INVESTOR DAY

George Savvides, Managing Director

27 October 2015

AGENDA FOR THE DAY

Time	Business item		Presenter
10.00	Introduction	(10 minutes)	George Savvides
10.10	Group strategy	(20 minutes)	David Koczkar
10.30	Profitable growth – two-brand strategy	(20 minutes)	David Koczkar, Chris Carroll, Fiona Le Brocq
10.50	– customer engagement	(15 minutes)	Simon Chamberlain
11.05	– Project DelPHI	(15 minutes)	Nicole Twyford
11.20	– Q&A	(20 minutes)	David Koczkar, Chris Carroll, Fiona Le Brocq, Simon Chamberlain, Nicole Twyford, George Savvides, Paul Koppelman
11.40	Coffee break	(15 minutes)	
11.55	Health cost leadership – overview	(20 minutes)	Dr Andrew Wilson
12.15	– hospital contracting	(15 minutes)	Ross Cooke
12.30	– delivering high value care	(15 minutes)	Dr Linda Swan
12.45	– payment integrity	(15 minutes)	Marc Miller
13.00	Lunch	(50 minutes)	
13.50	– Population health services	(15 minutes)	Justine Cain
14.05	– Integrated primary care	(15 minutes)	Rebecca Bell
14.20	– Q&A	(20 minutes)	Dr Andrew Wilson, Dr Linda Swan, Ross Cooke, Marc Miller, Justine Cain, Rebecca Bell, George Savvides, Paul Koppelman
14.40 – 15.00	Group Q&A, wrap-up	(20 minutes)	George Savvides, Paul Koppelman, David Koczkar, Dr Andrew Wilson, Kylie Bishop

EXECUTIVE COMMITTEE STRUCTURE

STRUCTURE ALIGNED WITH STRATEGY

George Savvides
Managing Director

David Koczkar Chief Operating Officer	Dr Andrew Wilson EGM Provider Networks and Integrated Care	Paul Koppelman Chief Financial Officer	Kylie Bishop EGM People & Culture	Sarah Harland EGM Technology & Operations
Health Insurance • Sales & Service • Group Strategy • Health Insurance Product – Portfolio Management • Distribution • Customer Experience • Marketing & Brand • ahm • Diversified	**Health Benefits** • Provider Network & Contracting • Claims Management • Health Benefit Data & Analytics • Integrated Care • Population Health (ADF/Garrison) • Telehealth	**Corporate Services** • Finance • Actuarial • Treasury • External Affairs • Accounting • General Counsel • Company Secretary • Risk • Internal Audit • Investor Relations	**People & Culture** • Recruitment & Engagement • Performance & Rewards • Talent, Capability & Culture • Health, Safety & Workplace Relations • Corporate Social Responsibility • Internal Communications	**Technology & Operations** • Technology • Procurement • Property • Shared Services • Operations

HEALTHCARE SYSTEM

LEAKAGES MUST BE ADDRESSED TO IMPROVE AFFORDABILITY

MEDIBANK FOCUSED ON HEALTH COST LEADERSHIP FOR A SUSTAINABLE HEALTH SYSTEM

FEDERAL GOVERNMENT $64b
STATE GOVERNMENT $41b
PATIENTS $28b
PRIVATE HEALTH INSURERS $13b
OTHER INSURANCE AND NON-GOV FUNDING $9b

$155b

PUBLIC HOSPITALS $46b
PRIVATE HOSPITALS $13b
DENTAL, OPTICAL & PHYSIO $14b
PRIMARY CARE & PHARMACEUTICALS $40b
CAPITAL EXPENDITURE/ ADMIN/OTHER $41b

LACK OF INFORMATION FOR DECISION MAKING
COMPLICATIONS (QUALITY & SAFETY)
HIGH CARE NEEDS (2%/35%)
INAPPROPRIATE AND UNNECESSARY PRACTICE
UNWARRANTED PRICE VARIATION

WASTE & INEFFICIENCY

SOURCE: AIHW 2015

GROUP STRATEGY

David Koczkar, Chief Operating Officer

STRATEGY, CUSTOMER AND OPERATIONAL EXCELLENCE TEAM

David Koczkar
Chief Operating Officer

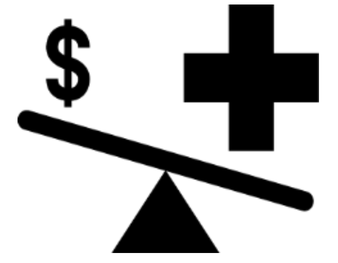
- **Alison Conn**
  GM
  Group Strategy
- **Franca Venetico**
  Div GM
  PHI Portfolio
- **Fiona Le Brocq**
  GM
  Marketing and Brand
- **Chris Carroll**
  GM
  ahm
- **Simon Chamberlain**
  Div GM
  Customer and Distribution
- **Nicole Twyford**
  Program Director – Project DelPHI

Presenting today

KEY TRENDS

FOUR KEY TRENDS IMPACTING THE PRIVATE HEALTH INSURANCE INDUSTRY

AFFORDABILITY



CONSUMER TRENDS

INDUSTRY DYNAMICS

REGULATORY ENVIRONMENT

AFFORDABILITY

AFFORDABILITY PRESSURES RISING; PARTICIPATION REMAINS STRONG

Private health insurance industry premium increases, inflation and hospital cover participation rate

8%
6%
4%
2%
0%

50%
48%
46%
44%
42%

7.16
7.40
0.96
1.22
5.06
5.60
1.20
2.40
3.00
1.50

2012
2013
2014
2015

Effect of lower rebate (LHS)
Industry weighted average PHI premium increase (LHS)
CPI (LHS)
Hospital cover participation rate (RHS)

Source: Premium increases & hospital cover participation rate – APRA (formerly PHIAC)
CPI - Australian Bureau of Statistics, using June data

CONSUMER TRENDS

CHANGING CONSUMER BEHAVIOUR CREATES OPPORTUNITIES

1. Reactive → Proactive
2. Transactions → Relationships
3. Experts → Empowered
4. Full-service → Self-service

INDUSTRY DYNAMICS

WELL POSITIONED TO TAKE ADVANTAGE OF CHANGING INDUSTRY DYNAMICS

Australian private health insurance market share by insurer[1]

Cumulative market share

Insurer	Market share (%)
medibank / ahm by Medibank	29.1
Bupa	26.7
HCF	10.8
hbf / gmf Part of hbf	7.9
nib	7.7
Australian Unity	3.2
Teachers Health Fund	2.0
GMHBA	1.9
Defence Health	1.7
CBHS Health Fund	1.3

(%) 35, 30, 25, 20, 15, 10, 5, 0

(%) 100, 80, 60, 40, 20, 0

23 funds have <1% market share each

23 funds = 7.7% not shown

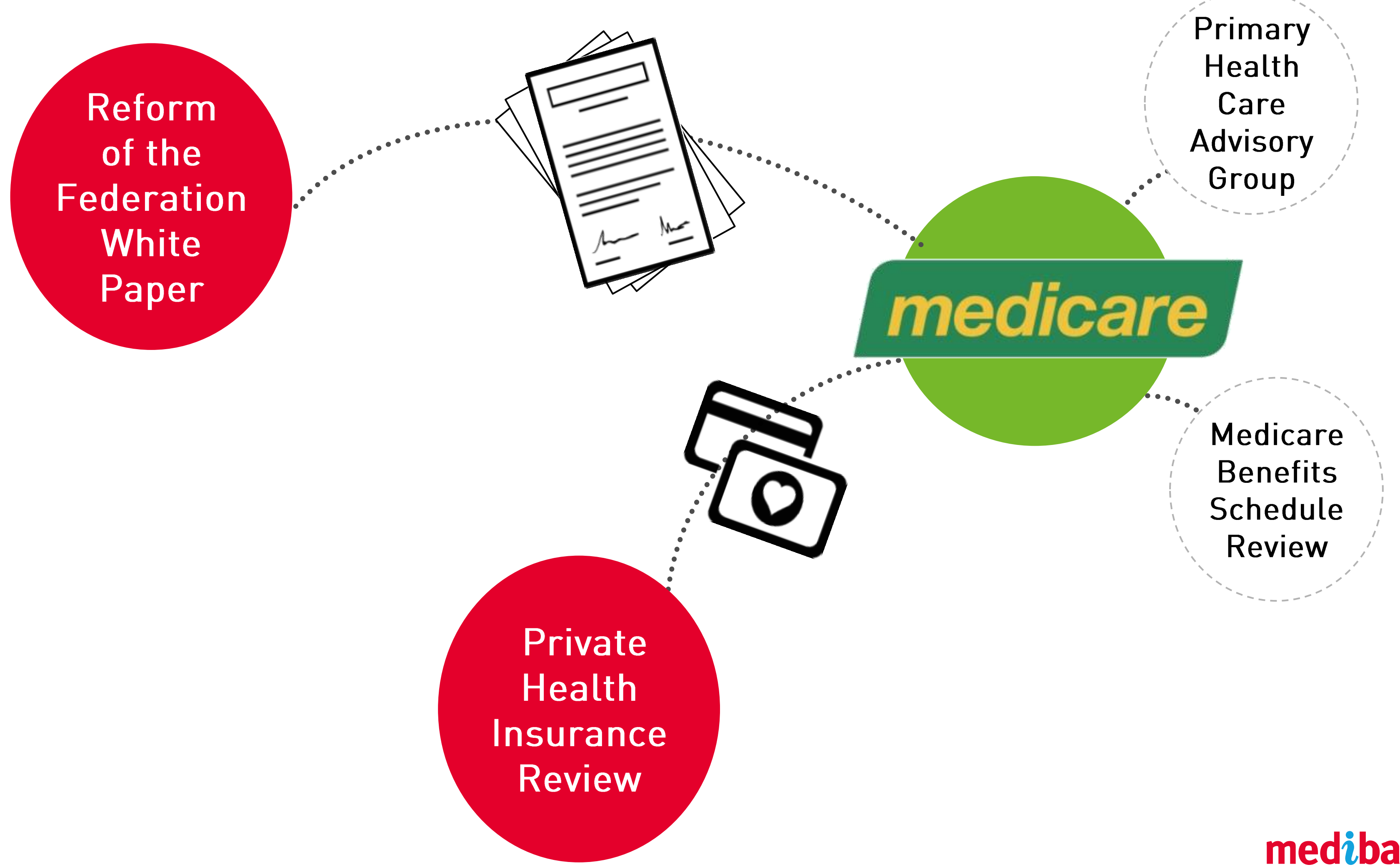
5 funds have >80% market share

1. By Policyholders as at 30 June 2014

Source: PHIAC, Operations of Private Health Insurers Annual Report 2013-2014.

REGULATORY ENVIRONMENT

ACTIVE PARTICIPANT IN REGULATORY CHANGE



medibank
For Better Health

SUSTAINING PROFITABLE GROWTH

OUR STRATEGY IS DESIGNED TO ADDRESS THE NEEDS OF ALL OUR MEMBERS

Chronic complex care

"At risk"

Healthy

Wellbeing

Health

Priority:
Better health outcomes
Better patient experience
Better value care

Priority:
Engagement
Primary prevention
Rewarding loyalty and good health

medibank
For Better Health

SUSTAINING PROFITABLE GROWTH

DEEPLY COMMITTED TO DRIVING BETTER HEALTH

PURPOSE For Better Health

VISION Australia's number 1 trusted partner to support whole of life health and wellness

HEALTH INSURANCE

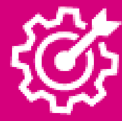
The right cover at every life stage

HEALTH ASSURANCE

Facilitating whole of life health and wellness

COMPLEMENTARY SERVICES

New health offerings that add value



OPERATIONAL EXCELLENCE

The simpler the better

PEOPLE CAPABILITY

Great people to make it happen

Customer focus

Accountability

Integrity

Respect

PROFITABLE GROWTH: TWO-BRAND STRATEGY

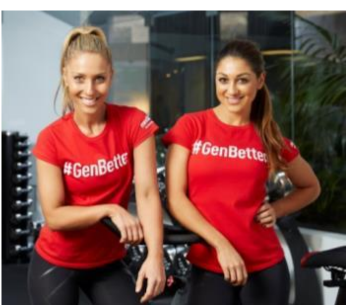
David Koczkar, Chief Operating Officer
Chris Carroll, General Manager – ahm
Fiona Le Brocq, General Manager – Marketing and Brand

medibank
For Better Health

PROFITABLE GROWTH

FOUR KEY AREAS TO DRIVE PROFITABLE GROWTH

- Active portfolio management
- **Differentiated marketing & communications:** segmentation, messaging and effectiveness
- Enhanced customer engagement & experience
- Rewarding membership



PORTFOLIO PERSPECTIVE

ACTIVELY BALANCE TRADE-OFFS ACROSS THE PORTFOLIO

Relative profitability	LOW (growth)	HIGH (growth)
HIGH	REPOSITION	PROMOTE
LOW	RETIRE	REMEDIATE

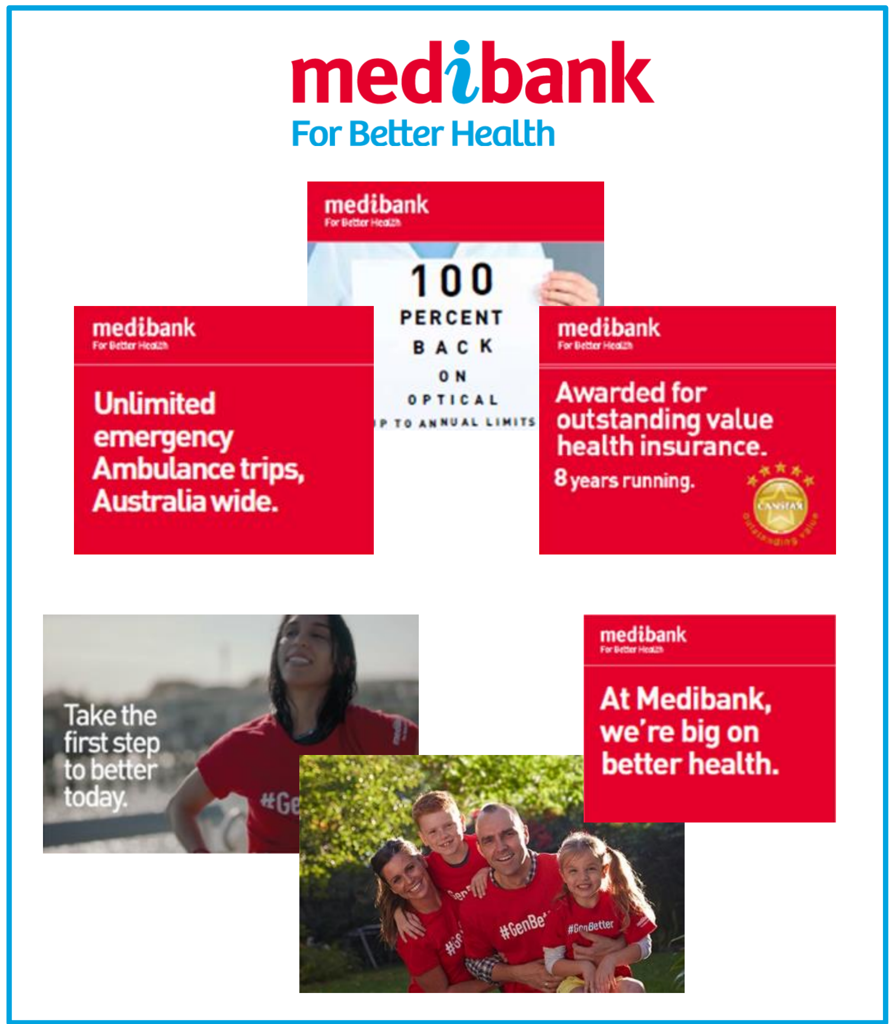
Relative growth rate

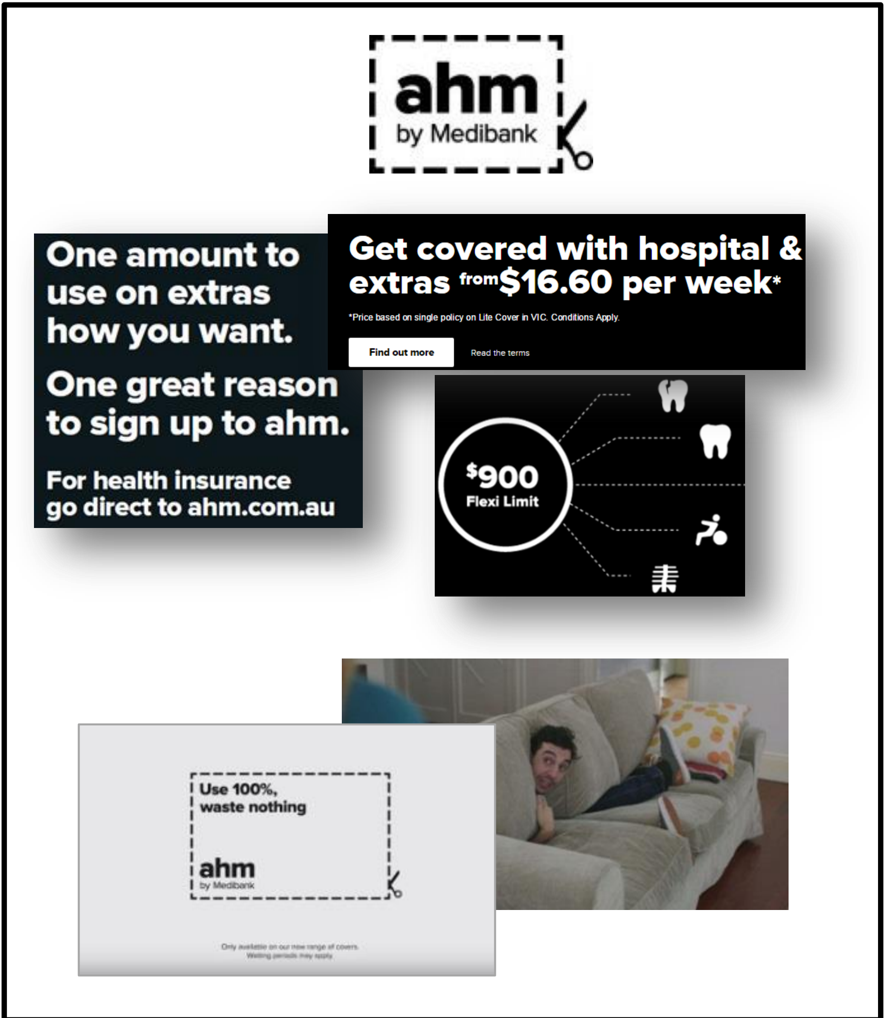
REFRESHED CUSTOMER SEGMENTATION

ADOPTING A NEW APPROACH TO ENGAGE MEMBERS

TWO-BRAND STRATEGY

DISTINCT BRAND POSITIONING





TWO-BRAND STRATEGY

THE TWO BRANDS ARE DISTINCT AND COMPLEMENT EACH OTHER THROUGHOUT THE VALUE CHAIN

Why we exist	For Better Health	Increasing health insurance accessibility, without unnecessary complexity
Differentiate by …	…service and options	…price and simplicity
Primary target	Consumers Overseas Corporates	Consumers
How we sell our service	Omni distribution	Virtual distribution

BUILDING STRENGTH THROUGHOUT THE SALES FUNNEL

EACH BRAND HAS A DIFFERENT PRIMARY FOCUS FOR IMPROVEMENT

ahm by Medibank

medibank For Better Health

Awareness

Consideration

Preference

Conversion

Retention is a priority for both brands

PROFITABLE GROWTH: CUSTOMER ENGAGEMENT

Simon Chamberlain, Divisional General Manager – Customer and Distribution

RETENTION IS A KEY PRIORITY

OUR AMBITION IS TO BE BEST IN CLASS IN RETENTION

Focused on lifting performance on retention: proactive, reactive and preventative

- Deep understanding of customer needs
- Market leading, customer-centric team
- Investments in education and talent acquisition
- Consolidated end-to-end resources focused on retention

MULTIPLE POINTS OF ENGAGEMENT

VARIETY OF TOUCHPOINTS AND OUTLETS FOR ENGAGEMENT IN PLACE AND UNDER DEVELOPMENT

Meeting needs

Generating loyalty

PARTNERING WITH MEMBERS FOR LIFE

BUILDING RELATIONSHIPS WITH OUR MEMBERS THROUGHOUT THEIR HEALTH JOURNEY

John

medibank
For Better Health

Could

GenBetter provides John with personalised reminders and options based on his family history

John has spent time in the sun this summer and books a checkup

Will

Medibank connects John with a quality provider at the right price

John injures his knee and makes an appointment with a Physio

Medibank ensures John is on the right cover, works with his GP to ensure high quality integrated care and helps him understand the current guidelines for management of his condition

John develops a heart condition

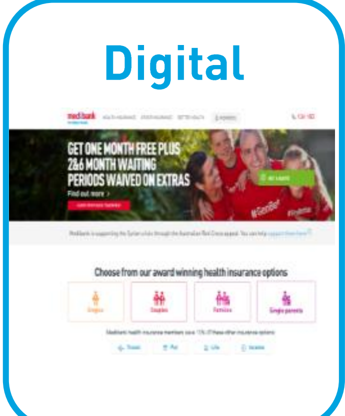
Should

Medibank helps John understand his options and choose the most appropriate hearing device at the best price

John's wife complains he has the tv volume too loud

OMNI CHANNEL APPROACH ACROSS THE BRANDS

PROVIDES CUSTOMERS WITH OPTIONS, ALLOWS CHANNEL OPTIMISATION



Partners

Aggregators

Brokers

Flybuys

Customer-centric distribution model

PROFITABLE GROWTH: PROJECT DELPHI

Nicole Twyford, Program Director – Project DelPHI

WHAT IS PROJECT DELPHI?

DelPHI

medibank
For Better Health

DELPHI INSIGHTS

PROJECT DELPHI WILL REPLACE LEGACY CUSTOMER, POLICY, PREMIUM AND PRODUCT MANAGEMENT SYSTEMS

- Customer-led transformation enablement program
- Fundamentally change the delivery of our health insurance offering
- Complete the legacy system replacement journey
- SAP software suite, with IBM as the system build and project management partner
- Simplify the IT landscape

DELIVERING BUSINESS PRIORITIES

TARGET BUSINESS OUTCOMES ARE CLEAR AND REMAIN VALID

Engaging

Empower and enable our people

- Simpler and more intuitive processes and technology
- Easier for our frontline staff to service our customers
- Support a true focus on sales and service interactions – not the systems
- Eliminate manual workarounds
- Minimal internal process touch points – more resolved on first interaction

Meeting needs

Ensure we are set up to meet customer needs

- Faster speed to market for product
- Improved lead and prospect management tools
- Optimise cost-to-serve and cost of acquisition
- Reduce operational risk
- Improve campaign effectiveness – better proactive customer engagement

Generating loyalty

Improve the customer experience and retention

- 360° customer view
- Remove known pain points through process failures
- Easier for customers to interact with us
- Consistent customer experience – cross-channel
- Enhanced self service functionality

DELPHI DESIGN PRINCIPLES

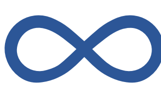
CUSTOMER EXPERIENCE IS TOP PRIORITY

CUSTOMER EXPERIENCE
must be top priority.

CURRENT FUNCTIONALITY IS THE ABSOLUTE MINIMUM
we can't retrograde.

AUTOMATE WHERE POSSIBLE
straight through processing, single point of data entry, automated workflow etc.

DESIGN FOR THE FUTURE
flexible, rules-based and configurable.

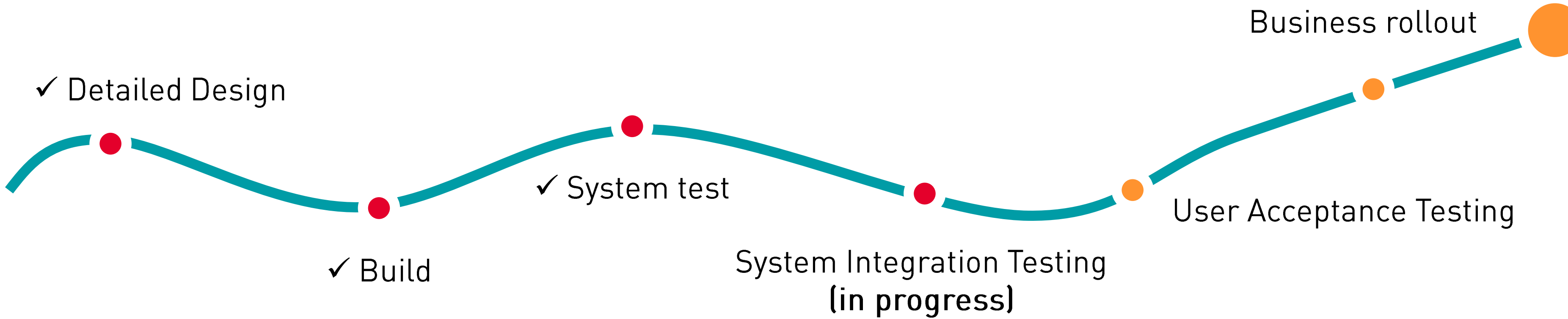


THINK 'END TO END'
business processes and variations e.g. customer, channel etc.

'OUT OF THE BOX'
functionality as a deliberate choice.

CURRENT STATUS

ON TRACK TO DELIVER THE FULL SCOPE OF BENEFITS BY END OF CALENDAR YEAR 2016



Q&A – PROFITABLE GROWTH

HEALTH COST LEADERSHIP: OVERVIEW

Dr Andrew Wilson, Executive General Manager – Provider Networks and Integrated Care

PROVIDER NETWORKS AND INTEGRATED CARE TEAM

Dr Andrew Wilson
EGM Provider Networks and Integrated Care

- **Natalie Kelly** – GM Strategy
- **Peter Derbyshire** – GM Health Strategy & Government
- **Monica King** – GM Analytics
- **Dermot Roche** – GM Telephone, Online & Population Health
- **Ross Cooke** – GM Operations
- **Dr Linda Swan** – Chief Medical Officer
- **Marc Miller** – GM Innovation and Payment Integrity
- **Justine Cain** – GM Population Health Delivery Networks
- **Rebecca Bell** – GM Utilisation Management

Presenting today

RISING COSTS OF HEALTHCARE

HEALTH COST LEADERSHIP REQUIRED TO BEND THE COST CURVE

THE AUSTRALIAN

Health fund seeks answers for cost blowouts

EXCLUSIVE

SEAN PARNELL
HEALTH EDITOR

Australia's largest health insurer, Medibank Private, wants to know how surgery can cost more than 70 per cent more in one hospital than in others.

The health fund is calling for an industry-wide program to improve quality and efficiency after its analysis of 2014 admissions shows significant variations in hospital provider charges, prostheses charges and medical provider charges, even taking into account complications and averaging the top 5 per cent and bottom 5 per cent of bills.

The analysis found an appendectomy, for example, cost between $7500 and $12,500 in a metropolitan hospital (67 per cent difference), and between $7500 and $11,000 in a regional or remote hospital (47 per cent difference). A hip replacement cost between $29,000 and $49,500 in a metropolitan hospital (71 per cent), and between $29,000 and $44,000 (52 per cent) in a regional or remote hospital.

Andrew Wilson, Medibank's executive general manager of provider networks and integrated care, told *The Australian* increasing health costs, which flow to members as higher premiums, were a big challenge for the public and private sectors.

Dr Wilson said inefficiency could waste up to 25 per cent of health expenditure, but system-wide reforms were difficult to achieve. "We've got ways of doing things, ways of charging for things that probably reflect the health system of 20 to 30 years ago, not a health system facing all of the pressures we know it is under now," he said.

Dr Wilson said the analysis raised inexplicable variations that could be caused only by poor clinical practice or mismanagement.

"Inevitably there's going to need to be a move towards an efficient price and standardised pricing, and also a move towards outcome-based funding," he said.

"Currently, in most private-hospital contexts, higher payments are made where there is additional complexity, without regard to what has driven the complexity. If it is driven by poor management or poor practice, the system needs to become sophisticated enough to not only recognise that but discourage it."

The managing director of Bupa's Australian health-insurance business, Dwayne Crombie, said quality of care was crucial.

Dr Crombie said variations in clinical practice and clinical intervention led to unnecessary procedures, adverse outcomes, readmissions, and avoidable suffering for patients. "We need to hold some of our doctors and providers accountable to their own best-practice guidelines," he said.

Although some insurers have quality-based funding agreements with hospital networks, there has been no government intervention despite the huge cost of the insurance rebate.

An industry initiative, Choosing Wisely, was launched recently with the aim of reducing unnecessary procedures. The Royal Australasian College of Surgeons has also said it wants to expand reporting and auditing of death and complication rates.

PM's health check

Medicare shake-up targets 'unnecessary' surgery

EXCLUSIVE

SAMANTHA MAIDEN
NATIONAL POLITICS EDITOR

A MAJOR Medicare shake-up will target tonsil surgery in kids, scans for lower back pain and bone density tests for seniors as unnecessary or overused services face the scrap.

All 5700 items and services that doctors can charge to taxpayers will be reviewed after the Turnbull Government announced a clean-up of the system.

According to the figures, Australians are going to the doctor on average up to 17 times a year at a cost of nearly $900 to taxpayers.

The sweeping review follows the Abbott government's failed attempt to introduce a $5 fee to see a GP.

Instead, Prime Minister Malcolm Turnbull and Health Minister Sussan Ley plan to target over-servicing and outdated Medicare items in the system.

Some examples of Medicare items that experts fear are being used too frequently include knee arthroscopy, imaging for lower back pain and tonsillectomies.

"We've seen growth in Medicare claims triple that of new patients over the past decade to one million per day and there's increasing consensus between patients and health professionals that not every one of these is best practice, let alone necessary," Ms Ley said.

"Every dollar we put into an unnecessary service with questionable benefits for patients is a dollar we could be putting into new treatments that will improve or save people's lives."

There are concerns 68 per cent of tonsillectomies are on children aged under 15 and studies show many people improve without surgery.

There are no limits to the number of bone density tests over 70s can ask for and there is concern overservicing is rife.

The *Sunday Herald Sun* can also reveal there are even fears Australians are undergoing "too many, or too frequent" colonoscopies.

About 300,000 Australians were tested for lower back pain last year and, in many cases, patients feel better soon after, regardless of the testing. X-rays may also show up unrelated problems that do not need treatment but can result in unnecessary stress and surgery.

Knee arthroscopies are of little benefit if the problem is osteoarthritis. One in three services are for patients aged over 60 and often they are suffering from osteoarthritis.

They are "painful, inconvenient and costly for patients and provide them with no benefit", in some cases.

There are also concerns about the frequency of bone density testing for over 70s.

Ms Ley said the figures showed the importance of providing doctors and their patients with access to medical tests and treatments that reflected modern clinical practice.

"Patient safety is at the core of our plan to build a healthier Medicare and we want to empower health professionals with a modern system that reflects 21st-century medicine," Ms Ley said.

"Unfortunately the current system is lagging in the last century, with only 3 per cent of all 5700 Medicare items ever assessed or tested to see whether they actually work, are out-of-date or even harmful.

"Inefficient and unsafe practices and procedures also cost the nation dearly because they stop taxpayers being able to invest in new, innovative medical treatments and technologies."

samantha.maiden@news.com.au

THE AUSTRALIAN

Health insurers unite in dispute

EXCLUSIVE

SARAH-JANE TASKER
INSURANCE

Australia's second-largest health insurer, Bupa, has backed its biggest rival in what is tipped to be a long, hard-fought stoush with private hospitals over contract negotiations amid rising concerns about affordability.

Dwayne Crombie, managing director of Bupa's Australian health insurance business, said its major competitor, Medibank Private, and every health insurer needed to get better value for the customer.

"We get the impression that private hospitals and doctors are living in a world of their own, thinking the golden goose will never stop laying the eggs," he said.

"We have a clear appreciation for the customer and how they feel about things. When we negotiate with hospitals, they live in a different world. They don't really give us a sense they understand how much (financial) pain the consumer is in."

He warned there was going to be a greater "blowtorch" on poor quality or in appropriate care.

"I think you are going to see much blunter discussions," he said. "I totally support Medibank's approach and we would think similarly."

Medibank Private's recent contract negotiation with Calvary Hospitals has created a new battleground for the two industries, with vocal supporters of both sides entering the debate.

Australian Medical Association president Brian Owler warned last week the industry body would take up the fight and "educate" members about insurance products, while Private Healthcare Australia has argued health insurers should be calling for better quality and safety standards in hospitals.

Medibank and Calvary are in mediation talks after the health insurer terminated the contract between the two after negotiations broke down. One issue Medibank and Calvary can't agree on is a list of 165 "highly preventable adverse events", which Medibank has said it will no longer cover.

"Medibank's desire to root out waste and to make things more affordable is absolutely the right conversation, but health insurers can't do it by themselves," Mr Crombie said.

"There needs to be political will, and quite frankly doctors need to own the thing a bit more."

The insurance head of Bupa, which has its next big negotiation with Ramsay Health Care in nine months' time, said Medibank was being unfairly picked on through the claim it was focused on shareholder returns because it was now a listed company.

"We don't have shareholders, nor does HBF, and we are facing the same kind of pressure to try and make life better. If we don't

Continued on Page 23

THE Daily Telegraph

Doctors urged to cut down on unnecessary treatments

CARLEEN FROST

DOCTORS should review if every test and procedure they ordered was necessary to prevent costly "over intervention and diagnosis" — potentially saving the state millions in the face of funding cuts.

Former federal health department secretary Stephen Duckett said "over diagnosis" was raised as a concern for the health industry, especially in expensive fields like diagnostic imaging, during a conference in Sydney yesterday.

Dr Duckett, now Grattan Institute program director, said the states had to urgently consider such health rationing.

"If you mean doctors have to look more carefully at every test they order, that's a good thing," he said.

"If you mean we are going to draw a line and rule out people who are going to get particular treatments, than that's a bad thing.

"We need to look at if everything they do will benefit the patient and at the moment that's not what happens."

Different levels of health rationing have been suggested over the years as a way to combat funding problems, although Mr Duckett and many other public health experts agree it should be ruled out in its most severe form.

The Australian Medical Association NSW said, in lieu of additional funding from the Commonwealth, it would back Premier Mike Baird's proposal to raise the GST to plug the funding shortfall.

AMA vice-president Brad Frankum said it was the job of federal and state governments — not doctors, surgeons or nurses — to ensure public hospitals were funded.

"The Premier's statements have been that a rise in the GST would be largely to pay for health so if that was the approach and the money was used to fund health we would not be against that," Professor Frankum said.

"The problem with any taxation change is we would not want the poorest and sickest to shoulder an unfair burden.

"We know if that happens, people are less inclined to seek help."

EDITORIAL PAGE 74

HEALTHCARE SYSTEM

LEAKAGES MUST BE ADDRESSED TO IMPROVE AFFORDABILITY

MEDIBANK FOCUSED ON HEALTH COST LEADERSHIP FOR A SUSTAINABLE HEALTH SYSTEM

FEDERAL GOVERNMENT $64b

STATE GOVERNMENT $41b

PATIENTS $28b

PRIVATE HEALTH INSURERS $13b

OTHER INSURANCE AND NON-GOV FUNDING $9b

$155b

PUBLIC HOSPITALS $46b

PRIVATE HOSPITALS $13b

DENTAL, OPTICAL & PHYSIO $14b

PRIMARY CARE & PHARMACEUTICALS $40b

CAPITAL EXPENDITURE/ ADMIN/OTHER $41b

LACK OF INFORMATION FOR DECISION MAKING

COMPLICATIONS (QUALITY & SAFETY)

HIGH CARE NEEDS (2%/35%)

INAPPROPRIATE AND UNNECESSARY PRACTICE

UNWARRANTED PRICE VARIATION

WASTE & INEFFICIENCY

SOURCE: AIHW 2015

REGULATORY REFORM – ESTIMATED TIMELINE

MOMENTUM FOR CHANGE BUILDING

Move to APRA

National Diabetes Strategy Advisory Group

Medicare compliance

Medicare Benefits Schedule Review

Primary Health Care Advisory Group

July 2015 | September | December | March | June 2016

Reform of the Federation White Paper

Parliamentary inquiry into Chronic Disease Management

Federal election Aug-Nov

Other upcoming potential reviews:

- Private Health Insurance Review

Budget 2016
10 May

MEDIBANK'S APPROACH

REVERSING THE TREND REQUIRES ACTION ON MULTIPLE FRONTS

Helping deliver value and affordability within healthcare

- Ensuring payment integrity
- Performance-based contracting
- Improving patient outcomes and experience
- Supporting our members and their doctors outside of hospital

AUSTRALIAN HEALTHCARE EXPENDITURE AND CLAIMS

OUTGROWN GDP OVER 10 YEARS

Average annual growth rate (%) from 2003-04 to 2012-13

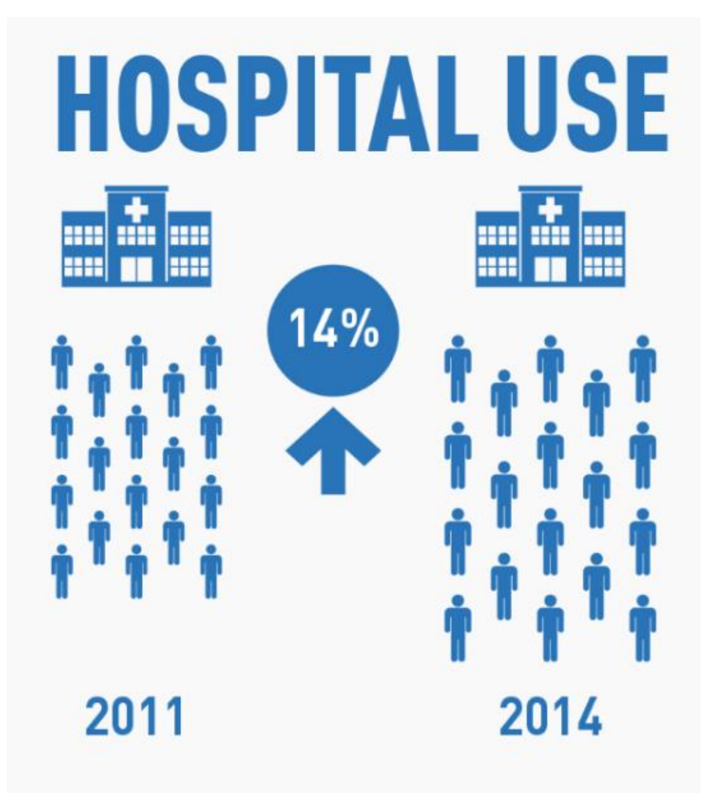
Category	Growth rate
Private health insurance claims paid	8.65%
Total hospital expenditure	7.90%
Total health expenditure	5.07%
GDP	3.00%
Population	1.61%

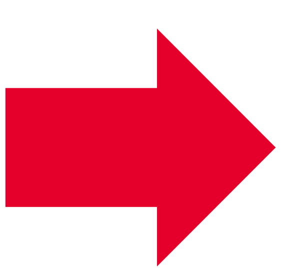
MPL claims growth FY15: 4.3%

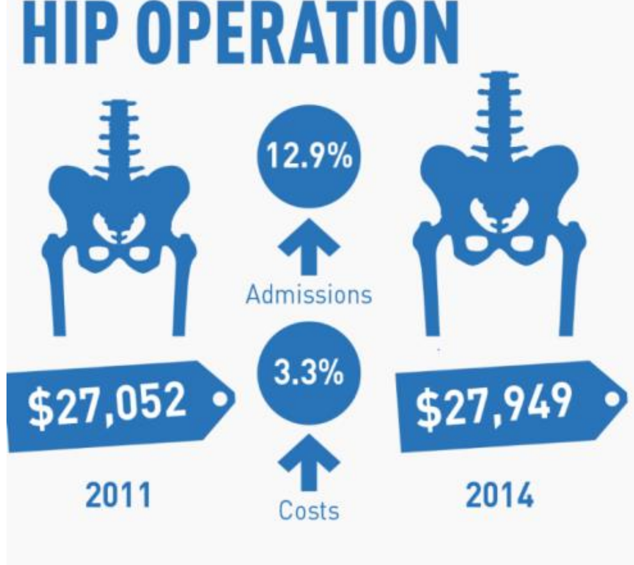
Sources:
Population – *ABS*
Hospital & Health expenditure & GDP - *Health expenditure Australia 2012-13: analysis by sector, supplementary tables and figures & AIHW health expenditure database*
Claims paid - *PHIAC Operations of PHI Annual report statistical tables 2003-04 – 2012-13*

AUSTRALIAN HEALTHCARE EXPENDITURE AND CLAIMS

INCREASED ADMISSIONS DRIVING COSTS FOR INDUSTRY AND MEDIBANK



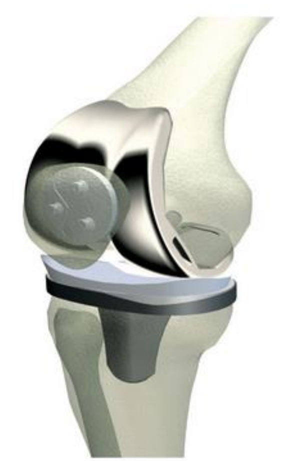




Source: Medibank data

AUSTRALIAN HEALTHCARE EXPENDITURE AND CLAIMS

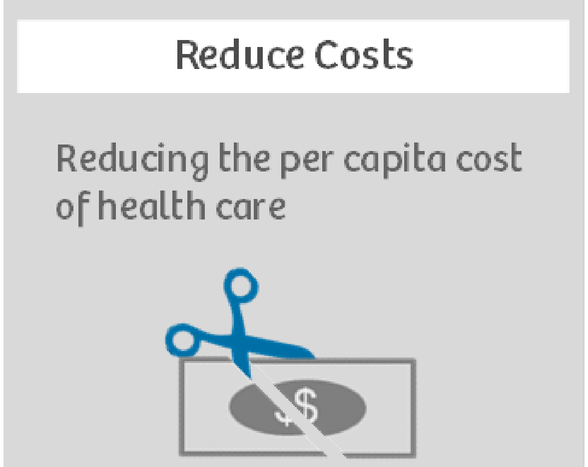
TECHNOLOGY AND CHRONIC DISEASE ARE DRIVING THE TREND OF INCREASING COSTS

Our growing but ageing population	New technologies	Increasing prevalence of chronic disease
		

A sustainable healthcare system continues to innovate and delivers efficiencies to offset these growing cost pressures

THE CHALLENGE FOR HEALTHCARE

TRIPLE AIM OF HEALTHCARE THE KEY FOCUS



Reference: Institute for Healthcare Improvement

HOSPITAL ACQUIRED COMPLICATIONS

HIGHER COST DOESN'T ALWAYS MEAN BETTER OUTCOMES

Hospital acquired complications

Hospital	Hospital acquired complications
Hospital 1	0.52%
Hospital 2	0.80%
Hospital 3	0.74%
Hospital 4	0.49%
Hospital 5	1.49%
Hospital 6	0.72%
Hospital 7	1.12%
Hospital 8	0.47%
Most expensive hospital	1.51%
Hospital 10	0.91%
Hospital 11	1.38%

Source: Medibank claims data showing % of total FY13 admissions:
A comparison of 11 major hospitals with more than 100 beds and ICU

READMISSIONS

HIGHER COST DOESN'T ALWAYS MEAN BETTER OUTCOMES

Unplanned, related readmissions within 28 days

Hospital	Readmissions
Hospital 1	0.80%
Hospital 2	1.26%
Hospital 3	0.79%
Hospital 4	0.98%
Hospital 5	1.86%
Hospital 6	1.09%
Hospital 7	0.92%
Hospital 8	0.96%
Most expensive hospital	1.49%
Hospital 10	1.19%
Hospital 11	1.78%

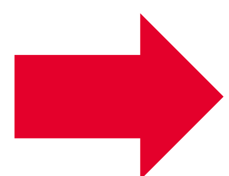
Source: Medibank claims data showing % of total FY13 admissions:
A comparison of 11 major hospitals with more than 100 beds and ICU

THE CHALLENGE FOR HEALTHCARE

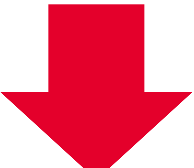
CREATING SUSTAINABILITY THROUGH A FOCUS ON HEALTH OUTCOMES

MEDIBANK

Shared value for our policyholders and shareholders



We keep our members healthy and out of hospital



The value of private healthcare is strengthened and our business is kept healthy

It will take true collaboration from all parts of the health system to create sustainability

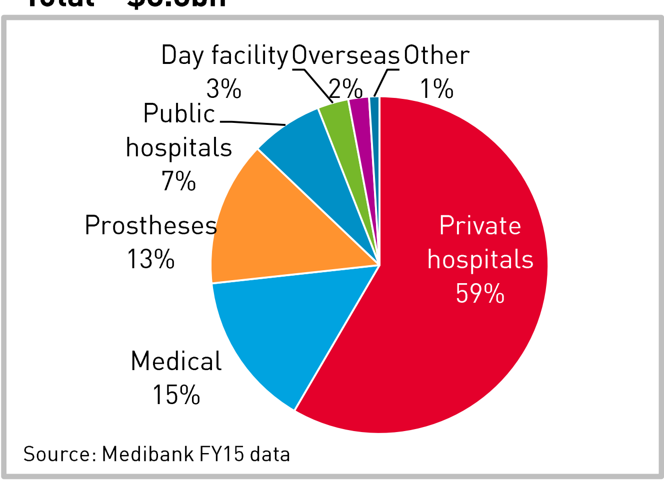
HEALTH COST LEADERSHIP: HOSPITAL CONTRACTING

Ross Cooke, General Manager Operations
– Provider Networks and Integrated Care

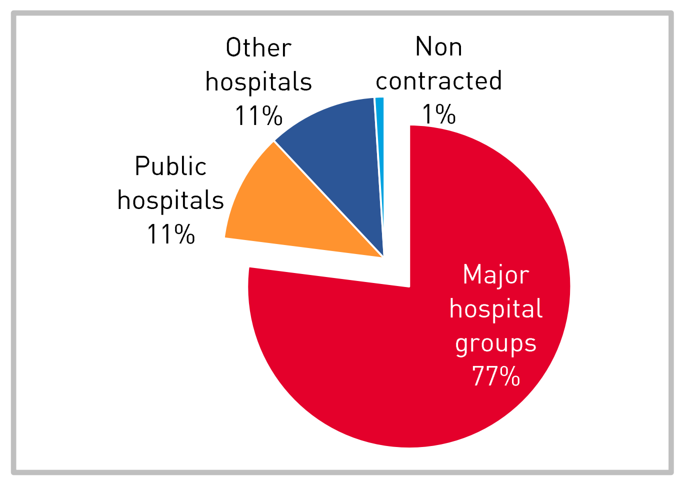
HOSPITAL HEALTH BENEFIT CLAIMS

CONTRACTS WITH HOSPITALS TO MEET THE HEALTHCARE NEEDS OF MEMBERS

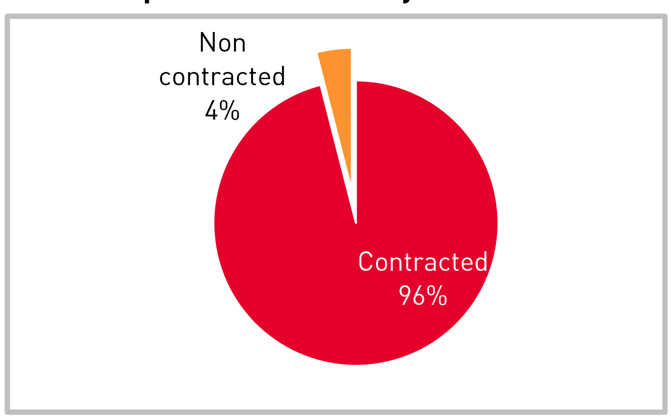
Hospital health benefit claims, by type
Total – $3.8bn



Health benefit claims, by types of hospitals



Hospital contracts – by % of beds



Types of hospitals	Beds ('000s)	% of beds
Acute hospitals	23	79%
Rehabilitation	2	7%
Psychiatric	2	7%
Same day	2	7%

Source: Medibank data

FUNDING MECHANISM

INDUSTRY FUNDING IS NOW MAINLY ACTIVITY BASED/ CASE MIX

- Two funding models used for hospital benefits
  - Case mix
  - Per diem
- Historically – per diem
- Today – mainly case mix
- Future funding – similar to current structures

Funding by hospital type

Types of hospitals	Funding
Acute hospitals	Majority is case mix funding Price Weight of One (PWO) – 85%, Per diem – 2%
Rehabilitation	Per diem 4%
Psychiatric	Per diem 4%
Same day	Mixture of case mix for specific items and theatre and accommodation bands 5%

HOSPITAL CONTRACTING

VARIETY OF LEVERS USED AS PART OF CONTRACT NEGOTIATION

New hospital contracts contain a mix of price and clinical levers to:

- meet business objectives
- deliver quality service
- provide great outcomes for our members

Price indexation

Clinical clauses

Payment terms

New terms and conditions

Bed clauses

OUT OF CONTRACT (OOC) SCENARIO

OUR PREFERENCE IS TO STAY IN CONTRACT

- Contract planning for provider negotiation involves months of preparation

- PHI Act – Still obliged to pay 85% of the state average as second tier rate; providers may choose to charge the member an out of pocket expense

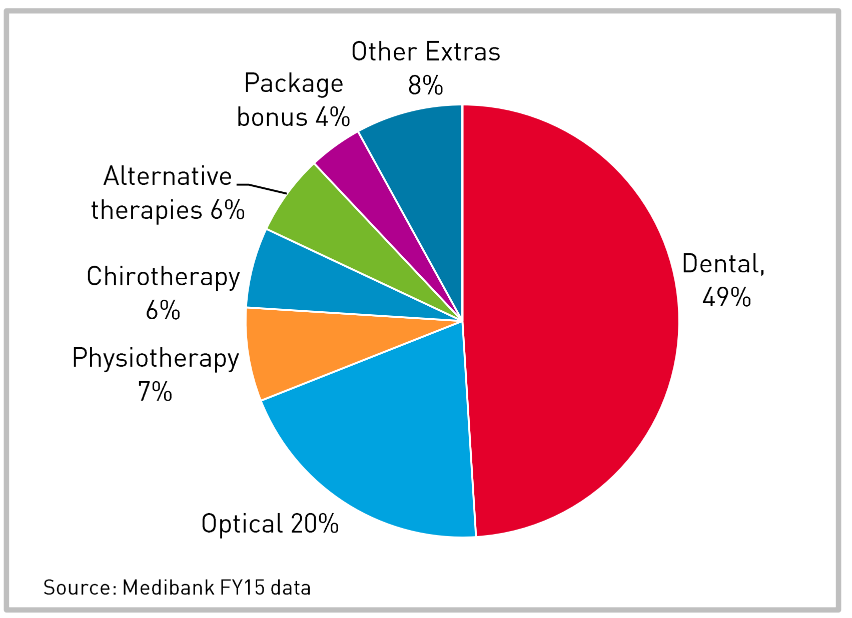
- Where a negotiated outcome cannot be reached, there is an independent mediation process overseen by PHIO

- Dedicated team in-house to manage any OOC scenarios to minimise impact to our members and mitigate risk to business

ANCILLARY

FOCUS ON MINIMISING GROWTH IN COSTS WHILE ENSURING QUALITY HEALTH SERVICES TO MEMBERS

Extras claims expense, by type
Total – $1.3bn



Drivers of cost inflation in ancillary services

Modality	Cost driver
Major dental	Average benefit (i.e. cost per episode)
Optical	Utilisation
Physiotherapy	Utilisation
Chirotherapy	Utilisation & average benefit
Alternative therapies	Average benefit (i.e. cost per episode)

Health benefit claims managed on multiple fronts

- Payment integrity programs
- Health benefit claims monitoring & reporting
- External industry relationships
- Provider contracting

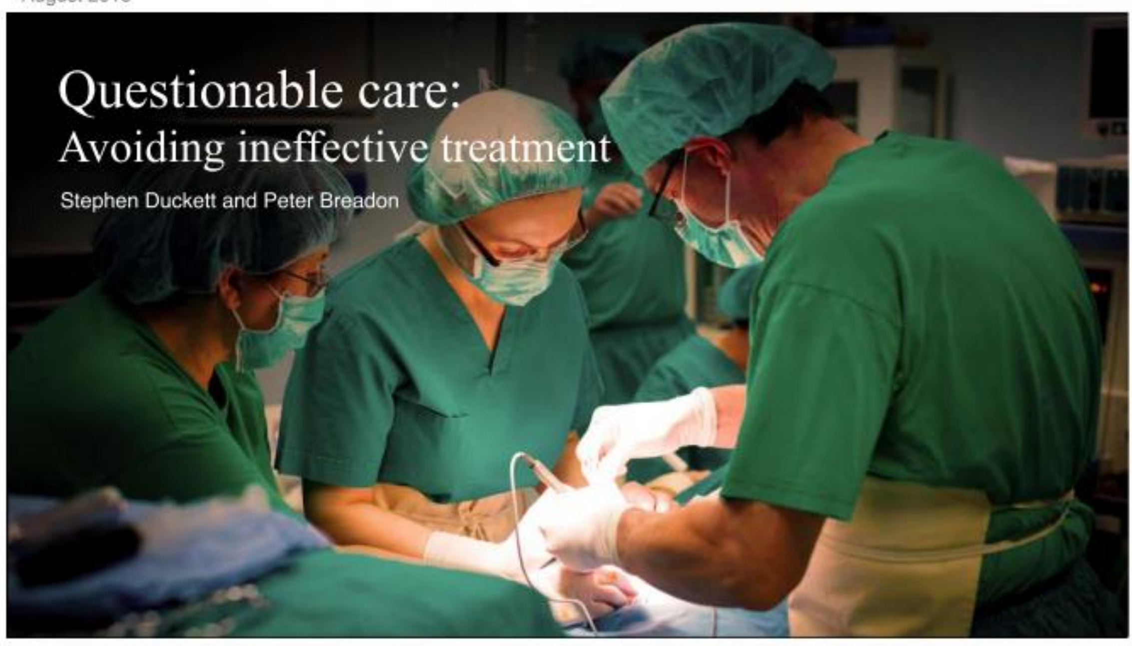
HEALTH COST LEADERSHIP: DELIVERING HIGH VALUE CARE

Dr Linda Swan, Chief Medical Officer

CURRENT STATUS IS NOT ACCEPTABLE

GRATTAN Institute

August 2015

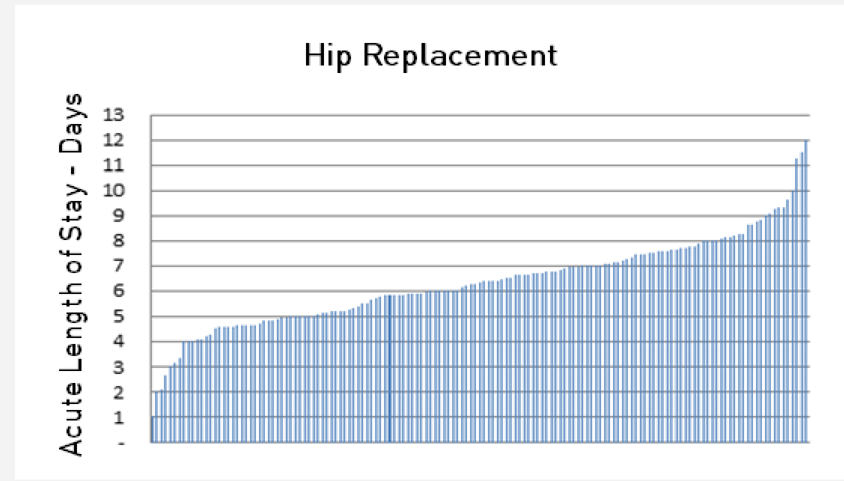


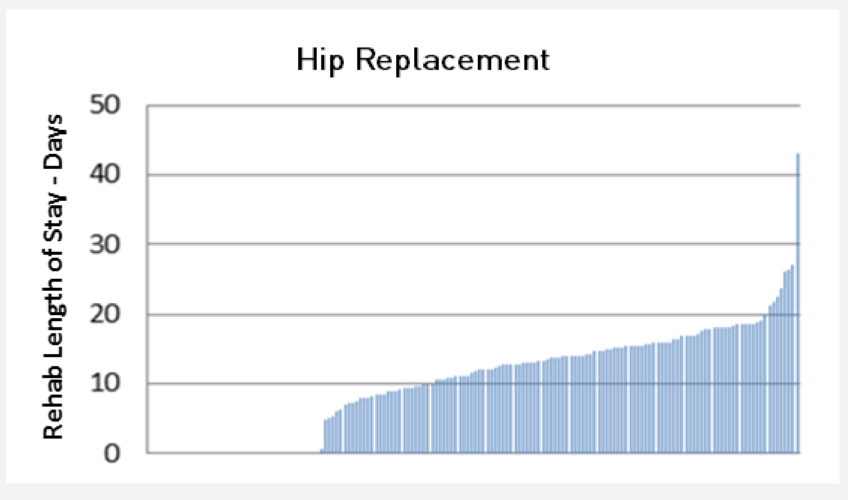
"Far too many patients in some Australian hospitals get a treatment they should not receive, against all evidence that the treatment is unnecessary or does not work."

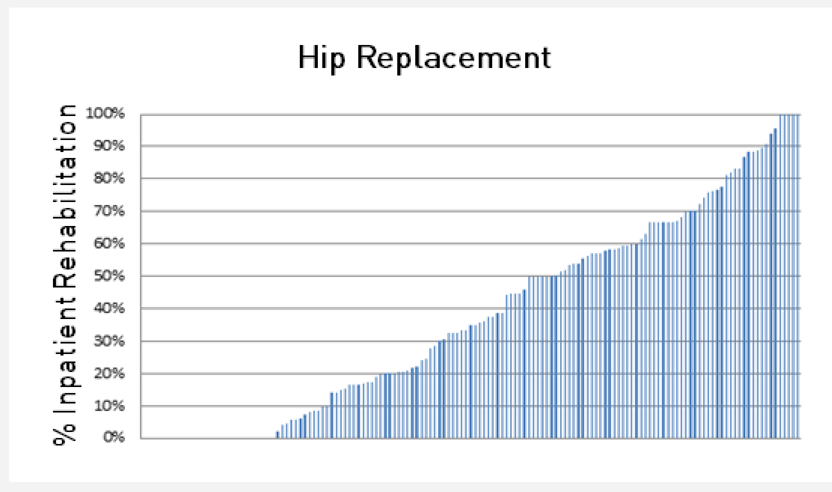
Source: Grattan Institute, 'Questionable care: avoiding ineffective treatment'

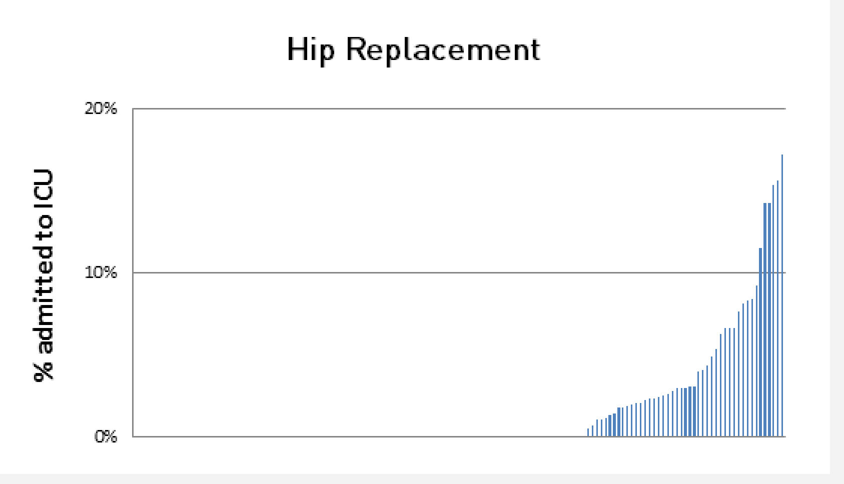
UNWARRANTED VARIATION

HIGH LEVELS OF VARIANCE IN TREATMENT OUTCOMES





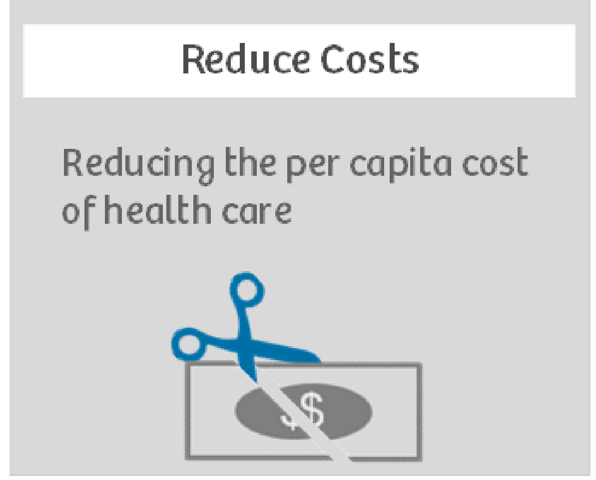




Source: Medibank data

TRIPLE AIM OF HEALTHCARE

HEALTH PROVISION AND REFORM MUST ADDRESS ALL THREE AREAS



- Recognised international paradigm for health reform
- Core concept is that health reform needs to address all three areas.
- Requires a balanced approach to ensure reform delivers optimal value

Reference: Institute for Healthcare Improvement

HIGH VALUE CARE

Improves health outcomes

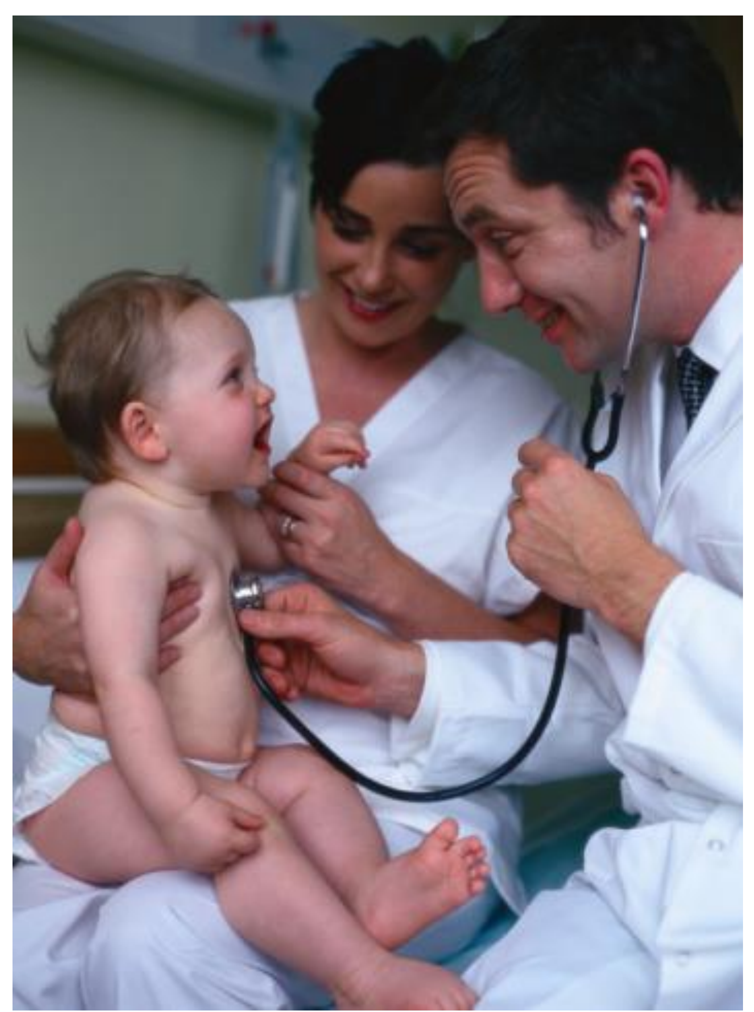
- Safe
- Appropriate
- Evidence-based

Improves patient experience of care

- Patient-centred
- Informed

Reduces healthcare costs

- Efficient
- Economical



HOSPITAL ACQUIRED COMPLICATIONS

Not good value for our members

- Poor health outcome
- Poor member experience
- Increases healthcare costs

We selected core areas where hospital intervention can reduce event rate

- Falls
- Bed sores
- Some surgical complications e.g. infections

We recover the additional hospital costs associated with these events

Independent medical review available for contentious cases

LEADERSHIP

DRIVING CHANGE WILL CREATE DEBATE

The full story...

AMA accuses Medibank Private of ignoring patient needs

MEDIBANK PRIVATE RELEASES LIST OF PROCEDURES NOT COVERED AT CALVARY HOSPITALS; CRISIS TALKS

A big list of medical procedures and complications will not be covered by Australia's biggest private health insurer, Medibank Private, as the stoush between

A Medibank spokesman said meetings had been held at a "variety of levels" with Calvary representatives almost daily for the past two weeks but the talks were at a stalemate.

Peter Martin, John Thistleton *August 30, 2015*

Medibank and Calvary resolve health insurance dispute at 11th hour

THE AUSTRALIAN

Bupa backs Medibank Private in hospital dispute

HEALTH COST LEADERSHIP: PAYMENT INTEGRITY

Marc Miller, General Manager – Innovation and Payment Integrity

CONTEXT

IMPROPER CLAIMS ARE NOT UNIQUE TO AUSTRALIA

International context

- Benchmarks
- Experience
- Activity

Australian context

- Healthcare system
- Private health insurance
- Medibank

Medibank Payment Integrity Program

- Corporate culture
- People
- Processes
- Systems

PAYMENT INTEGRITY PROGRAM

AN OVER-ARCHING GROUPING OF MULTIPLE RELATED PROGRAMS

	Submission/ prevention	Assessment/ validation	Payment	Recovery
Processes – Valid claims				
Processes – Improper payments				
Systems				
Org/people				

CURRENT SPECTRUM OF ACTIVITY

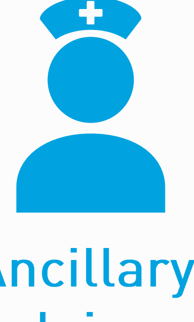
WIDE AND VARYING WAYS FOR IMPROPER CLAIMS TO OCCUR

Hospital claims

- Billing errors
- Coding errors
- Readmissions
- HACs
- ICU
- Prostheses
- Compensables

Medical claims

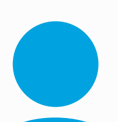
- Billing errors
- Coding errors
- Cosmetic surgery
- Practice variance
- Compensables



Ancillary claims

Improper payments:

- Dental
- Optical
- Physiotherapy
- Podiatry
- Natural therapies
- Other modalities
- Compensables



Member claims

- Identity fraud
- Improper payments in online, retail and postal channels:
  - Ancillary claims
  - Hospital claims
  - Medical claims
  - Compensables

General — Portability — Backdating — Eligibility

OPPORTUNITY IDENTIFICATION

Hypothesis-based opportunity identification

Medibank's Health Audit & Investigations Teams

Custom-built expert panels

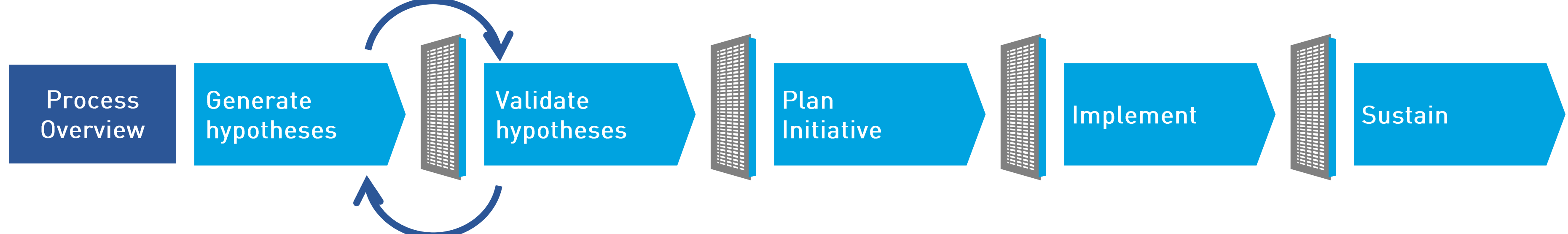
Crunching claims data

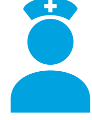
External partnerships

SOURCES OF INSIGHTS

METHODOLOGY

STRUCTURED APPROACH TO CONVERT OPPORTUNITIES INTO REALISED GAINS





Ancillary modalities example

1. Generate hypotheses
2. Conduct cluster analysis
3. Flag anomalous behaviour
4. Risk Stratifi-cation
5. Manual review
6. Define and apply action levers
7. Refine and periodically repeat

Hospital example

1. Contractual arrangements
2. Automated reporting
3. Flag aberrant claims
4. Initiate audit and request for information
5. Manual review
6. Recover
7. Refine and periodically repeat

LEVERS

DIFFERENT LEVERS ARE APPLIED TO DIFFERENT RISK CATEGORIES

Goal	Actions
Prevent improper claims	Suspend provider/member relationship
	Maintain provider/member relationship
Do not pay claim	Trigger audit
	Change system rules
	Change claims rules
	Strengthen payment system
Recover claim	Offset claims
	Engage 3rd party recovery agent
	Request payment
	Negotiate
	Withhold further payment
	Undertake legal proceedings

Blueprints for how to implement each lever have been created as part of the implementation process

PIPELINE

ONGOING OPPORTUNITIES EXIST TO REALISE FURTHER IMPROVEMENTS

- Refine hypotheses, tests, processes and repeat activity regularly
- Expand to new areas of claims, adapt to contractual and regulatory changes
- Increased focus on unwarranted variation
- Assist in quality and outcome based initiatives
- Improve process efficiency and efficacy through ERM system investment

BETTER HEALTH FOR SPECIFIC AUSTRALIAN POPULATIONS

Justine Cain, General Manager – Population Health Delivery Networks

FURTHER BENEFITS OF POPULATION HEALTH SOLUTIONS

ADDING VALUE TO EVERY HEALTH INTERACTION

CLINICAL ASSURANCE

A CUSTOMISED SERVICE

A NATIONAL PROVIDER NETWORK

REGIONALLY ADAPTED

QUALITY, CREDENTIALED PROVIDERS

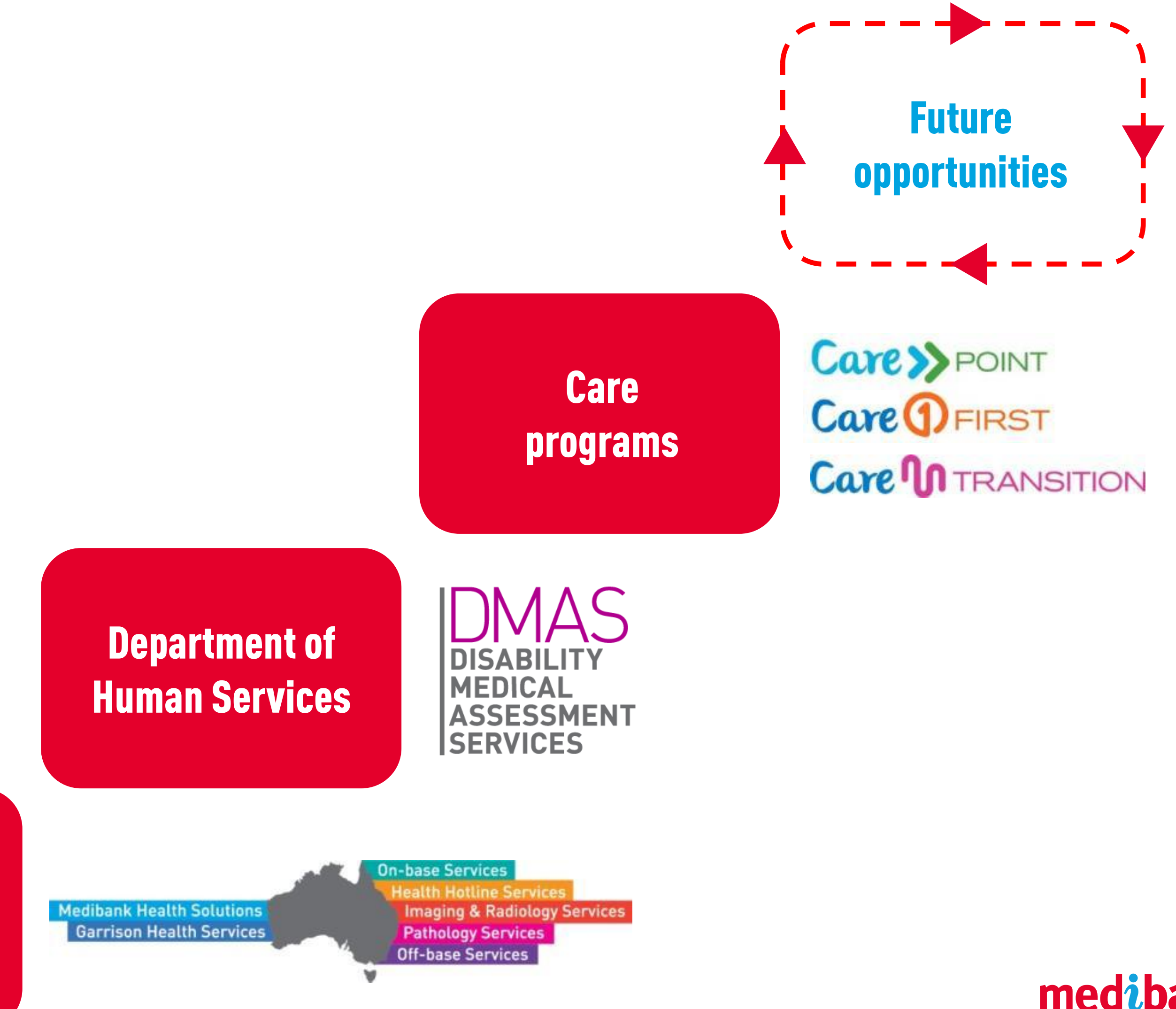
CENTRALISED MODEL

COST CERTAINTY

HEALTH INFORMATICS

KEY POPULATION HEALTH SOLUTIONS

PROVIDING ACCESS TO, AND MANAGEMENT OF, INTEGRATED HEALTH SERVICES FOR SPECIFIC AUSTRALIAN POPULATIONS



medibank For Better Health

GARRISON HEALTH SERVICES

REDEFINING INTEGRATED HEALTHCARE DELIVERY FOR THE ADF

A first-of-a-kind contract which redefines integrated healthcare delivery in Australia.

Rationalisation of the number of health service contracts being managed by Joint Health Command.

Improved national standardisation of health service delivery and consistency in healthcare.

Benefits in leveraging the purchasing power of industry service providers.

GARRISON HEALTH SERVICES

AN INTEGRATED HEALTHCARE SOLUTION

Through Medibank's extensive network, Garrison Health Services (GHS) provides seamless access to quality healthcare to the 60 000+ permanent and 20 000+ reservist uniformed ADF personnel—from point of injury or illness to recovery.

GHS manages and coordinates relationships with

- 4000+ medical specialists
- 260+ hospitals
- 1100+ on-base primary healthcare experts*
- Diagnostic, treatment and rehabilitation services*
- 8000+ allied health professionals

*subcontracted to Aspen Medical

*through key subcontractors and service providers

GARRISON HEALTH SERVICES

MULTIPLE ON-BASE PRIMARY CARE SERVICES

MENTAL HEALTH CLINICIANS
- Psychologists
- Mental Health Nurses

DOCTORS
- General Practitioners
- General Practitioner Trainers
- Aviation Specialists
- Under Water Dive Medical Specialists

ALLIED HEALTH
- Pharmacists
- Physiotherapists
- Exercise Therapists

QUALITY MANAGERS
- Supporting roles

NURSES
- Nurse coordinators
- Registered Nurses
- Endorsed Enrolled Nurses
- Enrolled Nurses
- Theatre Nurses

DENTAL
- Dentists
- Hygienists
- Sterilisation Technicians
- Dental Assistants

ON-BASE HEALTHCARE PROFESSIONALS

GARRISON HEALTH SERVICES

A SEAMLESS AND CONSISTENT APPROACH TO HEALTHCARE ACCESS

DISABILITY MEDICAL ASSESSMENT SERVICES

PROVIDING A COORDINATED ACCESS POINT TO A NATIONAL PROVIDER NETWORK FOR THE DEPARTMENT OF HUMAN SERVICES

DMAS
DISABILITY
MEDICAL
ASSESSMENT
SERVICES

- Government contracted psychologists
- Government contracted doctors
- Centralised operations
- Data collation, monitoring and reporting

GARRISON HEALTH SERVICES IN ACTION

Garrison Health Services

In partnership with Joint Health Command

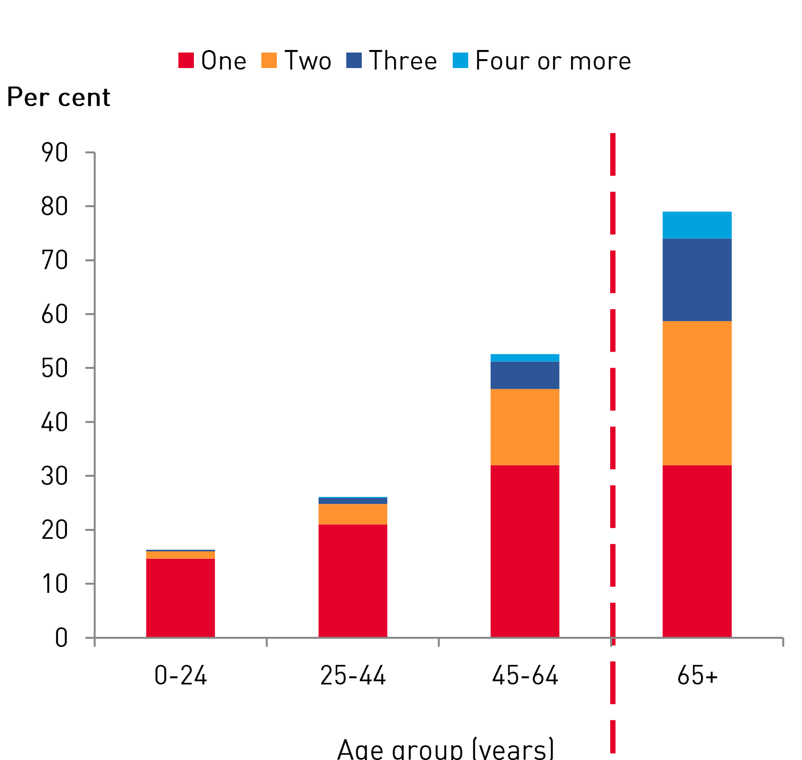
Delivering a world-class health service to the Australian Defence Force

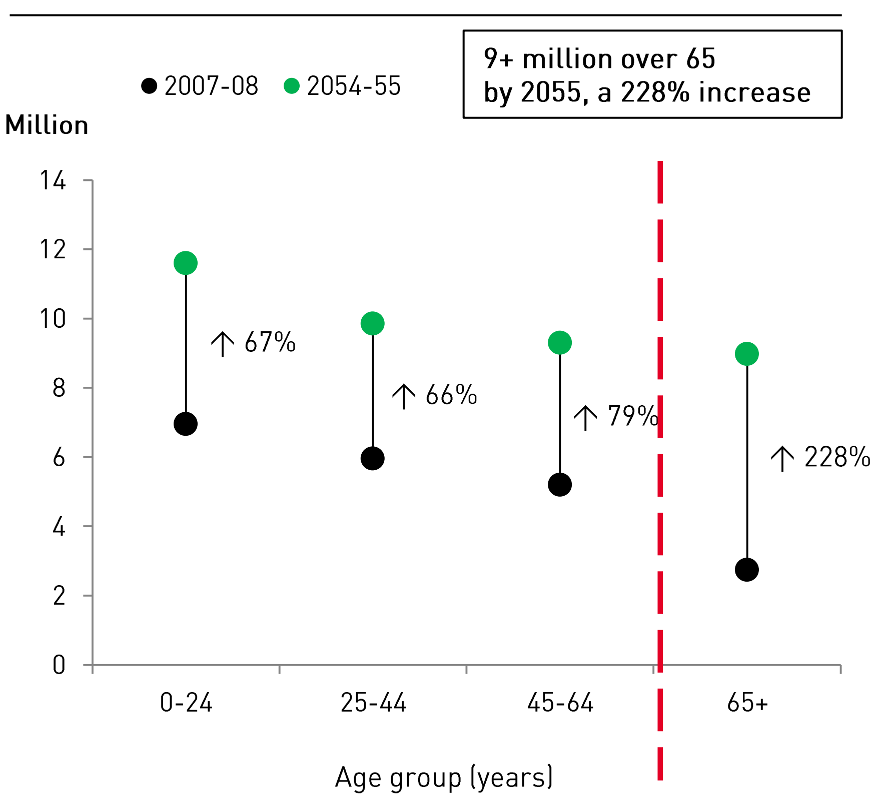
PRIMARY CARE AND THE CARE SUITE OF PROGRAMS

Rebecca Bell, General Manager – Utilisation Management

CHRONIC DISEASE

THE CHALLENGE AND IMPACT IS INCREASING





Note: Chronic conditions are self reported and comprise of; asthma, type 2 diabetes, ischaemic heart disease, cerebrovascular disease, arthritis, osteoporosis, chronic obstructive pulmonary disease, depression and high blood pressure

Sources: AIHW analysis of the 2007-2008 National Health Survey, Figure 6.22: Number of selected chronic conditions, by age group, 2007-08, Intergenerational Report 2015 (ABS + Treasury)

CONCENTRATION OF HEALTHCARE COSTS

OUR OWN MEMBERS SHOW SIMILAR TRENDS TO WHAT WE SEE NATIONALLY

2.2% of Medibank members

Consume 35% of all hospital and medical expenditure

70% of this group have underlying chronic disease

- 69 years old on average
- Approx. 13 hospital separations in 4 years
- 40% of all hospital bed days
- 3 Major Diagnostics Categories in 4 years

Source: Medibank data

FEE FOR SERVICE IS COMPROMISING THE ABILITY TO PROVIDE GOOD PRIMARY CARE FOR PATIENTS WITH COMPLEX CONDITIONS

"I can't fit them into a 10 minute consult slot. Patients have multiple co-morbidities; diabetes, osteoarthritis etc, but they come in to me when they have a cold and I have to deal with that cold – I don't get the opportunity to talk about their blood glucose or weight management."

OUR CARE SUITE OF PROGRAMS

Care POINT
The right direction for your health

Integrated care program targeting people who experience chronic & complex conditions.

Care 1 FIRST

Behaviour change focused model supported by telephonic & online education & navigation.

Care TRANSITION

Program integrated into the hospital discharge process that addresses the care needs of those most at risk of unplanned readmissions to hospital.

Complexity and cost of member needs

Integrated Care

Chronic Disease Management

Discharge assistance

Health Promotion for Healthy Populations
(no target healthcare needs)

Belle – a CarePoint case study

Belle is a confident and organised 81 year old woman. She has history of falls, Osteoarthritis, Osteoporosis, Bilateral knee joint replacements and recurrent Urinary Tract Infections. Belle lives with her elderly husband and spends most of her day in bed.

Home visit

- Revealed a history of falls and a wrist fracture (Belle's GP was unaware of frequent recent falls).
- Frequent Urinary Tract Infections – Belle does not usually report these to her GP until she is acutely unwell.

Interventions

An urgent OT home assessment organised and funded by CarePoint (the wait list for community OT was 8-12 weeks). OT assessment completed within three days of referral, subsequent implementation of falls minimisation education and strategies.

OT recommendations implemented by CarePoint Clinician which include referral for council funded personal care support to assist with energy conservation, and minimise falls risk due to fatigue. Introduction of a walking frame to support mobility and reduce falls risk, funded by patient.

Provision of OT recommended equipment to reduce risk of pressure areas and increase Belle's comfort and safety whilst in and out of bed. Funding to be a combination of community and brokerage.

CarePoint Clinician received call from Belle, reporting that she had a temperature, no appetite and thought she should go to hospital because she had no way to get to the GP.

CarePoint Clinician consulted with a GP who arranged for a Practice Registrar to visit Belle at home that day. Antibiotic therapy was commenced and further investigations scheduled as an outpatient. Hospital presentation was avoided.

Belle was unaware of supports available to her, including urgent GP appointments, afterhours GP visits and a Nurse on-call. The service suite was explained to Belle and her husband, with supporting brochures and fridge magnets placed in prominent positions in the home.

Feedback provided to GP regarding the falls who will reinforce recommendations of OT and Physiotherapist with the view to a Neurological review.

Marg – a CareFirst case study

Marg is 69 and diagnoses of Asthma, Coronary Heart Disease, Diabetes Type II and Osteoarthritis + BMI 37

My motivation: "I want to lose weight so I can be more mobile or healthy."

This goal was given a 'Priority 1' by the patient which represents its importance, and that Marg is ready to start immediately. Focused with "completing the six month CareFirst Program", the patient identified that she is "willing to change her diet as per a Dieticians advice and also exercises as recommended by the Physio".

Interventions

Medication review resulting in a new Diabetes medication with stabilised HBA1C.

Marg attended three Dietician consultations and has made improvements with regards to controlling carbohydrate intake, eating smaller portions, and "the patient reported a better understanding of correct portions and food types."

Marg engaged with a Physio, Dietician, Ophthalmologist and Podiatrist during the course of the program.

Through her coaching sessions with the Practice Nurse, Marg has developed a better understating of her health conditions and her confidence in managing them has increased.

Marg started personal training sessions, including organised pool sessions to help with movement in the context of pain. Marg also reports following an exercise video at home that her trainer provided.

Results

- Marg has achieved weight loss of >3 kgs.
- Exercise has increased from no activity per week, to 240 minutes.
- Healthy food choices are now being made five days per week.
- Marg has established ongoing plans for organised physical activity.
- Risk of hospitalisation (HARP tool) reduced from 20 (med-high) to three (low).

PROVING IT WORKS

STRUCTURED APPROACH TO DEMONSTRATING BENEFITS

Evaluation is a core component of the suite of programs:
We are working with Macquarie University, University of NSW, University of WA, University of Melbourne and Boston Consulting Group to ensure robust and efficacious evaluation.

We are constantly evaluating:

Process	Impact	Outcome
Did the program work? Did patients sufficiently enrol/attrite? Did GPs accept it?	Clinical indicators: blood glucose, weight loss etc. Patient self efficacy	Claims reductions as compared to matched statistical control groups

Q&A – HEALTH COST LEADERSHIP

GROUP Q&A

INVESTOR DAY

27 October 2015