INNOVATION IN FOCUS: WHAT DOES SMART IMPLEMENTATION OF AI IN HEALTH LOOK LIKE?

Announcer 00:00

Please welcome the panel on "What Does Smart Implementation of AI in Health Look Like," moderated by Michael Milken, Chairman, Milken Institute.

Michael Milken 00:48

Well, good afternoon, everyone. Today is November 5, 2025 and we're into the last end of our panels. We probably had 40 or 50 today, and today, we have an unusual challenge, among others, with our panelists: No.1, we have the largest company in the world. You might know that, but CMS is the largest company in the world. And Amy, what, what is your annual payments—you're paying, passing out?

Amy Gleason 01:27

About 2 billion. About 2 trillion! 2 trillion. I'm sorry, that's right, 2 trillion. Thank you.

Michael Milken 01:35

Okay, so just think about that. And over $5 trillion being spent on health care, the largest part of our economy. And, Eric, tell us a little bit about the growth of Tempus. How much data are you storing today?

Eric Lefkofsky 01:57

We're storing about 408 petabytes of data today, and it's been growing pretty rapidly, so the—just for—so Tempus is a leader in bringing AI to health care; in particular, bringing AI to diagnostics. And our basic focus is, how do you use technology to contextualize diagnostics in real time so you can help physicians make data-driven decisions? And the way we do that is, we're connected to about 5,000 providers in the US, so, a significant percentage of the US health-care system. And every time we run a test, or kind of ingest some kind of laboratory test result, we connect that to all the clinical data for those patients, and then try to marry that up in real time so we can say really intelligent things to a physician, so that they can make the most intelligent decision for the patients.

Michael Milken 02:48

So everyone in the room today is involved in some area of health care, and the thousands of people watching online also, but I thought we might start on a personal story of both Amy and Eric. What piqued their interest in health care? So Amy, let's talk about you.

Amy Gleason 03:12

So I started out. I was a child of a hospital administrator, so I grew up kind of in health care, but I started out in nursing in the emergency room, where I realized how important it was to have the information at the fingertips of the provider. Patients are stressed, they're scared, they're in pain, and they wouldn't be able to remember their medications or what doctors they've seen, or any of their history, and so it really depended on how well they were treated. And so I became a little bit obsessed about technology and how it could make that better. So I worked in electronic medical records, practice management, supply chain, lab pharmacy systems, really trying to help clinicians have the data they needed to spend more time with patients and to be able to give better treatment. But then, in 2010, my then 11-year-old daughter was diagnosed with a rare disease, and that's when it all really became a lot more personal for me. She was a competitive gymnast and cheerleader. Was very active. We called her the "Energizer Bunny" because she just never stopped moving. And she suddenly started having kind of these weird symptoms that seemed unrelated at the time. She had these rashes on her elbows and on her knees, but she was a gymnast, and she was hitting the mats all the time, and we just kind of thought that was that. And she had strep throat several times, had her tonsils out, but a lot of kids have that. And she kind of broke several bones in ways that seemed, kind of, like she shouldn't have broken them, you know: walking down the street and just barely twisted her ankle and broke her ankle; broke her elbow on a seemingly small fall. And the doctors kept saying her bones look fine, and she started having all these stomach aches and headaches, and she was missing a lot of school, but we really didn't get that alarmed until she started losing all of her tumbling. She was a very good tumbler, and soon she couldn't do a back handspring, and then she couldn't do a handstand, and she couldn't stand up off the floor or walk up the stairs. She was seeing all these doctors, but nobody had all of her information in one place, and they didn't put it all together until she happened to have a skin biopsy at a dermatologist's that relayed that she had juvenile dermatomyositis, which is a rare autoimmune vascular disease that can be life threatening. And so she now sees 12 doctors across six health systems in four states, and takes 21 pills a day, gets two infusions every month, and it's quite a lot

to manage. It can be a full time job. And so I really believe that if someone had had all of her information at one place at that time, and especially if they had modern AI like we have now, that somebody would have figured out what was going on, or even back then, somebody would have said, why is an 11-year-old going to the doctor this much? So it's really changed my passion, and I'm really, really passionate about fixing this, helping patients be empowered, having doctors have the information they need, but also having patients and families have the information that they need.

Michael Milken 05:56

Amy, just review, how long did it take for you to get the final diagnosis from the first time this was occurring?

Amy Gleason 06:05

From the first symptoms that we really started tracking, it took about a year and three months. Which, her disease, is actually if you get treatment early, you have a much better outcome. So all of that time is 487 days that she went that her disease got worse.

Michael Milken 06:19

And we're not counting, right? Okay, so, Eric, you were one of our country's great entrepreneurs. All the companies you were interacting with, I couldn't think of any of them that were involved with medical, then what happened?

Eric Lefkofsky 06:36

Yeah, for me, 11 years ago, my wife was diagnosed with breast cancer, and I found myself, as a lot of people do, kind of in the middle of this system that felt very foreign to me. And the weird experience I had was, I just felt like I was going back in time. I would tell people, it's like, here I was running these tech companies, and I felt like I was firmly in the 21st century. And then you would go into this hospital, and in her case, it was a great hospital—University of Chicago—and it just felt like I was being teleported back in time, like in the 1980s. And it seemed crazy to me, and I've said this before, that we give more technology to, like, truck drivers delivering pallets of water than we do to physicians making life-or-death decisions. And so I just pivoted and decided that I would take—at that time, I'd probably spent 15 years in tech—and I decided I would just leave behind that world and focus solely on health care and trying to find some way to bring technology to the US health-care system.

Michael Milken 07:40

So if we look, kind of, at history, I was a student at Berkeley in the mid-60s, and when I changed my major to finance, there was data available to me, which was overseen by the University of Chicago, called the "CRSP tape." So if you had theories, you could test this out over a long period of time, and you could take a look what people were saying that was wrong or right, but you had data. But at that time, there were no medical digital records that you could access, and the cost of creating files was prohibitive at that time. So today, we're going to cover a lot of ground in the next couple of minutes, but one of the first things we're going to start with here is, we're going to try to take $1 trillion—and tell you, Eric and Amy, how to do it in the next 20 minutes—out of our health-care system and, at the same time, provide both better care for patients and better information for health-care professionals. So, Amy, you have a technology background, you're here at the largest company in the world that we've agreed is doing $2 trillion, not $2 billion, and it was a decade ago that we did a study with Stanford School of Medicine on pathologists diagnosing what you had. And the results of that study showed that there was only a 60 percent chance that a pathologist, two pathologists, would even agree on what the diagnosis was. So we've come a long way thinking about these issues, how we're addressing the issues. Let me start with you, Amy: What are the things you're focused on that provide, No. 1, better knowledge to the patient, the provider, and, at the same time, substantially reduce costs?

Amy Gleason 09:49

I think the first thing I'm sure you've seen a lot of coverage on, is that CMS is really focused on taking fraud and waste and abuse out of the system and decreasing the administrative costs. So just last week, Administrator Oz had posted about over a billion and a half wasted dollars that we had found in the Medicaid program, and over a billion from a state and Medicare, and that was just recently in a very small population—six states for Medicaid and one for Medicare. And so, there's obviously a lot of waste and fraud that need to come out of the system, but the administrative costs have also gotten extremely high year over year, and it keeps growing. So I think the biggest initiative that we've launched this year is to really try to stop the effects on patients that aren't getting the treatment they need, empowering them and helping providers and patients all have the data that they need. So we launched an event in July at the White House with the president, called Make Health Technology Great Again. And we joked that it might be for the first time, but we called it the healthtech ecosystem, and it has two main parts. One is all about getting the data to the right people at the right time. So we started this CMS Interoperability Framework, and it's really about empowering patients to get their data. I don't know if you've ever tried to get your health records, but it's not an easy task—involves a lot of faxing and a lot of going and showing up and getting CDs. Good luck trying to figure out how to open that CD, since computers don't usually have CD drives anymore. So we're trying to create this CMS-aligned network where a patient can request their information through an app of their choosing, where they validated their identity with something modern, like CLEAR or ID.me, and then they can request their information from all the networks that have providers and payers on them. And without having to know all the doctors they've seen or all the portals that they have or logins or passwords, they can get all their medical information into that app of their choosing, and then they can use that for different use cases. As well as right now, even though it's hard for patients to get their information, your data is going around all over the place, in places you don't know. So we think patients should have transparency into where their data is going. The second part is really getting providers access to that data, and making—clearing some of those barriers. And then starting some operational use cases, so things like quality measures and payers that are getting a claim to be able to ask for the clinical records alongside that. So, that's also moving into modern technology, using "FHIR-

mediated" data. So that's kind of the first bucket, is interoperability. The second bucket is really all about empowering patients. So the first bucket is called "Kill the Clipboard." So, and the idea—my daughter that goes to the doctor, she has 47 patient portals. She does not remember where her data is. It has different slices of her information [inaudible] and no more clipboard. She has to fill out that clipboard at every visit and write 21 pills down every single time, all of her history. And it gets, you know, then they ask her again when she gets in the exam room. So, it's her No. 1 thing. I'm trying to take that out for Morgan. The second thing is conversational AI. So once a patient can get all their information, being able to have conversational AI on top of that. So right now, of course, lots of patients, including my daughter, are using conversational AI, but if it doesn't have your information, it's not personalized, so it just gives you generic information. So I'm going to tell you two quick stories on how this can help people from Morgan's recent experience. So she applied for a CAR-T trial, which could be the first curative hope we've heard of in 15 years since she was diagnosed. And so she was rejected for the trial because she has ulcerative colitis, which was an exclusion criterion. And her doctor resubmitted it and said she'd been pretty stable, and they still denied it. And so she was frustrated, and so she went to her favorite LLM and said, "I want some kind of clinical trial. I'm tired of this. Find me something I can do." And she's put all of her medical records in there, and it said, "Actually, I think you're eligible for that trial, because I don't think you have ulcerative colitis." So when it looked back at her records and the pathology reports, it found that she had microscopic lymphocytic colitis, which is not an exclusion for the trial. Wouldn't have changed any of her treatment over this past time, but it does make her eligible for the treatment. So that's one example, but it was personalized because it had her information. The second example is she just had a very high-dose steroid treatment because she had this painful prior auth issue. Whole other topic, but she was delayed getting her infusion, and she had to go on high-dose steroids. It's been a while, so she was feeling really sick. She called me and said, "I think I have to go the ER. I can't figure out what's wrong. I called the doctor: they said I should probably go the ER, but I really don't want to go." So one last- ditch effort. She asked her favorite LLM, "I really don't want to go to the ER. These are the symptoms I'm having." And it said, "Didn't you just finish steroids? Did you do a taper?" And she had forgotten to do a taper, and so the doctor didn't think of that. I didn't think of that, but her LLM did, and it saved an ER visit. So you start to multiply that by millions of people and millions of ER visits. It starts to take a lot of costs out of the system. Then the last piece is really managing your disease. So as you go to the doctor, being able to understand what you're supposed to do. She only sees her doctor a few times a year, but she can talk to this LLM every day and get advice and feedback, and it can help her manage her disease, and she'll tell it things she won't tell her doctor. So I think by empowering patients and empowering doctors and payers alike with data and tools, we can take a lot of the expense out of the system.

Michael Milken 15:18

Eric, one more question I'd like you to follow up on. Where are you recruiting from? We all are aware that, you know, a lot of most talented people might—are attracted now to the technology firms. They might be attracted to Tempus, etc. Where have you brought this team of technology experts from that have joined in? What are the types of companies they're coming from?

Amy Gleason 15:47

Yeah. So we're recruiting very heavily for very senior, top tech talent. You don't have to come and make a career in the federal service forever. You can come for six months, 12 months, two years. Come and do a service, a tour of duty, if you will. So we're recruiting people from the major tech companies—Apple, Google, Microsoft, Amazon—as well as smaller startup companies, Square, PayPal, all the different companies out there that are—have a good footprint—but we also like people that have been in a startup, because they have a lot of grit and have figured out a lot of things. So, I would tell you, please help us recruit. You can go to usds.gov and apply there, and we help supply all the different agencies, but especially CMS and HHS.

Michael Milken 16:26

How have the existing infrastructure and people at CMS adjusted to the people coming from the tech world?

Amy Gleason 16:37

So when I got to CMS in January, we could only find 12 engineers. In all of CMS, there are thousands of contractors and 12 engineers. So I think it was like one to 275 people, employee to contractor. So there's no way that anybody can have any oversight of what's being built or how it's being done, or getting any real kind of feedback. So I think there was a little bit of a shock when we came in and started asking a lot of questions and started bringing a lot of talent. But I think now people are starting to see the benefits of that, and we're not having to repeat things so much, having faster deliverables. People are pleased with the results, and it's changing the culture.

Michael Milken 17:13

So Eric, I'd like you to take us down the line of this more than $5 to $6 trillion of medical expenses. And as we start to think what is part of it, let's take a look at the drugs. Let's look at the doctors. Give us a little breakdown on that.

Eric Lefkofsky 17:32

I think we generally agree. I mean, you can come at this from the patient angle, which is awesome. You can come at it from the physician angle, but at the end of the day, the challenge is: When you have a system, we'll spend about $5.7 trillion on health care. And the real problem is that it's growing at about 7.5 percent. So if you—and it's been growing at that rate for a while, so if you continue, if you kind of like, play that out for the next 20 years, the size of health care will actually eclipse the size of the entire US economy. So it's not sustainable, and if you look at the pockets of expense, we spend way too much time focused on pockets that won't actually save us a ton of money. So if drug companies made zero profit, I think it would save us around $112 billion. If payers made zero profit, it would be like another $25 billion

or so related to the payments they make. So you're kind of getting at 2.5 percent of the problem. The other 97.5 percent of the problem is over to the side. And it, what it really comes down to, is the system is riddled with complexity, middlemen, a lot was basically errors and waste that cause all the problems. You just—too often we make a mistake. We don't catch something early. We don't—this is an exact example—we lose 467 days, or whatever it is, and now a problem which would have been at one level is now 10 times the level. And the example that people—usually is quite good is, you know, the old rocket ship example. If you catch a bad bolt or an O ring in a rocket at the beginning, you can fix it for $10. If you catch it at the end, you've got a $65 million crashed rocket. And in the US system, we constantly are trying to fix crashed rockets. It doesn't work. So we have to find some way to get at the problem earlier. And if you think about the money we're spending, what's really most insane about it is we spend $5.7 trillion taking care of 340 million people. That's as much as the next-largest 19 countries who take care of 4.4 billion people. And yet in this country, our average life expectancy is about 78, give or take, between men and women, which means countries who spend one 10th of us, one 20th of us, are living to 82, 83, 84, and so the whole thing has to be rethought. And yet you can't rewire a system that's this large. What people don't realize—I mean, you're talking about, I've got a $2 trillion payer right here, another $3.7 trillion off to the side—22 million people work in health care, one out of every 11 people working in this country. So you're not going to, like, rewire that overnight. But we can find a way to infuse technology—in particular, AI—into the system in ways that doctors can absorb and patients can absorb, and begin to chip away at all this error, all this mistake, all this waste. We want to catch things earlier. We want to make sure patients are always on the right therapeutic path. We want good doctors to be great doctors and great doctors to be superhuman doctors. And that's probably the only short-term solution.

Michael Milken 20:44

So if we look at projections—for example, health-care-focused AI machine learning and the size of the market—it is projected to grow at 33 to 37 percent a year. So this is one of the great growth areas that we're looking at. If we look at AI-assisted diagnosis today, we're seeing better results. And then if we look at artificial intelligence and bio R&D, we're seeing these dramatic changes, and in a recent report on physicians versus artificial intelligence, this is the Microsoft AI case: across 304 cases achieved 4x the accuracy of doctors from this standpoint. So there is—and I think Eric, you're referring to—there's been a number of issues where you have the wrong diagnosis, you're giving the wrong treatment in this area. And so you've done a lot of work, Eric, on what type of treatment is the best for an individual, once you've sequenced them, sequenced their disease, etc. So, if one in two men in America will get cancer and one in three women, you have a pretty large set just in this to work on. How can I use in what you're building today to provide the actual treatment a person wants on a much better basis?

Eric Lefkofsky 22:25

Yeah, I mean, I think in cancer, it's really—you know—I think at this point, pretty accepted that sequencing patients— especially late-stage cancer patients—produces targets, and those targets produce much better therapies. And so, we sequence lots of patients. When you think about the larger ecosystem, I'll go to something that's kind of very conventional. Take, for example, electrocardiograms or ECGs. We run about 300 million ECGs in this country, and the technology is quite old. It's not that it's been around for 50 years.

It turns out that, essentially, 3 percent of patients have an ECG, they're told by their physician, "You're fine, everything looks good," and within a year they have a heart attack or stroke, which is staggering. Now, a heart attack or stroke in this country costs about $125,000 to treat. It's not cheap to treat somebody who had a heart attack. So the real question is, why are we tolerating—we, Tempus has two FDA-approved devices, one that predicts undiagnosed atrial fibrillation, one that predicts undiagnosed low ejection fraction, this is the cause of 70 percent of those heart attacks or strokes. There are other companies that also have FDA-approved algorithms, Mayo has one. So the real question is, why don't we find a way to ensure that these FDA-approved algorithms are somehow being used out in the system to avoid all those heart attacks and strokes. And it's just math, right? We have to do the math and say, what are we willing to pay for these kinds of technologies to be deployed, given the savings on the other end? And I think AI is tricky, right? We don't want to deploy AI that's a black box. We don't want to deploy AI that just has the system spending more money. We have to find ways to measure it, and we have to find ways, even if we bring AI into the system, if we got it wrong, and we're not producing patient outcome, we're not saving the system money. We should get rid of that AI. We should stop paying for it, but where it's producing tangible benefit, where it's actually bringing value-based care into the system. We've got to find a way to deploy technology, or we're just never going to get at those millions of patients that have conditions they don't need to have.

Michael Milken 24:32

So Amy, when we think of the government, we don't necessarily, historically, think of smarter, adaptive, changing environment here. And so you're in the White House now looking at CMS from the White House now you're inside, looking out at CMS today. What do we need to do to be more adaptive, flexible, etc. at CMS, and how will that affect the system?

Amy Gleason 25:05

I think one thing is making sure that technology is part of the policy discussions. A lot of times, policy gets passed and it dictates things that have to be done a certain way in tech, and then you're kind of stuck with that. So for example, X12 was written into HIPAA, and so now, many years later, we're still using X12 because it was literally written into the law. So I think we're getting better at involving technology people and trying to leave the specific tech out of policy and let that be guidance later. I think the other thing is that government really needs to set the guardrails and build some infrastructure and then let the private sector do the innovation and build. So I think a good example of that as part of our healthtech ecosystem, we're building a provider directory. So I'm sure many of you have built a provider directory or struggle to have accurate information on providers, because providers have to get their NPI from CMS, and then most providers become Medicare providers. We have a lot of that information at CMS, but it's split across eight different databases. So we're consolidating those and figuring out the right information we have, but then we're working with the private sector to keep that information up to date so that everyone else can use that from one source and stop rebuilding this over and over in the private sector. I think that's a good example of infrastructure that the government should own, because they're really the only one that can have enough data, and people will trust to share their data with, that everyone can take the benefit of. We're also starting to add modern identity to our systems. So we're adding that to medicare.gov, for

example, where a Medicare beneficiary can use login.gov, or id.me, or Clear, and validate that they are who they say they are, and then that allows the rest of the private sector to use those same credentials, and patients have already gotten through that process, and helps people innovate and use that faster, but by kind of starting those guardrails, that allows the private sector really to innovate. And so all of the apps that I was talking about, like Kill the Clipboard, and conversational AI and disease management items: those should all be in the private sector, so that the government is not in that business, and the government can't go fast enough and nimbly enough to build those kinds of solutions anyway and make them competitive. So I think there's a great example of how the government can build some things where it makes sense to provide that infrastructure, but really unleash the power of the private sector.

Michael Milken 27:25

So Eric, you know when I think back on things that changed medicine, care, delivery, it was '93 and a company called Intuitive Surgical had this idea of minimally invasive surgery. And so we were in meetings 32 years ago, and many of the leaders—if you were the head of oncology or urology at Memorial or MD Anderson or Hopkins etc, you were generally a surgeon. You've spent your whole career, you learned how to do surgery, you're highly respected, and now there's a new technology coming on which could obsolete you. And so the answer was, how do we know the results are going to be the same 10 years later? Why don't we wait 10 years and we'll see, yes, less blood, less trauma. One day in the hospital, not a week. You don't have a scar that looks like railroad tracks on your body. If you've had your appendix taken out with minimally invasive, you can't find the scar in others. You look like you have railroad tracks on your body. And so it essentially delayed almost 10 years the implementation of this, because the most senior people were either going to have to learn something new, or they were going to be obsolete. And so as you looked at Intuitive Surgical and that stock on April 11, 2001, this is now eight years afterwards, it had a market cap of $283 million. And if you look at it today— hopefully we have a little bit—it's $196 billion. So when we think of all those patients that could have had in that eight to 10-year period, different treatment, the amount of hospital bills and cost that was built up. So today, we're thinking about AI and your approach today, and you're interacting with the clinician, the medical professional, etc. How willing are they to absorb new data from you and the analysis you're giving them?

Eric Lefkofsky 29:50

Yeah, you know, I'll tell you, like, one of the most amazing things for me when I entered—I had spent a long time in tech before coming to health care, and everyone said, "Oh, you're going to hate it." And I'm like, I actually love it. I mean, I found the whole system to be really—their motivations are aligned. They're incredibly smart. They want to do the right thing for patients. There are 74 NCI cancer centers, I've been to, I think, 72. I spend more time talking to doctors than almost anyone. And as a group, they are unbelievably willing to embrace new technologies to help their patients. The problem is not physicians. The problem is we just—finding a way to get the technology into the system in a way they can digest, is where all the challenge is. Because they're in Epic or Cerner or whatever system they're in, all day long, they can't leave that system and go somewhere else. They can't add an hour to their day. So the real magic here is, how do we get technology to doctors? And that is going to take, unfortunately, economics: We will get the behavior we incent if we can find a way to responsibly bring AI to health care, it will come to

health care. If we don't incent it, it won't come to health care. And so all of our challenge—we share the same challenge from different sides of the coin—is, how do we bring these amazing technologies? Large language models and large multimodal models can do unbelievable things. So how do we now take these technologies and actually begin to chip away at this problem? And if we—I think this is the defining moment—if we don't bend the curve, we're going to be sitting here 10 years from now, in a place we don't want to be with a $10 trillion system that can't be paid for.

Michael Milken 31:30

So let's go to the future now in closing. What does CMS look like, Amy? We're only going to give you now four years. What does CMS—you and your team that's come there look like, and how does it affect the individuals living in this country? Four years from now, you're ready to move on—how does, what does it look like?

Amy Gleason 31:58

Well, I think we can make a lot of difference in four years, we're already launching our ecosystem. The first results are in the first quarter, which, by the way, everyone in this room should come join our ecosystem. If you google CMS health tech ecosystem, you can take the pledge and join us. But we're going to keep tacking on every six months some goals for that. And I think we'll see, maybe by the end of four years, patients, a lot of patients, have this AI assistant that they can use every day, and that we've maybe knocked the interoperability challenge once and for all for providers to have their data.

Michael Milken 32:31

Eric, what is your dream? You told me you might be retiring when your youngest gets out of college. Here, let's take us out four years.

Eric Lefkofsky 32:42

That'll get me in trouble as a public company. So let's, let's assume that's not necessarily—might is the keyword. Look, my dream, my dream as long as I'm at Tempus, my dream is that we find a way to kind of—the benefits of chronic health care records and sequencing the human genome and cloud computing and all these amazing technologies, we've got to find a way to take all this data and actually bring it to patients and bring it to physicians and bend this curve. I think we're very close. The most amazing part of this administration is at least I've been doing this now 10 years. It's the first time I've seen a group of people really willing to say, "how do we partner with industry? How do we start with a clean slate? How do we do this differently?" We're not afraid to be innovative and take risk. And if we can seize this moment when all these incredible technologies exist that are touching our lives, I think we can fundamentally keep millions of patients living longer and healthier lives, spend way less money and kind of fix this broken system.

Michael Milken 33:50

So how long, last question, Amy and Eric, before we each have our own AI advisor—medical advisor—that's reviewed all the information constantly, and since we can keep track of 9 billion cell phones today, sending us messages. How soon I'm going to call that advisor, Jiminy Cricket? How long before all of us will have our own Cricket? You talked about CMS and AI, is that next year, two years, three years? How long?

Amy Gleason 34:26

I think a year from now, you'll have a pretty early version of an AI companion that can guide you through what to do in health care, prompt you for healthy things in the day, and help you have a better patient experience.

Eric Lefkofsky 34:36

Yeah, I mean, I was—I recently did a tour, and I was at a bunch of the big tech companies, including some of the big frontier model companies. And one of the crazy statistics of one of them was they were shocked since the last release of their most updated model, the amount of health information that was loaded up, literally, you know, molecular tests and clinical notes and pathology reports and radiology reports, and they were just blown away at the tens of millions of documents that were that were loaded. So I think it presents a huge opportunity. I think to some extent, people already kind of have a little mini AI assistant, because they're going into Chat, or Claude, or, you know, whatever, and they're asking these questions. So now we have to kind of do two things. One, we need to make those systems really good, because they inevitably can be kind of good, but not really good. And two, we need to bring them to physicians. The tsunami that would be untenable is that patients are walking in by the millions and kind of saying to their doctor, "You're wrong," when, in reality, the patient might be right. We just need that imbalance to not exist. So we have to find a way to arm providers with the same information we're arming patients.

Michael Milken 34:36

Eric?

Michael Milken 35:50

Well, I want to thank both of you. We look forward to what you accomplish, not in four years, but one year, two years, three years. Thank you both for joining us tonight. [Applause]

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