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Health Care Position Monitor Update

US Health System vs COVID-19, THC Credit Default Swaps & Trackers, TDOC Update

March 16, 2020

Hedgeye Health Care

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Health Care Position Monitor

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For Week of March 16, 2020

Best Ideas - Longs LONG		Price	Mkt Cap ($B)	Trend	Tail	Best Ideas - Shorts SHORT		Price	Mkt Cap ($B)	Trend	Tail
Active Longs						Active Shorts					
GH	Guardant Health, Inc.	$ 63.52	$6.0B	√	√	EXAS	Exact Sciences Corporation	$ 47.37	$7.0B	×	×
AMN	AMN Healthcare Services, Inc.	$ 70.72	$3.3B	√		HQY	HealthEquity Inc	$ 46.69	$3.3B	×	×
						NVTA	Invitae Corp.	$ 10.86	$1.1B	×	×
Long Bias						Short Bias					
TDOC	Teladoc Health, Inc.	$ 122.79	$9.0B			HCA	HCA Healthcare Inc	$ 94.84	$32.1B		
MYGN	Myriad Genetics, Inc.	$ 12.03	$0.9B			UNH	UnitedHealth Group Incorporated	$ 238.64	$226.4B		
TXG	10x Genomics Inc Class A	$ 60.55	$1.3B			DVA	DaVita Inc.	$ 75.03	$9.4B		
UHS	Universal Health Services, Inc. Class B	$ 93.70	$7.4B			DXCM	DexCom, Inc.	$ 211.35	$19.4B		
ZBH	Zimmer Biomet Holdings, Inc.	$ 88.73	$18.3B			THC	Tenet Healthcare Corporation	$ 16.85	$1.8B		
ANTM	Anthem, Inc.	$ 241.37	$60.9B			MD	MEDNAX, Inc.	$ 11.66	$1.0B		
						SGRY	Surgery Partners, Inc.	$ 5.30	$0.3B		

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US Health System Capacity vs COVID-19

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Mitigation is focused on preventing hospitalization rates that overwhelm the system

Population	Count
United States Population (2018)	327000000
65-90 Poor Health	2891896
45-64 Poor Health	3391706
Total Poor Health	**6283602**

Ventilator capacity	Units
Full feature	62000
Basic function	98000
SRS	15000
Total	**175000**

AGE	Good	Fair	Poor	Total
0 - 4 AGE	6.08%	0.11%	0.01%	6.21%
5 - 17 AGE	16.52%	0.35%	0.03%	16.91%
18 - 24 AGE	8.82%	0.34%	0.03%	9.20%
25 - 44 AGE	23.93%	1.83%	0.39%	26.15%
45 - 64 AGE	22.03%	3.12%	1.06%	26.21%
65 - 90 AGE	12.11%	2.33%	0.90%	15.34%
Total	89.49%	8.08%	2.43%	100.00%

Scenario	Hospitalized	Ventilation	Hospitalizaiton Percentage	Ventilation Percentage	Ventilation % Hospitalization	Hospitalized as a % of Poor Health AGE 45-90	Ventilator surplus/(deficit)
Moderate (1958/68-like)	856000	64875	0.26%	0.02%	7.58%	13.62%	110,125
Severe (1918-like)	9900000	742500	3.03%	0.23%	7.50%	157.55%	(567,500)
COVID-19	817500	61313	0.25%	0.02%	7.50%	13.01%	113,688
COVID-19	1635000	122625	0.50%	0.04%	7.50%	26.02%	52,375
COVID-19	2452500	183938	0.75%	0.06%	7.50%	39.03%	(8,938)
COVID-19	3270000	245250	1.00%	0.08%	7.50%	52.04%	(70,250)

VENTILATOR STOCKPILING AND AVAILABILITY IN THE US AND INTERNATIONALLY The US Department of Health and Human Services (HHS) estimates that 865,000 US residents would be hospitalized during a moderate pandemic (as in 1957 and 1968) and 9.9 million during a severe pandemic (as in 1918).1 o Moderate (1958/68-like) = 64,875 would need mechanical ventilation o Severe (1918-like) = 742,500 would need mechanical ventilation.

The regulatory response to COVID-19 has been severe despite a relatively benign prognosis for young and healthy people.

There are ~6M people with a health status of Poor over the age of 45 in the United States, 792,417 staffed hospital beds, 97,776 ICU beds, and 175,000 ventilators including strategic stockpiles.

The goal of interventions is to prevent COVID-19 from overrunning available acute care capacity.

Data Source: Center for Health Security, MEPS, US Census

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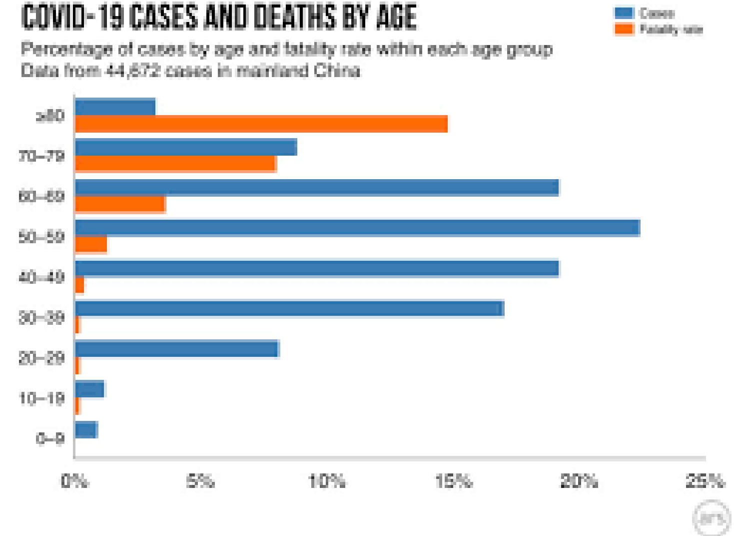
COVID-19 Impact on inpatient hospital care

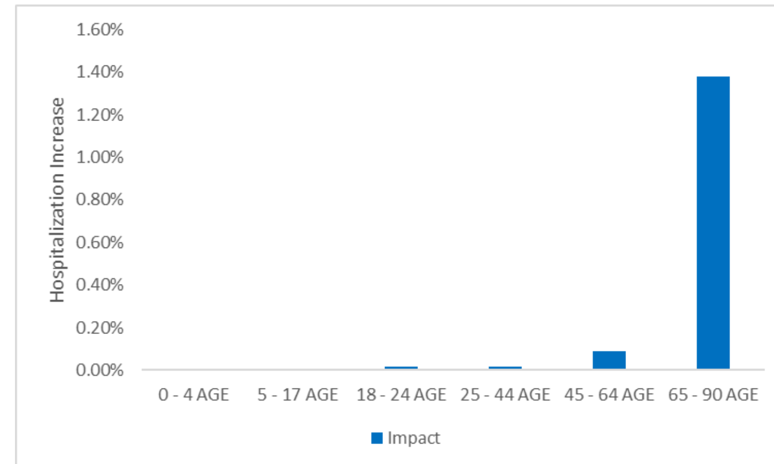
Elective procedures declines and COVID-19 admissions ramp higher

COVID-19 Infection rate	30.00%
Hospitalization rate	10.00%
Increase in hospitalization	3.00%
Elective, percentage	40.00%
Increase/(Decrease) from elective	-80.00%
Increase/Decrease elective	-32.00%
COVID-19 Case reimbursement	$200,000.00
Increase/(Decrease)	-$14,762,946,974
Percentage Increase/(Decrease)	-3.46%



Surgeon General advises hospitals to cancel elective surgeries

He warned that every elective surgery could spread coronavirus within a medical center.



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CDC Mitigating Strategies

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"Cancel elective and non-urgent procedures"

Healthcare settings and healthcare provider (includes outpatient, nursing homes/long-term care facilities, inpatient, telehealth)	• Institute temperature/symptom checks for staff, visitors, limit visitor movement in the facility. • Implement triage before entering facilities (e.g. parking lot triage, front door); phone triage and telemedicine; limit unnecessary healthcare visits. • Actively monitor HCP absenteeism and respiratory illness among HCP and patients. • Actively monitor PPE supplies. • Establish processes to evaluate and test large numbers of patients and HCP with respiratory symptoms (e.g., designated clinics for people with fever, surge tent for overflow triage, offsite testing locations) • Permit asymptomatic exposed HCP to work while wearing a facemask. • Cross train HCP for working in other units to support staffing shortages. • Restrict all visitors from facility entry to reduce facility-based transmission; exceptions for end-of-life visitors but restrict such visitors' movements within the facility. • Identify areas of operations that may be subject to alternative standards of care and implement necessary changes (e.g., allowing mildly symptomatic HCP to work while wearing a facemask). • Cancel elective and non-urgent procedures. • Establish cohort units or facilities for large numbers of patients. • Consider requiring all HCP to wear a facemask when in the facility depending on supply. • Consider suspension of new admissions to facilities.

Guidance	2020	
	Low	High
Net cash provided by operations	1250	1525
Payments for restructuring, litigation, acquisition, other	225	200
Adjusted net cash from operations	1475	1725
PP&E	-700	-750
Adjusted Free Cash Flow Guidance	**775**	**975**
EBITDA guidance		
Hospital	1430	1490
Ambulatory	970	1000
Conifer	385	395
Total	**2785**	**2885**

The breadth and depth of mitigating strategies appear likely to be increasingly severe. NYC is considering more aggressive actions as of March 13th even after implementing a State of Emergency earlier this week. Under a full elective procedure prohibition, the situation includes a discussion of liquidity, hospital bailouts, etc.

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THC | Credit Default Swaps

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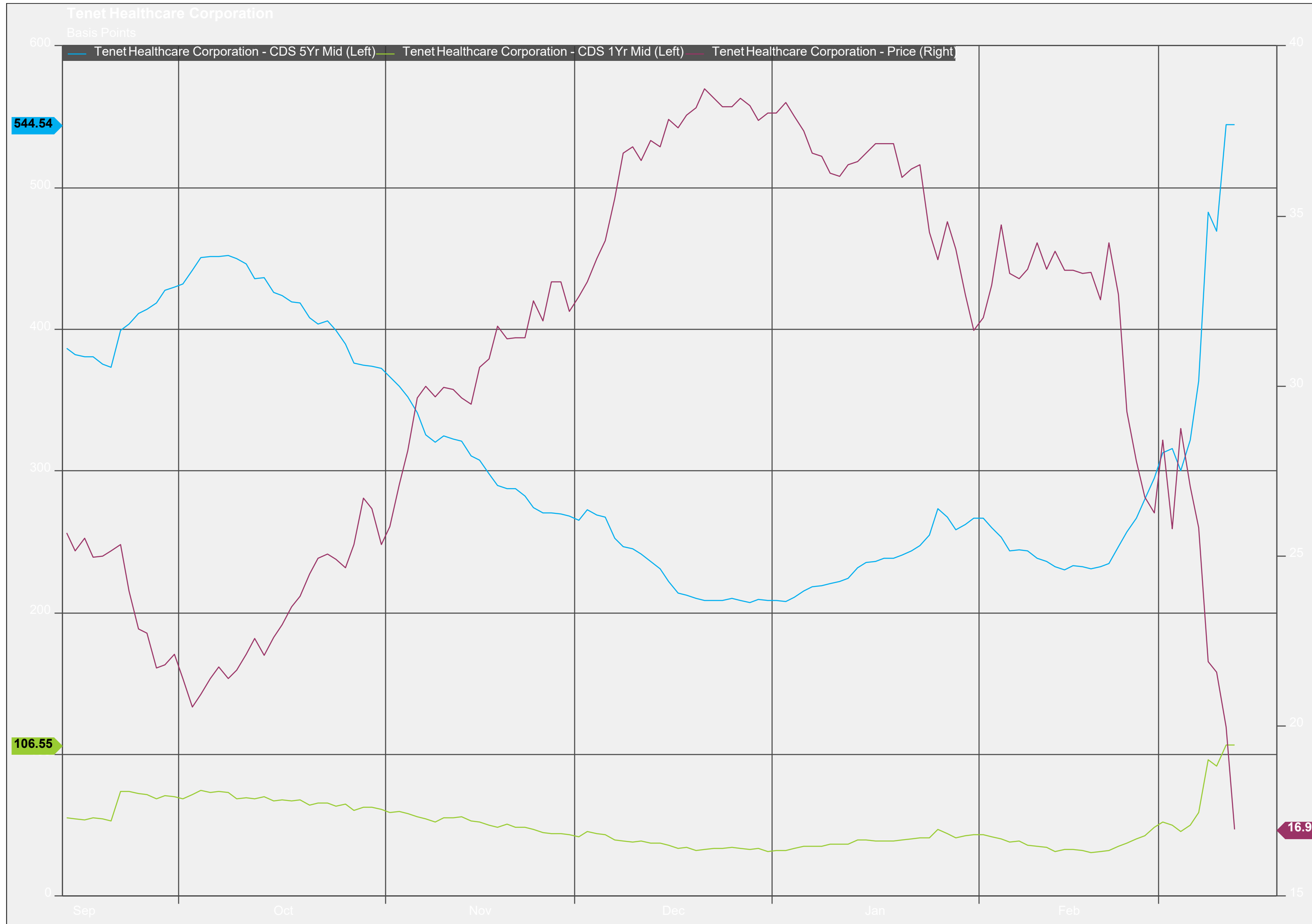
Leverage in a Macro Quad 4



THC's 5-year credit default swap has made new highs in two steps over the last 6 weeks and as the Macro Quad 4 took hold and COVID-19 expanded in the US. Mitigation risk has increased substantially in the last few days.

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THC | Tracker Ambulatory

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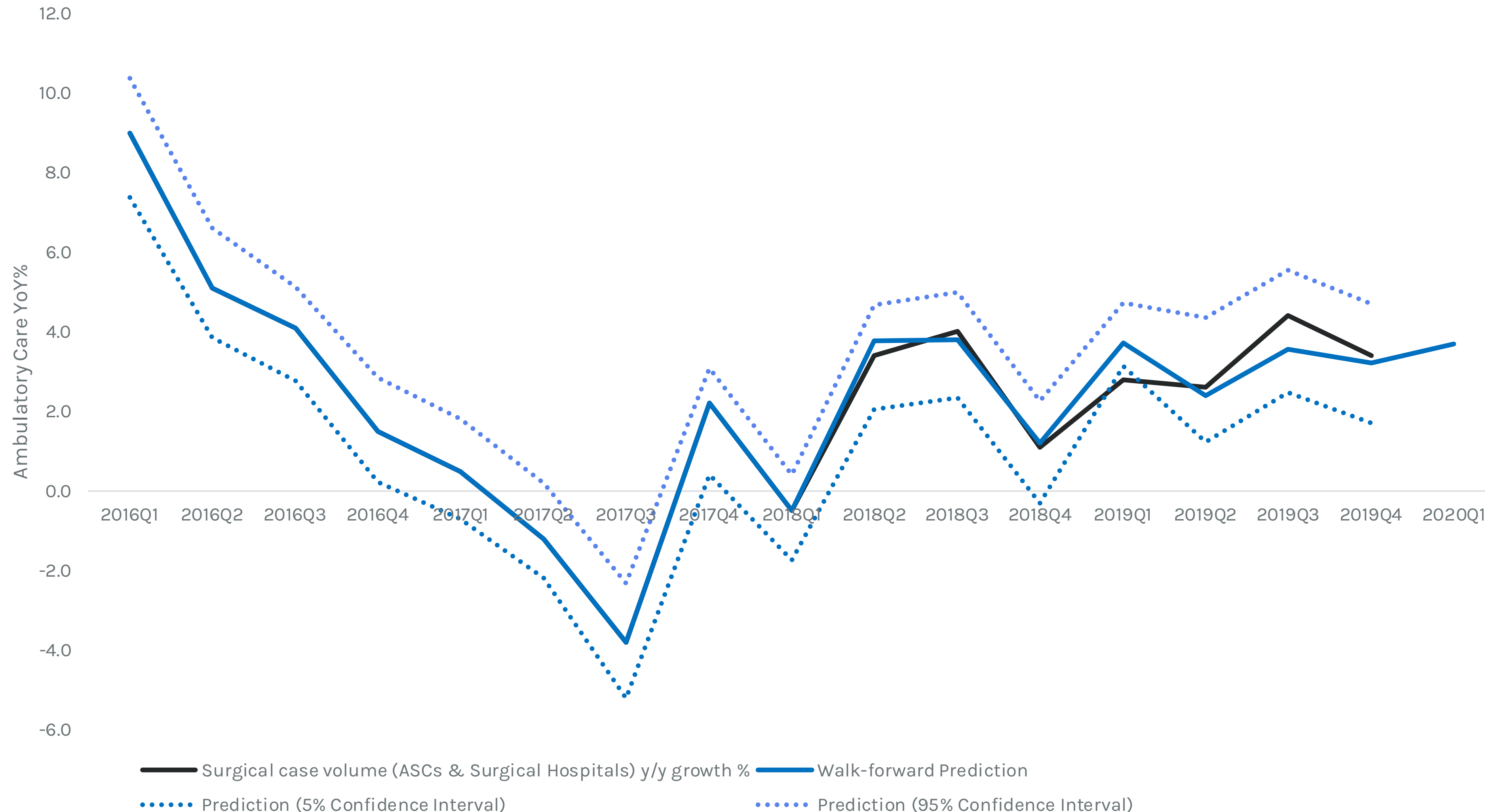
Ambulatory Volume Tracker (data pre-COVID-19)



Surgical case volume reported in the ASCs and Surgical hospitals on a same facility basis, forecast pre-COVID-19.

With the prohibition of elective procedures expanding across the United States, this forecast will be heading lower and soon.

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THC | Tracker Hospital

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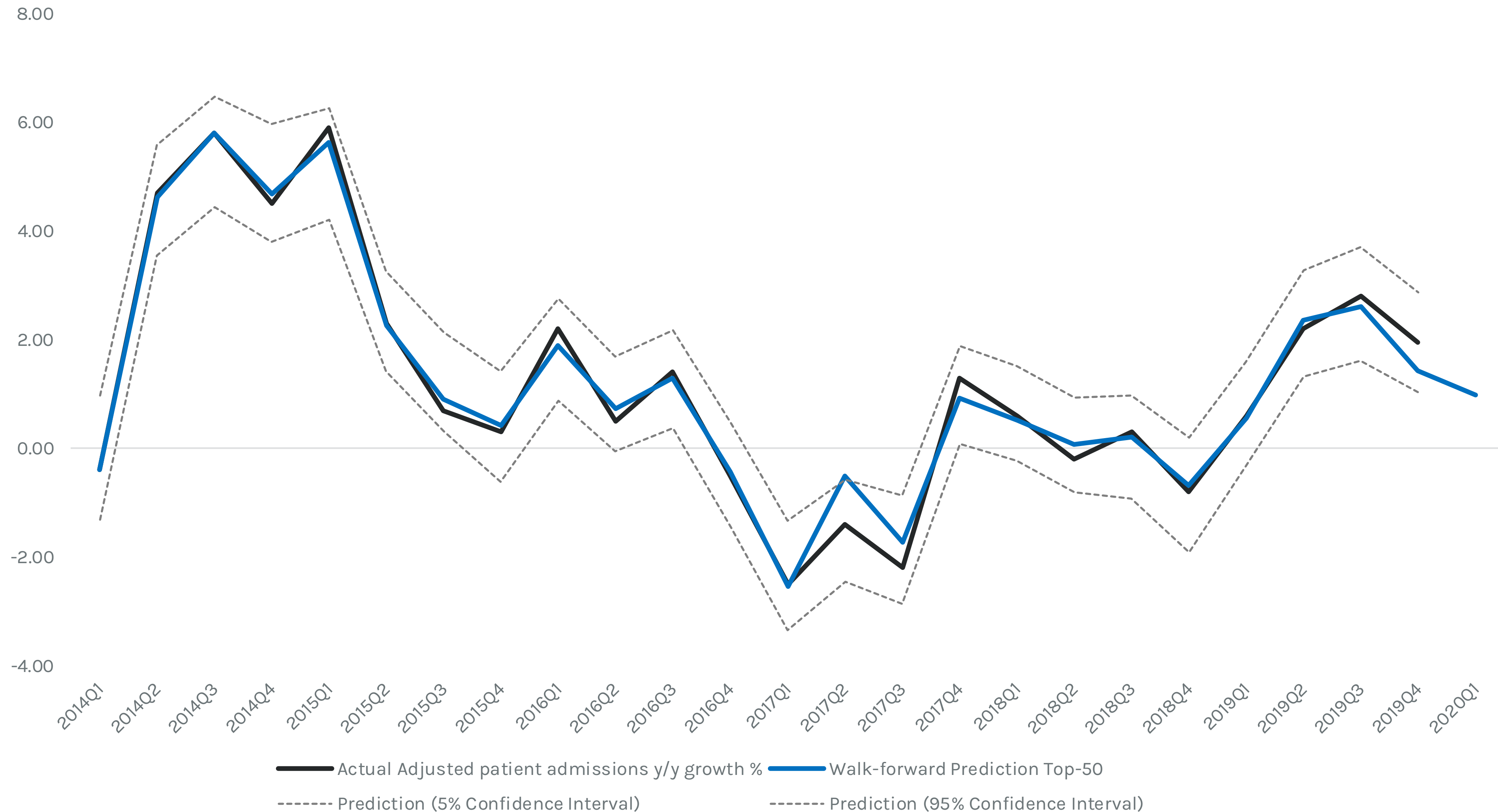
Adjusted Admissions – Hospital Volume Tracker (data pre-COVID-19)



Our Tracker should be sensitive to Adjusted Admissions as the economic slowdown ripples through the economy offset by rising COVID-19 cases.

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TDOC | App Downloads

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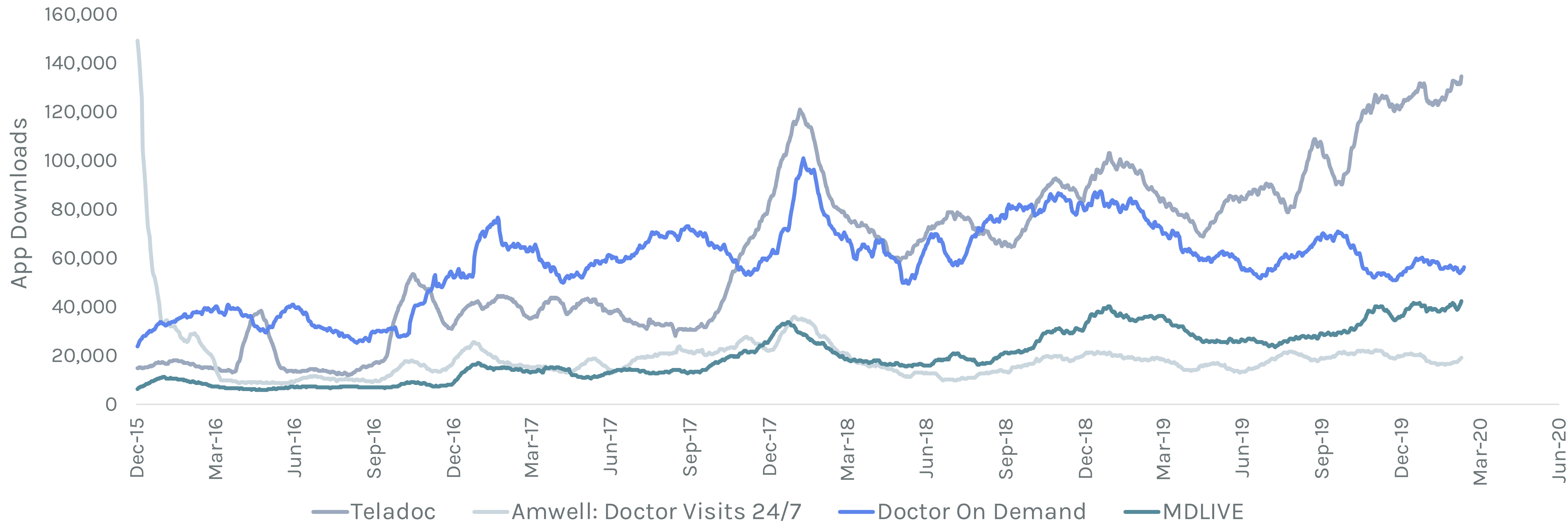
Teladoc outpacing rivals



TDOC is outpacing rivals since 4Q19.

Data Source: BLS, BEA, CDC, Hedgeye estimates

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TDOC | App Downloads

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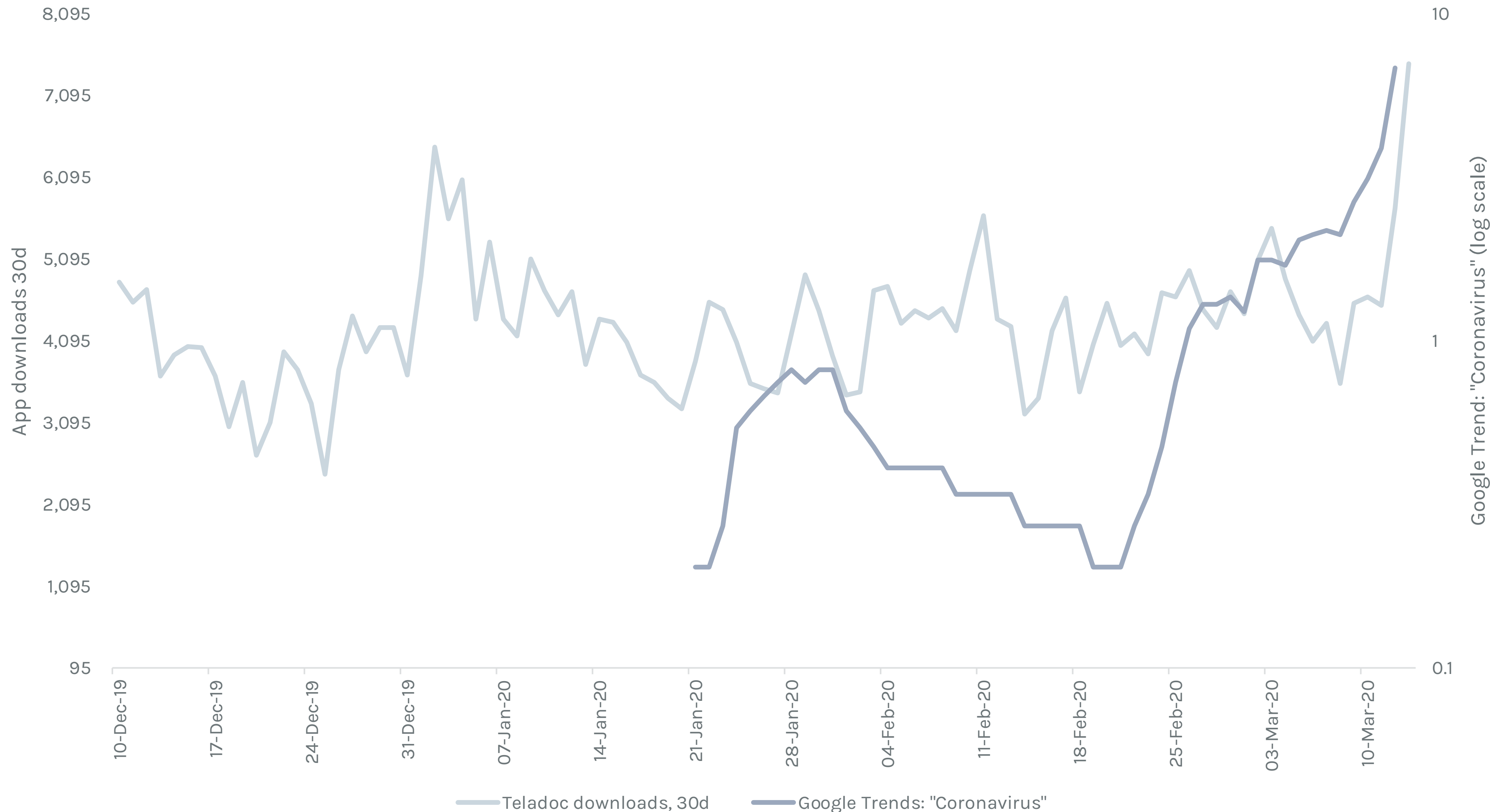
Coronavirus is ramping, shutting patients indoors and forcing them online



Google Trends on a log scale versus downloads.

"Teladoc Health Inc on Friday said it experienced a 50% spike in patient visit volume over the prior week, in what the telehealth company called an "unprecedented daily visit volume" in the United States, as the coronavirus spreads globally." - Reuters

Home bound patients will likely convert office-based care to TDOC's platform, some of which will be a permanent shift.

Data Source: SensorTower, Google Trends

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TDOC | Medical and Behavioral

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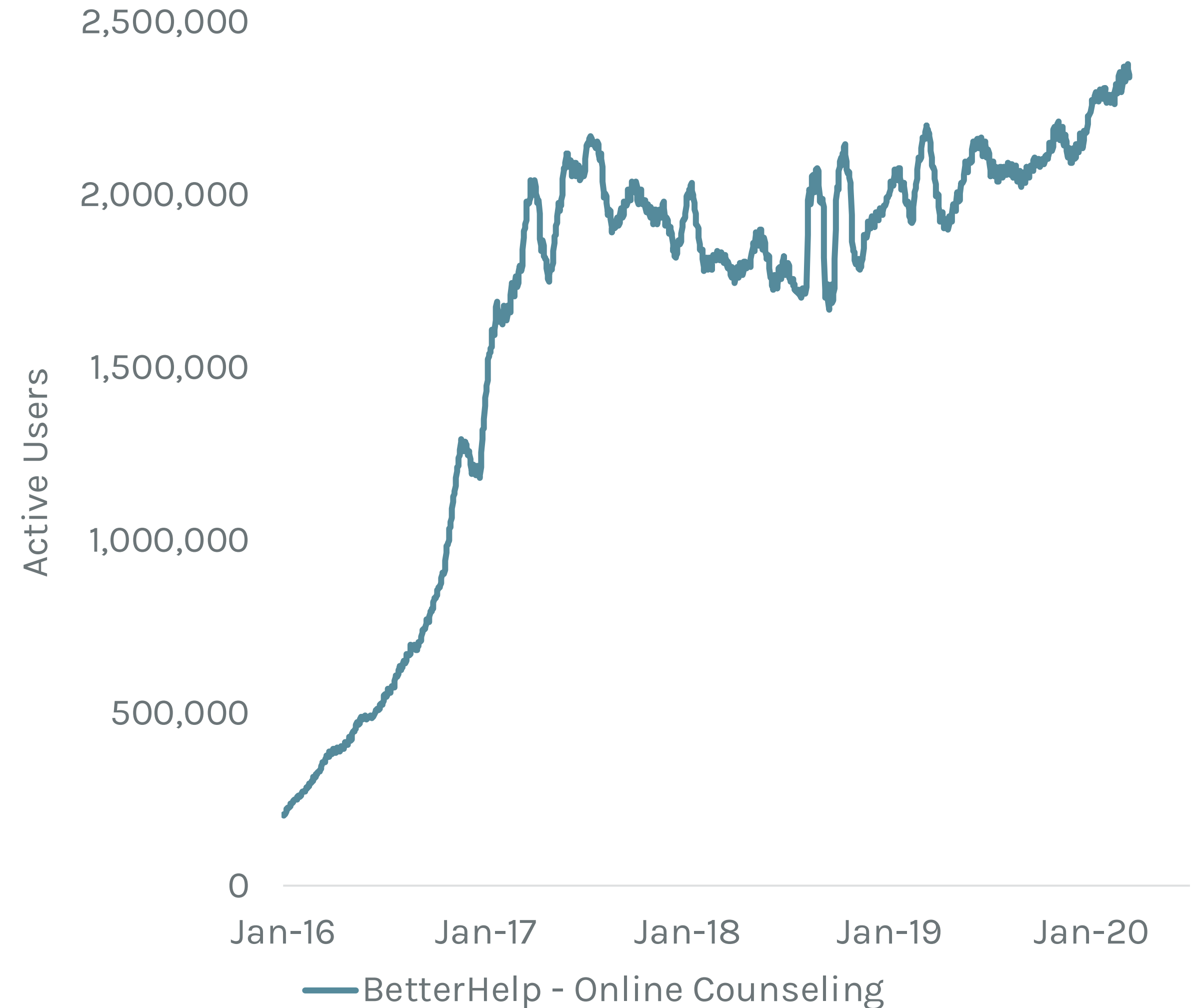
BetterHelp and mental health utilization is likely to increase alongside converting medical



Data Source: SensorTower

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TDOC | Potential Patient Volume is Large

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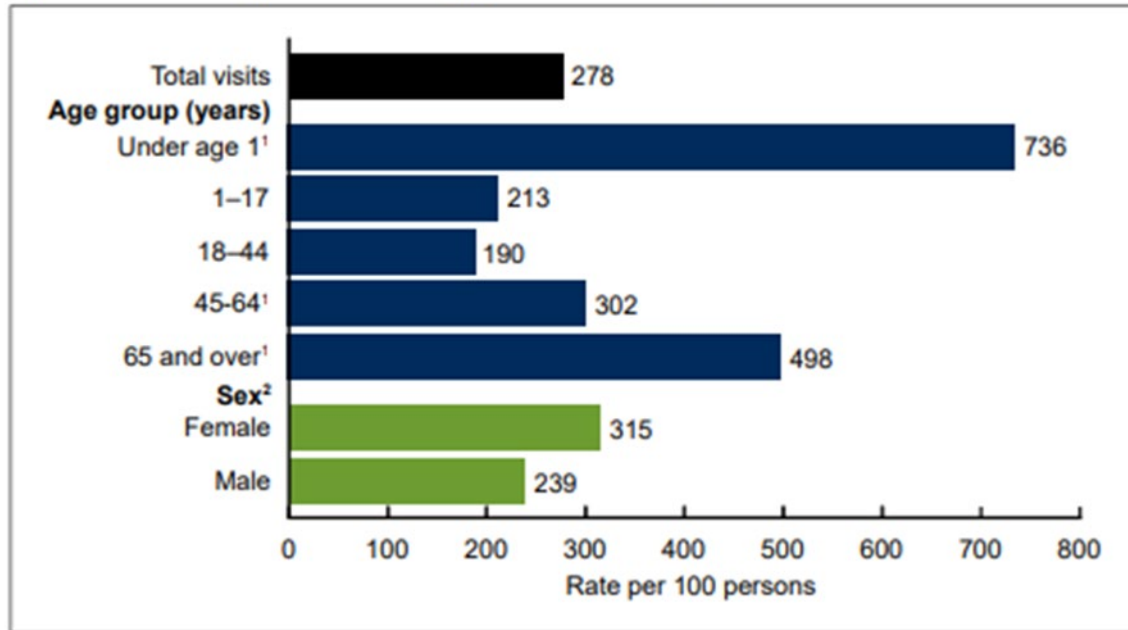
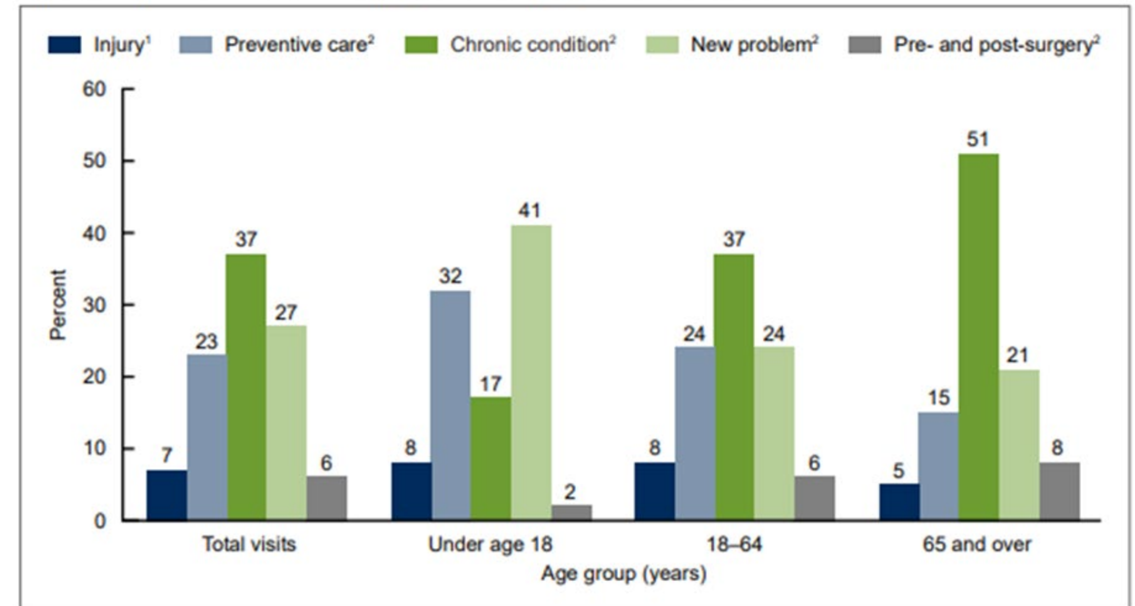
Current utilization levels ~4.0% based on ~3.0 visits per member

Figure 1. Visit rates, by selected demographics: United States, 2016



[1]Significant difference in estimates among all age groups.
[2]Significant difference in estimates between females and males.
NOTES: Visit rates are based on the July 1, 2016, set of estimates of the civilian noninstitutionalized population of the United States, as developed by the Population Division, U.S. Census Bureau. Total visits includes all visits by patients of all ages. For more information, see the 2016 National Ambulatory Medical Care Survey Documentation, ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc2016.pdf. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db331_tables-508.pdf#1.
SOURCE: NCHS, National Ambulatory Medical Care Survey, 2016.

Figure 3. Major reason for office-based physician visit, by age: United States, 2016



[1]Significant difference in estimates between those aged 65 and over and both those aged under 18 and those aged 18–64.
[2]Significant difference in estimates among all age groups.
NOTES: Provider-assessed major reason for visit was combined with injury to create a combined mutually exclusive reason for visit, with an injury visit having precedence over all other reasons. In 2016, the definition of injury changed due to the switch from using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) to the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD–10–CM) to code injury and poisoning diagnoses. Therefore, estimates for injury should not be considered comparable with previous years of injury estimates. Total visits includes all visits by patients of all ages. Numbers may not add to 100% due to rounding. Figures exclude 2.3% (weighted) of visits for which data were missing either injury or reason for visit. For more information, please see the 2016 NAMCS documentation, ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc2016.pdf. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db331_tables-508.pdf#3.
SOURCE: NCHS, National Ambulatory Medical Care Survey, 2016.

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TDOC | Valuation Multiple

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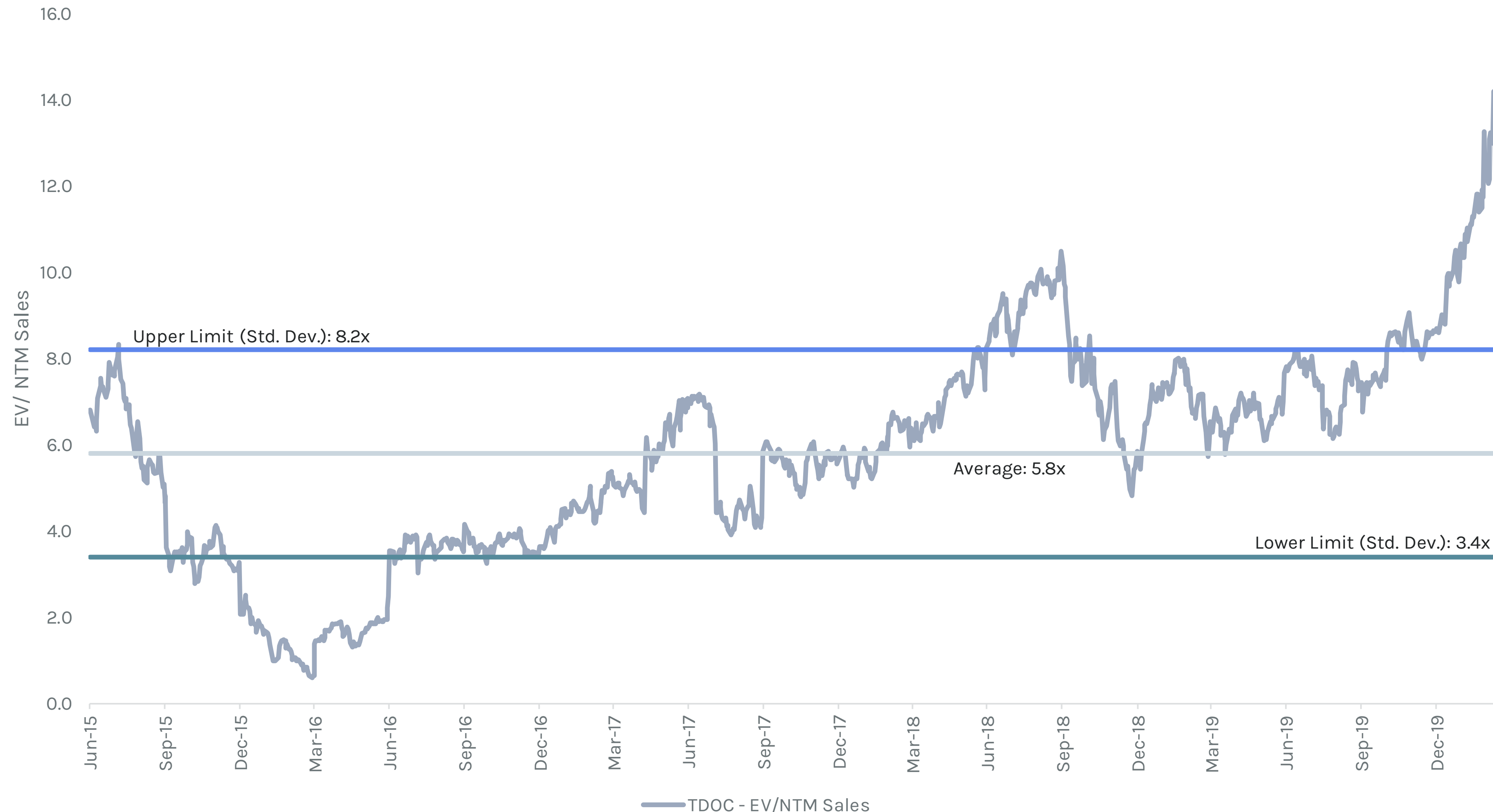
EV/NTM Sales



To get the shares back into previous EV/Sales ranges implies ~$1,300M in revenue compared to the guidance of $695-$705M.

Assuming $50 per visit, this gap equates to 12M visits, a utilization factor of 10.9% versus the reported 2.4%.

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