan into a Health Savings Account (HSA) or a Roth version of an HSA that they could use to invest in their health, purchase insurance, or simply and directly pay transparent, transactable cash prices directly to providers.

Thank you for the opportunity to share my testimony.

Mr. BURLISON. Thank you, Mr. Whorley.

I now recognize Dr. Lakdawalla for his opening statement.

## STATEMENT OF DR. DARIUS LAKDAWALLA QUINTILES CHAIR IN PHARMACEUTICAL DEVELOPMENT AND REGULATORY INNOVATION AND CHIEF SCIENTIFIC OFFICER, SCHAEFFER CENTER FOR HEALTH POLICY AND ECONOMICS, UNIVERSITY OF SOUTHERN CALIFORNIA

Dr. LAKDAWALLA. Chairman Burlison, Chairman Grothman, Ranking Member Frost, Ranking Member Krishnamoorthi, and honorable Members of the Subcommittees, thank you for the opportunity to testify today about accelerating medical innovation through regulatory reform. The opinions I offer today are my own and do not represent the views of USC or the Schaeffer Center.

In 1965, the world's first beta-blocker drug, propranolol, was readily available to patients in Europe. Unfortunately, American patients would have to wait 11 years to fully benefit from this revolutionary treatment for cardiovascular disease.

We now know that delay was deadly. Clinical trials show propranolol reduced stroke risk by 25 percent and cut heart attack mortality by nearly 30 percent.

Later, USC Schaeffer research discovered this delay hurt the least-educated households the most because they lacked the means for the complex diet and exercise regimens that serve as the key alternative treatment option.

Propranolol was not an isolated case. From 1972 to 1987, new drugs were twice as likely to launch overseas first.

Then, in response to growing calls for timelier approvals driven by the AIDS crisis, the FDA pioneered a series of reforms, including the fast-track approval of HIV drug AZT in 1987.

Thanks to these and other forward-thinking regulatory reforms, America is now the preferred launch market for breakthrough medicines.

What is needed today is the next generation of forward-thinking regulatory reforms that would encourage critical innovation and improve the health of American patients.

First, Medicare's Coverage With Evidence Development program needs urgent reform. Despite its name, CED limits both coverage and evidence development.

USC Schaeffer analysis reveals how it creates stark disparities. CED-qualified hospitals are half as likely to treat patients that reside in rural areas. Similarly, they treat fewer low-income, subsidy-enrolled patients and fewer patients residing in socioeconomically disadvantaged neighborhoods.

Not only do these kinds of constraints reduce equitable access, but they also undermine a key goal of CED: to generate evidence on a nationally representative sample of clinically eligible patients.

Several steps could move CED in the right direction: developing a clear definition of Centers for Medicare & Medicaid Services (CMS)' "reasonable and necessary" standard, limiting coverage constraints only to those circumstances where clinical risks matter to patients, and providing transparent milestones that would end CED restrictions.

Second, the current approach to Medicare Advantage risk adjustment weakens or sometimes even eliminates incentives for long-term prevention.

For instance, academic research shows that including pneumonia in risk adjustment coincided with reductions in the influenza vaccinations that help prevent pneumonia. That is because risk adjustment insulates insurers from the cost of long-term illness and eliminates their financial rewards from preventing such illness.

On the provider side, alternative payment models also encourage short-term thinking by limiting shared savings from prevention to just 12-month horizons.

Treatment and prevention of obesity is a good example of long-term thinking. Our research proves investing in obesity treatments for the Medicare population generates at least a 13 percent annual rate of return—greater than the stock market.

This recent Medicare coverage expansion for obesity treatments can help unlock this value, especially if coupled with a framework that encourages broader preventive investments.

As USC Schaeffer research has suggested, CMS could allow multiyear enrollment in MA plans with premiums fixed over the enrollment period and set to reflect average growth in cost.

Lengthening the payback period would align insurers' incentives with the health of beneficiaries, especially because beneficiaries tend to stay with the same MA plan for about six years.

Third, we must tackle healthcare's pricing opacity. USC Schaeffer research demonstrates that opaque pricing systems profit from complexity.

Imagine grocery shopping where price tags are removed, and you receive one aggregated bill at checkout. You would have no idea if milk costs $5 or $50. That is American healthcare today.

The economic logic is clear: when buyers cannot see prices, sellers exploit that blindness.

In healthcare, aggregated payments and complex billing hide true costs. This is not just inefficient. It is a transfer of wealth from American families to healthcare intermediaries who profit from confusion.

American patients deserve a healthcare system that delivers breakthrough innovations efficiently, equitably, and transparently. These reforms can deliver that system but only if we act decisively.

Thank you.

Mr. BURLISON. Thank you.

I now recognize Dr. Obermeyer for his opening statement.

**STATEMENT OF DR. ZIAD OBERMEYER**
**BLUE CROSS OF CALIFORNIA DISTINGUISHED ASSOCIATE PROFESSOR, HEALTH POLICY AND MANAGEMENT, UNIVERSITY OF CALIFORNIA-BERKELEY**

Dr. OBERMEYER. Thank you for this invitation to testify. I am a physician and a researcher at Berkeley where my focus is on artificial intelligence applied to health. I am also the Cofounder of a company called Dandelion and a nonprofit called Nightingale Open Science, both of which are dedicated to accelerating the development of health AI.

Every time a new technology comes around somebody says this time is different, but when it comes to healthcare costs, new technology always seems to increase them. That is because the technology is expensive, but also because the more choices we have of technology, the harder it is to make good decisions, and that leads to waste and poor quality.

So, I am going to tell you that artificial intelligence is different, and you should be suspicious, but let me try to convince you.

The reason is because AI is a tool for making better decisions, and that is how it can give us a rare two-for-one opportunity to reduce the cost of care and improve the quality at the same time.

Let me give you an example. Every year 300,000 Americans drop dead suddenly because of cardiac arrhythmias. As an emergency doctor, I have seen too many of those patients, and I would guess some of you in this room also know somebody.

What makes these deaths so tragic is that we have a cure. A defibrillator implanted into the heart could save those lives, but doctors have trouble deciding which patients should get a

defibrillator, and that means a lot of people die without a defibrillator.

But it means something else, too. Two-thirds of the defibrillators that doctors actually put in never fire, never deliver a lifesaving shock, because the patients we thought were at high risk are not at high risk and never go on to develop those arrhythmias. That is a $50,000 procedure with real risks, but in this case zero benefit.

My colleagues and I have built an AI system to help solve that problem. It looks at a patient's electrocardiogram and estimates their risk of sudden cardiac death, and our early testing shows it does so far more accurately than what doctors are currently using to decide.

We are already starting to test that system, working with an incredible team at Providence St. Patrick Hospital in Missoula, Montana, and rural hospitals around there to get defibrillators to people who need them and spare the hearts and the pocketbooks of those who do not.

If saving lives and cutting wasteful spending sounds good to you, there are a few ways that the Federal Government can help.

First, data access.

When I started this work, it was so difficult to get the data that we needed here in the United States that I ended up doing this research in Sweden. That process took ten years, but it was still faster than doing it here despite European data regulations.

That is a real problem for patients who do not know that they are at high risk and a problem if we want the United States to lead in health AI.

The major culprit here is the many layers of permissions and approvals required to touch health data. Most of that burdensome paperwork does not actually keep patients or their data safe, and it also opens the door to ideological bias. The paperwork is used to decide which questions get asked and which do not, instead of assuring that any question can be asked in a safe and ethical way.

Concretely, Federal agencies that hold health data should set clear targets for delivering it. Health and Human Services (HHS) should also green-light modern technical tools for rapid de-identification of AI-ready data, like images and notes, and ONC should prevent vendors from locking up those data with fees and delays.

None of this means compromising privacy or safety. In fact, just the opposite. Adopting modern data management methods can increase speed and access while improving safeguards.

Second, FDA evaluation.

Today we regulate artificial intelligence under statutes written in 1938, which treat it as a medical device, but AI is quite different from a thermometer.

AI makes predictions about measurable outcomes, and that gives us a simple and rigorous way to evaluate it: does AI predict what it is supposed to predict in populations that look like all of America?

The FDA should put that question at the center of its approach to AI and build or partner on data infrastructure for a rigorous, independent evaluation. That transparency is essential for rapid progress and for catching problems like algorithmic racial bias, as I have shown in my prior work.

Third, CMS should pay for AI that does good.

The private sector is currently underinvesting in AI tools because of deep uncertainty about what payers will pay. CMS has the power to shape that, and the new Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model is a promising new step in that direction, but CMS should go further by creating payment codes for AI tools that are shown to improve outcomes, reduce cost, and detect fraud and abuse.

As my 5 minutes draw to a close, three Americans have experienced sudden cardiac death since I started to speak. They might still be alive if my data access had taken nine years instead of ten. Speed is important for patients. It is also important for the fiscal health of the United States—and it is important because we are in a race.

We have a head start in that race with great data, world class universities, and purchasing power, and if we make it easier to use data, regulate well, and pay for high-value tools, we can reduce cost, save lives, and secure American leadership in AI.

Mr. BURLISON. On the dot, Dr. Obermeyer.

I now recognize Mr. Jacobs for his opening statement.

**STATEMENT OF MR. CHRIS JACOBS**

**FOUNDER, JUNIPER RESEARCH GROUP**

Mr. JACOBS. Thank you, Chairmen Burlison and Grothman, Ranking Members Frost and Krishnamoorthi, and Members of the Subcommittee.

Good morning. Thank you for inviting me to testify. My entire written statement is before you, so I will not repeat it, but instead make three main points regarding healthcare costs and insurance coverage.

First, Obamacare has not met its stated objectives. The law singularly failed to achieve candidate Obama's 2008 promise that his healthcare plan would, "bring premiums down by $2,500 for the typical family."

Individual health insurance premiums more than doubled in the law's first four years of full implementation and continue to rise faster than premiums for employer-sponsored coverage. Meanwhile, the law encourages insurers to avoid the sickest patients, often harming those it most intended to help.

Second, despite what some may believe, there is a surprising amount of bipartisan consensus about the law's failure to control healthcare costs.

Two years ago, Senator Elizabeth Warren coauthored a letter noting that Obamacare's medical loss ratio provisions have encouraged insurance companies to acquire other businesses, like pharmaceutical benefit managers, and to overcharge patients through PBMs to shift profits from their insurance business, where Obamacare caps their profits, to pharmacies and other businesses without such restrictions.

Indeed, healthcare has only become more consolidated since Obamacare's passage with hospitals and health insurers buying up physician practices—and each other—to gain additional market clout.

Provisions like the medical loss ratio (MLR) have led progressives to write analyses discussing, "How Obamacare Created Big Medicine."

A separate academic study concluded that the 340B prescription drug discount program, which Obamacare greatly expanded, raised exchange benchmark premiums by 1.8 percent in 2024, resulting in $2.2 billion in additional Federal spending on insurance subsidies.

Third, as to the enhanced premium subsidies expiring on December 31, this Republican Congress should follow the example Democrats set regarding the child tax credit in 2021 and allow this temporary COVID-era policy to expire.

The myriad studies regarding fraud on the exchanges, including last week's Government Accountability Office report, demonstrate why Washington should not spend 350 billion taxpayer dollars, plus interest, to mask flaws in a law that has made healthcare less affordable.

Thus far, during open enrollment, 400,000 more people have signed up for exchange plans than did so at the same time last year, notwithstanding the impending expiration of the enhanced subsidies.

These preliminary data suggest that the worst-case scenario cited by enhanced subsidy supporters have not come to pass, reinforcing why Congress should let them expire.

Instead, lawmakers should pursue alternative policies that will enhance insurance portability, realign incentives, and promote price and quality transparency.

Thank you very much for the opportunity to testify, and I look forward to your questions.

Mr. BURLISON. Thank you, Mr. Jacobs.

I now recognize Ms. Tripoli for her opening statement.

**STATEMENT OF MS. SOPHIA TRIPOLI (MINORITY WITNESS)**

**SENIOR DIRECTOR OF HEALTH POLICY, FAMILIES USA**

Ms. TRIPOLI. Chairs Comer, Grothman, and Burlison, Ranking Members Garcia, Frost, and Krishnamoorthi, and Members of the Committee, thank you for the opportunity to testify today.

On behalf of Families USA, a leading national nonpartisan voice for healthcare consumers, I want to thank you for this critical discussion.

The United States is in a full-on healthcare affordability crisis, and our Nation's families are breaking under the weight of it.

We all see it. Parents who cannot afford the treatment their kids were prescribed. Families delaying care because their deductibles wipe out their savings. Workers who technically have insurance but cannot actually afford to use it. Employers who want to offer good insurance but are being crushed by rising premiums. And Federal and State lawmakers in gridlock over how to balance budgets and which services to prioritize.

Today's focus on technology is important given the rapid advancements in technology over the last century, which has revolutionized healthcare delivery on everything from reducing medical errors to strengthening diagnostics and treatment protocols to streamlining eligibility and enrollment determinations for coverage.

But it is important to note that while technology is a critical tool that can drive innovation and increase efficiency with appropriate patient protections in place, it is not a replacement for comprehensive, affordable health insurance.

People without insurance are in no position to benefit from healthcare technology, and technology itself does not address the core drivers of unaffordable care.

The trajectory of healthcare costs in this country is unsustainable for consumers, for the public sector, and for the private sector alike. But this is not caused by people using too much care or because immigrant families need healthcare.

Our affordability crisis is caused by corporate health systems, whether it is big insurance giants, drug companies, or corporate hospital chains charging excessive prices that have absolutely no relationship to healthcare quality or outcomes and with no accountability from lawmakers.

These excessive prices generate record profits for these corporate health systems all on the backs of the millions of Americans who cannot afford to buy groceries or pay rent because of rising healthcare costs.

But instead of taking on the corporate price gouging at the core of our Nation's affordability crisis, this Congress cut a trillion dollars from the very programs built to provide a safety net and ensure access to affordable care and has so far failed to extend the enhanced premium tax credits that keep coverage affordable for 22 million Americans.

Poll after poll confirms that heading into 2026, voters want lawmakers to address healthcare costs above all other priorities—jobs and unemployment, immigration, crime, and the budget deficit. Ninety-one percent of the American people, from conservative Republicans to progressive Democrats, are begging this Congress and the President to lower their healthcare costs, not strip away their only lifelines to more affordable coverage.

Voters want Congress to rein in the corporate profiteering making healthcare unaffordable, and your decisions have real-life consequences for everyday Americans.

For people like Tony Gonzales in Pennsylvania who is fighting cancer and can only afford the treatment keeping him alive because of premium tax credits.

And Brick Williams, a small business owner in Utah who needs regular infusions to stay alive, costing $150,000 a year without insurance. Enhanced premium tax credits are the only reason he can afford his lifesaving care.

And Cassandra Nelson in rural Georgia who cares for her daughter with Type 1 diabetes and seizures and has been crushed by the weight of medical debt and the dread of wondering whether she can afford the care her child needs.

These families and millions more across the country are doing everything right and playing by the rules, yet stand to lose everything in a system that is rigged against ordinary Americans and built to fuel corporate greed.

As challenging as this moment appears in our Nation's history, there is good news. We already know the solutions that will lower healthcare costs and hold corporate health systems accountable for

charging the excessive prices driving our Nation's healthcare affordability crisis.

The solutions are to immediately pass a clean extension of the enhanced premium tax credits; to enact site-neutral payments to stop big hospital systems from charging Medicare more for the same procedure if it is performed at a hospital instead of a doctor's office; to allow Medicare to negotiate prices on more drugs and closing legal loopholes that allow drug companies to block lower-cost drugs from coming into the market; to stop Medicare Advantage companies from exaggerating patients' health risks just to get paid more; and to scrutinize the growth of private equity and the monopoly power of big corporate healthcare chains that drive up healthcare prices for all of us.

These policy solutions are wildly popular and garner almost no opposition from voters across political parties. The American people are fed up with the broken healthcare system, and they are frustrated with politicians who choose to play politics with their health and financial security instead of delivering meaningful reforms.

We appreciate today's discussion on technology and its role in potentially reducing cost and the opportunity to draw attention to the healthcare affordability crisis.

Congress has the power to advance policies that will lower healthcare costs and hold corporate health systems accountable for our Nation's affordability crisis. We urge you to take action.

I thank the Committee for your time, and I look forward to answering your questions.

Mr. BURLISON. I am very thankful for the opportunity to co-chair this Subcommittee hearing along with my colleague, Chairman Grothman, and I want to thank again the witnesses for being here today on this important issue.

Unnecessary government regulation is an obstacle to developing innovation in healthcare technology. This is technology that will not only—I am sorry. I am supposed to recognize myself for 5 minutes. I am yielding to myself for 5 minutes.

Unnecessary government regulation is an obstacle to developing innovation in healthcare technology, something that I worked in for almost 22 years. This is technology that will, if left alone, lower costs but improve patient outcomes and save lives.

But bureaucrats often step in the way, just like the Biden Administration did when they attempted to force a one-size-fits-all approach to the healthcare sector while failing to consider what is happening at the local level.

While I served in the Missouri Legislature, I introduced a plan that was called the Health Care Compact, trying to wrestle that one-size-fits-all authority back to the states. And I am pleased today that I have another fellow Missourian who is thinking outside of the box, Mr. Whorley, on how to address the healthcare costs for patients.

Mr. Whorley, what have you found to be the greatest obstacle in your business to develop this new kind of way in which people can pay?

Mr. WHORLEY. Every single day we are motivated by one single goal, and that is to help people better access and afford care.

We employ a team of incredibly talented people to make the unsure, uncertain moment that is facing Americans all across the country something of the past. And so, we want to give people the confidence, the ability, and the dignity to easily and effortlessly access and pay for care.

I think our biggest barrier to that is just the inertia of the status quo, and moving that uphill requires the best efforts from all of us.

Mr. BURLISON. Would you say that the status quo is propped up by the regulations that this town has created that really kind of—that stop innovation like yourself, like what your company has provided?

Mr. WHORLEY. I think the degree, to the extent that we can—the best regulation is probably no regulate—the ability for us to innovate and have degrees of freedom to respond to the market and respond to the customers and partners that we serve, that is what we are attuned to.

Mr. BURLISON. And how would you say that your business under the previous administration, now that you have had ten months under this administration, have you recognized any kind of change?

Mr. WHORLEY. 2025 has been a transformational watershed year in that we have enabled nearly 20 million people to more easily access and afford care. We are providing people with the peace of mind and certainty and ensuring that that unsure, uncertain moment that they are standing in a pharmacy is something of the past. We are giving them the ability to take care of themselves and their loved ones, and that is with the launch of the bipartisan Medicare Prescription Payment Plan.

Mr. BURLISON. Thank you.

Mr. Jacobs, how has the Affordable Care Act caused healthcare to actually be unaffordable?

Mr. JACOBS. Thank you, Mr. Chairman.

It has really encouraged consolidation within the healthcare sector. I talked in both my prepared testimony and my written comments about how the medical loss ratio encourages consolidations, that we essentially have healthcare oligopolies now, that it encouraged insurers to buy pharmaceutical benefit managers and other forms of businesses where they could offload and shift their profits.

Mr. BURLISON. Vertical integration.

Mr. JACOBS. Correct.

Mr. BURLISON. Forced vertical integration.

Mr. JACOBS. And there is also vertical integration within the hospital sector.

Ms. Tripoli's statement noted the significant amount of hospital mergers that have taken place over the years and I believe said that 40 percent of those occurred between 2010 and 2015.

Well, there was a law Congress passed in 2010. It is called Obamacare. And to say that that did not have an impact, I think it very clearly did have an impact.

Whether it is accountable care organizations, that entities wanted to purchase physician practices, they wanted to purchase each other to get additional market clout to negotiate more power to negotiate with the insurers across the table from them.

Mr. BURLISON. Yes.

Dr. Obermeyer, you addressed that in order to move forward you need access to data. One of the previous bills that was passed before Obamacare was passed was actually to create these health information exchanges, but, in my opinion, having worked in that space, it has been an abysmal failure. It does not work. It does not benefit patients. The data does not go from doctor to doctor.

And then to hear that you say that it is not even accessible for research, you know, anonymized, this is something that we have to get our hands on, particularly if AI is going to be moving forward. And I worry about where we are with that.

How do we address that in a way in which we can still properly secure somebody's health information?

Dr. OBERMEYER. We are used to thinking about a tradeoff between how easy it is to access the data and how safe it is. I think that tradeoff is largely a product of using old technology and old data management systems.

The most sensitive data in the world are kept on modern systems that let people access it when they need it and keep out others. I think, paired with a strict approach to law enforcement, we can have the best of both worlds.

Mr. BURLISON. Thank you.

I now recognize Mr. Frost for his line of questions.

Mr. FROST. Thank you so much, Mr. Chairman.

And thank you so much to our witnesses for being here.

Mr. Whorley, you were chatting a little bit about in the last question line that you guys were able to help 20 million people in 2025. How does that compare to other years with your company?

Mr. WHORLEY. It is an enormous step up.

So, on January 1, 2025, it was the launch of the Medicare Prescription Payment Plan. That gave nearly 54 million American seniors with Part D coverage the ability to more efficiently and effectively get care, to smooth their costs over time.

Mr. FROST. Yes. Thank you.

So, how would you describe the demand for your services?

Mr. WHORLEY. It is increasing.

Mr. FOSTER. Okay.

If more people have to opt in for worse healthcare plans, higher deductibles, different things like that, would that also increase demand?

Mr. WHORLEY. The demand has increased as insurers and employers are recognizing that they can have both a lower-cost health plan and compassionately ensure people can access care. It is a programmatic approach that enables people to get the care they need and pay for that care at the time of service.

Mr. FROST. No, I appreciate it.

And so, your company, essentially you make money helping people to pay their healthcare bills in a more smooth way.

If there are more people who cannot pay for their healthcare bills at once, will there be more demand for software like yours?

Mr. WHORLEY. Yes.

Mr. FOSTER. And if healthcare becomes more affordable, if we had, let us say, my North Star, single payer healthcare, something like that, people that need to enter payment plans for healthcare,

there probably would not be as much of a demand for the services, right?

Mr. WHORLEY. No. I think that the North Star and what affordability is, affordability is an emotion, it is the ability to take care of yourself. And what we do is we give people the financial ability to manage whatever financial responsibility——

Mr. FOSTER. Whatever the costs are, yes.

Mr. WHORLEY [continuing]. May well be.

Mr. FROST. No, I appreciate that. And I am not trying to paint you as a bad person or anything. It is to make a point. Because you are a serial entrepreneur who finds a problem, right, and figures out a solution, and that is your prerogative, right?

And we do have a problem. Healthcare is too damn expensive. The cost of healthcare is too high. And I would submit that part of the reason why there is such a bigger demand for your services than ever before is because the cost of healthcare is going up and up and up.

And that is why I am confused on why my Republican colleagues have you as a witness here on this panel about affordable healthcare. Not a dig at you personally but because I think it shows—because there is so much more demand for companies like yours, it shows that we are failing in Congress, and whatever policies are being done right now are not helping people afford their healthcare and bring down the cost of healthcare.

We are here to talk about bringing down the cost of healthcare, and if you cannot afford to get it, right, when you receive that bill, it means you cannot afford it.

My dad was always strict with money. He always told me, if you could not afford it when you got it, you cannot afford it at all. If you have to buy now, pay later, you cannot afford it. And that is part of the issue.

And I think it makes sense why more people need services like yours, is because healthcare is too damn expensive, and President Trump and congressional Republicans are making it worse.

And that is why I come back to this extension of the Affordable Care Act tax subsidies. We have just five weeks until the ACA open enrollment ends, and in five weeks 189,000 people in my district alone are going to see their healthcare skyrocket.

I cannot tell you how many of my own friends and family have called me saying: "What the hell? What are you guys going to do about this? I mean, I used to pay this much and now I am going to be paying this much. I cannot afford it."

And this is going to happen to 25 million of our people. That's why I keep coming back to this, because there's something right in front of us that has to do with affordability.

I want to talk about the subject of technology and AI in healthcare. I think this is an important hearing to have. But right in front of us we have a cliff that is coming up, and if we do not do our job, more people are not going to be able to afford their healthcare and more people are going to have to do buy now, pay later plans to be able to pay to stay healthy in the richest country on the face of the Earth, which I think is disgusting and I think is a failure of our government.

Ms. Tripoli, if the subsidies expire how will this impact how often people go to the doctor, how sick they get, and how much debt they have to take on?

Ms. TRIPOLI. Thank you for the question.

If the subsidies expire, we will see premiums more than double. For some families, we will see increases of 300 percent. For older couples, we will see—just above the 400 percent of poverty—we will see them paying about a quarter of their income on healthcare costs.

We know in the midst of an affordability crisis that it is unaffordable. It will force people to forego care, drop out of coverage if they have to. And, of course, when folks drop out of coverage, we know that they do not go to the doctor, they delay, or they end up in the emergency room, which is the most expensive care setting to get healthcare.

Mr. FROST. And, Ms. Tripoli, if we have folks who say, you know what, I disagree with a lot of different parts of our healthcare system—look, I know we have a broken healthcare system, but we have this clock ticking, this countdown timer in front of us.

Would you advise us to let the countdown end and have healthcare go up for so many working families while we try to figure out a plan that no one really has right now, or would you say that we deal with what is right in front of us and then have those conversations.

Ms. TRIPOLI. Time is of the essence. The first thing you do when somebody is bleeding is you stop the bleed. The tax credits need to be passed with a clean extension immediately. It is a lifeline for 22, 24 million Americans. And then let us come back to the table and talk about how we address the root drivers on drugs, on hospitals, and others to bring down the underlying cost of care.

Mr. FROST. That is why we have to pass the extensions for the Affordable Care Act, because our people are suffering right now. The cost of everything is too damn high. And if we do not do our job, 25 million Americans are going to see their healthcare go up anywhere from 50 to 300 percent. Then let us get back to the table and figure out what we do to fix this broken healthcare system.

I yield back.

Mr. BURLISON. Thank you.

I have a document to submit for the record from the *Juniper Research Group* titled "No, Obamacare Premiums Are NOT Doubling in 2026" that I am submitting for the record.

Without objection.

And with that, I recognize——

Mr. FROST. Mr. Chairman, I request unanimous consent of a UC. I have a UC, a document.

Mr. BURLISON. You are recognized.

Mr. FROST. Mr. Chairman, I ask unanimous consent to enter to the record fact sheets from Keep Americans Covered that shows that my Republican colleagues on this Committee represent 738,000 people who depend on the Affordable Care Act tax credits.

Mr. BURLISON. Without objection.

I now recognize——

Mr. GROTHMAN. I would like to—can I submit for the record——

Mr. BURLISON. Yes. Mr. Grothman.

Mr. GROTHMAN [continuing]. A CMS fact sheet with regard to historical national health expenditure data and an *AMA* fact sheet on trends for healthcare spending?

Mr. BURLISON. Without objection.

Mr. GROTHMAN. Thank you very much.

Mr. BURLISON. I now recognize Chairman Grothman.

Mr. GROTHMAN. Okay. First of all, I am grateful for an opportunity to have this hearing with my Co-Chair, and I want to thank the witnesses one more time for coming over here.

A few weeks ago, the Health Care and Financial Services Subcommittee held a hearing where we heard from the Trump Administration about the youth healthcare crisis. Not only are our children facing chronic diseases at rates never seen before, but the healthcare system seems to only get more expensive without any noticeable improvement in outcomes.

Recent data published by the Trump Administration and confirmed by several other independent sources indicate that one-third of healthcare costs are wasteful and do not improve patient health.

We will start with Mr. Jacobs.

Why are one-third of healthcare costs wasteful and fail to improve patient health? Do you believe that is true?

Mr. JACOBS. I certainly think there is a great amount of waste in the healthcare system. Unfortunately, we, as I mentioned in my testimony, we do not have correctly aligned incentives. The traditional example is the all-you-can-eat buffet. Everybody does a good job of spending everyone else's money in healthcare.

Obviously, there are circumstances. You are not going to try to shop for care when you are in an ambulance on the way to the hospital or anything else like that.

But we do need to realign incentives at the margins to show where people can be smarter shoppers of healthcare, but first that requires price and quality transparency. I have had personal difficulties myself on numerous occasions finding out what the heck things cost.

Mr. GROTHMAN. I will give you guys another question, and anybody can jump in here.

Utilization rates vary from doctor to doctor and state for state. Does anybody want to comment on that or have any information on examples of overutilization which would indicate that more is being spent than has to be spent?

Dr. LAKDAWALLA. Well, Chairman Grothman, one issue is that if you look at that variation from state to state, it tends to be greater in Medicare than it tends to be in the commercial insurance market, and I think that indicates that when there is oversight in terms of what is valuable care, it helps to mitigate overuse.

Examples of overuse, a prominent one is what is known as defensive medicine. So, it is testing that is undertaken because of malpractice risk. It probably adds, our research suggests, around ten percent to medical spending. So, that is one important source as well.

Mr. GROTHMAN. Okay. And that varies from state to state?

Dr. LAKDAWALLA. It does, yes.

Mr. GROTHMAN. Can you give examples of a high state and a low state or just a shot at a specific example of dramatically higher costs in one state than another state?

Dr. LAKDAWALLA. Typically, the states that award higher jury awards in malpractice cases tend to have more defensive medicine.

Mr. GROTHMAN. Okay.

I think we can all agree we have a problem when one-third of healthcare spending, according to some people, goes to waste. Can you explain why that is such a problem and how it affects the healthcare market?

Mr. Whorley, I guess we will start with you.

Mr. WHORLEY. Yes. Healthcare costs are a combination of the volume of care we seek and the prices we pay.

Enabling people to pay the price and enabling more and more cash prices and direct prices, for there to be a single price for all versus a single payer for all, enabling people to actually know what the price is ahead of time, the real price that intermediaries or AI cannot reprice, that is important to enable patients and employers, purchasers of care, to get the signal: Is it the right price?

I think it is important that in terms of volume, where there is overconsumption, there is also underconsumption in the market as people are unable to pay for care. That is why nearly 30 percent of ACA markets have built solutions like Paytient into ACA plans to ensure that people are able to get care when it happens because healthcare is a necessity.

Mr. GROTHMAN. Okay. What I will do is go down the line starting with Dr. Lakdawalla.

How have you personally experienced rising healthcare costs in your individual field or from the perspective that you are in right now, and specifically what would you like to see Congress do to rein in those costs?

Dr. LAKDAWALLA. I would like to see attention paid to measuring the value of different healthcare procedures, drugs, devices, and the like, and ensuring that we are not continually investing in low-value care, which is happening.

For example, most Americans say they do not want to die. They do not want to spend their last days of life in a hospital. Yet a majority of individuals end up there. That is wasteful care because it is not aligned with what patients value and their families value.

Mr. GROTHMAN. In other words, people are—well, go ahead. I am running out of time. So, we will go down the line.

Dr. OBERMEYER. I will just tell you one fact from my own experience as a physician.

I have ordered a lot of wasteful tests, for example, in the ER, tests for heart attack that expose patients to risk and costs and come back negative. At the same time, heart attack is one of the most common reasons that doctors get sued, because we miss it.

And so, even though, of course, there is a lot of contribution from incentives, fear of malpractice, the core of the problem, at least from my perspective, is that it is really hard to make decisions about who needs care. And I think that is why I am so optimistic that artificial intelligence can help us make better decisions. And, thus, reduce the cost of care, but also improve the quality by taking

some of those costs and giving it back to patients who need the care.

Mr. GROTHMAN. Mr. Jacobs?

Mr. JACOBS. As an exchange customer here in D.C. who is facing a premium increase starting next month, I certainly understand the cost because I have to pay all of those out of pocket. I am self-employed. So, I do not have an employer to subsidize.

I actually agree with Ms. Tripoli. I think site neutral payments—and there is a good amount of bipartisan agreement on this—is a good policy that Congress should be enacting. I just recently went to a specialist for a second opinion on an orthopedic issue, and I ended up paying twice what I normally pay at my usual specialist, primarily because the second opinion was affiliated with the hospital, and it is a physician office visit, but it is billed through a different service. It is billed as an outpatient clinic visit, and so I pay twice as much.

We should not be inviting these kind of disparities, and that encourages more physician practices to merge with hospitals because they can charge more.

Mr. GROTHMAN. I am going to break the rules and ask the final question to Ms. Tripoli, the Democrat witness.

Ms. TRIPOLI. Well, I actually agree that the underlying incentives—the payment incentives of the healthcare system are misaligned. All the incentives are to get bigger and bigger and to charge more volume of high-price services rather than making sure that people are getting the high-value care that they need to get healthy and stay healthy.

And so, I do think that there is a longer term conversation about how do we structurally realign incentives with the health and financial security of the American people, but I will tell you that it is very hard to have that conversation when you have got 22 to 24 million people right now who need the enhanced premium tax credits extended. And so that is the lifeline they need today.

And, then, I encourage Congress to have a conversation about how to realign payment incentives in the healthcare system. Absolutely.

Mr. GROTHMAN [continuing]. Thank you.

Mr. BURLISON. Thank you.

I now recognize Ranking Member Krishnamoorthi for his opening statement—or for his line of questions.

Mr. KRISHNAMOORTHI. I can do that, too. Thank you. Thank you, Mr. Chair, and thank you to the witnesses. Your answers have been very thoughtful and really appreciate your participation.

Ms. Tripoli, I want to share the story of the family of a woman named Krystle from central Illinois, which is where I am from. She is in contact with my office, and here is a picture of her three children, who have some medical—very complex medical issues.

After growing up on Medicaid, Krystle finally secured a job with employer health coverage. But the plan's cost for her three medically complex children were so high, the employer-sponsored coverage was effectively unusable. With the ACA's enhanced premium tax credits, however, she can, instead, buy coverage for her three children at $800 a month on the exchange.

Now, if we let those tax credits expire, her premiums will nearly double to $1,400 a month, trapping her in a coverage gap.

Ms. Tripoli, the Medicaid coverage gap, which Krystle is experiencing, affects millions of Americans who earn too much to qualify for Medicaid but not enough to afford private health insurance coverage. That is why the tax credits were created in the first place, to enable people to afford, like Mr. Jacobs and others, the health insurance that is available on the exchanges.

And, Mr. Jacobs, I am also on the exchange like yourself.

So, here is my question to you, Ms. Tripoli. Unfortunately, Krystle does not have an extra $600 a month to pay for her insurance. So, to get out of the coverage gap, she would be forced to leave her job so that her kids can qualify for Medicaid coverage because the only alternative to risking their health is basically going without coverage, which is a choice no parent should ever have to face.

Ms. Tripoli, Krystle's story is not unique, right?

Ms. TRIPOLI. It is absolutely not unique. And you are highlighting the exact reason why we need the enhanced premium tax credits extended immediately, not to mention the challenges that were imposed from H.R. 1 in terms of Medicaid work reporting requirements and how difficult it will be for people to meet—who are working, but to meet those requirements under the new Federal rules.

And so, there is absolutely a need for families like Krystle—and there are millions of families like hers across the country—to get the relief they need right now, and that is through extending the enhanced tax credits.

Mr. KRISHNAMOORTHI. Folks, as we approach the holiday season, please keep in mind families like Krystle's. I mean, we have to extend these. Even if we are going to negotiate future iterations of these tax credits, let us do the humane and right thing, which is to extend these tax credits for some period of time while we negotiate the rest of the ACA.

Mr. Jacobs, you recently wrote this article entitled, "The Middle Class Cannot Keep Up With Persistent Inflation Forever," right?

Mr. JACOBS. Yes.

Mr. KRISHNAMOORTHI. It was from December 1st of—this month, right?

Mr. JACOBS. That is correct.

Mr. KRISHNAMOORTHI. You wrote, "American households feel stuck in an ever-growing vice by prices rising faster than their incomes can keep up," correct?

Mr. JACOBS. Yes.

Mr. KRISHNAMOORTHI. Donald Trump recently claimed that the affordability crisis is a "hoax."

You wrote in this article—and I agree with you—"Trying to claim inflation does not exist will not cut it," correct?

Mr. JACOBS. True.

Mr. KRISHNAMOORTHI. You also wrote, "I see it every week when I go to the grocery store. I consider myself luckier than most, but the weekly shop still feels painful." That is what you wrote, right?

Mr. JACOBS. Yes.

Mr. KRISHNAMOORTHI. You also, in part, blame Trump's tariff policy for high prices on things like bananas and coffee, writing, "It seems foolhardy ever to have imposed levies on items that our climate will not allow us to grow in sufficient quantities domestically, but, at a minimum, ending the tariffs will provide a bit of relief." That is what you wrote, right?

Mr. JACOBS. That is correct.

Mr. KRISHNAMOORTHI. Despite controlling the House, the Senate, and the White House, Republicans have done nothing to bring down high prices. On the contrary, your article title could not be truer, Mr. Jacobs. The middle class cannot keep up with persistent inflation forever. President Trump's tariffs only make them worse.

Now, let me turn to my final topic, and that is AI. Ms. Tripoli, AI has become increasingly prevalent in healthcare settings. In fact, a recent study from Rand, Brown University, and Harvard found that one in eight adolescents and young adults use AI chat bots for mental health advice.

You do not dispute they found that, right?

Ms. TRIPOLI. No, I do not.

Mr. KRISHNAMOORTHI. Time Magazine recently reported that, when asked about self-harm, some of these bots have offered guidance on how to, "safely cut oneself or what to include in a suicide note."

Ms. Tripoli, again, this is what Time and other news outlets have been reporting, right?

Ms. TRIPOLI. Correct.

Mr. KRISHNAMOORTHI. My home state of Illinois has banned AI chat bots from offering any kind of psychotherapy for anyone. Other states have similarly instituted different guardrails for AI.

Unfortunately, there is a move currently from the White House to preempt all state laws with a national law preventing this type of legislation that Illinois and other states have instituted or enacted to put guardrails on AI.

Dr. Obermeyer, your testimony today—and I read—we read through your testimony—does not endorse preemption and, in fact, does not even mention it, correct?

Dr. OBERMEYER. Correct.

Mr. KRISHNAMOORTHI. Mr. Chair, the Majority's own witness did not mention preemption in its testimony because it is premature. There are great things happening in red and blue states alike that are protecting our children.

We have one of the few chances right now to come together and say "no" to a really hasty national preemption plan that the White House is initiating, and I hope we do not lose that opportunity to work together.

Thank you, and I yield back.

Mr. BURLISON. Thank you. Chairman Grothman.

Mr. GROTHMAN. I would like to submit another document for the record called "How much does that MRI cost?" put together by *Unleash Prosperity*. I want you all to look at it. It shows similar procedures varying from $300 to $7500 depending upon the provider.

Mr. BURLISON. Thank you. Without objection.

I now recognize Mr. McGuire for his 5 minutes of questions.

Mr. MCGUIRE. Thank you, Mr. Chairman, and thank you to the witnesses for being here today.

The tariffs—by the way, I heard mention of tariffs. Tariffs are working. For the first time in a decade, we have a surplus. That means our government has been spending more per month than we bring in per month.

If you ran your house like that, you would be on the street. And, if you ran your business like that, you would be out of business.

Now, the tariffs are important. I mean, American steel is back, bigger contracts than they have ever had. You cannot do anything without steel. And gas prices are coming down because we are drilling more today than we ever have.

In fact, in Roanoke, Virginia, this weekend someone sent me a screenshot at the pump, under a dollar—under $2 gas. I think it is $2.35 today, but still, we have not seen prices like that in five years.

Now, we got into a big mess over the last four years, and we have only been here about 11 months or so. It takes a while to turn the ship. But the One Big Beautiful Bill puts jet fuel on our economy, and, hopefully, by the spring you are going to see this.

The problem is the government does not do a whole lot right. If they built you a car, it would cost a million dollars, and, you probably would be a year or two late in getting it, and it would fall apart. That is why we need free market competition.

You have heard about COPN, a certificate of public need. It is like there is a monopoly and in control from those in charge. And, if we had free market competition, it would drive down prices.

I think the first calculator was this big. It was $5,000. But, with innovation and free market competition, it got better and smaller and better and smaller, and now you can buy a calculator for $1 at the dollar store.

We have not been allowing competition because the government is involved. And, again, I can talk about the U.S. Post Office. I talked—in my district, we have health clinics, 41 I think, and several hospitals. And I asked them, "You have to deliver medications every week to people that rely on these medications for life or death. Do you use the U.S. Postal Service?" They said, "No. We use FedEx and UPS." And I said, "How reliable are they?" They said, "100 percent reliable." And I said, "How reliable is the post office run by the government?" And they said, "Not reliable at all. We cannot use it." I said, "Well, give me a worst-case example." And they said, "Well, we mailed some medicine in 2013, and we got it returned to us in 2023."

And so, I think the big problem with the cost overrun is—Obamacare, for example, they call it the Affordable Care Act. I would call it the un-Affordable Care Act because it took away the free market competition, and it totally benefited the insurance companies, and they can charge whatever they want.

When talking with hospitals about COPN, a doctor would say to me, "Hey, I want to start—in rural Virginia, far away from a hospital, I want to start an MRI clinic because I can do it for $500 apiece, or you can go to a hospital and spend $1,500, $2,000 apiece." Sounds like common sense, right?

But then the folks at the hospital said, "Well, the problem is there are a lot of things we do at the hospital that do not make money. So, then, at the hospital, we charge a whole lot, to make up for the programs that do not make money." So, again, it is nonsensical. It is a mess. And we need free-market competition.

We also need a preventative healthcare system. When you buy a car, it tells you, "At 2,000 miles, do this; at 5,000 miles, do this; at 15,000 miles, do this." We seem to have a system where you put Band-Aids on it and wish and hope and wing it and modify it. And it does not work that way in the business world. You would be out of business if you did not have some sense.

For example, would you rather find a tumor when it is this small or when it is this big, and if you had a system of checkups and things like that?

But, be that as it may, we are where we are. And so, I guess what I would ask is—we do not have a lot of time. Let us get some yes-and-noes.

Do you agree that a productive rather than reactive system would help us shrink government? That is just a yes or no. I do not have time.

Mr. WHORLEY. Yes.

Dr. LAKDAWALLA. Yes.

Dr. OBERMEYER. Yes, and AI can help.

Mr. JACOBS. Sure. Yes.

Mr. MCGUIRE. I totally agree with that.

And, for all the witnesses, do you agree that more competition in medical tech will lead to better outcomes for patients? Yes or no, because I do not have time.

Mr. WHORLEY. Yes.

Dr. LAKDAWALLA. Yes.

Dr. OBERMEYER. Yes.

Mr. JACOBS. Yes.

Ms. TRIPOLI. More competition is always good, yes.

Mr. MCGUIRE. I like it. I like it. All right.

I am also hopeful that data-driven approach to healthcare can help speed up FDA approval processes and reduce our reliance on countries like China for tests, and it is terrible that some of our most important medicines are made in China.

Do you guys agree with this, yes or no?

Mr. WHORLEY. Yes.

Dr. LAKDAWALLA. Probably.

Dr. OBERMEYER. Yes.

Mr. JACOBS. Yes, I think we should be near-shoring those kind of critical materials, yes.

Mr. MCGUIRE. You cannot exercise your way out of bad nutrition.

So, do you guys agree that a preventative healthcare system that they say the positive effects of fitness on the brain and mental health by having proper nutrition and exercise is very important? Do you agree with this?

Mr. WHORLEY. Americans being in better health is better for America.

Dr. LAKDAWALLA. Prevention is underused and needs more use.

Dr. OBERMEYER. Yes.

Mr. JACOBS. Yes.

Ms. TRIPOLI. Your best prevention is having access to affordable care.

Mr. MCGUIRE. Well, thank you. I ran out of time. I yield back.

Mr. BURLISON. Thank you.

Ranking Member Frost?

Mr. FROST. Mr. Chairman, I have a unanimous consent request to enter into the record.

*The Hill* article, states "Medicaid cuts will harm rural Republican communities most."

Mr. BURLISON. Without objection.

I now recognize Ms. Randall for her line of questions.

Ms. RANDALL. Thank you so much, Mr. Chair, and thank you to our witnesses for being here today.

I love a robust conversation about how we can improve our healthcare system. I do not think any of us on either side would say that the system that we have is perfect and is working exactly as it was intended to.

I do, however, have real concerns about saying, "It is not working. So, we should not reinstate these affordable care tax credits so that more people can lose their healthcare so that the system is even more broken, and then we have to decide how to fix it." I do not think that is the way to meet the healthcare needs of the American people. It is not the way that they are asking us to meet their healthcare needs, and it is, I think, frankly, dangerous for our country.

We have, as my colleagues have said, a ticking clock on these ACA tax credits. We were so quick to act when, you know, billionaire and big corporation tax credits were set to expire. Congress was called back into session from vacation to make them permanent.

I do not understand why we would not act immediately for the benefit of the American people who are struggling with affordability and are struggling with the healthcare system.

That said, you know, I think, even the original drafters of the Affordable Care Act, including President Obama himself, would argue that the ACA was not the be-all, end-all dream of, you know, healthcare for people in this country. They did not have the votes for public option.

So, yes, giving money to the insurance companies is a large part of what the ACA is able to do because that is how people are guaranteed healthcare.

Before the ACA—I do not know how everyone's memories are on this. Folks may not have been super-engaged. Before the ACA, women who had been pregnant could be denied healthcare coverage. Folks who had other preexisting conditions, any healthcare needs could be denied healthcare coverage. We had very high uninsured rates and high rates of people unable to access healthcare.

There are lots of ways to make sure that we solve that problem. The Affordable Care Act was the bill that had the votes to pass at the time. It has been a while. We can revisit rebuilding a healthcare system like Mr. Frost has said, like single-payer, that meets the needs of the people, lowers costs, and ensures a more healthy future for all of us.

There are lots of different approaches that countries around the world have taken that have been explored. In the United States, I, as a member of the legislature in Washington State, worked on establishing Washington State's universal healthcare commission, some of the strongest universal healthcare policy to be passed by any state in the last ten years.

We know that we need improvements, but we also know that the free market is not the solution for healthcare. An unchecked free market means that, you know, folks who do not have coverage, who do not have the ability to afford care just will not get it. They will die often.

Yes, you cannot shop around in the ambulance, but there are ways that we can provide more transparency into healthcare costs, like Washington and many other states who have created an all-payer claims data base that collects and publishes data so that you can look up how much it costs on average to get a mammogram and how much those mammograms cost at different facilities near you.

But the problem for most people, especially in rural communities, including many in my own district, many in the districts of my Republican colleagues, are that there are not that many healthcare facilities available and accessible. And those that are, are at risk of closing because of the dramatic cuts from the big, ugly bill to Medicaid.

Rural healthcare was at risk before we passed H.R. 1, and now it is hanging by a thread. What does it matter if you could shop around if your nearest two hospitals are two and three hours away from you.

I also think we need to make space for technology, and I know that is what we are here to do today, to talk about how innovation and technology can help lower costs for families. But I hear a lot from my neighbors on Medicare who are worried about unchecked technology and AI impacting their ability to access care.

Dr. Obermeyer, I am concerned about the Wasteful and Inappropriate Service Reduction (WISeR) Model and what that unchecked AI implementation will do to folks' abilities to access care. That is why I am a cosponsor of the SMARTER Care Act, a measure to ban the WISeR Model from Medicare claims.

Do you believe that AI systems need independent oversight to ensure patients are not denied medically necessary care?

Dr. OBERMEYER. Absolutely.

Ms. RANDALL. Thank you.

I would like to request unanimous consent to enter into the record a letter from a retired physician in my district, how WISeR will enable companies to profit from pain.

Mr. BURLISON. Without objection.

Ms. RANDALL. Thank you.

Mr. BURLISON. And your time has expired.

Ms. RANDALL. I know my time is up. I will just wrap up by saying, I agree we have to fight consolidation. I agree we have to fight to take some of the costs out of the healthcare system. I agree that more people need access to better healthcare.

And what we know is that vertical integration and consolidation of our healthcare systems does not lower costs for patients at all.

It may lower costs for the provider groups. It may lower costs for the shareholders, but it does not lower costs for patients. Thank you.

Mr. BURLISON. Thank you.

I now recognize the Governor—I am sorry—the gentleman from Florida, Mr. Donalds.

Mr. DONALDS. Thank you, Chairman. I appreciate your sentiment.

Before I get into questions, I think it is important to acknowledge what was just said. I want to start with some of the positives I just heard.

The truth is that, yes, more competition in healthcare is going to be critical to deliver affordable care to consumers, and that is something I think which is a very bipartisan statement. I think both sides of the aisle can agree on that.

I think one of the things that was also just acknowledged is that the entire purpose of the Affordable Care Act was not the Affordable Care Act. It was to take the United States toward single-payer healthcare. That was the design 15 years ago.

So, the American people need to understand, the reason why costs are rising in healthcare and in health insurance is by design, by congressional Democrats at the time, and by then-President Barack Obama. They did want a public option. They wanted to put a public option in the Affordable Care Act that was going to be lower cost than what their own regulatory framework would allow in the private markets.

The only reason they did not get the public option is because they did not have the votes. A guy named Scott Brown won a Senate election in Massachusetts—I know that sounds crazy today, but he did—and it stopped them from actually pushing forward with the public option, which, by the way, its entire design was to move America toward single-payer healthcare.

The arc of history in healthcare needs to be clear on this point: single-payer healthcare does not work. It never will because, to the point of my colleague from the other side of the aisle, single-payer is the very definition of vertical integration of the healthcare system, which will not lead to lower costs for the American people. But I digress.

Mr. Jacobs, you referenced that a single Social Security number was linked to over 26,000 days of subsidized healthcare coverage across more than 125 insurance policies in 2023.

What mechanisms can be put in place to detect and prevent this level of exploitation of taxpayer funds, and what underlying vulnerabilities contributed to this abuse?

Mr. JACOBS. Yes, Mr. Donalds, that is correct. And the Government Accountability Office report that was released last week was just one of many data points suggesting that there are significant amounts of improper enrollment and potential fraud on the exchanges.

I think some of it is driven by—there are certainly rogue agents and brokers that have been acting in CMS both under the Biden Administration and certainly under the Trump Administration have acted to crack down on that. I think eliminating zero premium plans, I think, is a matter of good policy that I think, regard-

less, we should be asking everyone to pay at least a little bit of something toward their health insurance every——

Mr. DONALDS. Not to cut you off, but I want to acknowledge something that you just said.

In your opinion, do zero premium plans lead to fraud and abuse?

Mr. JACOBS. I think without a doubt. The system responds to incentives. And we have only had zero premium plans for the past few years under the enhanced subsidy regime, and we have seen that the amount—the concerns about improper enrollments, whether it is CBO or CMS with the data regarding zero claim enrollees in exchange coverage, all of them have been pointing to increased incidents of improper enrollments and fraud.

Mr. DONALDS. Okay. Thank you for that.

Dr. Obermeyer, if artificial intelligence becomes significantly integrated into medical practice, what impacts should we expect on the healthcare workforce?

Dr. OBERMEYER. I think what we have learned from the history of automation and technology adoption is that it does not necessarily eliminate jobs. It actually changes the nature of those jobs.

So, doctors will start to need to interact with these tools and learn from them, and I think they will start to augment the capabilities of especially nurses, community health workers, and others who can now have access to cutting-edge technology applied to the data from patients to help them make better decisions.

Mr. DONALDS. Real quick, a quick follow-up to that. Do you think that the Affordable Care Act's regulatory framework allows for this type of internal innovation in the healthcare system?

Dr. OBERMEYER. I do not know about the ACA specifically. I think right now there are not very strong incentives for a lot of health systems to adopt this AI technology. I think the ACCESS program that was recently announced from CMS is a good start in that direction by incentivizing preventive care augmented by technology.

But I think that government programs can do more by, for example, creating payment codes for AI technology that drives lower costs, higher value care, and even detects the kinds of fraud, waste, and abuse that you mentioned earlier.

Mr. DONALDS. Well, look, I am all for efficiency. One of the things I do have a concern about is I hear that, yes, AI is being used in some respects in healthcare, a lot of it for upcoding as opposed to pushing for efficiencies. And I think that is a major issue that we definitely have to get our heads around, both here federally and at the state level.

Chairman, if I might indulge, I did want to ask a quick question of Ms. Tripoli. I know—I was hearing your dialog with one of my colleagues earlier about affordability. I recognize everybody has a concern about it. Honest question.

Do you really think that a centralized healthcare system will lead to efficiencies and lower costs for the American people?

Ms. TRIPOLI. I think there are a lot of different models to get to a universal system of coverage that make sure that every person in the country has access to the affordable high-quality healthcare and health that they deserve.

In any of those systems, you have to actually address the incentives and the way the prices in the healthcare system are set. And whether you are in the current system we have now or some future system, the reality is that the biggest drivers of our affordability crisis in this country on healthcare are the massive consolidation from corporate health systems, from insurance plans to drug companies to hospital chains.

And so, in any universal system of coverage, that issue has to be addressed. And, of course, most immediately, if people cannot afford care, then they cannot access care. And before us right now, there is a decision about extending the enhanced premium tax credits, and we urge the Congress to act on that.

Mr. DONALDS. Well, Ms. Tripoli, we will have some agreement on consolidation. I have serious concerns about that consolidation as well.

I think if we are talking the universe one-size-fits-all system, I mean, I have not seen one that has worked just about anywhere in any industry that has ever existed on this planet, but I know people will continue to try.

Sorry, Chair. I know I am over. I yield.

Mr. BURLISON. Thank you.

I now recognize my colleague from Missouri, Mr. Bell, for his 5 minutes.

Mr. BELL. Thank you, Mr. Chair, Ranking Member, and our witnesses for being here today.

The purpose of today's hearing is to discuss how technology can help reduce the future cost of healthcare, but I find this topic very ironic because we cannot look forward to the future of healthcare while ignoring the challenges that Americans are facing now.

The reality is that there are over 24 million Americans facing unaffordable healthcare with the pending expiration of the ACA premium tax credits. In Missouri alone, premium tax credits assist 95 percent of our marketplace enrollees.

And so, I heard a few comments that have me over here scratching my head. Mr. Jacobs, you said that the ACA has not—did not make it—has not met its stated objectives, and costs continue to rise faster, and there is a failure to control healthcare costs.

You remember saying all that, right?

Mr. JACOBS. Yes.

Mr. BELL. So, I want to use an analogy again. So, would everyone agree that Social Security overall is a good thing? Any objections to that? Okay.

So, when Social Security was created in the 1930s, most women were excluded; intermittent workers were excluded; nearly half the workforce population was excluded. And then it gets really rich with Black folks. Two-thirds of African Americans were excluded, 70 to 80 percent in certain regions of the—of African Americans were excluded.

But, over the years, Social Security was improved. And I would say mostly by Democrats, but there was some bipartisan efforts there throughout the years to improve it.

So, we would—I think it is safe to say that there was a point in time Social Security was not necessarily effective and a good thing

and supporting folks, a lot of folks who needed it, and it got better because folks worked at it.

So, it is befuddling to me when, when we talk about the ACA, when Republicans talk about how bad the ACA is, first, it is the best thing we have got going right now. Yes, it could be improved, so let us improve it.

And so, let us talk about the history. I am a data person. So, in 2010, Republicans unanimously opposed the Affordable Care Act—we all know that—and did not offer any alternatives, right? No alternatives. Just opposed it, every single Republican.

2011, as soon as Republicans retook control of the House, they voted to repeal the ACA. Remember, the whole repeal and replace? We never got the replace idea, but that is a different subject. Every Republican voted to repeal it.

2012, Republicans unsuccessfully challenged the ACA in court. Now, was there any court filings that the Republicans championed to improve the ACA? No. Just to repeal it.

I got a lot here, too. I am going to try to get it in here.

In 2013, Republicans refused to fund the government without delaying or repealing the ACA. They did not say: "Hey, we got some ways to improve it. We just want to repeal it."

2015, Republicans passed a bill repealing the ACA that was voted—that was vetoed by President Obama. No—no help—no ways, suggestions to improve it.

In 2017, days after taking office, President Trump canceled ACA enrollment outreach advertising during open enrollment.

Ms. Tripoli, does that help get the word out and help get coverage for folks?

Ms. TRIPOLI. No.

Mr. BELL. In 2017, Republicans tried and failed to repeal the ACA again. In 2017, Republicans passed Donald Trump's tax plan gutting the ACA's individual coverage mandate. Notice, there was no legislation to improve it, make it better for Americans.

In 2017, the first Trump Administration cut enrollment outreach funding by 90 percent. They did not do anything to improve the ACA.

So, when we are three weeks away from the end of the year in the middle of open enrollment season, and I am still waiting, we are all still waiting for a vote to protect the American people, so, again, I got to ask, where is it? Where is this vote? Where is the help? Where is this plan? Where is the action to back up the promises and talking points?

And so—where is the evidence that you all truly care about the affordable access to healthcare for the American people? Because every single thing that we see is just to repeal what is—what has done the best to control costs for Americans. Yes, it could be better, but Republicans got to work with us.

Americans are screaming for relief with healthcare costs. And I appreciate some of the things that you are doing, particularly Mr. Whorley in Missouri, but these are only layers of things that we need to improve healthcare costs.

But we have to address these issues head on, and it is going to take Democrats and Republicans actually working together and stop playing politics and actually get in the room and do it. If you

do not want to call it Obamacare, great, we will call it something else. We can call it the Obama-Trump plan. I do not care. Let us just do what we can to work for the American people and bring the costs down.

And right now Republicans for the last—since this act was implemented, have not given us one single plan to improve it or to—to help Americans address these issues.

Thank you. And I yield back.

Mr. BURLISON. Thank you.

I now recognize the gentleman from Texas, Mr. Gill, for 5 minutes.

Mr. GILL. Thank you, Mr. Chairman. Thank you for holding this hearing, and thank you to the witnesses for taking the time to be here. We certainly really appreciate it.

I appreciate my colleague on the other side of the aisle and their sincerity and their desire to fix our healthcare system and make it better. I would suggest that Social Security and our healthcare system are not comparable or perhaps even analogous.

Our healthcare system is $5 trillion. It is about 18 percent of our GDP. And Social Security does not have the same bloated cost structure that is inherent in a single-payer healthcare system, which our colleagues on the other side of the aisle have been ultimately proposing. And I think we need to think a little bit more deeply about ways that we can bring those costs down rather than bringing in, I think, incomparable and unanalogous other government programs.

But, with that said, I do think that there is a lot of bipartisanship in healthcare, and I think that there are a lot of things that we would agree on.

Ms. Tripoli, thank you for being here, and thank you for your testimony. I believe in your testimony you urge policymakers to get the root causes of high and irrational prices in our healthcare system. Is that correct?

Ms. TRIPOLI. Yes.

Mr. GILL. And you would agree that healthcare consolidation is one of the main drivers of high prices for patients?

Ms. TRIPOLI. Yes.

Mr. GILL. I certainly agree.

And you also mentioned price disclosure, that hospitals should disclose the rates that they charge openly in dollars and cents, I believe, were your words. Is that right?

Ms. TRIPOLI. Absolutely, yes.

Mr. GILL. I certainly agree. You also mentioned site neutrality, that we ought to prohibit health systems from charging Medicare more for the same procedure if it is done in a hospital versus a doctor's office. Is that right?

Ms. TRIPOLI. Yes.

Mr. GILL. Those are, I think, all things that we can agree on, which is really, really nice to hear. So, I appreciate that.

Mr. Jacobs, I want to ask you about Obamacare. Obamacare was sold to the American people as a program that would drive down premiums. I think the number that was thrown out by President Obama at the time was $2,500.

Has that promise come to fruition?

Mr. JACOBS. No, it has not, Congressman. And premiums on individual health insurance policies on the marketplaces and the exchange has more than doubled in the law's first four years. And that is primarily from the regulatory mandates that the law imposed. And prices have continued—premiums have continued to increase substantially, and they continue to increase substantially more so on the exchanges than for employer-sponsored coverage.

Mr. GILL. So, you would say that Obamacare did not slow the growth of premiums in any meaningful way?

Mr. JACOBS. I think, if anything, quite the contrary. I mean, Senator Welch, I believe, last month admitted on the Senate Floor that the law failed to reduce costs.

But, more than that, I think it has accelerated the cost growth because of the consolidation that has come about in terms of hospital mergers, insurers buying PBMs, et cetera, et cetera.

Mr. GILL. And that is what I was getting to. Did Obamacare address or fix any issues related to price transparency?

Mr. JACOBS. Ultimately, there have been regulatory efforts. Some of the Trump Administration efforts were actually linked to regulatory requirements in the law. But I think we can and should do more, and I think we have also seen that hospitals are not necessarily complying with that law either willingly or easily.

Mr. GILL. Did Obamacare address or fix issues related to pricing disclosure?

Mr. JACOBS. I think we need to do more is what I would say.

Mr. GILL. Got it. And it is your testimony as well, if I heard you correctly, that Obamacare actually exacerbated pricing issues related to healthcare consolidation?

Mr. JACOBS. That is correct. And we have seen that in many areas.

For instance, the Congressional Budget Office recently released a report on the 340B program and how the 340B program encourages increasing Federal spending and consolidation.

Now, Obamacare did not create the program—the 340B program, but it certainly dramatically expanded it and is one of reasons why it continues to grow and continues to accelerate health costs.

Mr. GILL. Got it. And, with the remaining 30 seconds, as you know, there is a lot of debate right now about potentially extending COVID-era enhanced premium tax credits.

In your opinion, would that lower overall healthcare costs, or would it raise overall healthcare costs?

Mr. JACOBS. The subsidy regime is inherently inflationary because, once an individual hits their income in terms of how it is structured in the law, the percentage of income, every marginal dollar of a premium increase gets paid by the Federal Government.

So, insurers have no incentive to control costs because, whether the premium goes up by one percent or 100 percent, the Feds subsidize that. And so, it is an inherently inflationary structure. We have seen the concerns about fraud.

I think those reasons, coupled with the fact that enrollments have held study thus far in open enrollment, all suggest that we should allow the enhanced subsidies to expire.

Mr. GILL. Got it. Thank you.

Mr. BURLISON. Thank you.

I now recognize the gentlelady from California, Ms. Simon, for 5 minutes.

Ms. SIMON. Thank you all for coming today to be a part of this conversation. I especially want to say hello to my constituent from UC Berkeley, Dr. Obermeyer. Thank you so much for being here.

And I know we are talking about the affordability of healthcare and ACA credits, which I will expand on in my short remarks.

But I want to say, I am a widow, and I lost my husband, who left me parenting two girls by myself. And he was diagnosed with a terminal cancer that was so rare, only about ten people in the United States get this cancer each year. And, after five years, despite the intervention and the treatment, they all die.

Kevin had T-cell prolymphocytic leukemia. And, even with insurance, flying across the country to find just a little bit more time and getting into a clinical trial, it took all that we had. And, post his passing, myself and my little girls were left with a mountain of debt, a mountain of debt. I am so thankful to our insurance providers because, without them, that debt would have been in the millions, not just a million.

$27,000 a day for a bag of Campath that hung while he had amino therapy every day for nine months before transplant. I could not imagine—I could not imagine where we would be even though we struggled without health insurance.

In January there will be families, tens of thousands of them across the Nation—maybe in the hundreds of thousands—they will see their rates, but triple. Many of them will have no choice but to just bail out—we know that—and use emergency room care.

The Democrats and Republicans, for whatever reason—maybe we have not independently personally suffered enough in our own families to figure out how to put politics aside and get it right for families who are suffering, who are waiting on a call for a clinical trial, families who are waiting for labs like the CRISPR lab to develop just one more innovation that might give dad or mom or that baby with TPN in her nose just a little bit more time.

So, all has been said on this panel. But one of the things that I think it is important for me personally and politically, having talked to thousands of families as a cancer mom and as a cancer widow, we cannot innovate fast enough.

You know, during the congressional Black Caucus Foundation's annual legislative conference, I actually hosted a panel with OpenAI and Akido Labs, and the Hidden Genius Project and a brilliant scholar, Rashad Robinson, on how AI is transforming medicine and innovation.

I am from the Bay Area, the home of AI, the home of biotech innovation, and I am so proud to represent that sector. I am so proud to represent that region.

We know that we can, in fact, democratize medicine. We can democratize innovation. New technologies, including AI, present exciting opportunities for patients, physicians, scientists, and families.

We already know that AI is advancing lifesaving early detection for cancer, Alzheimer's—right in Berkeley at the CRISPR lab. We know we are this close. Doc, you know this—to providing sickle cell patients with a new lease on life. This close. Unfortunately, the

Trump Administration took millions from that lab, leaving folks waiting.

As someone, myself, who was born a preemie with a congenital visual impairment, I know how important these technologies are for disabled communities. I know how, as I talked about before, important these technologies are for clinicians, who, when my husband was diagnosed with T-PLL, they were using—you all know who are physicians—they were using up-to-date printouts, you know, up to date. Can you imagine in ten years where we will be when physicians and pathologists will have the technology to immediately access gazillions of language models, again, to give patients and families more days?

So, I have some questions. I do not have the time, but what I am committed to doing here with you all in my district and beyond and with Members of this Committee across the aisle is engaging in a short-and long-term conversation that hopefully involves action to get it right for the people who need us most.

I want to thank you all for coming today. I cannot wait to work with you all in my office a little bit more, hopefully a lot of bit more, and to continue to be someone who yells from the rooftops about what our people deserve and what, hopefully, they will get.

And I will yield back. Thank you so much.

Mr. BURLISON. Mr. Frost?

Mr. FROST. Mr. Chairman, I ask unanimous consent to enter into the record a Commonwealth Fund report entitled "Expiring ACA Premium Tax Credits Could Lead to nearly 340,000 jobs lost across the United States in 2026."

Mr. BURLISON. Without objection.

Mr. FROST. And one more. This is from the *Center on Budget and Policy Priorities*, entitled "By The Members, Harmful Republican Megabill Will Take Away Healthcare Coverage Away from Millions of People and Raise Families' Costs."

Mr. BURLISON. Without objection.

In closing, I want to say thank you again to our witnesses today for your testimony.

And, with that, I will yield to Ranking Member Frost for his closing remarks.

Mr. FROST. Thank you so much to our witnesses for being here, and thank you so much to Chairs, plural, for having us here today.

This conversation of healthcare affordability is incredibly important, very personal to so many people on this panel. And it is important that we look at what is right in front of us, which is the expiration of the Affordable Care Act tax subsidies.

Like I mentioned and I entered into the record earlier, my Republican colleagues on this hearing represent 738,000 people who depend on the Affordable Care Act tax credits.

In Missouri Seventh; that is 59,000 people. In Wisconsin Sixth, that is 34,000 people. In Alabama Sixth, that is 56,000 people. In Arizona's Ninth, that is 44,000 people. In Louisiana's Third, that is 44,000 people. In Texas 17th, that is 76,000 people. In Florida's 19th, that is 149,000 people. In Florida's 13th, that is 101,000 people. In Pennsylvania's 10th, that is 25,000 people. In Virginia's Fifth, that is 36,000 people. In Colorado's Fourth, that is 24,000 people. And, in Texas 26th, that is 90,000 people.

These are not just statistics and numbers. Behind every number, there is a person who is at risk of having their healthcare going up from anywhere from 50 to 300 percent. I think this conversation is an important conversation we need to have after we deal with the healthcare crisis right in front of us.

Let us pass and extend these tax credits to make sure that working-class people in this country do not see their healthcare costs go up so much that so many of them will just decide not to have health insurance, and then let us get to fixing this broken healthcare system.

I yield back.

Mr. BURLISON. Thank you. I now recognize myself for a closing statement.

We heard from expert panel witnesses on how to make healthcare more affordable for the American people. And Americans want simple, affordable, transparent healthcare, but our current system hides the prices. It blocks competition and routes every decision through an unnecessary regulation and bureaucracy. We must prioritize innovative technologies and pathways forward to help lower these costs.

Today our witnesses spoke about their personal experience navigating the healthcare market. They testified on how misaligned structures in the current healthcare system are keeping healthcare costs high because there are not incentives to drive the costs down.

Artificial intelligence will eliminate unnecessary costs, if allowed, and may allow providers to direct their efforts fully toward making patients healthier. And the Trump Administration is paving the way forward for entrepreneurs to develop the best healthcare in the world while also promoting consumer choice.

We need this innovation because the status quo is totally broken. The American people are suffering from the un-Affordable Care Act passed by the Democrats.

Since 2014, Obamacare has skyrocketed the costs of healthcare and has not led to better patient health outcomes. The one thing that we might be unanimous on in this country is that Obamacare has failed in its goal of reducing healthcare costs. In fact, it has made it worse.

We hear you, America. You are not getting simple, affordable, and transparent healthcare right now. And that is why, rather than have the hearing and just have conversations, I am taking action. That is why I am introducing a bill called the Make America Healthy Again (MAHA) Act that will put consumers back in the driver's seat and allow for free market, as intended, to spur competition and lower costs and give people back their freedom and their choice.

The MAHA Act will allow consumers to shop on the price and the quality of healthcare services. Unlike under Obamacare, this will force providers to compete in the open market, driving down costs and making those costs actually transparent.

Consumers will have access to tax-free health wallet that patients can use as real money as opposed to coupons that are controlled by an insurance carrier. This account will be portable from job to job, giving workers their freedom back instead of being locked into a job because of fear of losing their health coverage.

This program will also make prices clear by encouraging price posting and upfront costs, creating a true consumer-focused market. The American healthcare system is facing a nationwide shortage across all major category of providers, and my plan would encourage the elimination of medical education inflation and scope creep, expand and modernize residency training, and eliminate arbitrary hospital caps on residency slots, increasing the supply of doctors and medical professionals.

The American people have spoken. They want more affordable healthcare. Today's hearing lays the foundation for a more affordable healthcare system in America by focusing on innovative technology and new pathways forward.

The Democrats have failed. Obamacare has failed. The American people and Republicans are ready to act. And this act, my MAHA Act, will fix this broken system, lower healthcare costs for Americans, and put American families back in the driver's seat for their healthcare decisions.

And I now recognize Chairman Grothman for his closing remarks.

Mr. GROTHMAN. Thank you. Sorry, I had another hearing.

First of all, I would like to thank the chairman for getting us together on this very informative hearing, and I would like to thank all of you for coming from all the country, four corners of this nation, to educate us on the higher cost of healthcare.

I think we have seen consensus here today that there is probably too much being spent on administration and that, in some areas, there is overutilization driven by greed.

I want to thank our witnesses again. Americans want transparency on where their money is going, and we have the responsibility to deliver solutions and provide our citizens with the best healthcare system.

We learned today that implementing the innovative technology can provide a solution to tackle wasteful spending and misaligned pay incentives. The application of technology has the potential to address the large administrative cost burden that many patients must pay that they do not have knowledge of.

Many of us have experienced high cost within the healthcare without receiving high-value care for ourselves and families. One-third of healthcare spending in the United States goes to waste, and we must act now to address this growing problem.

It is going to be tough because, of course, if we spend less money in our healthcare system, somebody is going to be getting no check or a smaller check. So, the special interests will be out looking to protect the status quo.

But I think the Republican Conference is up to it, and I think we will stand up to those special interests and find a way to reduce the out-of-control costs, which is such a burden on your average American patient.

Thank you again for letting me in the room.

Mr. BURLISON. Thank you, Chairman Grothman.

Thank you, Ranking Member Frost.

And, with that, without objection, all Members have 5 legislative days within which to submit materials and additional written questions for the witnesses, which will be forwarded to the witnesses.

And, if there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 11:58 a.m., the Subcommittee was adjourned.]