Summary: White Glove House Call, a convenient mobile replacement for traditional office-based primary care needs and physicians.

Conclusion: Despite White Glove House Call's high growth rate and management team, its competitive advantage is limited by low barriers to entry. Additional concerns are health-related litigation and compliance with regulations. With currently available information, investment would not be prudent at this time. We need additional information discussed below and significant planning for contingencies involving future competition.

Value Proposition. Appears to be high--exceedingly low number of cancellations (almost 0), though it should be noted that 65% of their members are "business-affiliated" members that presumably have their membership fees paid by their employer, so the consumers themselves have little reason to cancel. Anecdotally, 10 homes in one neighborhood signing up for the service means word-of-mouth can sell the service. Businesses see great value: the low-overhead visits by insured consumers cost their plan much less. Consumers see cheap, fast doctor visits.

Competitive Advantage/Tech. Does not appear to be sustainable in short run until the brand name is ubiquitous (like, say, TiVO); large shortfalls compared to competition. Current competition (ER's, UCC's) has many disadvantages (costs of travel, inconvenience) but one primary advantage: care continuity from the same primary care physician who went to medical school, not a nurse practitioner. May be difficult to convert patients to this model. Another problem: if the model is successful, it can be copied easily despite their claims of proprietary software development. With their $200k startup costs per area, a competitor could start something similar to their product, spend another $300k on a web development team (a fairly large amount of web development—6 man-years at $50k/yr), and be up and running for half a million dollars in one area. Many doctors have this sort of capital accessible via a home equity line of credit; insurance companies and especially HMO's may enter the market themselves (low entry barriers). We should be prepared to spend a significant amount of money buying out competitors or driving them out by lowering costs, or by developing something that is truly difficult to replicate. Perhaps the "nationwide access" angle could be exploited to keep competitors out of the market once the business reached a critical mass (or at least to all major metro markets, covering most business travelers).

Market Opportunity. Massive potential market, but highly litigious area and large jury awards are possible. The business has tried to protect itself by making physicians independent contractors, but the nurse practitioners sound like employees, and they are the ones performing most of the services. Before investment, we need as much

information as possible on the likelihood of malpractice claims against the entity and amount of malpractice insurance carried. Texas tort reform caps noneconomic damages, but other states do not; this may slow expansion into other markets to capture their touted $500B total market size. Also, the market is highly regulated (ERISA, HIPAA, state health insurance codes, medical licensing boards). Ensuring complex regulatory compliance is a must to avoid fines and breaking state/federal law.

Management. Excellent current management experience in starting companies, especially with web component; physician is on the management team to shore up knowledge gaps.

Economics. Very favorable economies of scale, depending on average amount of usage. The business is partly an insurance company: a large, healthy customer base is key to the success of the business as unhealthy groups will overuse the service, creating losses. Ideal customer with 0 visits creates only $420 annual revenue, but customers using service 7+ times annually need to be cut. ERISA federal law may prevent "cherry picking" within a group insurance plan if an employer enrolls all employees. However, given existing number of customers over-using plan, this seems unlikely to be a problem on average: two visits annually is the average per member. This translates into $310 annual profit per member, assuming their $55 cost-per-visit number accounts for all variable and fixed costs of a visit. If this number only accounts for variable costs, then we would need to subtract those. This could significantly impact the bottom line, and should be clarified.

Partners. Reasonable partnerships & opportunities, though not astonishing. The Humana contract apparently was profitable and helpful to get a large number of members enrolled, but the terms of the contract were not disclosed. Since profit depends primarily on the membership fee, the contract needs to be examined closely—was Humana getting a discount? I would like to see long term partnerships with medium-to-large businesses or longer term agreements with a host of insurers. Tying themselves purely to Humana or one other insurer will limit their ability to capture the entire market.

Sales & Marketing. Improving sales and marketing approach. Direct-sales to business appears to have been moderately successful in the past, but recent allowing brokers to resell the service is an additional advantage. Lock-in of customers for 1 year is helpful, though few cancel anyway. Cost-per-customer-acquisition is unknown and should be disclosed.