*Doc Eifrig:* All right. Here we go. We're late because of that first guy, the first majestic guy. Thank you. I'll be here all day. All right. I'd like to introduce you to these two folks in case you don't know who they are.

Matt Weinschenk is a CFA holder, worked for Agora for a few years before he decided to come and work with me and my group, what we loosely call the retirement team. Matt has just been promoted to be head of Stansberry Research.

He's one of the sharpest guys I know and he's the reason all my stuff has actually looked good. So if there's a dip in quality the next couple of years, it's because Matt has become head of research. Nope. Thank you. Yeah.

*Male Participant:* \_\_\_\_\_.

*Doc Eifrig:* Yeah. Thank you, thank you.

*Male Participant:* \_\_\_\_\_.

*Doc Eifrig:* By the dip. Thank you. Thank you. On my right is Tom Carroll. Tom joined us three years ago and it was one of the most enjoyable interviews I've ever had, partly because he had experience what I would call on the investment banking and Wall Street side, and was interested in a change, and philosophically had kind of the same interests that we had.

And I don't think he believed me when I said you can kind of do whatever you want. You get to keep reading, you get to travel and you get to write. And I think he was most nervous like me about writing and he's excelled and we've got plans for him. What happened is about two months ago, Matt approached us and said, "Hey, would we sit on a panel to start before the editor's panel and just talk about healthcare?"

And so, I'm going to turn this over to our head of research, director of research, Matt Weinschenk, and I think we'll fly through it fast enough. We'll have Q&A. And I would say if you have Q&A, at least for me, normally I like to wait until the end.

But I think if we say something that you're concerned about or didn't hear just shout something out and we'll engage you. And I'll repeat the question to the recording group. So thanks.

*Matt Weinschenk:* Okay. Well, as an investor, I consider myself a generalist. I like to know a lot about a lot of things and try and find my investment opportunities that way. And that's a great way to operate. I think they say investing is the last liberal art. And I think a lot of you probably are curious people who like to know the way the world works and you express that through your investing. But also you need to know when to access the experts.

So we've got Doc and Tom and I get to go and talk to them all the time, whenever I want. And then I have ten new ideas to go back and Google and learn about. So I see some very exciting things happening in healthcare and biotechnology, we've been calling it a decade of biotech. And I wanted to maybe give you access to the conversations that I get to have because I find them so exciting.

So we thought we'd do this in a conversational form. So there are two main sections we're going to talk here about. I'm not moving here, is it moving out there? Okay. So when we talk about healthcare, there's really two distinct groups here.

There's life sciences, which is biology, biotech, medicine. And there is healthcare services, which is doctors, hospitals, insurance companies, and more digital technology.

So we're gonna talk about both of those sort of one at a time. But they work together, but they are pretty distinct. But the first thing I wanna do is just say, Tom you've devoted your investing career very specifically to healthcare and Doc, you've sort of devoted your life to healthcare in the same way.

So Tom, can you give me your two minute pitch? Why is knowing about healthcare investing so important and particularly today?

*Tom Carroll:* Just two minutes, that's it?

*Matt Weinschenk:* You can have five.

*Tom Carroll:* All right. I got cut short yesterday too. I grew up in a healthcare family, so I've been kind of indoctrinated in it my whole life, and have heard from the very start we are all customers in this industry. It is full of emotion, it is full of money, as we all know, and it is full of inefficiency and it's complicated.

Those four things mixed up together make a perfect environment for investing. And healthcare is not two percent of the economy, we're at 18 and a half, 19 percent right now. So my belief is you could spend your entire investing life as I have just in healthcare and be perfectly fine and see great returns.

And I showed some slides yesterday about companies like United Healthcare, which was a small cap stock when I started recommending it and today it's the number one weighted stock in the Dow.

So it's just an amazing industry. Again, it's something that we as, forget investors, but just we as human beings should have a much better understanding of the system in which we get services, how we pay for it, to make us better decision makers, such that when we need the system and perhaps we need it urgently, we don't have to rapidly think and make decisions in two or three minutes that might not be the best for our lives physically and certainly our wallets.

So that's why really I have devoted my entire career to healthcare on the finance side, primarily. I remember years ago my mother said, "You don't wanna go to medical school, you wanna go into the finance side of healthcare." And I remember listening to her and thanking her years later still for that. So how's that, is that two minutes?

*Matt Weinschenk:* That is wonderful, yeah. And I think within healthcare you can find value stocks, dividend stocks, growth, you can get defensive, you can find companies with huge economic moats that can't be competed with, you can find disruptors.

So really whatever you're looking for, I think you can find in the healthcare space as an investor. What I'd like to do now is I'd like to give you guys my pitch for why we're gonna see a boom in medical science. And you're gonna let me know if I'm crazy or if I'm on the right track. Ready?

*Doc Eifrig:* I don't get two minutes?

*Matt Weinschenk:* You can have five minutes. All right. So I think we're entering an era of an accelerated rate of change in biotechnology. And I'm gonna come at this from two angles. I'm gonna come at it from the capital side and then the science side.

So on the capital side biotech or, let me skip ahead here, biotech or healthcare is a capital intensive industry. If you're trying to discover a drug, you've gotta put in hundreds of millions of dollars, you wait a few years to see if it even comes back. But we've been in now an era for two decades the era of cheap capital.

There's too much money sloshing around low interest rates and it's looking for something to go. So it's never been easier to fund biotech projects than it has been before. There's also a new model of funding. It used to be that the big pharma firms would decide what to work on. They'd take drugs right from the beginning and try and put them all the way through the process.

It's been a process, but it's become more of a startup culture where there's a smaller startup biotechs, they take the drugs along to a certain point. And when they hit a certain level of success, the big guys buy them out and get the drugs to market, but that allows much more experimentation, much more nimble process. We're getting more shots on goal, so that's speeding innovation as well.

And there's also capital coming from Silicon Valley is turning its eyes not away from tech, but they're adding biotech to their portfolios. Google, Apple, Amazon all have big healthcare initiatives within their companies.

So there's a lot of capital coming into the industry. You wanna quantify that in another way, this is the number of US employees in biotech. This has doubled in the last ten years, more employees, we should be getting more discoveries. And those guys are working on the science.

So let's talk about the science for a second. We all know that there's always progress being made, but right now in particular, there is a wide range of very important breakthroughs happening all at once. And you've heard about all these things. I'm gonna go through them quickly.

We know that it's gone from $100,000 to $1,000 to sequence a human genome. We know we have CRISPR now that allows us to selectively edit DNA. Google's AlphaFold AI program has essentially solved the problem of predicting the structure of a protein.

That's an incredibly important thing to do, proteins are just about everything in biology. A year ago, we only had 17 percent of a model through a long experimental process. Google's AI system now we have 98.5 percent of the proteins in the human body modeled and it's out there open source for anyone to use.

mRNA vaccines, these essentially turn the cells in your body into a little protein manufacturer. So pair that with AlphaFold, it's going to be ridiculous. And under all this is advances in AI and computing power that are powering these advances. So –

*Doc Eifrig:* Can I just go back to that slide for a second? I think what you should look at and appreciate is that on the left in 2001 was the year I graduated from medical school. And at that point I'd already been a founder of a biotech company in gene therapy, but look at the cost to get a picture, a snapshot information on the human genome.

We're talking hundreds of thousands, a million dollars and it's plummeted. So the costs now, all of us can go in and for $1,000.00 you can have your genome scanned and uploaded into the cloud.

And then you can share it with anyone you want to, anyone you don't want to, but that information and then the interaction with what happens in real life is incredible. It's incredible opportunity and incredible place we are sitting, because 23andMe, if you didn't know, they bought something a company recently, I can't remember the name.

It is Lyme, do you remember the name they just bought? It's called Lyme something. And what they'll do is integrate people, their disease. So if you have diabetes, if you have this, if you have that, if you have freckles, if you burn easily, eventually this will all get sort of reported as people start to fill out questionnaires and things, and then we'll understand that you might be something like Alzheimer's in a couple of genes, it might be a different set of genes as well.

And when it's a million bucks and $2 million to research that who can research it? But when it's $1,000.00, to Matt's point, then startups can do it. You can start researching it in your basement by looking at data sets and doing things that Matt likes to do at night, which take econometric models and integrate and try to figure out what the associations are and where they are. So that's the exciting thing. And to me, the huge message is this input cost has plummeted.

*Matt Weinschenk:* And what's important about all those things I just mentioned is none of them are a single breakthrough or a treatment, those are all tools to create discoveries. And a tool is much more valuable than a single discovery. And there's something in complexity theory called innovation cascades. And essentially normally innovation happens step wise.

So we had like germ theory in the 1850s and then molecular theory in about 100 years later and sort of things go in big leaps. But when you get this innovation cascade, you get things fueling one another, things start to really ramp up.

So again, we always like to try and prove things are happening. Biotech patent by year is on the rise, number of studies filed with the FDA has more than doubled in the last five years. So a skeptic would say, I've heard about personalized medicine, I've heard about gene editing, I still go to the doctor and things are the same for me. So am I too optimistic? Am I buying the hype or do we really have a sort of a phase change happening here?

*Tom Carroll:* So I guess I would say there's been, actually let me start, I was just thinking while you were talking. We originally called this the golden age of healthcare. It's actually better than that, this is like the Bitcoin age of healthcare. Bitcoin's better than gold, right?

I can't remember. I've been trying to figure that out last couple of days. But no, things have been – it's the absolute greatest time to be in healthcare right now. Of course I've said that every ten years, but if you saw one of my slides yesterday, it was towards the end of my presentation. And over the last 10 years, there's been about $80 billion invested.

And this is smaller investors, private equity investors, putting money into small disruptive startup companies that are going to be the next publicly traded companies. That is where the next 10, 20, 30X investments are coming from in healthcare.

And all these slides that you're showing Matt, totally align with that view as well. And some of the stocks I mentioned yesterday came from the last 10 years Teladoc, Livongo, Accolade, Phreesia, which we'll talk about a little bit here as well.

*Matt Weinschenk:* All right. Let's get into these life sciences a bit. So Doc, in the early 2000s, when you were still doing your research, you discovered a gene mutation in the eye. And of course now everybody knows that polymorphic corneal amyloidosis is a disorder due to a novel mutation of the transforming growth factor, beta induced gene.

*Doc Eifrig:* Yes.

*Matt Weinschenk:* But this was –

*Doc Eifrig:* By the way, there are a couple ophthalmologists here. I like to call this the, it's a corneal disease and they're called dystrophy. So this in my house it's the Eifrig dystrophy. Thank you.

*Matt Weinschenk:* But this was very difficult to do at the time, right?

*Doc Eifrig:* Yeah. So again, here's the point of this, what this is and this put me on the map in ophthalmology, I'm a first author in the journal called Ophthalmology, The Blue Journal. And I did it with a guy at Duke who's since passed, but the cornea clouds there's a single point gene mutation where the wrong protein is made.

And by the time people are 16 or 17 years old, their cornea starts to cloud. And by the time they're in their late twenties, they have to get a corneal transplant, someone else cadaver transplant the eye.

And what's interesting about this is there's another paper that I didn't put it up, but this is to make the case that back then there was nothing to do about it, except do a corneal transplant. You couldn't do anything with that one particular gene.

And that meant that person might even have to have a second corneal transplant and your eye gets worse and worse the more of those you get. I also in that process discovered that there were a couple of families in the United States that had this it's inherited in an autosomal dominant fashion. And I discovered a couple of families in my research that had spontaneous single point gene mutation.

So in their lifetime, they had no relatives with it and suddenly they got it and got it midlife. If you go to the next slide, please, what this means is, and if you look down on the third line where it says protein, this is for sickle cell and same thing where normally it's produced as glutamine, that now the defect produces veiling [inaudible 00:17:24] and that leads to pain and early death for people that have sickle cell.

Well, there are companies and there are technology and these trials have already happened to take these single point genes, go in and use technology, take the coding. And the coding is at the top, you see that GAG is instead on the sickle cell, it's a GTG. They go back and they take the T out and they put the A back in.

And so all of a sudden you don't have that. And if you can get it in enough cells in the right place, your disease goes away. So they've tried this, there are companies we have a list here that have done gene editing.

And to our point today, that was just a dream in 2000, that was just a fantasy and now it's happening. So you can imagine what's next. And I was just reading over the last week – are you going to talk about? No.

I was just reading about there's even more refined ways called base editing that's even more efficient and more specific and doesn't have, because you can imagine if you give somebody something and it doesn't quite cut it in the right place, substitutes T somewhere else, you could have problems.

And so that's a technology problem that will be fixed. And so it'll be like Star Trek, 70 years old and they'll scan Tom and say, "Oh yeah, these seven base pairs just went out of alignment," and they'll give you the drug that'll go and find that, fix it. Not saying it means we'll be ageless, but it's potential.

*Tom Carroll:* It's like a chiropractor for your genes. Realign them.

*Doc Eifrig:* Yeah.

*Tom Carroll:* I was gonna add that the sickle cell therapy was highlighted on a 60 minutes. So if you're interested, go look that up. It was very, very good young woman basically cured.

*Matt Weinschenk:* And Doc, you're obviously a biology guy, you come from the biology side of this. But when we've talked, you've been more excited about the AI applications in drug discovery in healthcare. Is that true?

*Doc Eifrig:* Yeah. So in the AI side is in my mind, Matt knows more about this because you're masters in econometrics from Johns Hopkins. If your computing power and ability to take the information, keep measuring it, keep creating correlations, keep using math models to figure out what it is that's happening, what is correlated with what, what needs to change and where the problem is.

That's just, again, back to Moore's law, the cheaper that technology gets, the cheaper the ability to scan things, the more opportunity there is. And that's just the point we go to the idea that we like –

*Matt Weinschenk:* Yeah, we can talk about a few life science companies before we move on to healthcare services. So if you think about that big chart of all the new employees, they're gonna be working in labs, they're gonna need reagents and materials. With the aging of America and more things we can diagnose, we're going to have more tests.

So Thermo Fisher supplies, lab materials. These other companies are testing companies, and they have basically a stranglehold on this industry, a huge moat, very hard to compete with, that's what Theranos tried to do and we saw what happened to them. So these are great safe dividend payers that you can hold for a long time.

We've also long liked the mega cash gushing biotechs. So you remember that new innovation model where the smaller companies kind of come up with it and they get bought by the bigger companies? Well, these guys have been great at getting the right drugs, building up patent thicket around them, just creating huge cashflows, paying huge dividends.

And you don't really have to predict the trials on these guys, they are just well-run companies with great capital efficiency.

*Doc Eifrig:* Yeah. And just go back to that slide before, again, this idea of picks and shovels, the key here and if you've ever worked in any sort of laboratory, if you're going to do tests, you usually have machines. And so you buy the machines, but it's that razorblade model.

It's the model where you buy the nice razor and then you buy the razors repeatedly. Same thing with these companies, the picks and shovels, you buy a $400,000.00, $200,000.00 PCR machine, and you have to use the reagents, the products, the things that fit in there.

And unless you get another funding grant from the government or someone wants to fund you privately, you're stuck with that product. And you keep using it, using it, using it, and as the information comes out of it easier and easier and cheaper, more and more of these things, these picks and shovels get used. So that's why we really like stuff on this slide, as well as the next. Thank you.

*Matt Weinschenk:* So let's move into healthcare services and medical technology a bit. So that's I was gonna say rocket science, I guess that stuff is brain surgery. But there's similar things that some of the technology companies are doing that are I'm sure they're difficult to do, but they seem like simple interventions in healthcare that can lead to better outcomes.

And you guys have both told me before about the problem of medicine adherence, is that the right term?

*Tom Carroll:* Medicine adherence, yes, essentially taking your medicine and taking it on time and appropriately.

*Matt Weinschenk:* And people never do it.

*Tom Carroll:* Yeah. It's one of the, it's called the nut that hasn't been cracked in healthcare and quite simply and actually, I would reverse it around and say medication non-adherence is the actual problem. I think I mentioned yesterday, I forget, so we spend about $350 billion on prescription drugs in the United States every year.

And then we spend another $300 billion to fix people because they don't take their medicine correctly or they use their inhaler incorrectly. Or they start taking their meds, maybe it has a side effect, they stop taking it. They don't tell anybody about it, and they end up in the ER.

So that's like free money, right there, $300 billion. If people would just take their meds and do their stuff appropriately, they could save a lot of money for the system themselves and save a lot of angst physically for them.

*Doc Eifrig:* I have a funny story about medical adherence. In ophthalmology, there's a disease known as glaucoma. And at the time, the only treatment for it was to lower pressure, you could do some surgical things. And someone thought what's going on?

These drugs work in animals, you put a drop in the eye, the pressure drops. Why isn't it working in humans? And the study is fascinating, what they did was they gave a person not just the bottle of medicine, but a little thing to put the dropper on and told them it has to go in there when you're done with the dropper, not telling them that it measured both the squeeze of the bottle and how often you lifted the bottle up.

And what you might expect is glaucoma is really hard to treat, and these drugs work really well for lowering pressure if you take them regularly. Turns out most people wait three months to their next doctor appointment and literally grab the bottle that they haven't been taking the drops, squeeze the drops out as fast and hard as they can guessing about how much they've taken.

And then take that thing back to the doctor to show I have been taking my drops doctor. That's just amazing what people will go to, to imagine that they're adhering to their doctor's advice and the medical advice, but that's classic in ophthalmology with eyedrops.

*Tom Carroll:* Yeah. So I was gonna share a story about kind of digital healthcare and I talk about the $80 billion being invested in. So there's a small company that came out of Johns Hopkins School of Medicine.

The technology was basically created in the mid two 2006, 2007, 2008, to basically monitor that people in very rural Africa, there was a tuberculosis outbreak. We gotta monitor that these people are taking their meds, their tuberculosis regimen of meds completely. And the technology was basically on a very simple smartphone in 2008, it wasn't that smart back then.

And it leveraged the only therapy that has been shown to improve medication here and tried to get it towards above 90 percent. And that's a therapy called directly observed therapy. And so that's fancy words for me watching you take your meds, to confirm that you actually ingested or inhaled your meds.

And so what these people did is basically videoed themselves in a very early arcane video, taking their meds. And then that video was asynchronously sent to the folks that were monitoring this population. And it was confirmed and checked off.

And what they learned is they didn't just see somebody taking their meds, they saw everything around them. They saw stuff that was happening, they saw potential bad weather or maybe you're outside and you shouldn't be outside. And so these other social determinants of health that potentially impact that person.

And there was these two entrepreneurs that said, "Hey, this would be a really great technology to build up and push it into the population here in the United States. So money was raised and some management was pulled together and this is a company now called Emocha Healthcare.

And it is the number one provider of a technology levered directly observe therapy for almost every department of public health in the United States. And we've recently started saying, let's push this into health plans, let's try to get this to physicians so that they can give to their patients that need to take meds, that need to take those eyedrops, like that story.

So what Doc was talking about is he had a dropper that measured when you turned it over, that is a proxy for adherence, but it doesn't confirm inherence. If you got somebody on video taking their meds, that is confirmation that it has been taken.

Now we have had instances where people hide the meds and stuff like that, but very rare that folks do that. If they're going to start taking a video of themselves, they're going to take their meds.

And it's funny when I first started learning about this company, in full disclosure, I'm an investor in it. I remember thinking who's gonna do this? You're really gonna take your iPhone out, nine o'clock in the morning, you got bedhead, take your meds. But we've got over a million videos right now that suggest otherwise.

In fact, we ran a pilot with a Medicaid HMO in the Mid Atlantic, it's a hospital system that owns the health plan that takes care of Medicaid population in the region. And that hospital system is gonna get a $500,000 bonus this year directly related to the medication adherence improvement that our technology gave them. So really, really fascinating stuff.

And so that's just a simple, that's just an example of how technology has come to a certain level and is really simplifying a solution for this very difficult challenge in healthcare that really hasn't been solved yet.

*Doc Eifrig:* I'm going to run with that idea of technology and where we're headed and where it's going. How many people here in the last year have been on a Peloton bike run? Okay.

So a few of you. So this next slide shows a picture of Robin Arzon, and Robin, when she was eight months pregnant, I could not keep up with her on the Peloton. She is an elite athlete to the finest level. She's also a Type I diabetic, impossible 15 years ago.

Here she is, she's got a little monitor on her skin that sits there all the time and tells her exactly where her glucose level is. There's even more advanced machines that then can take sort of an external pancreas that measures that and figures out what's the optimal amount of insulin to release and even other peptides into the human body.

So again, technology things just like iPhones, something to put on your arm and she can beat me up on the bike, exciting times.

*Tom Carroll:* Can I add another story from [inaudible 00:30:31]?

*Doc Eifrig:* Yeah.

*Tom Carroll:* You just reminded me. So there's the insulin pump has been a revolution, but it was kind of the same structure over and over again for a number of years until a little company called Tandem Diabetes came up with a new pump that was variable.

You could adjust it on your cell phone, sort of the convergence of this technology that had been created and pull it together with the ease of the user changing things or their doctor changing things or the doctor telling them to change things on their iPhone right to their pump.

I have a good friend that worked at Tandem and he did some research on it, and basically I'm like, this is revolutionary. This is gonna change the world in terms of Type I diabetics.

And this is the early company that basically it was gonna run out of money. The stock fell to, I wanna say like two bucks a share, and this is a great example of where a lot of people just left it for dead, a lot of investors. All you needed to do is go a couple inches down in that story to realize that this was the real deal.

And someone out there was going to fund this company. Tandem Diabetes, that one stock paid all my bills in, I forgot what year it was, 2018 or something. And today it's $125 stock. So lots of stories like that in healthcare and that's just a medical device example.

*Matt Weinschenk:* And do you still like Tandem going forward? Just I'm sure we'd get that –

*Tom Carroll:* I do. I think it's more fairly priced today than it was obviously at $2.00 a share. And it is not a cheap stock. So I think it's a nay, I think do I still own it? I still own a little bit of it, but I've sold most of it.

But it's one I keep an eye on and if the mechanics of the market drop it 15, 20 percent because we missed by 2 cents or some nonsense like that, I'll step in and buy a little more of it. But that's one to put on your radar screen, T-N-D-M.

*Doc Eifrig:* But because he owns it, he can't recommend it. Let's just be clear.

*Tom Carroll:* Thank you. There you go.

*Doc Eifrig:* I'm serious.

*Matt Weinschenk:* Okay. Yesterday, I'm sorry, on Monday Porter came up and he spent some time talking about software as a service companies and from the business side, they are remarkably capital efficient. But I think the reason they're booming is because from the customer side, they make so much sense for large companies.

When you have a big company that needs software, you have to do updates and compliance and security, and people don't want to have an expert in house to run these things. It just doesn't work. It's much easier to sign up for these subscriptions.

So when I think of healthcare and I think of compliance and security and updates and complicated systems for patients and all these things, it seems to me that healthcare is ripe for software as a service disruption.

And I think it's already happening, but I also think it's more complicated than the other ones. So it's a little behind the curve so far. So there's an opportunity there, am I right?

*Tom Carroll:* No, I agree. I think everything technology in healthcare is behind the curve. But software as a service, basically you think if you're a small physician office with two or three docs, you've gotta have a patient intake system, you have to have a financial system, you have to be able to create schedules.

And a lot of this stuff is still on paper, some of the software systems you can bring in are kind of the traditional license models.

And so now companies are starting to see, like Phreesia has a whole patient intake system that basically takes all of that out of the doctors and the administrators' hands, and gives it primarily to the patient.

And so now, how great is it to be able to get online. Like open table, you wanna get a reservation for dinner, you can do that for your doc without having to pick the phone up and call.

You look through all of the open appointments and just pick what you need, that's a simple example of some of the functionality, but I think you get my point. And their net promoter scores are off the chart.

So net promoter score is how likely is a customer to recommend this product to somebody else. And it's a measure that has been gaining in popularity and Phreesia has huge net promoter scores. My sister works for, she's an executive at a big urological practice in the Mid-Atlantic and they adopted Phreesia about two years ago.

And this was before Phreesia was public and they absolutely love it. I know the CEO at the company and he can't speak enough about it. So that really is what put it, having that contact in the industry put Phreesia on the radar screen for me before it came public, such that when they did come public, boom, I was right there to look at it and go through the S1.

*Matt Weinschenk:* And I see Accolade here, what do we want to say about Accolade?

*Tom Carroll:* Yeah. So accolade is a stock we actually pitched last year, again, a little I called SaaS ish yesterday. It's not a complete SaaS model. But this is a company that was started by the guy who did Concor.

And if you remember, years ago, Concur was like one of the first business expense software programs. And he sold that business for a bazillion dollars. And so today he runs Accolade, which a mostly SaaS business that kinda does the same thing, but it brings the others.

When you're an employer, you have health insurance, life insurance, different software. And then you have employees and management and customers on the other side, and it brings all the connectivity, all of that stuff together into one, again, very easy to use technology that the company basically just pays a subscription for.

And it functionality gets updated automatically. And net promoter scores again, are off the charts with it. I actually recommended it last year when it was in the low thirties. And the stock went to north of 60 bucks a share, I think in the following six months and both Phreesia and Accolade have sold off hard here in the last three to four months as just the tech has just sold off with the broader macro issues in the market right now.

So I'm fully recommending Accolade again and Phreesia, I think is fantastic as well. Oh, so the question is, how does it compare to Epic? Totally different kind of thing? Epic is a big healthcare system that's installed within hospitals that has tentacles out to align physicians.

They have an electronic medical record component, so how's it compare? There are chunks of Epic that they could pull the functionality out and separate and distinct. So Epic tries to be everything for everyone.

*Matt Weinschenk:* So all these changes are happening in our big broken healthcare system. I think everybody agrees, there are lots of challenges, but as an investor or a business where things are broken or where things can be improved is where you wanna look, that's where the opportunity is. But I think as a country, we don't even really agree how to fix these things, what the right path is, it's political and it is a big mess.

But without asking you guys to predict the political winds, which I'm gonna guess you're free to, but I feel like that's a difficult exercise. Is there an opportunity from the patient side for healthcare delivery to really improve in the next 10 years, or is it just gonna be rising cost? Is it just gonna stay the same?

*Tom Carroll:* Can I start on that one? So forever, as long as I've been in healthcare, you see the reports each and every year. Healthcare costs went up another eight percent, another ten percent, another nine percent. And the punchline there was “This can't continue, it can continue, it can't continue,” yet it did.

I highlighted a statistic yesterday that the 50 years ending 2016 medical cost inflation averaged about 10.7 percent a year, which I just find amazing. But I truly believe we're at a tipping point now. And the difference today versus say ten or 15 years ago is that stuff is happening.

10 or 15 years ago, you still had this kind of really the same big players. You had health insurance companies, you had hospitals, you had drug distributors, you had medical device companies, you had pharma and it was the same cast of players.

Today, you have a whole new layer of what I call digital healthcare companies and solutions that are coming into the mix. We're talking about them a little bit here. And I don't know if you saw my presentation yesterday, but sitting on the beach this summer, there's a banner polar demanding hospital price transparency.

All these little data points are around us suggesting that something has got to change. I personally feel like I call it healthcare reform version 2.0 is coming. I originally predicted it would start happening in 2020, I was wrong on that. But we're starting to see little data points now that is moving us in that direction.

We've had some things that have kind of distracted us at the national level and the global level the last few years. But yeah, I think it's really starting again. And I like to say don't be afraid of healthcare reform. Chances are, it's not really gonna impact you that much.

But there will be winners and losers across the healthcare continuum. And a lot of those companies are publicly traded. And it's a great opportunity to make some investments.

But I guess just before I throw it back over to you, I think that we are at a point from a regulatory standpoint, from a digital solution standpoint, and from a frustration standpoint, if you will, amongst all of us as customers that things are changing and are gonna happen.

And again, I'm not a fan of a single payer system, but I think we have already in place things like the Medicare Advantage Program. And again, it's not the greatest program for everyone, but that could very easily represent kind of a base layer of healthcare protection for every American.

And if you have more resources, there's gonna be private sector solutions on top of that that allow you to go from a Honda Accord to a Cadillac. And I really think that's happening in the next ten years.

*Doc Eifrig:* Yeah. I would add a little bit of a political angle to it is that I've been listening for a long time everyone talking about healthcare can't be a larger and larger component of GDP.

But I would argue especially in the baby boomer group and folks who are older, and now I put myself in that crowd, how much of your money will you spend on improving the quality of your healthcare? And I think it could go higher and higher.

And I think the efficiencies that we're gonna start to see from things like genome costs and everything you can imagine, information computing, that it'll still rise, but it'll be more efficacious, the product, the outputs will find out things. You can walk around with a watch now that tells me my VO2 max, and I can give myself an EKG while I'm up here and I can check my heart rate.

I mean, that's coming for what – Okay. My phone says, "Oop, I'm supposed to eat some lettuce. Now, go find some lettuce, go find some blueberries." And I'm completely serious, and that will be integrated with your gene type.

That's gonna happen and you might embrace it or not and say, "No, I don't wanna be at an optimal weight, I want to wake up in the morning instead and ache and pain and can't bend over and tie my shoes." Or you might say, "Hey, this is a possibility, it'll happen very quickly." So I'm excited about that.

*Tom Carroll:* No. And so, I'm all about spending more money on healthcare. I mean, like I said yesterday, it's our number one asset. Why wouldn't you want to invest in your number one asset? But today, we're not getting the value out of what we're spending. We spend a lot of money on healthcare, the most on the earth. And we have really, really crappy outcomes clinically, and it doesn't work for everybody.

I mean, we're the richest country on the planet, and we have people that are not getting the care. I mean, tuberculosis is still an issue in the United States. It's amazing to me. So, as countries get richer, they spend more on their health and wellness, and that makes perfect sense. We spend more and more and more, but we're not getting the quality and the results for it.

*Doc Eifrig:* I would challenge you on this idea that we're the quality of healthcare. I've seen lots of things that say the quality on this aspect and this aspect isn't great. I have Canadians in my family, and that's a debate. And I point out to them that most countries in the world, you would never think of taking a neonatal, a baby, a newborn who's premature by you name the number of we peaks and try to save their lives.

Most countries, they don't even have the technology or bother. Well, that gives us terrible scores for neonatal healthcare. And that shows up as where we're 12. But in fact, we're number one in a lot of this technology because we try things and it's about liberty and freedom. And I'll come back to that in my talk a little later, but it's still political about how are you gonna allocate care? And we are gonna have to make tough decisions. So anyway, I'm –

*Tom Carroll:* That's totally fair. And so, comparing, and that's a great example, we're expending a lot of money to go after and save lives of children that are born prematurely, and not all of them are gonna make it. So those go on the wrong side of the scorecard, whereas other countries, it's not an apples to apples comparison, so fair.

And I do like the comment, and I think it applies here from one of the gentlemen last night on the panel, he said the worst day in the United States is the best day in a lot of other countries. So thank God we have the system we have. It's not perfect. Lots of people come here to get their healthcare, but it definitely is not good. And any physicians in the audience know and feel this every single day.

*Matt Weinschenk:* Great. All right. Well, we're coming up on question time. I just want to check real quick. Does anyone have plans to raise their healthcare allocation over the next few quarters here? We convinced anyone? All right. Well, I just want to say we have Doc and Tom. Of course, you also have access to Dave Lashmet who is a biotech genius.

We have John Engel, former bench scientist who worked on these discoveries, he's with Stansberry Innovation. Our new friend, Matt McCall, some of his biggest winners are in biotech. So we have a lot coming your way. You're probably gonna see some more of Tom. We're coming up with some ideas get more of the ideas in front of you. So hopefully, we can help you guys get invested.

*Tom Carroll:* And can I just say I love talking about this. I am passionate about healthcare. Yesterday after my talk, I had some people come up to me saying, "Man, thanks so much. It's the greatest talk I ever heard." I had other people saying, "You're such a stupid moron. You don't know what the freak you're talking about." And man, I love both of those conversation because it educates me. It makes me a better person in terms of a study of the business.

And so, when I was an analyst, I'm not an MBA guy. I went to school of Public Health at Johns Hopkins. I was kind of a misfit on Wall Street. And I kind of called things the way I saw them, which were very typically non-consensus from my peer analysts.

And as I got a following, people knew that I really knew stuff about the system, they said, "Hey, this guy really kind of knows something."

So I used to go into an hour meeting and spend 30 to 35 minutes talking about the stocks that this investor wanted to talk about in the next 25 minutes on the best way for their parents to get their Medicare Benefits, or something else that they had heard or slides showed that they'd seen about another healthcare company, and how it impacted their families directly. So please come up to me with whatever opinions you have. I love to chat about it.

*Doc Eifrig:* Question out there?

*Matt Weinschenk:* Hi. this is very, very interesting. I wanted to ask a question about what we should avoid. So we currently have some talk about drug price regulation, which is probably reasonable considering how much we pay relative to everybody else. And there may be some other issues. So as you see healthcare unfolding let's say in the next five years or so, are there sectors that we should be very careful about investing in?

*Tom Carroll:* Can I start there? Sorry, I want to jump right please. Sorry, Doc. I know I keep stealing your thunder. You've been here for 20 years. I've been here for three, give some time. Hospital sucks.

*Doc Eifrig:* But you're older. You're older.

*Tom Carroll:* I would say hospital stocks. Beware of hospital stock. Is that your question, right? Investing in healthcare? Yeah. So I would say hospital stocks. There's a handful of them out there still today. As I mentioned yesterday, hospitals are 50 percent of the medical dollar in the United States.

They avoided any kind of scrutiny in the affordable care act ten years ago 2010, which was just amazing to me because hospitals are what drive the half of the expenses in this country. And the next round, version 2.0 of healthcare form, I don't see how hospitals don't get squeezed in some way, shape, or form.

That said, I've always viewed them as kind of trading stocks over the years. They're on a radar screen, and as they get to certain levels, I want to buy them, as they come back up, I want to sell them. So I think they're potentially at risk.

*Doc Eifrig:* Any other questions? Over there, and then we'll come this way. Sure. Go ahead.

*Matt Weinschenk:* Oh. How to put this, there are peer-reviewed studies all over the world that Ivermectin saved countless lives and yet it's actually been nearly illegal to use it here.

*Doc Eifrig:* I'll save you that question. So the question is, Ivermectin, it was an FDA approved drug, it's been used. I've taken it when I was in medical school for fun because I wanted to see if I had any worms. I did not.

What's happened is the craziness of the politicizing of things that aren't big pharma and the act of, and the practice of medicine in the United States, if the drug is FDA-approved, which Ivermectin is, a physician can prescribe any drug off-label. Now, if they get in trouble and start killing people and harming people, they're gonna have to face their medical board in the state.

But if you have good science and you can back up the mechanism of action, there's, nothing wrong with a physician prescribing Ivermectin at some point if they deem it helpful for COVID, but why would someone think it would be helpful for COVID? Because in the lab, in a cell dish, viruses particularly coronaviruses die when they're exposed to Ivermectin.

So it would be a rational, normal thing to do. There have been a couple of small, I understand them to be okay, randomized controlled trials. I mean, I'm like they're not what I would call ideal. It wouldn't lead me to take Ivermectin or not take it, but people jump on that, and I'll talk on my thing. But did that answer your question?

So there are people that have report anecdotally good use with Ivermectin physicians who prescribe it. The problem is, and the anecdotes you see, there's a thing in New England Journal of Medicine that they said, "Oh, here's an example where it doesn't work.

A person went and got it from their veterinarian and took it and died." Really? This is now in the New England Journal of Medicine. Like, come on, don't go to your veterinarian and take and get Ivermectin for COVID. Come on. That's not science. Okay? Next.

*Doc Eifrig:* Sorry, the question I have is around the results or maybe you could talk a little bit about Primary Direct Care. And things like if you stay outside of the insurance system, you can end up with bills for like an MRI that's less than $300. So, how do you rationalize that? Is that gonna be an impact on our medical system in the future?

*Tom Carroll:* Yeah, let me take that. So I think the question is, if you stay outside of your insurance coverage, you can get stuff for less money than you have paid inside your insurance. Is that it? Or is it a surprise medical?

*Doc Eifrig:* Yes.

*Tom Carroll:* I thought you were going to say surprise medical bills.

*Doc Eifrig:* No, no. It's actually that if you take, you can get so much better deals outside of insurance.

*Tom Carroll:* Yeah. So I guess two things there absolutely one shop around. That's absolutely true. And it's absolutely true for pharmaceuticals. I have gone to my pharmacy to pick up meds a number of times and they say, "Mr. Carroll, that'll be, $63.00 for this med." And I say, "Was that through my insurance?" "Oh yes, sir. Absolutely." "Well, how much is it if I just pay cash? That'll be $18.00, please." Happens all the time. So, insurance companies have bills –

*Doc Eifrig:* Is that for the blue pills for only $18.00?

*Tom Carroll:* I don't need the blue pills yet. Apparently, somebody knows about the blue pills though.

*Matt Weinschenk:* Okay. We're gonna cut it off right there. We're out of time. We're done. Guys, thank you so much for joining us.

*Doc Eifrig:* All right. That's the last question. Sorry. Thanks very much.

*Tom Carroll:* Shop around. Shop around. You absolutely can find it cheaper.

*Doc Eifrig:* Stay here. We're bringing out Stansberry editors. Like I said, it'll four of these next sets of panels. Come and go as you want, but know that we're gonna start here in just a second again.

*[End of Audio]*