1Life Healthcare (Q1 2020 Earnings)
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Corporate Speakers

- Rose Salzwedel; 1Life Healthcare (One Medical); Director of Investor Relations
- Amir Dan Rubin; 1Life Healthcare (One Medical); Chair & CEO
- Bjorn Thaler; 1Life Healthcare (One Medical); CFO

Participants

- Ricky Goldwasser; Morgan Stanley; Analyst
- Sean Wieland; Piper Sandler & Co.; Analyst
- Lisa Gill; JP Morgan Chase & Co; Analyst
- Ralph Giacobbe; Citigroup Inc; Analyst
- Sandy Draper; SunTrust Robinson Humphrey, Inc.; Analyst
- Ryan Daniels; William Blair & Company L.L.C.; Analyst
- Matthew Gillmor; Robert W. Baird & Co. Incorporated; Analyst
- Unidentified Participant; ; Analyst

PRESENTATION

Operator: Ladies and gentlemen, thank you for standing by, and welcome to the 1Life Healthcare One Medical First Quarter 2020 Earnings Results Conference Call. (Operator Instructions)

I would now like to hand the conference to your speaker today, Rose Salzwedel, Director of Investor Relations. Please go ahead, ma'am.

Rose Salzwedel: Thank you, operator. Hello, and welcome to One Medical's Fiscal 2020 First Quarter Earnings Call. With me on the call today are Amir Dan Rubin, Chair, and CEO and President of One Medical; and Bjorn Thaler, Chief Financial Officer of One Medical.

A complete disclosure of our results can be found in our press release issued earlier today as well as in our related Form 8-K furnished to the SEC, all of which are available on our website at investor.onemedical.com.

As a reminder, today's call is being recorded, and a replay will be available on our website.

As part of our comments today, we will make forward-looking statements. These statements are based on management's current expectations, views and assumptions and are subject to various risks and uncertainties. Actual results may differ materially, and we disclaim any obligation to update any forward-looking statements or outlook.

Please refer to the risk factors in our annual report for the year ended December 31, 2019, as updated from time to time by our other reports and filings with the SEC, including our quarterly report for the three months ended March 31, 2020.

We believe that the COVID-19 crisis creates particular complexity when it comes to providing a forward-looking view of the business, and we are providing our guidance on a good faith basis per recent SEC recommendation. We would like to specifically caution investors that our future performance will be harder to predict for the foreseeable future given the crisis.

Our forward-looking statements are based on assumptions that we believe are reasonable as of today's date, May 13, 2020. Of note, it is One Medical's policy to neither reiterate nor adjust the financial guidance provided on today's call unless it is also done through a public disclosure such as a press release or through the filing of a Form 8-K.

Today, we will also discuss non-GAAP metrics that we believe can aid in the understanding of our financial results. A historical reconciliation to comparable GAAP metrics can be found in today's earnings release.

Finally, during the call, we may offer incremental metrics to provide greater insights into the dynamic of our business. These details may be onetime in nature, and we may or may not provide updates in the future.

And with that, I shall turn the call over to Amir and Bjorn for their prepared remarks and to take your questions.

Amir Dan Rubin: Thank you, Rose, and thank you to everyone joining us on today's call. We hope all of you in here are doing as well as can be during these extraordinary times.

Let me open today by thanking our entire team for their dedication during this time of COVID-19. Our providers have donned PPE and delivered essential health care and testing services to those in need. They have continued to see patients in office when appropriate and now also through scheduled remote visits.

Our team has engaged with hundreds of thousands of members digitally, arranged for COVID-19 testing services, collected specimens, conducted video chats and virtually followed up with patients on results and any care needs. We have advanced our platform to launch scheduled remote visits, expanded our virtual behavioral health solution and stood up our One Medical Healthy Together worksite reentry screening program. Our enterprise sales and marketing efforts have brought on more employer accounts and members, and have arranged partnerships with local governments and businesses to serve people in the community.

With our health network partners, we have advanced our integration, opened a new market and even had some of our providers volunteer to work in partner hospitals. As the

virus has impacted society, we have been there to help our members, employers, partners and communities to quickly get the care they need and also be positioned for worksite reentry. While our January IPO feels so long ago, let me also congratulate our entire team on our first quarter as a public company.

Our momentum entering the year during ordinary times combined with our model's power during these extraordinary times drove our strong financial performance in Q1. We ended the quarter with 455,000 members, up 25% year-over-year and well ahead of our expectations. As our Q2 membership guide implies, we are on track to add more members in the first half of this year than any other first half in our history.

Turning to our Q1 P&L. We delivered net revenue of $78.8 million, also up 25% year-over-year. We delivered care margin of $27.2 million and adjusted EBITDA loss of $13.5 million. We had a very strong start in January and February, and we were pleased to deliver these results despite the evolving impact of COVID-19.

Please keep in mind, as discussed on our last call, that we began to feel the financial impact of COVID-19 only in the final few weeks of Q1 when governments enacted shelter-in-place order and also restricted nonessential health care services. As Bjorn will discuss further, while our Q2 guidance reflects a larger financial headwind from extended quarantines and self-isolation practices, during this time, we are uniquely demonstrating the power of our model and continue to increase market awareness and accelerate our membership base.

Let me turn to how our model has performed during both ordinary and extraordinary times. Since our last call, we have extended our digital solution, expanded in-person care and testing services, grown our geographic reach, added more members and enterprise relationships, advanced our health network partnerships, began new ways to support testing in the community, and launched our worksite reentry program.

Delving into our digital platform, we have long provided synchronous video chats and asynchronous assessments and messaging. We further embedded COVID-19 symptom assessments for members within our mobile app providing frictionless access to screening. As COVID-19 concerns spiked, nearly 0.25 million members sought care digitally with us over the span of several weeks. Our platform allowed us to quickly digitally assess symptoms, schedule specimen collection for testing as needed, and follow up on test results and care plans.

In late Q1, our digital platform expanded to offer remote visits. With remote visits, members can now schedule billable video appointments with their primary care providers supporting continuity of care and social distancing. While still early, we have seen great initial uptake and plan on continuing these services into the future.

Through our mindset by One Medical offering, we have expanded our virtual and in-person behavioral health suite embedded in our primary care model to serve employers seeking further support for employee stress, anxiety, depression and insomnia.

Turning to in-person care, we have continued seeing members in our medical offices to deliver essential care. Moreover, in the midst of COVID-19 in March, we opened our doors for the first time in Portland, Oregon, delivering care to a new market for us. Across all our communities, we have designated select offices as respiratory care clinics, separating patients symptomatic of upper respiratory infections from those with other needs. We're also well equipped to deliver outpatient COVID-19 treatments and vaccines when they should become available.

In regards to COVID-19 testing, as discussed on our last call, we have meaningfully mobilized to serve our communities. Our model was inherently built to move quickly. We can digitally screen, provide in-patient -- in-person care and testing services, and follow up on test results and care plans, in short, supporting our members through a spectrum of COVID-19 care needs.

In a matter of weeks, we stood up 18 mobile testing sites, along with in-office testing locations across our markets. In Q1, our testing services focused on symptomatic and high-risk individuals in parallel with CDC guidelines. In Q2, as the CDC broadened testing guidelines, we expanded testing to frontline responders and essential workers. We also announced partnerships with the mayors of New York City and San Francisco to support high-risk populations and other essential health workers. These community engagement efforts allowed us to offer free screening and testing services to those in need while extending our community presence and brand awareness.

Let me also now acknowledge the valiant efforts of our health network partners. Community shelter-in-place requirements reduced not just our visit revenue but also the primary care visit revenue our health network partners are able to generate from One Medical members through our partnership arrangements with them. Moreover, as they position themselves to care for potential influx of COVID-19 patients, they canceled profitable elective volumes to create surge capacity. In places such as New York City, where this influx became overwhelming, many of our providers signed up to volunteer in the wards and emergency rooms at the hospitals of our partner, Mount Sinai, continuing to work there through today.

During these months, we have also advanced our clinical and digital integration with our new partner, Mass General Brigham, and have begun our launch efforts in Austin, Texas with our partner, Ascension Healthcare. Moreover, in March, we launched our newest market, Portland, Oregon, in partnership with Providence St. Joseph Health.

We also continued growing our enterprise business. We see tremendous demand from employers, both new and existing. We continue to sell to a diverse set of employers, and in Q1, we began new relationships in industries across financial services, transportation, health care, media, the nonprofit sector and professional services.

During this extraordinary time, we launched our One Medical Healthy Together worksite reentry program to support employers as they begin to transition workforces back into

shared environments. Through our program, we can virtually screen employees for key symptoms and clinical risk factors, offer testing services and support ongoing digital screening, further testing and follow-up care as needed.

Furthermore, as previously noted, we expanded our mindset by One Medical behavioral health services to further support employee mental and emotional well-being every day and during these extraordinary times when stress, anxiety, depression and insomnia needs are heightened.

As our nation looks ahead to uncertain times, our value proposition to employers has never been stronger. We recently shared the results of a peer-reviewed study published in JAMA, the Journal of the American Medical Association, JAMA Network Open. This study found that our membership-based primary care model combining virtual, near-site and worksite services saved one of our employers 45% in total health care costs.

Employees who had utilized the One Medical model, including those with chronic conditions, had lower overall health spending on a risk-adjusted basis, equating to employer savings of $167 per member per month. By offering an effective health care home base for employees with both virtual and in-person primary care, we can help eliminate avoidable and expensive downstream care and reduce overall health benefit costs.

During our IPO, we highlighted our mission to transform health care for all of our key stakeholders, including consumers, employers, providers and health network partners. And we shared how our human-centered and technology-powered model could deliver better health, better care and lower cost. Since then, we have launched COVID digital assessments, remote billable visits, COVID testing and expanded behavioral health services. We've continued to delivering NPS scores in the 90s while accelerating our membership growth. We've demonstrated significant employer savings in a peer-reviewed JAMA article and launched our One Medical Healthy Together worksite reentry program. We've collaborated closely with our health network partners and even opened to a new market in Portland during this time. Furthermore, our balance sheet remains strong with ample liquidity and very little debt, supporting our ability to invest in serving our members. While the full extent of COVID-19 on our financials continues to be uncertain, we are even more optimistic about the impacts we can make for all key stakeholders and the long-term tailwinds for our company.

With that, we thank you for your continued support and partnership and our mission. Now let me turn it over to Bjorn, our Chief Financial Officer.

Bjorn Thaler: Thank you, Amir, and good to be with everyone. Despite unprecedented times, we are pleased to deliver strong Q1 results. This reflects strong momentum in January and February and better-than-anticipated performance in March when COVID-19 began to impact our financials. As previewed on our last call, COVID-19 has driven an acceleration in membership growth while, at the same time, creating near-term revenue headwinds. While we face uncertainty, particularly in Q2, we believe our

collective initiatives can position us to emerge from the pandemic with more members, more brand loyalty, a broader portfolio of services and lower capital intensity, all of which should provide long-term tailwinds to both revenue and margins.

Now let me discuss our Q1 results, the impact of COVID-19 on our financials and our current outlook. In Q1, we accelerated our membership growth to 25% year-over-year, ending the quarter with 455,000 members. We were tracking favorably against our membership projections throughout January and February with even stronger acceleration in March. This organic acceleration highlights our value proposition to both enterprise clients and consumer members. To be clear, this membership count excludes any short-term or free community memberships to facilitate testing.

Turning to revenue. In total, we delivered $78.8 million in net revenue in Q1, up 25% year-over-year. This includes membership revenue of $15.2 million, which grew 27% year-over-year. We delivered net patient service revenue of $34.1 million and partnership revenue of $29.5 million. Collectively, these two revenue streams grew 25% year-over-year driven by our growing membership base and the momentum we had entering the quarter. As you know, both net patient service revenue and partnership revenue ultimately result from us providing primary care to our members. And as mentioned on our last earnings call, we had strong utilization of our services in January and February within office utilization and corresponding revenue declining in March due to COVID and community quarantines.

Moving down the P&L. We delivered Q1 care margin of $27.2 million or 35% of net revenue. We did not incur material increases in Q1 expenses as a result of COVID-19, but we did see a reduction of revenue going into March as I mentioned earlier. Our Q1 care margin also reflects our expansion into Portland as well as the opening of additional offices across our markets.

In terms of operating expenses below the cost of care line, this past quarter reflects the continued investments we made to fuel growth and final preparations to be a public company, which we became on January 31. As previously shared, we expect these investments to be largely fixed, and we expect to see efficiencies as we grow. As a result of the COVID-19 revenue headwinds and those investments, our Q1 adjusted EBITDA was a loss of $13.5 million.

Lastly, following our IPO in January, our Q1 balance sheet is exceptionally strong. We ended Q1 with $375.4 million of cash and short-term marketable securities and only $2.2 million of debt. We have ample capital to continue to fuel responsible growth and take advantage of the current dislocation in the market.

Let me now take a few minutes to discuss the COVID-19 impact on our financials as there are several dynamic factors. These include the current utilization mix of our services, the evolving reimbursement landscape as well as our capital preservation plans.

Starting with utilization. Our in-office volumes continued to decline into early April before settling into a suppressed level. However, we launched billable remote visits in late March and have seen accelerating week-over-week adoption. We are equally seeing increased COVID-19 testing visits as guidelines have broadened. During April, our total utilization across all billable services, which includes in-office volumes, remote visits and COVID-19 testing, averaged approximately 55% of pre-COVID levels. And beginning in early May, we have seen a further increase in those total billable visits.

Let me also quickly discuss the reimbursement landscape for remote visits and COVID-19 testing. With recent regulatory changes, remote visits are currently reimbursed at equivalent rates to similar in-office visits. That said, remote visits do not involve procedures or the administration of services like vaccines or reproductive care. For this reason, the average remote visit typically results in a lower average fee-for-service reimbursement. Finally, average reimbursement for COVID-19 testing is typically lower than average reimbursement for both remote visits and in-office visits.

Turning to our capital preservation strategy. We have enacted several cost-saving initiatives with additional options to deploy should COVID-19 headwinds persist for some time. As COVID-19 started to emerge, we had immediately cut most discretionary spending. In addition, we have stopped hiring for almost all nonclinical roles, and we are also judiciously managing our variable costs, including marketing. While we are spending more on COVID-19-specific PPE and materials, we are working to offset that with other cost-saving initiatives while staying true to our mission.

Further, we are actively reviewing our clinical real estate footprint. A positive outcome of launching remote visits and changing demand patterns for in-person care is that we have an opportunity to further optimize our office footprint and provider staffing model. Over time, we may increase the number of providers we staff per office with providers working some shifts in office and some shifts remotely. Long term, this may reduce our physical footprint per member. We now expect to open 20 to 25 new offices in 2020, having deferred some offices that were due to open in the latter half of the year into 2021. As I turn to guidance, we expect to finish Q2 with total membership between 465,000 to 475,000 members, which continues to show our strong and growing value proposition to consumers and enterprise customers.

Turning to revenue. We continue to expect an influx from deferred care at the appropriate time, although we cannot predict when and how sharply our in-office volumes will return. This will include care for chronic disease management, cancer screening, reproductive health, behavioral health and wellness visits to name a few. In the long term, COVID-19 may also drive an influx of demand for future vaccinations or other treatments.

Having said that, some of our largest geographies, including the San Francisco Bay Area and New York City, continue to have strict shelter-in-place orders in effect. Yet, as COVID-19 has meaningfully accelerated demand for virtual services, we expect long-term tailwinds from remote visits as Amir mentioned earlier.

Acknowledging these uncertainties, we expect to deliver Q2 revenue between $56 million and $66 million. This range is based on a variety of scenarios from the uncertainties I just mentioned, such as the timing for and amount of pent-up demand, and the scope and duration of shelter-in-place orders in our markets. In addition, some of the swing factors that could influence our Q2 results include the reimbursement rate for COVID-19 and virtual visits, compensation for the uninsured care we continue to provide, return-to-work screening and testing, and the financial strain of our health network partners to name a few.

Turning to profitability. We continue to service strong demand for virtual services and COVID-19 care and are preparing for the previously mentioned pent-up demand for in-office visits, and continue to sign up new members. As a result, we have not furloughed or laid off any employees. We, therefore, expect to deliver Q2 care margin between $1 million and $11 million and Q2 adjusted EBITDA between a loss of $36 million and a loss of $26 million. These ranges reflect our revenue guidance, our largely fixed cost profile and the incremental costs for COVID-19 care offset by our cost reduction initiatives.

For the full year 2020, we continue to see strong interest in our model. In particular, we are having conversations with more employers than ever before with a very robust and growing pipeline. As Amir mentioned, we are on track to have the strongest first half of net new members in our history. Even with rising levels of unemployment, we remain confident in our value proposition to members. As a result, we are raising our 2020 membership guidance and we now expect to end 2020 with a membership count between 500,000 to 515,000 members.

From a P&L perspective, we are not providing 2020 guidance given the uncertainty surrounding COVID. However, we believe Q2 will represent a trough and that both Q3 and Q4 will sequentially improve. We are in a unique time to demonstrate the power of our model, accelerating our membership growth, increasing brand loyalty and driving diverse product adoption. We believe these factors will provide long-term tailwinds to our revenue and margins. We equally remain confident that we can deliver the attractive long-term financial targets that we previewed during our IPO.

Before I close, I want to express my sincere gratitude to all of our team members who have been working under ever-changing conditions, some of them side by side with our hospital system partners, some of them on the front lines of COVID-19 testing and care and others seamlessly adjusting to remote work environments. There is no other team I would rather navigate these times with than the One Medical team.

Thank you for joining our call today. With that, we'd be happy to take your questions.

QUESTIONS AND ANSWERS

Operator: (Operator Instructions) Our first question comes from Ricky Goldwasser with Morgan Stanley.

Ricky Goldwasser: My question is around 2Q guide. I mean, obviously, it's a wide range, and there's a range of potential scenarios here in a highly dynamic environment. But maybe you can give us some context when we think about the high end of the guidance of $66 million. What are the recovery assumptions that you're making at the high end versus low end?

Bjorn Thaler: Yes. Ricky, thanks, and it's been an interesting couple of weeks, certainly, for our friends in New York, so our thoughts are with you and your friends as well. As I think about the guidance, obviously, there are lots of different swing factors here that could get us to the higher end of the guidance versus to the lower end of the guidance. And we acknowledged some of those in the call, right?

Obviously, when I think about our largest markets, which include certainly San Francisco and also New York. We are still under pretty strict shelter-in-place guidelines. So obviously, how and when these get lifted is certainly one of the swing factors here that we think about. And then there are other things as well like return-to-work testing that could move the numbers one way or the other. And then last but not least, as you know, we have big relationships with the city of San Francisco, with the city of New York to really help them, from a community perspective, to get as many folks tested as possible. And the reimbursement for those tests, frankly, varies by geography and varies by member. For some of those, we get paid through the local municipalities. In other locations, we bill insurance. And then we also opened our doors for many folks who don't have insurance and that this is about getting tested, and we'll figure out the reimbursement between the federal government and the states and the local governments later.

So there are a lot of different swing factors that could move us in our Q2 guidance one way or the other.

Ricky Goldwasser: Okay. So maybe -- and understood. So maybe help us, as a follow-up, just kind of think about, as we go through the P&L, kind of like the care margin. The care margin obviously came in below where we were, we understand, kind of like the fixed cost component of the business. But what type of utilization increase do you need to see in order to go -- to see care margins going -- coming back to more normalized levels. Given your commentary also about how you're rethinking footprint versus number of physicians.

Bjorn Thaler: Yes. Great question. And actually, let me provide a little more detail there on sort of the first quarter and our margin there. So as I think about the first quarter impact, I know at our last call we talked about a $6 million to $8 million impact of COVID on Q1 expected. The reality is that we probably came in -- and it's hard to estimate, but we probably came in towards the lower end of that range. So to some extent, if you wanted to understand the run rate of the business going into COVID, you probably have to think about normalizing for that COVID impact.

Having said that, most of our headwind right now is coming from the lower fee-for-service revenue as we discussed. So most of the impact on our care margin is really simply the result of a reduction in revenue.

Operator: (Operator Instructions) Our next question comes from Sean Wieland with Piper Sandler.

Sean Wieland: What makes a telemedicine encounter billable versus non-billable? And if you could describe the environment on pricing parity on the billables and the -- on how long you expect that to stick around?

Amir Dan Rubin: Thank, Sean. It's Amir, and thanks for the question and your participation today. As you know, our model combines digital health and in-person care and testing. And historically, we had an on-demand digital health approach that included on-demand asynchronous messaging and chat structured questionnaires, like our COVID questionnaire now as well as an on-demand video chat and that we had part of our membership model. We have now added scheduled elective remote visits with primary care providers. And those we are billing to insurance and that's just how we've handled it in our model. There is nothing there that could not have been built previously to insurance. We have just begun that program now.

Operator: Our next question comes from Lisa Gill with JPMorgan.

Lisa Gill: I just want to follow up on that, Amir, just to understand as we think about billing for those visits. And I think you made a comment that post-COVID, you're looking at the business and looking at virtual care and how you'll provide virtual care in the new environment. Is your anticipation that the health plans will continue to pay a similar rate to what you have today and that there'll be a combination of, hey, we can do this in a virtual care setting but I need to get my annual vaccines, so then I'm going to come into the office for that. And then secondly, as we think about behavioral health and your Mindset product, how do we think about how you're billing for that and getting paid for that product as well.

Amir Dan Rubin: Yes. Great. Thank you, Lisa. So on the remote visits, we are billing them to insurance, and they are being reimbursed. It's hard for us to know should reimbursement change in the future. But as Bjorn mentioned in his comments, of course, during those visits, one isn't doing procedures; one isn't doing IV insertions; one isn't doing pap smears; one isn't doing others, suturing or suture removal.

So the overall intensity of some of those remote visits is less, and thus, what can be done in those remote visits is not equivalent necessarily that what one can do in person. Of course, in person, we're also doing testing in full PPE, both in our drive-thru, walk-through and in-office locations.

And then ultimately, we hope to have some therapeutics and eventually a vaccine that would also be delivered in person. But -- so we are billing for those. They are tending to be less -- of lesser intensity than other areas -- than in person.

In terms of the One Medical Mindset, this is a suite of behavioral health services that is embedded in our primary care. And the nice thing here is we already have longitudinal relationships with our members, so our members can engage with One Medical. They could get on the app. They could book an appointment with their primary care provider, including around behavioral health issues.

We also have group visits, including virtual group visits that are billed under a medical benefit. We have health coaching including virtual coaching. That is typically run through claims systems for self-insured employers but also has a case or an individual billing approach. We also have therapists, including on-site at employers as well as virtual therapists that are billed also typically through insurance. So we have a full range of approaches that fit within the insurance frameworks, but in particular, it fits within the primary care model. And so this is a natural continuation of care.

And thus, what we find is we can avoid actually a lot of the higher cost of referring out to specialists and subspecialists that you might see in other models that are just purely sending to therapists because we can handle a lot in our model. And then using our membership model in between these sessions, we can have asynchronous communications and follow-up check-ins. We also screen for anxiety and depression, and so we can stay on top of kind of a population's health over time.

Operator: Our next question comes from Ralph Giacobbe with Citi.

Ralph Giacobbe: Can you talk a little bit about your health system partners? And any discussions or changes with the structure of the economics? I'd imagine, given the struggles of hospitals, those that pay you upfront may want to revisit that. Or is that just not the case? And just remind us how are contracts set. Are they annual? Or -- just how are they structured?

Amir Dan Rubin: Yes. Thanks, Ralph. Yes. The strategic premise of health networks to partner with us as -- is as large as ever. We delivered 95-plus percent commercial payer mix. We put up the capital and staff to launch offices. We build and provide the technology, the virtual care, the remote access. We do the testing services. We attract members, and we developed direct-to-employer relationships. Our partners pay us for these services on a pay-as-you-go basis whether that is through a fee-for-service arrangement or a per member per month arrangement. A testament to the power of these partnerships is the fact that we're in ongoing discussions with several new potential partners in the midst of this pandemic.

Now we acknowledge that COVID has not only put a strain on our financials but also on the financials of health systems. And we acknowledge that COVID has reduced visits from our members not just in our fee-for-service markets but also in markets where we

collect the visit revenue on behalf of our health network partners when they pay out a PMPM. So as a result, we can see some health networks ask us for some consideration here given the unprecedented fluctuation in visit volumes, and thus, our guidance reflects this expectation. Yet overall the power of these partnerships and our long-term financial targets remain intact.

Ralph Giacobbe: Okay. Can you all quantify, I mean, how -- is it meaningful? Or, no in terms of those that have come back? It sounds like some have come back and want some trade-off or some money back relative to the fee upfront, unless I'm misunderstanding that.

Amir Dan Rubin: Yes, I did not say that. And so what I would say is just we recognize that there is a strain on their financials, and so we could see the potential for some of them to ask for some consideration, and this is reflected in our guidance.

Operator: Our next question comes from Sandy Draper with SunTrust.

Sandy Draper: I guess more on the expense side of the equation versus the revenue side. Has there been any change in thoughts -- you talked about, Bjorn, discretionary expenditures have come down, no new hire spend. I'm trying to think on the sales and marketing side. If I remember correctly, you had a fairly aggressive sales and marketing budget, especially in the first half of this year. As you're opening up your new markets, you wanted to drive volume there. Has there been changes in terms of your thoughts on the sales and marketing line and stuff you may hold back there, dial it back and push forward into 2021? Just sort of any thoughts about how we should be thinking about the sales and marketing expenditures going forward?

Bjorn Thaler: Yes. Thank you, Sandy. Great question. I think, of course, we are looking at all of our expenses, and as you heard from me earlier, marketing was one of them where, to your point, we had an aggressive plan, particularly earlier in the year that we started to look at and really reduced as COVID increasingly impacted our financials and our revenue. The model that we have, obviously, it does have a fairly large overall fixed cost basis. So as our revenues go down, from a care margin perspective, it's difficult to take immediate action. And in fairness, we actually think that there is going to be a fair amount of pent-up demand that we are standing ready to serve and that we fully expect will further drive our relationships with our customers and will really drive revenue.

So as we are staffing up to take advantage of the current dislocation in the market, obviously, below the care margin line, this is where we are starting to really look at our cost profile. And as I mentioned, we've immediately cut most discretionary spending, including marketing, and we've also reduced our costs. We reduced our hiring for nonclinical staff almost to zero, and we've done another couple of things to really reduce our SG&A spend overall.

Operator: Our next question comes from Ryan Daniels with William Blair.

Ryan Daniels: Wanted to speak to the 20 to 25 office locations. I guess my curiosity stems around if you're revisiting the actual longer-term need for a physical footprint given the increased awareness and utilization and success of telehealth or if that's more of a near-term initiative really just to preserve capital and protect the care margins given the current environment.

Bjorn Thaler: Yes, I can start that one, and Amir, feel free to jump in here. Yes. As you heard, we have started to push out some leases for offices that were due to launch at the latter half of this year into 2021. So in the near term, that's definitely one of our capital preservation mechanisms that we started to deploy. Having said that, we always said that offices are a part of our value proposition, but they are not the only part of our value proposition. This is why our measure of value, our measure of unit is really the member and not the number of offices because our members can have virtual interactions with us now increasing in billable remote visits or they come and visit any office that they want. We continue to believe that, that is an important part of our value proposition. So as we enter a new market, we will continue to develop a real estate footprint that actually helps us cover those members if and when they want to come in to get in-person care.

Yet at the same time, depending on how long-term demand patterns change, obviously, we are able to take care of more and more members virtually with remote visits. So you can easily see a scenario here where, on an average basis, we take care of more members in a specific geography with less offices because, while we need the offices to be present and offer the in-office opportunity, more and more members will take us up on the remote visits, which means that we can have more providers service more members with the same amount of office footprint.

Operator: Our next question comes from Matthew Gillmor with Baird.

Matthew Gillmor: I wanted to ask about the JAMA study you did in partnership with Collective Health. It seemed like that was some of the more robust data that you've shared, and it was obviously fairly compelling. What's the next step you take with those results? Does that just serve as a great marketing tool? Or are you in a position where you could guarantee savings to some of these enterprises?

Amir Dan Rubin: Yes. Thanks, Matt. Just to reiterate, I think this is one of the more compelling studies out there, right? So this is in JAMA. This is in a peer-reviewed prestigious journal that showed that we can take out 45% of the cost through our model. So we think this is absolutely a groundbreaking study of the highest quality in the highest quality journal showing this kind of savings. And really, it comes from our unique model that combines a membership model where we engage longitudinally with members with our digital health, with our outbound digital population health, with our near-site offices. In this instance, there is also an on-site, and then the ongoing testing and virtual care. And so we see this as a tremendous opportunity to just further the value proposition to employers.

As Bjorn said, we're on track to add more members in the first half of this year than any first half of any year in our history. And now you can add on top of it very, very strong compelling data. We've always had case studies that showed that we can save money and improve productivity. Now we have kind of the highest journal level and strong publication. So we think this actually further enhances or supports and justifies the value proposition to employers. And shows that this model, our model, in particular, can save employers money, which we think will increasingly be an important proof point.

Operator: Once again, [Josh], if your line is muted, please unmute.

Unidentified Participant: Sorry about that. I didn't hear you call my name. I appreciate you guys taking the question. Two questions really for you. Bjorn, I think I heard you say April down 55%, so that's helpful versus the March numbers that you were talking about two months ago. Any sense on first two weeks of May? And then the second, is there a way to tell -- do you guys have a sense of membership adds that were really related to testing? I think you made a comment around not including short-term people that may have just signed up or paid a month or something. I know it's early to figure out if they're not going to pay going forward. But was there a sign up for membership at the point of testing? Is there some sort of way to gauge that number?

Bjorn Thaler: Yes. Thanks, Josh. So to your first question, just to put a little bit of a fine point on it. We actually saw volumes that averaged approximately 55% of pre-COVID levels in April. So they [weren't] down 55%, but they went down to 55%. And then, yes, in the beginning of early May, we certainly have seen an increase of those. Now I would caution you that we are sitting here on the 13th of May, right, so not even two weeks in. Certainly, the uptick that we've seen was helpful, and it's incorporated in our guidance. But I think it's too early to really quantify that just given where we are from a calendar perspective.

And then relative to your membership, so again, a couple of different things. One, as you think about our first quarter, the impact of sort of those short-term memberships or the revenue that's associated with them was really minimal, right? I mean we really started to see COVID impacts in the last two weeks of March. So there wasn't that much of an impact there. And even as we think about May so far, from a revenue perspective, the impact is relatively modest, and we are obviously not counting these members as -- or people who take advantage of our testing facilities as full-time members in our membership count.

Frankly, we view this much more as an opportunity to show that we do the right thing by the communities that we serve to get our name out there and to show people what a One Medical experience can look like. That is much more important for us as we do those things than in the near-term potential on the revenue side.

Amir Dan Rubin: Bjorn, maybe just to -- thank you, Josh. Maybe just to add, I think really what we're seeing now is just One Medical further strengthening its value proposition, right? We always had this 90-plus Net Promoter Score. We always engage

the consumers. Consumers often say we're their most loved benefit from their employers. For employers, we always help employers attract and retain employees, keep them productive. And we always showed that we can save money, and now we have this JAMA article further showing that. Now we're also showing we can support testing and helping during these extraordinary times. We're showing we can support return to work. We're showing that during this sheltering in place, there's even more ways to have longitudinal care with your primary care provider. So I think, overall, we're showing just greater value across all the key stakeholders that we serve.

Operator: I am not showing any further questions at this time. I would now like to turn the call back over to Amir Rubin for closing remarks.

Amir Dan Rubin: Well, great. Well, I want to thank everybody for your support of One Medical, for your engagement with us, for your great research and your great questions today, and we wish you all the health out there. And if we can help you with your health care needs, One Medical is here to serve. So be well, everybody, and we'll see you next time. Thanks, everyone.

Operator: Ladies and gentlemen, this concludes today's conference call. Thank you for participating. You may now disconnect.