EY Australian Private Health Insurance Update 2022

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EY Port Jackson Partners
Strategic Advisory

PRIVATE HEALTH INSURANCE INDUSTRY OBSERVATIONS – DECEMBER 2022

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- **The private health insurance sector performed well over the last 5 years:**
  - PHI adoption increased from FY20 to FY22 due to COVID raising people's awareness of health risks. Hospital coverage is strong at ~45% of population
  - The industry gross margin was 17% in 2022
  - The benefit payout ratio for not-for-profit funds was 83.7% relative to for-profit funds at 80.7%. This is a higher payout than other insurance sectors like general insurance that pays out an overage of about 65%
  - Non- Health Insurance Business (HIB) expenses at for-profit funds grew 19% in the last five years as providers invested in technology modernisation and experimented with primary care, secondary care, wellness and home care services that could not be expensed as part of HIB
  - Medibank recently experienced a massive cyber breach with private customer data leaked over the dark web. This has been a major wake up call for the sector on the importance of technology modernisation and security
- **The market structure has been stable during the past 5 years following 20 years of consolidation:**
  - The market is dominated by the largest 5 players who have 78% of market share, followed by a long tail of smaller players
  - Medibank, Bupa and HBF lost share relative to smaller players over the last five years, with Medibank restoring some lost growth in last two years
- **While PHI participation increased in response to COVID there are concerns about a resumption in the long-term decline in participation – particularly for younger people - that has been evident since 2015**
- **There are further opportunities to improve healthcare outcomes and the long-term sustainability of PHI:**
  - Changes to what can be expensed within HIB would encourage further service innovation
  - A care coordinator role would support the customer to navigate through the treatment pathway, ensure all data follows the patient through the treatment journey, and ensure that treatment options are transparent and evidence based. However, cultural changes including challenges by the AMA and Specialist Colleges may be needed to enable third parties to act as a care adviser when dealing with health services
  - New models including home care, and value-based payments could dampen health cost inflation and improve health outcomes

The last five years has been positive for the sector, though margins and ROE have fallen recently due to slowing premium growth and increasing expenses

ASSESSMENT OF SECTOR PERFORMANCE 2018 - 2022

Performance driver	Assessment	Rationale / comment
Regulatory environment	→	• Greater standardisation and comparability of PHI tiers has encouraged people to move to lower basic coverage • Increasing the age of dependents in education to 30 years has increased participation between 20 to 30 years old
Macroeconomic environment	→	• COVID 19 reduced health benefits payments, reducing industry costs and driving up gross margins • Pressure on government healthcare expenditure from escalating costs of NDIS and increased budgets for strengthening Medicare, childcare, the environment, women's safety, and education
Health insurance premium growth	↘	• Premium growth averaged 2.7% per year over the past 5 years – much lower than the 5-year period preceding it • Pressure on funds not to increase premiums ahead of wages growth
Health insurance benefits growth	↗	• Barriers to accessing hospitals for private procedures during COVID contained HIB growth • The industry benefits payout ratio fell in the last 5 years by 2.7%
PHI adoption	↗	• Pandemic fears encouraged more people to adopt PHI – driving adoption of hospital coverage to over 45%
Gross margin / ROE	→	• Industry gross margin improved by 2.7% – mainly due to subdued claims on health benefits during COVID • For-profit fund ROE fell by 10% due to a combination of slow premium growth and increasing expenses
Health care innovation	↗	• There has been strong innovation including launches of health loyalty, health technology & analytics, short-stay no-gap hospitals, telehealth, pay-as-you-go, care in the home and managed care models

Source: EY PJP analysis

CONTENTS

Private Health Insurance is an important element of the Australian Healthcare Industry contributing about 12% of total funding and is an important driver of customer choice and private healthcare innovation

AUSTRALIAN HEALTHCARE INDUSTRY SUMMARY

Australian total healthcare costs were A$221 billion in FY21 with a majority going to health services providers

- World class: World class in terms of access and quality, with private health insurance helping drive private healthcare innovation
- Efficient: Globally efficient in terms of spend as a percent of GDP – Australia spends ~10.6% of GDP in health expenditure compared to 18.8% for US, 12.9% for Canada, 12.0% for UK and 11.5% for Sweden

Public funding has grown at 5.8% per year – putting pressure on government budgets

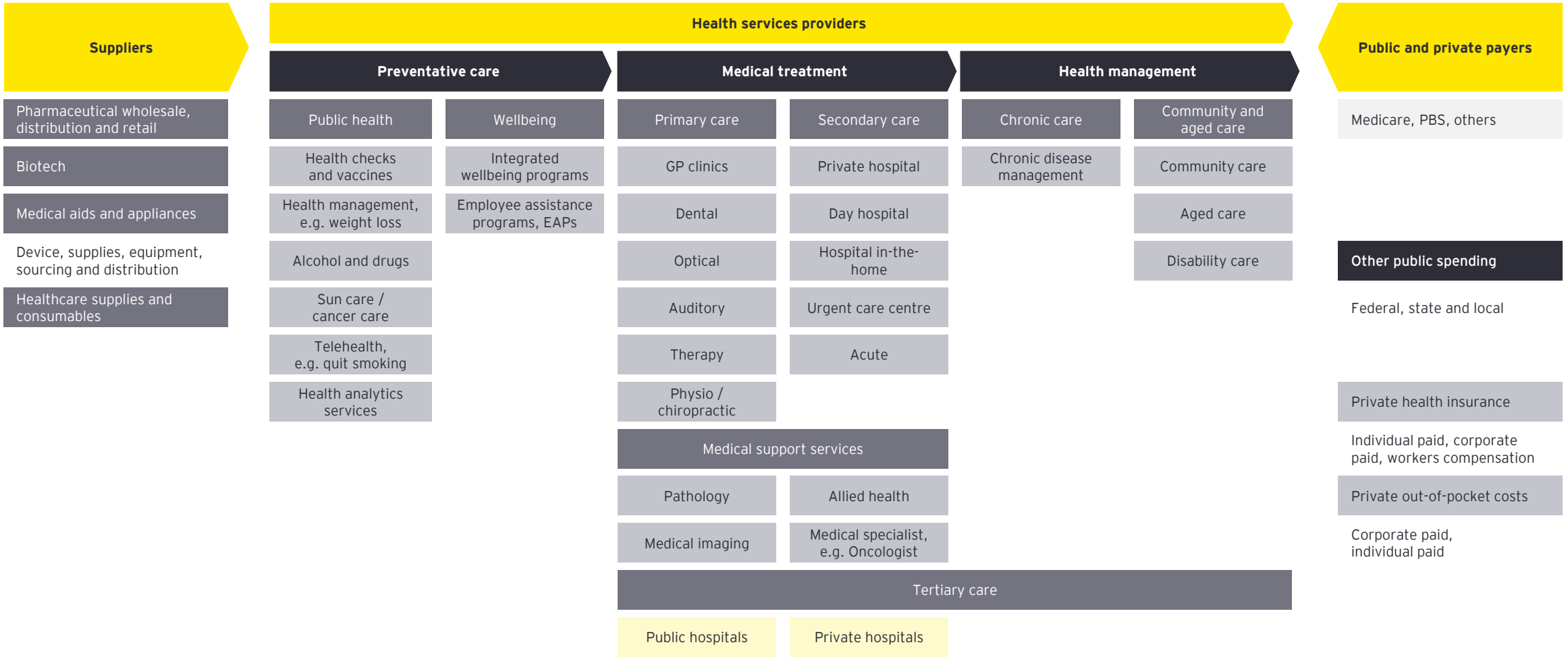
- There are long-term drivers of increased healthcare expenditure as a percentage of GDP in Australia including:
  - Aging population
  - Healthcare inflation
  - Incidence of chronic diseases
  - Increasing customer expectations
- Government funds about 70% of Australian Healthcare: Governments are seeking to reduce the public funding burden by more stringent funding of public hospitals, encouraging sources of non-public funding and encouraging system efficiency. The new Labor government has capped private health insurance rate increases at 2% per year for two years and wants lower-cost primary and community care, including regional medical clinics and home care

PHI funds about 12% of Australian Healthcare – which supports healthcare costs and drives innovation

- PHI provides choice to customers while relieving public funding pressure. Customers can switch between providers with portability of their benefits fully preserved
- PHI provides a secure source of funding for private health services. This encourages investment in private health services as well as a mechanism outside government to exercise some control over health spending
- The overall PHI industry risk profile is deteriorating as younger healthier people delay or refuse to join
- The highest growth in PHI membership over the last 4 years has been for age groups over 70 years old who drive health claims the most

Source: EY PJP analysis

Healthcare in Australia includes a set of public and private payers, public and private health services providers and private drug, equipment and consumables suppliers

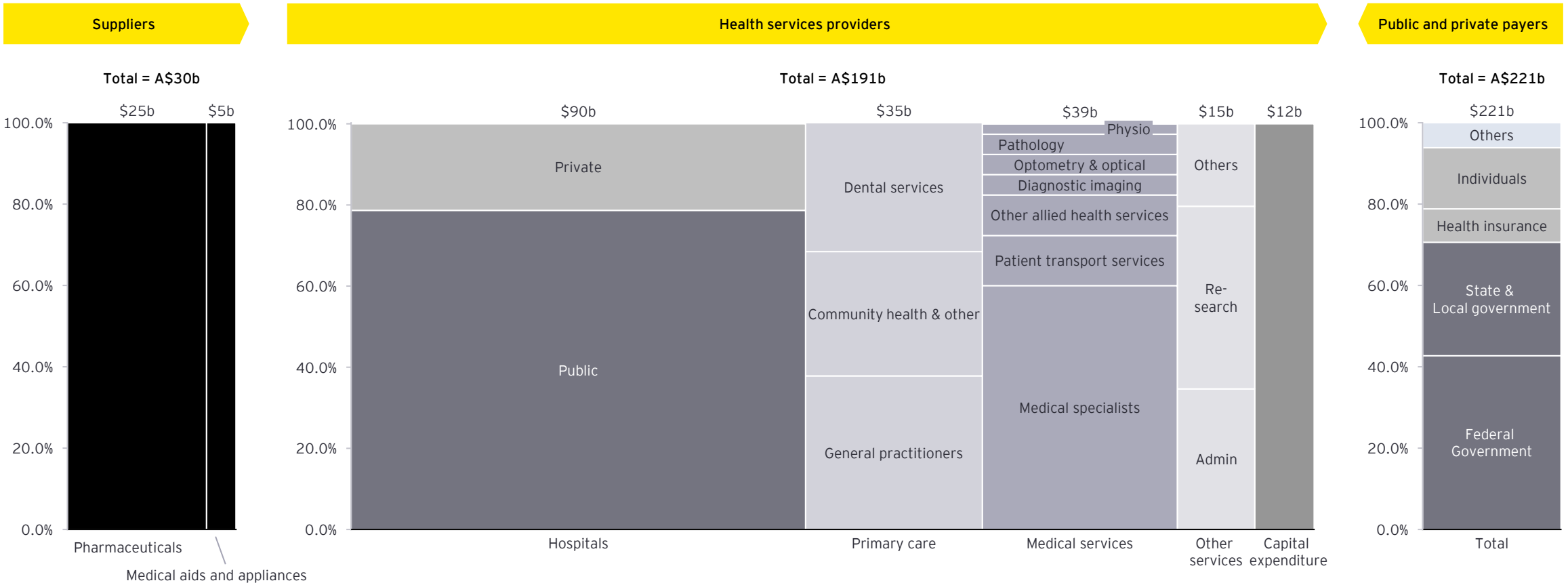


Source: EY PJP analysis

Australian healthcare is a ~AUD $221b market with most of the spend in health services providers; government provides ~70% of Australian healthcare funding

AUSTRALIAN HEALTH CARE EXPENDITURE FY21

$ Billions



Note: Values for medical specialists, other allied health services, diagnostic imaging, optometry and optical, pathology and physio are estimated

Source: AIHW Health Expenditure Australia 2020-2021; IBIS World; EY PJP analysis

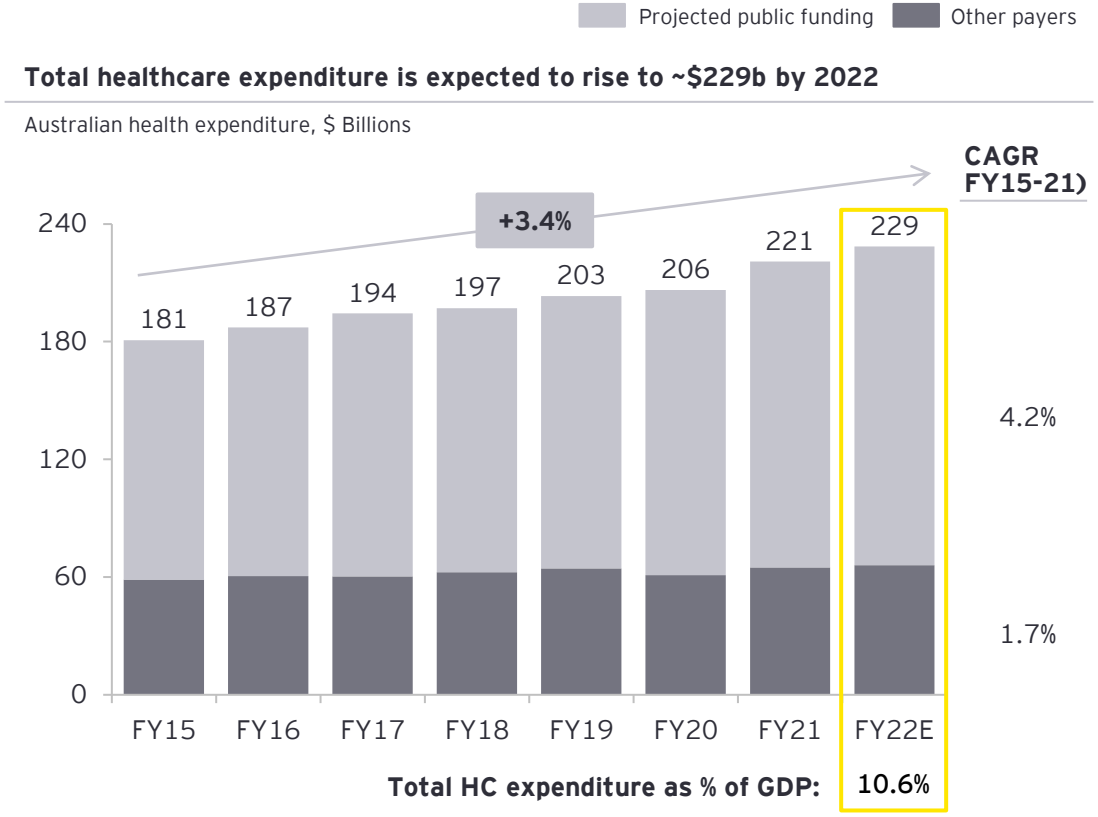
There are long-term drivers of increased healthcare expenditure as a percentage of GDP. We forecast that Australian health expenditure will grow to about 10.6% of GDP in 2022

DRIVERS OF HEALTHCARE EXPENDITURE

Drivers of increased healthcare costs in Australia

1.	**Aging population**	• Care costs rise as older people seek a higher volume of treatment, and cost per treatment increases
2.	**Healthcare inflation**	• Rapid expansion of new drugs, services, procedures and advanced medical technologies that cost more • Inflationary pressure from supply chain interruptions, health labour costs and labour shortages
3.	**Incidence of chronic diseases**	• Morbidity is increasing, complicating acute admissions • Chronic disease requires management that is more long-term than acute care
4.	**Changes in customer expectations**	• Demand for comfort in hospital rooms (privacy, bed quality, food quality, cable tv etc) • Expect health to be provided as a consumer service with digitisation and immediate response but still regard services as emotionally very personal

Total healthcare expenditure is expected to rise to ~$229b by 2022



Note: Reported numbers till 2021. 2022 values for total Australian expenditure as well as public funding and other payers expenditure calculated by applying CAGR rates on 2021 figures

Source: AIHW Health Expenditure Australia; ABS population projections; OECD GDP forecasts; Department of Health and Aged Care; EY PJP analysis

CONTENTS

The PHI market is dominated by the largest 5 players who have 78% market share, followed by a long tail of smaller players. The largest players have meaningful shares across key states

PRIVATE HEALTH INSURANCE STRUCTURE

- The market is dominated by the largest 5 funds who have 78% of market share, followed by a long tail of smaller players
- The largest 5 funds are a combination of listed and unlisted for-profit funds and not-for-profit funds
- There has been a gradual process of market consolidation and a handful of new entrants to PHI over the last 25 years
- The PHI market is regulated on a state-by-state basis. In most states the top-4 insurers BUPA, MPL, HCF, nib share about 70% to 80% share. The exceptions are in WA where HBF alone has 50% share and SA where BUPA has 47% share
- Bupa, Medibank and HBF lost share over the last 5 years to HCF, nib and smaller funds – though Medibank recovered some lost share in the last two years

Source: EY PJP analysis

There are 10 for-profit funds and 24 not-for-profit funds

MARKET PARTICIPANTS AS AT JUNE 30 2022

34 private health insurers as at 30 June 2022

10 for-profit funds

1 restricted membership

- Doctors Health Fund

9 open membership

- Australian Unity Health Limited
- BUPA Australia
- CUA Health Limited
- Medibank Private Ltd
- nib Health Funds
- Queensland Country Health Fund
- NHBA (OMF)
- CBHS Corporate Health Fund
- Transport Health

24 not-for-profit funds

10 restricted membership

- ACA Health Benefits Fund
- CBHS Health Fund
- Defence Health
- Navy Health
- Nurses & Midwives Health
- Police Health
- Reserve Bank Health Society
- Railway and Transport Health
- Teachers Federation Health
- Queensland Teachers' Union Health Fund

14 open membership

- CDH
- GMHBA and Frank Health Insurance
- HBF
- HCF
- Health Care Insurance
- Health Partners (HP)
- HIF
- Latrobe
- Mildura Health Fund
- MO Health Pty Ltd
- PeopleCare
- Phoenix Health
- St Lukes
- Westfund

Source: APRA PHI data; EY PJP analysis

There's been a gradual process of market consolidation over the last 25 years and a handful of new entrants to PHI

MARKET CONSOLIDATION

Mergers and acquisition	• Private health insurers Bupa and MBF merged in 2008 – a $2.4 billion agreement • Medibank and ahm finalised their merger in 2009, where Medibank wholly acquired ahm's health benefits fund • In December 2008, Manchester Unity merged with HCF resulting in HCF acquiring 11.5% of national market share at the time • Nib acquired GU health in October of 2017 • HBF announced in May 2021 it will acquire 100 per cent of the shares in CUA Health Limited (a for-profit wholly-owned subsidiary of the mutual bank CUA) • HCF are finalising a merger with Rail & Transport Health Fund Limited (a not-for-profit fund) • GMHBA Limited announced they have integrated their wholly-owned subsidiary health.com.au with an online brand Frank to create efficiencies
New entrants	• In 2016 CBHS Corporate Health (CBHSC) was established as a subsidiary of CBHS • Nurses & Midwives Health became a subsidiary of Australia's industry-based fund, Teachers Health on January 1, 2022 • Emergency Services Health was established as a subsidiary of the Police Health Group in 2016, and now operates a PHI fund • MOH – established 2017 now AIA health • Health.com.au established in 2011 now owned by GMHBA Limited (acquired in July 2015)

With the increasing commercial pressure on health funds, many are considering consolidation to maintain viability. In mid-2019, Peter Kohlhagen, from the Australian Prudential Regulation Authority ('APRA'), outlined the threat of forced mergers or closures in relation to individual insurers that failed to address viability concerns

More recently APRA has been asking certain insurers to provide a recovery plan:

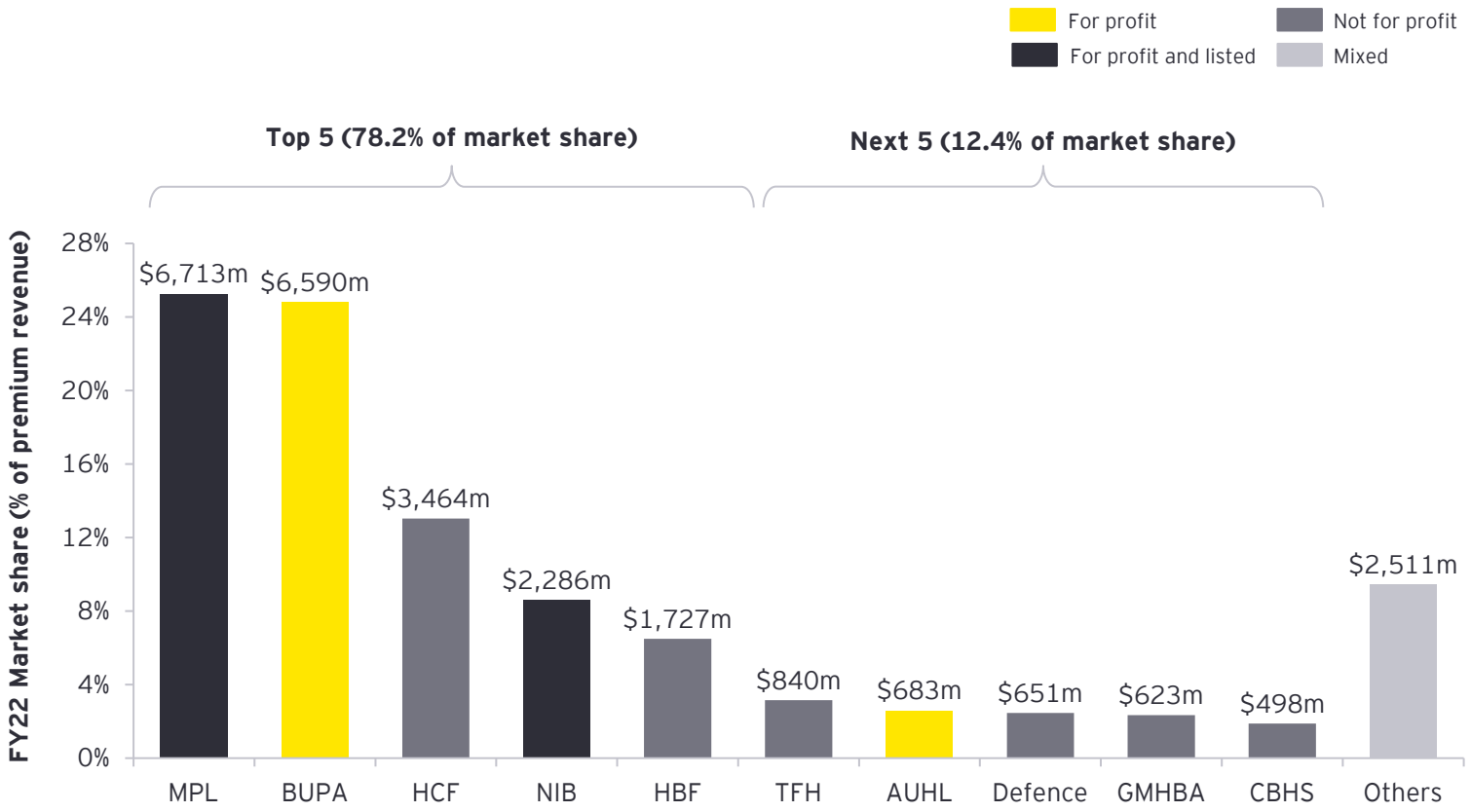
- Those identified were considered most likely to face sustainability challenges
- Aim was to manage affordability and policy change risks
- They were ask to define specific timeframes and guidance
- Designed to improve sector's preparedness for adverse event when merging

It is generally accepted that those funds at most risk of adverse events include smaller not-for-profit funds that do not have the flexibility and scale to adapt to changing market conditions

Source: APRA June 2022 PHI; company website; company annual reports; EY PJP analysis

The top 5 players have 78% market share, the next 5 have 12.4% followed by a long tail of other players

MARKET SHARES BY FUND, FY22



Key Insights

- The two market leaders MPL and Bupa have positioned themselves strongly and control over half of the market
- Further consolidation of the industry is hampered by high capital levels and difficulties in de-mutualising
- Smaller funds are challenged to invest in the health management and care coordination transition and to retain scarce talent
- Smaller funds can compete by forming alliances, such as the Australian Health Service Alliance ('AHSA'), when negotiating contracts with private healthcare providers. Funds can also group together to obtain services like technology, data and analytics including through the HAMBS platform used by many smaller funds. Members Health also supports non-for-profit funds to market benefits of mutuals in PHI
- APRA has taken a positive view on consolidation, stating that health insurers with low or negative member growth should actively consider mergers

Source: APRA June 2022 PHI (Private Health Insurance Operations Report 2021-22); EY PJP analysis

The top-5 funds include open not-for-profit funds and listed and unlisted for-profit funds

PROFILE OF TOP-5 PHI FUNDS

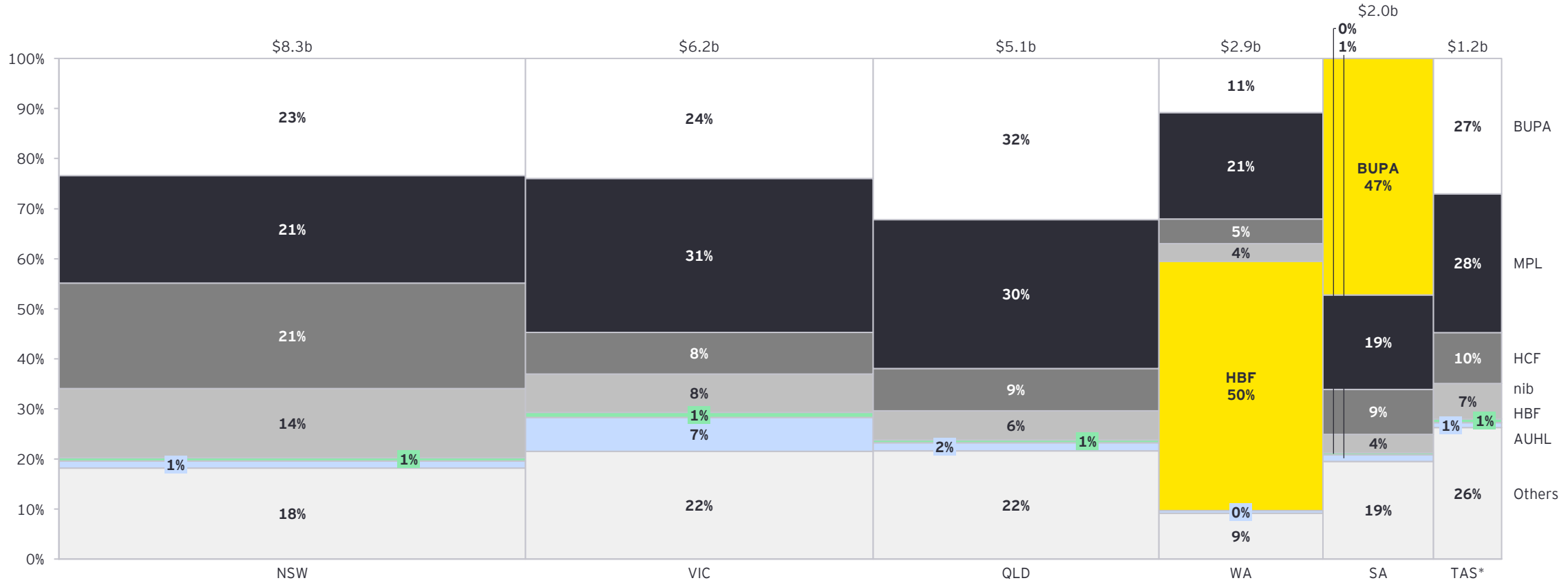
Type	Company	Description	Premium revenue FY22, A$ Millions
1. For-profit	medibank	• Largest player in Australia, with 25.2% share. Has been operating on a for-profit basis since being privatised in 2014 • Owns and operates ahm - acquired in 2009 • Investing in preventative health and reimagining healthcare to improve member experience • Pioneering at home care service • Recently launch a wellbeing app • Currently dealing with a major cyber attack which occurred in October of 2022	6.7 (25.2% share)
2. For-profit	Bupa	• For-profit, Australian subsidiary of a UK-based healthcare group (not-for-profit) • Second largest player in Australia with over 24.8% market share • The first health insurer to fund claims for services delivered via telehealth, also introduced new mental health support, access to a digital fitness wellbeing app, innovative diabetes management options and a new physiotherapy treatment service delivered by virtual reality • Pioneer in Aged Care provision as a PHI – but came under pressure from the Aged Care Royal Commission • Expanding their care offerings and is opening more GP clinics	6.6 (24.8% share)
3. Open not-for-profit	HCF	• Largest not-for-profit private health insurer – with a stronghold in NSW • Over 1.75m Australians covered under its 800,000+ policies, with average membership length of 12 years • Ranked #1 in member satisfaction of the major health funds (major competitors - Bupa, Medibank and nib) in FY2021 • Focus on building the best experience for members – recently delivered a large transformation project 'Project Phoenix' • Provider of dental and optical services for members in NSW	3.5 (13.0% share)
4. For-profit	nib	• Fourth-largest private health insurer – with a stronghold in Newcastle / NSW and has a NZ PHI business • Investing in delivering personalised healthcare to customers by applying data science and predictive analytics to develop deep insight into the health risk of individuals and treatment pathways – in partnership with Cigna through a joint venture named Honeysuckle • Strategy of promoting better health and wellness • Targets younger and healthier members including students and workers on visas • Recently announced it is raising $150m to fund acquisitions in NDIS plan partner growth strategy	2.3 (8.6% share)
5. Open not-for-profit	hbf	• Not-for-profit health fund operating primarily in the WA market, but diversifying into other markets at a rapid pace (from ~12% non-WA policies in 2021 to ~19% non-WA policies in 2022) • Australia's second-largest not-for-profit health fund, providing hospital and ancillary insurance to 1.1m members nationwide • Investments in technology to drive core digital transformation program • Focus on organic as well as inorganic growth including acquisition of CUA Health in FY22 • Proposed merger with HCF fell over in 2018	1.7 (6.5% share)

Source: APRA June 2022 PHI; company website; company annual reports; EY PJP analysis

In most states the top-4 insurers BUPA, MPL, HCF, nib share about 70 to 80% share. The exceptions are in WA where HBF alone has 50% share and SA where BUPA has 47% share

MARKET SHARE BY STATE

Percent



Note: TAS includes ACT and NT

Source: APRA June 2022 PHI (Operations of PHIAC Annual Reports); EY PJP analysis

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Bupa, Medibank and HBF lost share over the last 5 years to HCF, nib and smaller funds – though Medibank recovered lost share in last two years and is now the largest fund

AUSTRALIAN PHI MARKET SHARE BY INSURER, FY18-FY22

Percent of share premium revenue

Source: APRA June 2022 PHI; EY PJP analysis

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CONTENTS

PHI adoption has traditionally balanced on countervailing incentives for adoption which change from time to time based on government policy, pricing and customer understanding of PHI

PHI GROWTH AND ADOPTION

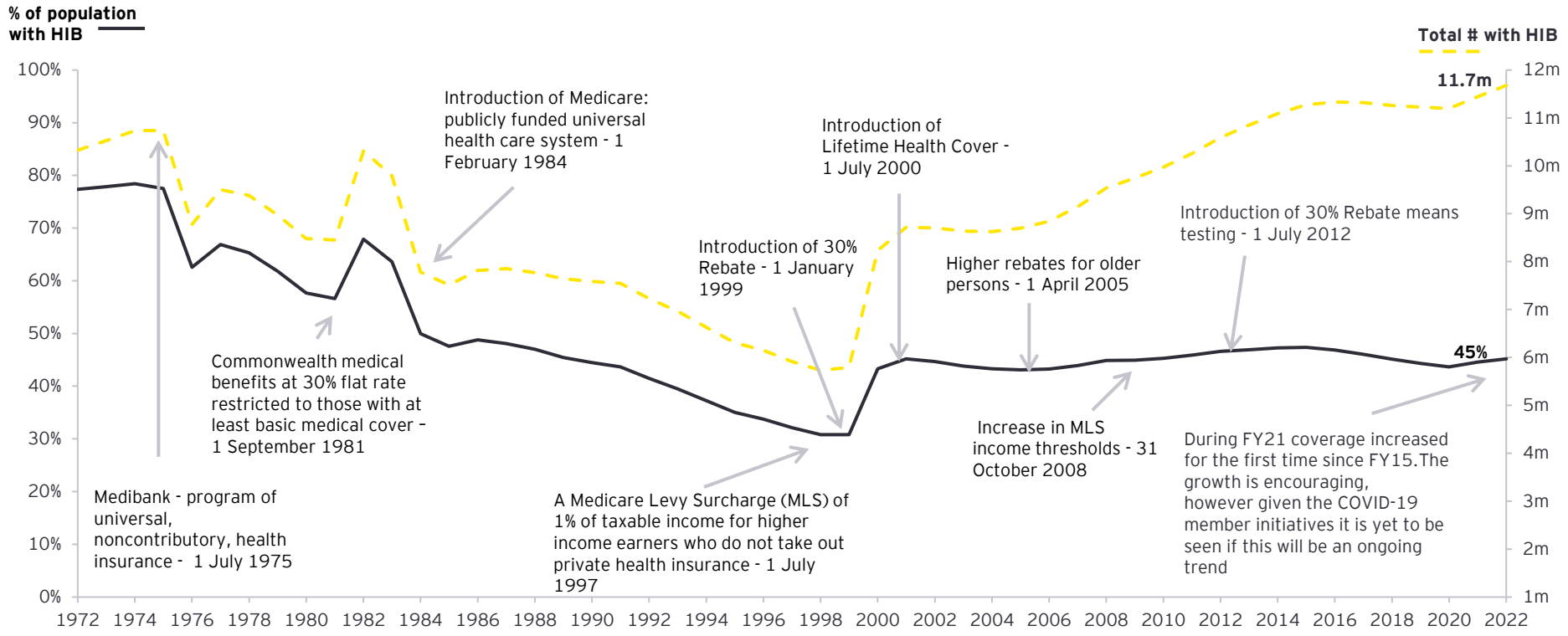
Government Policy	– Regulation of PHI includes community risk rating and risk equalisation which impacts fund ability to price discriminate or select risks. – This aims to ensure all Australians can access private health insurance and ensure portability of cover – PHI adoption declined from ~80% in 1972 to 45% in 2022 – Participation increases for people after 30 due to the lifetime health cover loading and the Medicare levy surcharge – Participation is low in the 20–29 age group but has increased though recent changes to enable dependent adolescents and students up to age 30 to remain on family policies – The introduction of product tiers has made it easier for customers to compare covers and reduce price for basic cover
Other drivers of adoption	– PHI adoption increased from FY20 to FY22 due to COVID raising people's awareness of health risks – The introduction of product tiers and the creation of basic and high excess products increased PHI adoption for younger single people – with most choosing the cheapest basic cover product – Affordability issues have become a concern as rate increases exceeded wage growth over the period 2015 to 2020 – when overall PHI adoption fell – Many policyholders have been sensitive to out-of-pocket fees for specialists not covered by PHI – There is a low overall consumer understanding of what is exactly being covered by the health insurance product

Source: EY PJP analysis

PHI adoption fell from ~80% of the population in 1972 to 45% in 2022, but the absolute numbers of Australian's covered has increased to about 12 million

PRIVATE HOSPITAL INSURANCE ADOPTION, 1972 TO 2022

Percent with HIB coverage

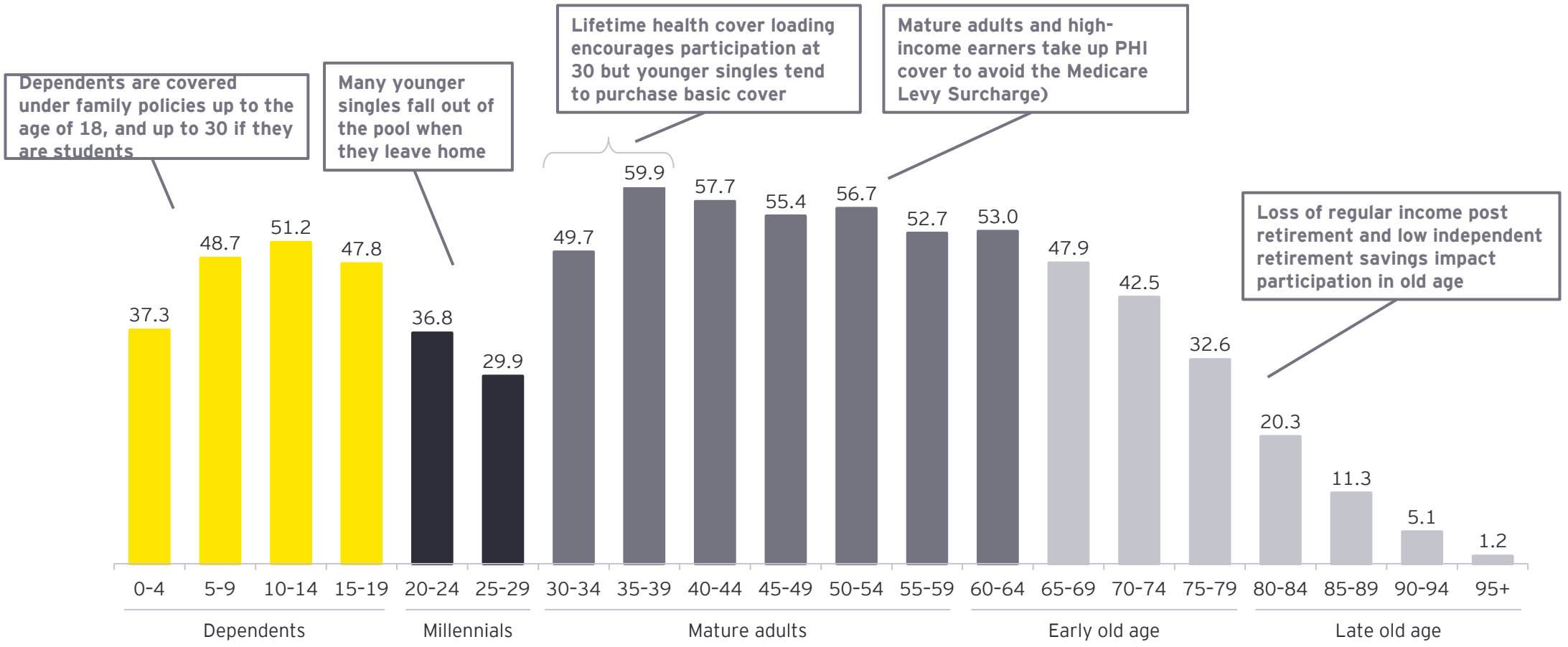


Source: APRA June 2022 PHI

Adoption falls in the 20-29 age group, but picks up after 30 due to the lifetime health cover loading. Higher income people stay insured to avoid the Medicare levy surcharge

PHI ADOPTION BY AGE GROUP*, FY22

Percent of population by age group



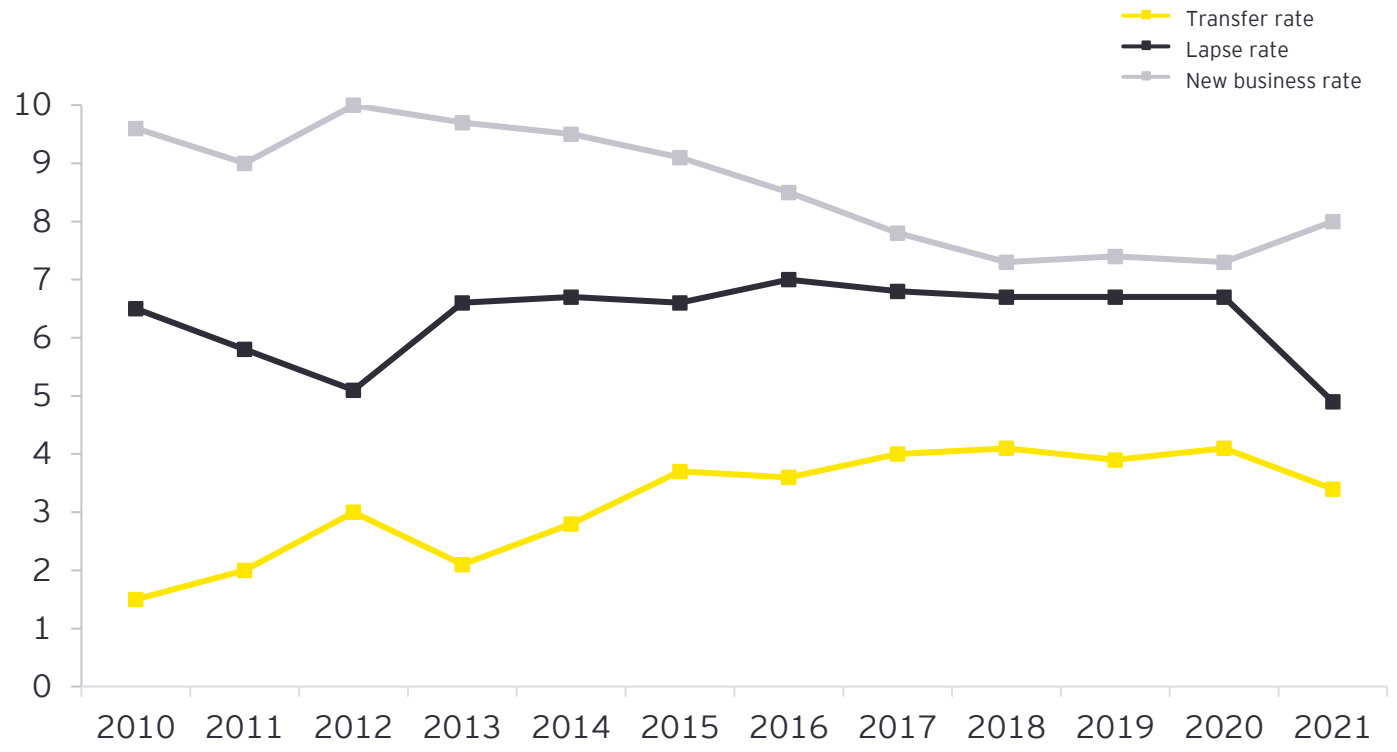
* Calculated participation rate by dividing total population by age group (ABS data – Dec 21) with Hospitals treatment insured persons by age (APRA PHI data – June 2022)

Source: APRA June 2022 PHI; ABS statistic; EY PJP analysis

Private health insurance transfer rates increased steadily after the emergence of comparison sites like iSelect in 2000 that encouraged policyholders to shop around and compare PHI prices

HISTORICAL INDUSTRY SALES, LAPSE AND TRANSFER RATES

Percent



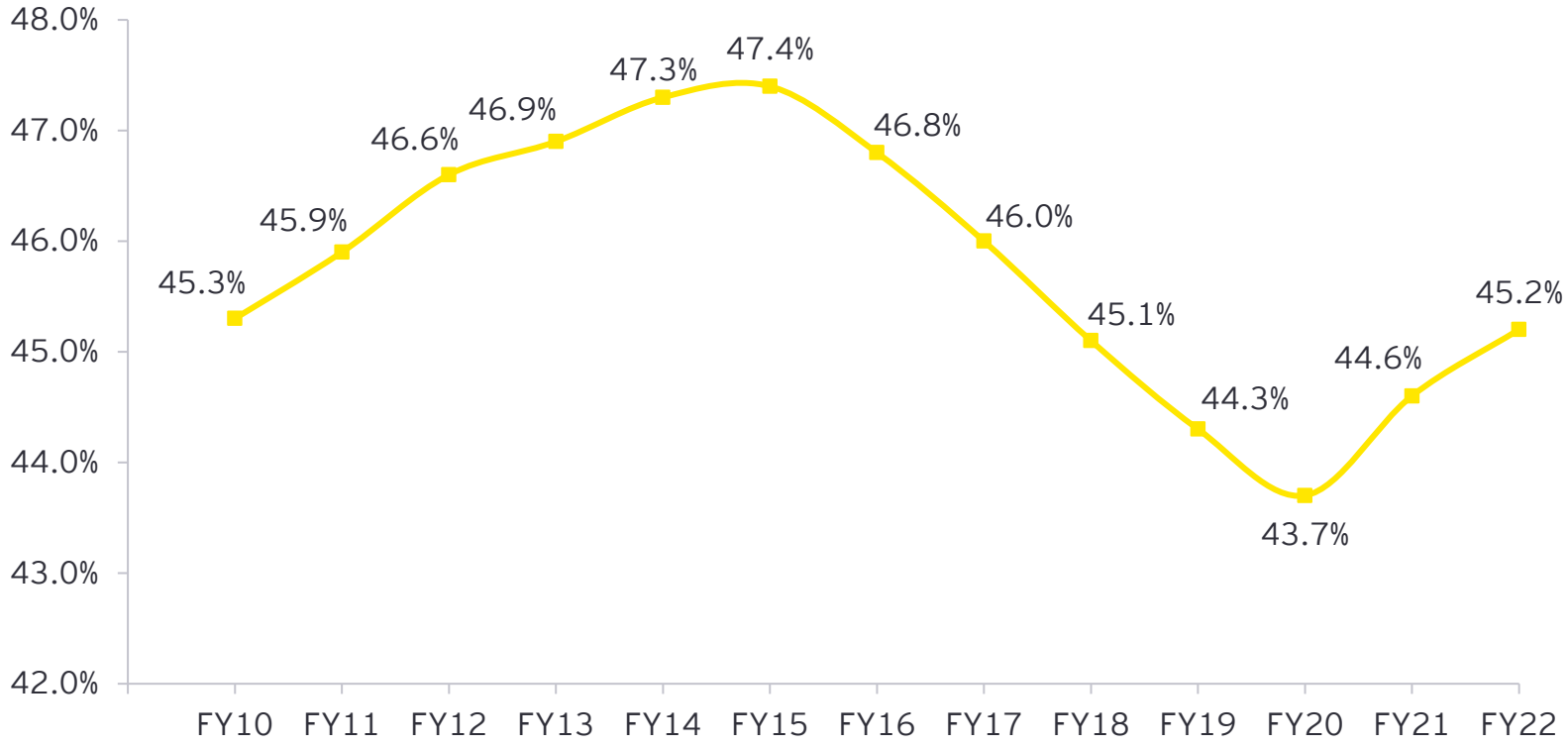
Key insights

- **Lapse rates have been stable for most of the last 10 years** but fell in COVID as people held onto their policies
- **New business rates have been falling for last 10 years** but stepped up in COVID as people felt the need for PHI
- **Transfer rates increased steadily in the last 10 years** from about1.5% to 3.5%, though this fell in 2021 with fears about health impacts from COVID
- **Switching is a double edged sword.** It demonstrates that people are exercising their consumer rights in a community rated market but it also costs the industry and consumers in the commissions paid on switching

PHI adoption fell from 2015 to 2020 and then increased from FY20 to FY22 due to COVID. PHI adoption post COVID remains a concern

PHI ADOPTION HOSPITAL COVERAGE

Percent of population



Key insights

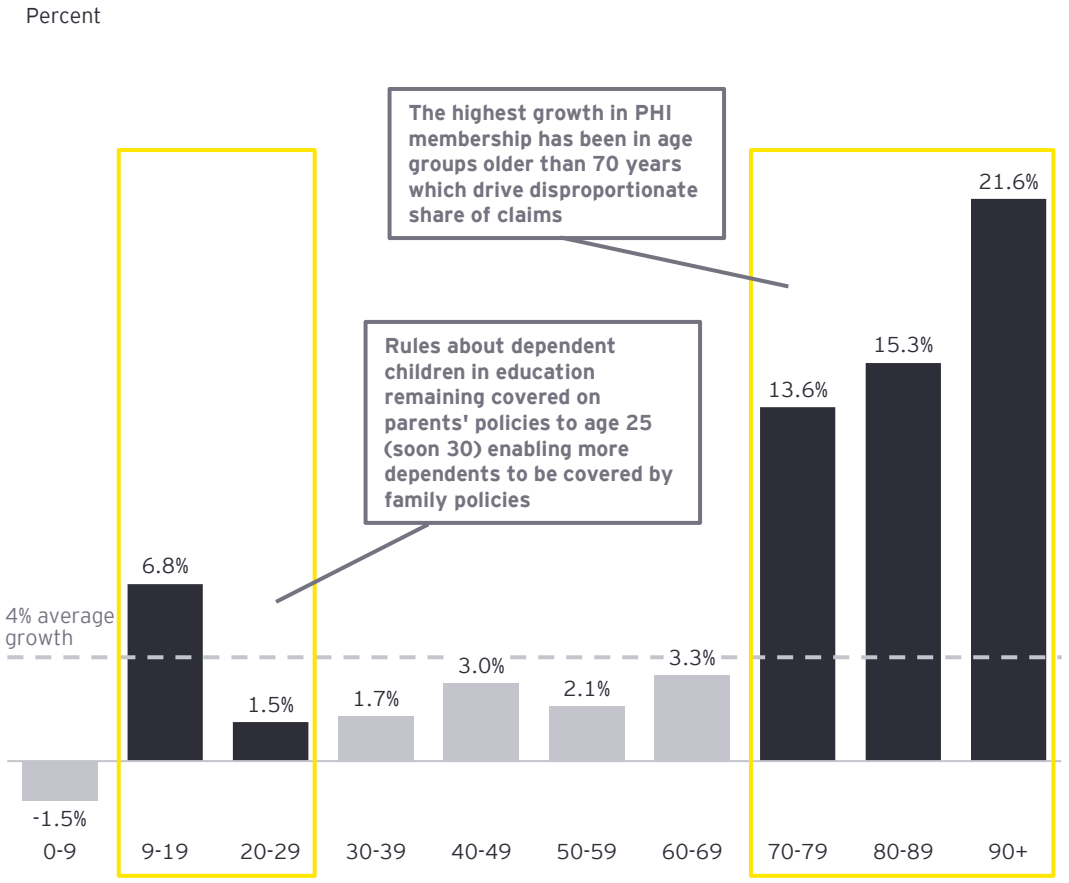
- Hospital coverage is strong at ~45% of population
- COVID-19 induced health concerns stimulated demand for hospital coverage between 2020 and 2022 which had been declining since 2015
- There are concerns that the industry will resume a downward trend in hospital coverage again when the impact of COVID starts to fade

Source: APRA June 2022 PHI; EY PJP analysis

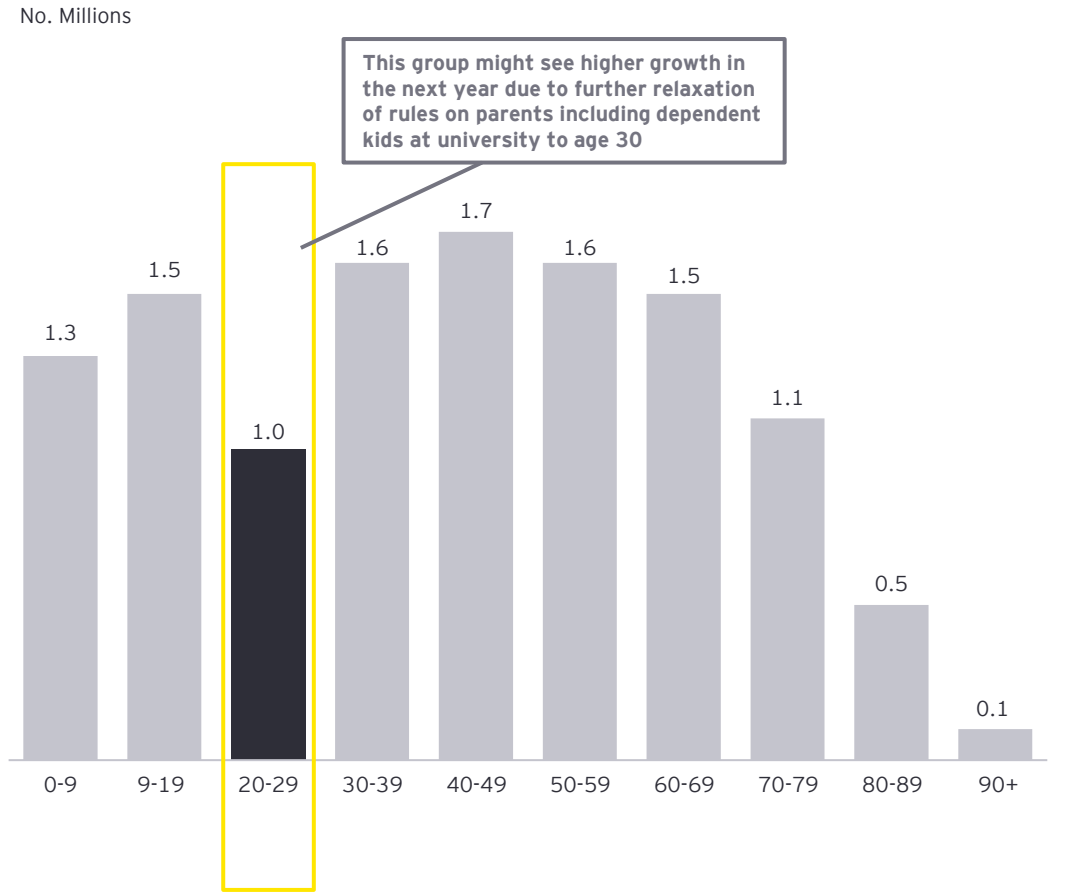
The highest rate of growth in PHI membership over the last 4 years has been for age segments over 70 years old who drive health claims the most

PHI HOSPITAL MEMBERSHIP BY AGE GROUP

Growth in membership, FY19-22



Membership by age group, FY22



Source: APRA June 2022 PHI; EY PJP analysis

The industry has embraced standard product tiers, under-30s discounts and higher hospital excesses to improve affordability introduced by the Liberal government

INDUSTRY PROGRESS ON GOVERNMENT REFORMS

Regulatory change	• **Product standardisation** – Mandatory requirement for all insurers to classify their hospital products into four categories; gold, silver, bronze and basic • **Under-30s discount** – Allowing insurers to discount hospital insurance premiums for 18 to 29 year-olds by up to 10 per cent • **Higher hospital excesses** – Increasing the allowable excess of MLS compliant hospital policies from $500 to $750 for singles and $1000 to $1500 for non-singles • Reducing benefits for medical devices / prostheses • Preventing insurers from offering some natural therapies benefits • Simplifying the administration of second-tier default benefit arrangements between insurers and hospitals
Progress on reforms	• Almost all insurers have now re-structured their existing products to align to the G / S / B / Basic clinical coverage classification • If implemented effectively, products with reduced levels of coverage will be more transparently marketed • Greater standardisation and comparability of products is likely to increase switching behaviour and price elasticity • May force an overall discount for young policyholders, resulting in a decrease in industry premiums • Its uncertain whether lower prices for young people will be offset by higher volumes of new younger PHI policyholders • Most insurers are already offering higher excess products at lower prices • The overall impact is still uncertain. Positive impacts of encouraging new policyholders to PHI via lower prices and reducing the extent of downgrading (i.e. downgrading excesses instead of product coverage levels) may be offset by negative impacts of encouraging risk averse / non-claiming policyholders not wishing to reduce coverage to downgrade excesses • Reduced claims costs and expenses • Insurers will be expected to demonstrate that these reduced costs are reflected in future rate rises

Labour has imposed a 2 year cap on rate increases of 2% per year and will prioritise Medicare and primary health over private health insurance

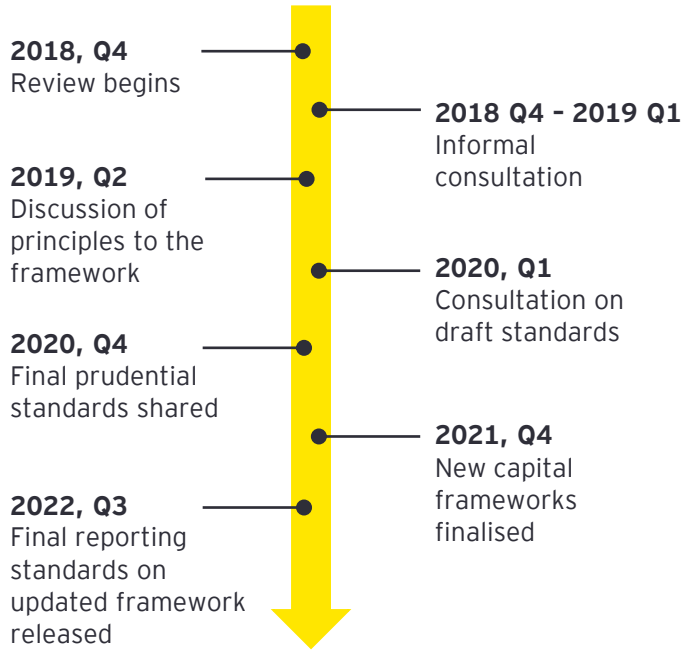
RECENT REFORMS TO PHI AND HEALTH POLICY

Liberal Government PHI reforms, 2019 - 2021

- First wave of reforms
  - Tier-based classification of private hospital cover
  - Discounts for younger population
  - Higher excess in exchange for lower premiums
  - Travel and accommodation benefits for people travelling long distances for hospital treatment
  - Improved access to mental health treatment
  - Strengthen powers to investigate complaints and other issues
- Second wave of reforms
  - Increasing the age of dependents to 30 years
  - Transparency of out-of-pocket costs
  - Expanding home and community-based mental health and rehabilitation care
  - Actuarial studies of incentives
- Third wave of reforms
  - Review and enhancement of the government's PHI Rebate Model
  - Investigation of private hospital default benefit arrangements
  - Improvements to the certification process for admitting patients to hospital

APRA capital regulation changes

- In Nov'18, APRA began a review of the capital requirements of private health insurers
- APRA stated that the objective of the review is not to increase or reduce the overall industry capital levels; but 'there are factors that may lead to increased minimum capital requirements'



Labor government PHI & NDIS policies, 2022

- Labor announced in 2019 that it would establish a permanent Australian Health Reform Commission – an independent, legislated body comparable to the Productivity Commission to advise State and Federal government on healthcare issues.
- Labor committed to cap private health rate increases at 2% per year for two years, to save families around $340 a year or $148 for young singles and $264 for a single parent
- Labor's health budget in 2022 focused on increasing public funding for Medicare by $6.4 billion over previous Liberal health budget
- Total spending on medical benefits including Medicare will hit $31.3 billion by 2025-26. This included increases pharmaceutical benefits
- The Labor government has committed $235 million to establish 50 Urgent Care Clinics for people requiring urgent but not life-threatening issues to take pressure off public hospitals and improve access to primary care in regional areas
- The Labor government invested $750 million of a 'Strengthening Medicare Fund' to improve patient access to doctors
- The Labor government has retained the 1st and 2nd wave of reforms to PHI introduced by the Liberal Government

Source: APRA publications; Department of Health and Aged Care; Finder

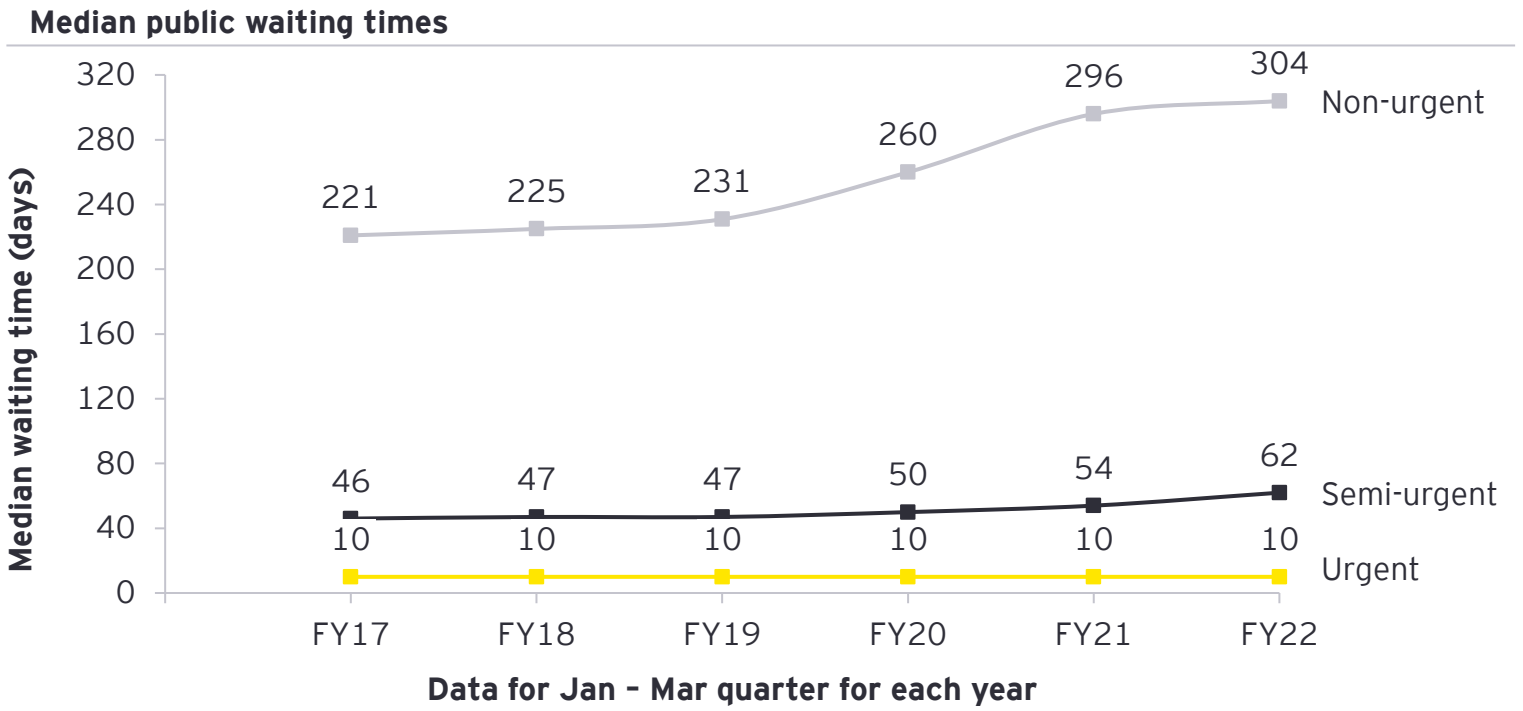
There's a delicate balance for PHI in creating and selling a compelling value proposition to different customer segments and addressing value challenges

AT A GLANCE: PHI VALUE PROPOSITION

Points of value	**Choice of specialists**	• PHI can enable policyholders to have choice over specialists, which can improve their health outcomes
	Avoid waiting lists	• PHI can help policyholders avoid public waiting lists and receive treatment in either public or private hospitals which is important when delays in public hospitals are over 300 days
	Peace of mind	• PHI can provide added protection again out of pocket expenses if treatment is needed
	Access to private health services	• Provides consumers with choice and access to private healthcare services, including private rooms and better facilities
	Access to higher level of service	• Ability to receive a higher level of service where the consumer is willing to pay for it
	Avoidance of tax	• Some consumers will purchase private health insurance to avoid the Medicare levy surcharge
Value challenges	**Tight regulations**	• PHI includes strict regulations around what must be covered and what can and cannot be covered by PHI
	Transparency	• There is a lack of transparency around what is covered and to what extent it is covered (out-of-pocket)
	Cost	• PHI inflation was consistently higher than CPI and wage inflation until 2022 which general inflation escalated sharply
	Complexity	• PHI products are very complex and this makes it hard for funds to differentiate themselves or for the customer to distinguish between products
	Perceived low value	• High (and increasing) out-of-pocket costs lead to decreased perception of PHI value
	High public health standard	• The high standard of the public health system means that consumers are less likely to need private health cover and there have been incentives for privately funded patients to admit to public hospitals to avoid out of pocket expenses and gap payments

PHI enables greater speed and choice for elective surgery which is important when public waiting times on non-urgent surgery exceed 300 days

INCREASES IN PUBLIC WAIT TIMES ENCOURAGE PHI PARTICIPATION



Key insights

- In the last 6 years median wait times for non-urgent hospital procedures has blown out from 221 days to over 300 days
- For some locations and procedures the waiting time can be multiple years
- Important procedures (e.g. tonsillectomies) can be accessed in under a month in the private system, but waiting times in the public system can stretch to several hundred days
- Deteriorating waitlists for public hospital procedures is likely to encourage PHI participation post COVID

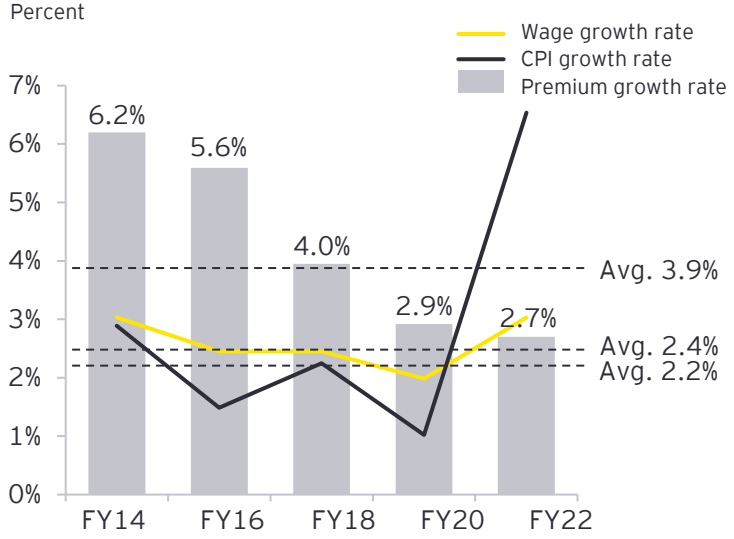
Source: Healthcare Quarterly (Jan-Mar 2022); EY PJP analysis

Until recently PHI premiums increased faster than wages putting pressure on affordability for members. Members have also expressed concerns about unexpected gap payments and have struggled to understand complexity of PHI. As a result many people have downgraded PHI cover levels to basic tiers

TREND TO DOWNGRADE PHI COVER

Premiums increases have been falling but still raising faster than wages until FY22

Average premium rate growth
Percent



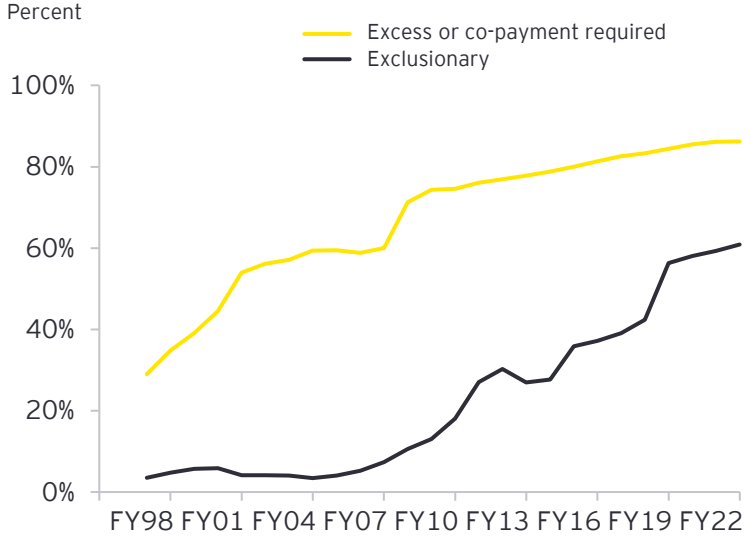
> Despite the lowest increase in two decades, health insurance premiums are still growing quicker than wages or inflation, raising concerns that affordability is spiralling out of control
>
> – The Choice, April 2022

Other member concerns

- Out-of-pocket costs can be significant, especially in hospital specialist fee 'gaps' in private hospitals
- PHI holders are admitting into public hospitals to avoid out-of-pocket expenses and gaps
- Private health insurers are excluded from primary health care and most out-of-hospital health services, possibly contributing to perception of high out-of-pocket costs
- Patients struggle to shop around for better value treatment because of a lack of information, cost, and the mental stress of injury
- Specialists drive healthcare pathways so patients do not always get presented with alternatives
- Complexity of PHI: Limited understanding of how it complements the 'free' public system
- High annual rate increases lead to switching behaviour, negative press, poor value propositions
- Comparison to a good public system: Reduces the value proposition of PHI, leads to members questioning why they need PHI

People have been downgrading PHI cover levels

PHI policies with excess/co-payments or exclusions
Percent



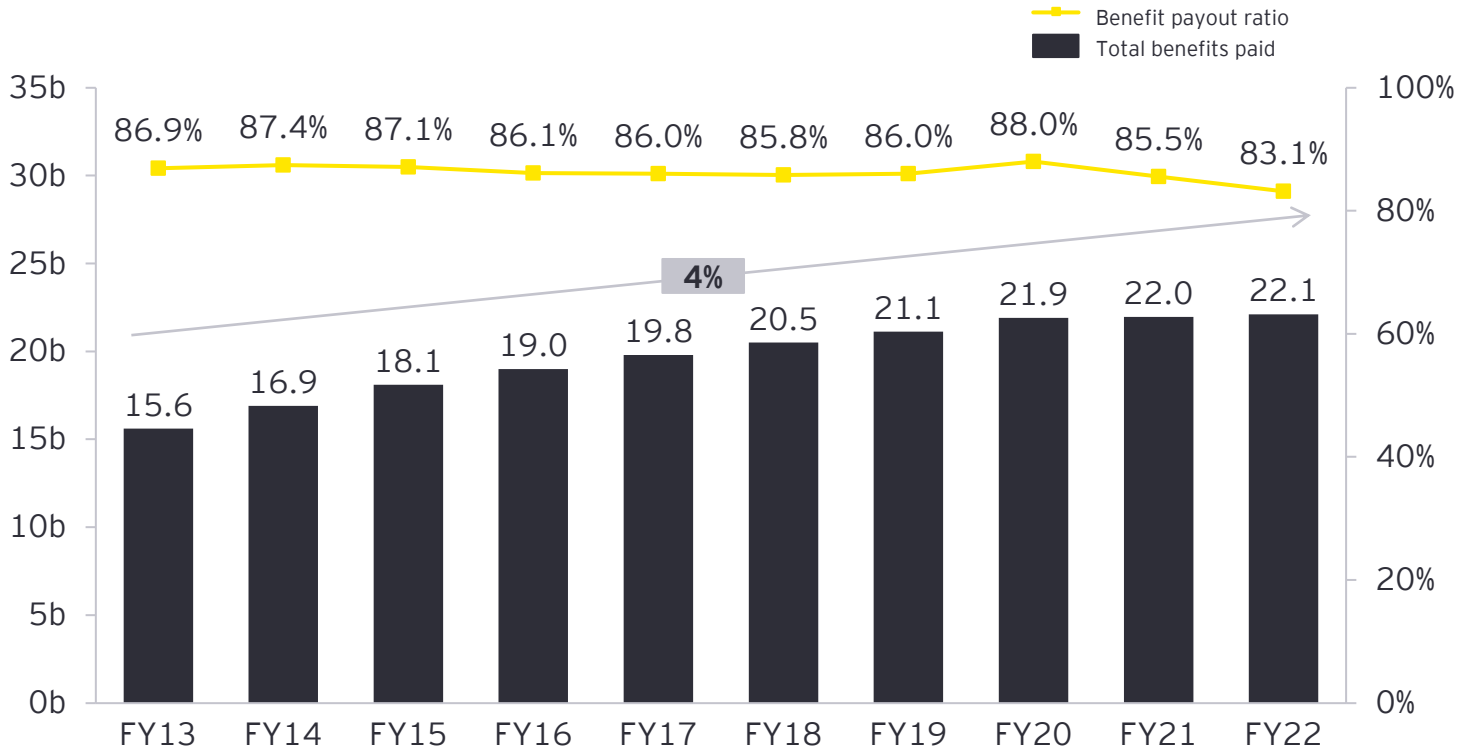
> Once insured, people, especially older people, tend to stay insured, and respond to premium increases by downgrading their cover, either in terms of what they are covered for, or taking on a higher excess they have to pay if they go to hospital
>
> – The Conversation, February 2020

Source: AIHW Admitted Patient Care 2020-21; ABS statistics, Australian hospital statistics; analyst reports; EY PJP analysis

Although the PHI sector has been paying out more HIB benefits to members, the benefits pay-out ratio fell by 3% to ~83% during COVID in 2020 due to reductions in access to private hospitals for private procedures

HIB BENEFITS, TOTAL BENEFITS PAID, FY13 -22*

$ Billions; Percent



Key insights

- HIB benefits paid has grown historically by 4% CAGR over 10 years
- The HIB benefit pay-out ratio in 2022 was 83% - which is much higher than for other insurance sectors like General Insurance averaging at about 65%
- The benefit pay-out ratio fell after 2020 as a result of challenges in getting access to hospitals during COVID
- The five-year reduction in the benefit pay-out ratio benefits was 2.7% , which compared with the 5-year premium increase of 2.7%

* Data for year ending June

Source: APRA June 2022 PHI; IBIS; EY PJP analysis

CONTENTS

Industry performance splits between for-profit and not-for-profit funds, with recent performance characterised by relatively low premium growth and solid HIB expense growth – offset by lower HIB expenses during COVID

PHI RECENT PERFORMANCE

- The PHI industry delivered $26.6 billion in HIB premium revenue in 2022 and grew premium over 5 years by 2.7% per year. HIB expenses increased over this 5-year period at a rate of 5.4%
- The HIB benefit payout ratio in 2022 for not-for-profit funds was 83.7% relative to for-profit funds at 80.7%
- The industry gross margin was 17% in 2022 with for-profit funds achieving about 19%, not-for-profit funds achieving about 16%
- Gross margin for the industry increased over the five years by 2.7% per year as a result premiums growing at 2.7% while health insurance benefits increasing by only 1.9% in this period
- While health insurance benefits grew at 1.9% per year, HIB expenses grew at 5.4% per year including funds providing more health services that cannot be treated as health insurance benefits and expenditure on technology modernisation
- The 2022 Managed Expense Ratio (MER) at for-profit funds was 9.1% relative to not-for-profit funds at 11.2%
- For-profit funds generated stronger ROE than not-for-profit funds due to lower levels of capital, though recent changes to APRA's capital adequacy rules will reduce the capital benefits with for-profit funds in the future

Source: EY PJP analysis

The PHI industry delivered over $26b of premium revenue in 2022. The benefit payout ratio was consistently over 80% for the industry – much higher than for general and life insurers

PHI RECENT PERFORMANCE, FY22

	Overall industry	For-profit	Not-for-profit
HIB Premiums	$26.6b	$16.8b	$9.8b
HIB Benefits	$22.1b	$13.7b	$8.4b
Gross margin	16.9%	19.3%	16.3%
HIB Expenses	$2.6b	$1.5b	$1.1b
Profit margin	5.5%	8.8%	-0.1%
MER	9.9%	9.1%	11.2%
MER (excluding claims handling expenses)	8.3%	7.5%	9.6%
ROE	10.4%	26.9%	-0.1%
Capital as % of HIB premiums	37.2%	22.8%	61.8%
Benefit payout ratio	83.1%	80.7%	83.7%

Source: APRA June 2022 PHI; EY PJP analysis

Not-for-profit funds achieved a 5.1% increase in premiums compared to 1.4% with for-profit funds over the past five years. For-profits experienced an increase in capital and reduction in ROE relative to not-for-profits in this period

PHI RECENT PERFORMANCE, FY18-FY22

Percent

		Overall industry	For-profit	Not-for-profit
CAGR	**HIB premium growth**	2.7	1.4	5.1
	HIB benefits growth	1.9	0.6	4.1
	HIB expense growth	5.4	3.0	9.3
Change 2018-2022	**Gross margin**	2.7	5.0	6.1
	Profit margin	-2.1	-0.8	-3.7
	MER	1.0	0.5	1.6
	MER (excluding claims handling expenses)	1.0	0.6	1.6
	ROE	-6.3	-9.9	-5.7
	Capital as % of HIB premiums	2.8	4.5	-4.3
	Benefit payout ratio	-2.7	-5.0	-6.1

Source: APRA June 2022 PHI; EY PJP analysis

The PHI industry delivered a net profit of $1.02b, with for-profit funds achieving a 19.3% gross margin and not-for-profit funds achieving a 16.3% gross margin

PHI INDUSTRY PROFITABILITY, FY22

$ Billions

Gross margin
Total industry: 16.9%
For profit funds: 19.3%
NFP funds: 16.3%

Profit margin
Total industry: 5.5%
For-profit funds: 8.8%
NFP funds: -0.1%

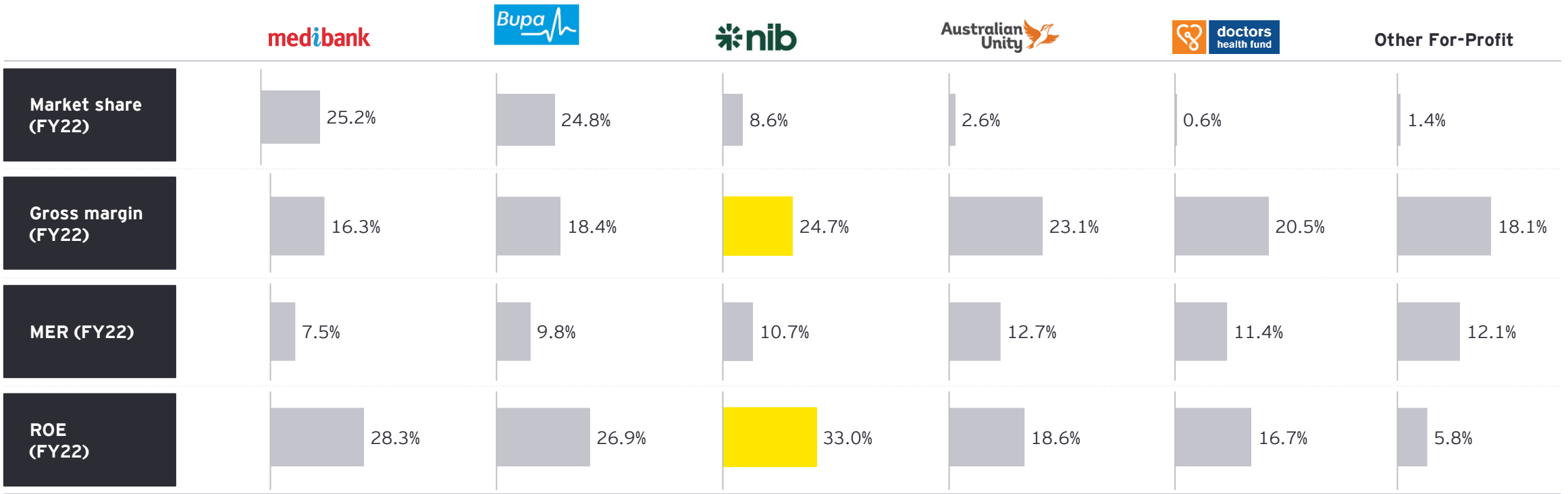
	Total industry	For-profit funds	Not-for-profit funds
	HIB Premium $26.59	HIB Premium $16.79	HIB Premium $9.80
⊕			
	Other revenue / loss $-0.30	Other revenue / loss $-0.06	Other revenue / loss $-0.24
⊖			
	HIB benefits** $22.10	HIB benefits** $13.66	HIB benefits** $8.44
⊖			
	HIB expenses $2.63	HIB expenses $1.53	HIB expenses $1.10
⊖			
	Other expenses $0.10	Other expenses $0.07	Other expenses $0.03
⊖			
	Tax $0.44	Tax $0.44	
	NPAT $1.02	NPAT $1.03	Net Profit (.$01)

* Financials are for 12 months ended June 2022
** Fund benefits include State ambulance levies of $0.3B

Source: APRA June 2022 PHI; EY PJP analysis

nib outperformed with a higher-gross margin and ROE than other for-profit funds in 2022

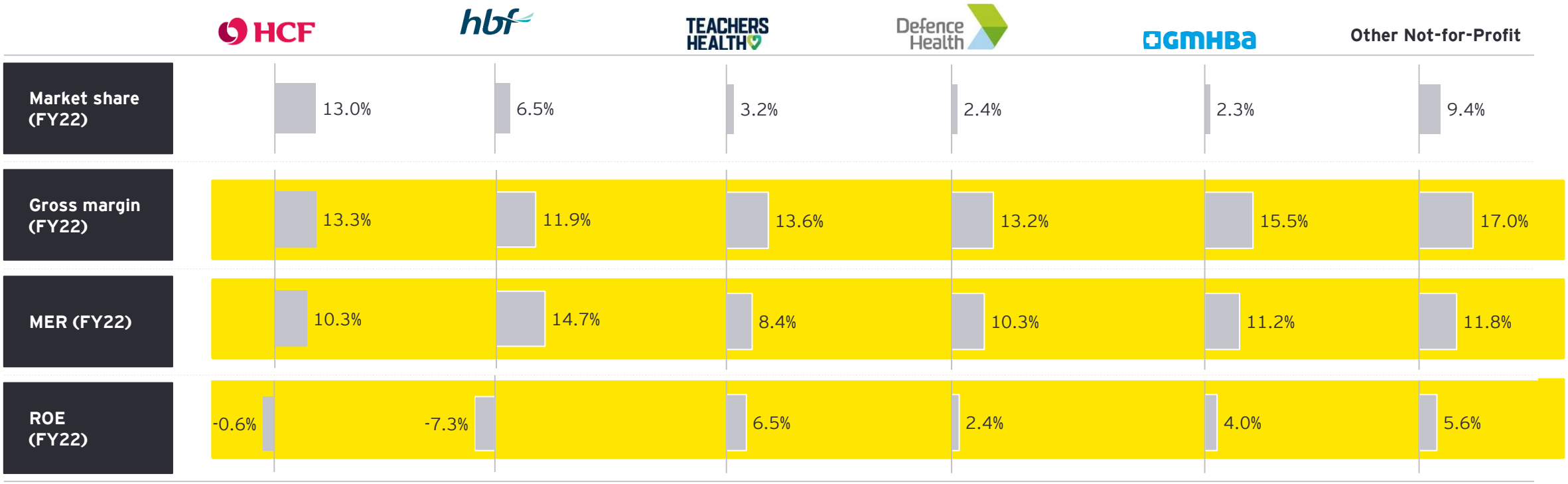
KEY PERFORMANCE METRICS BY TOP-FIVE FOR-PROFIT FUNDS, FY22



Source: APRA June 2022 PHI (Operations of PHIAC Annual Reports); EY PJP analysis

Not-for-profit funds achieved competitive gross margins but high MERs and low ROEs

KEY PERFORMANCE METRICS BY TOP-FIVE NOT-FOR-PROFIT FUNDS, FY22

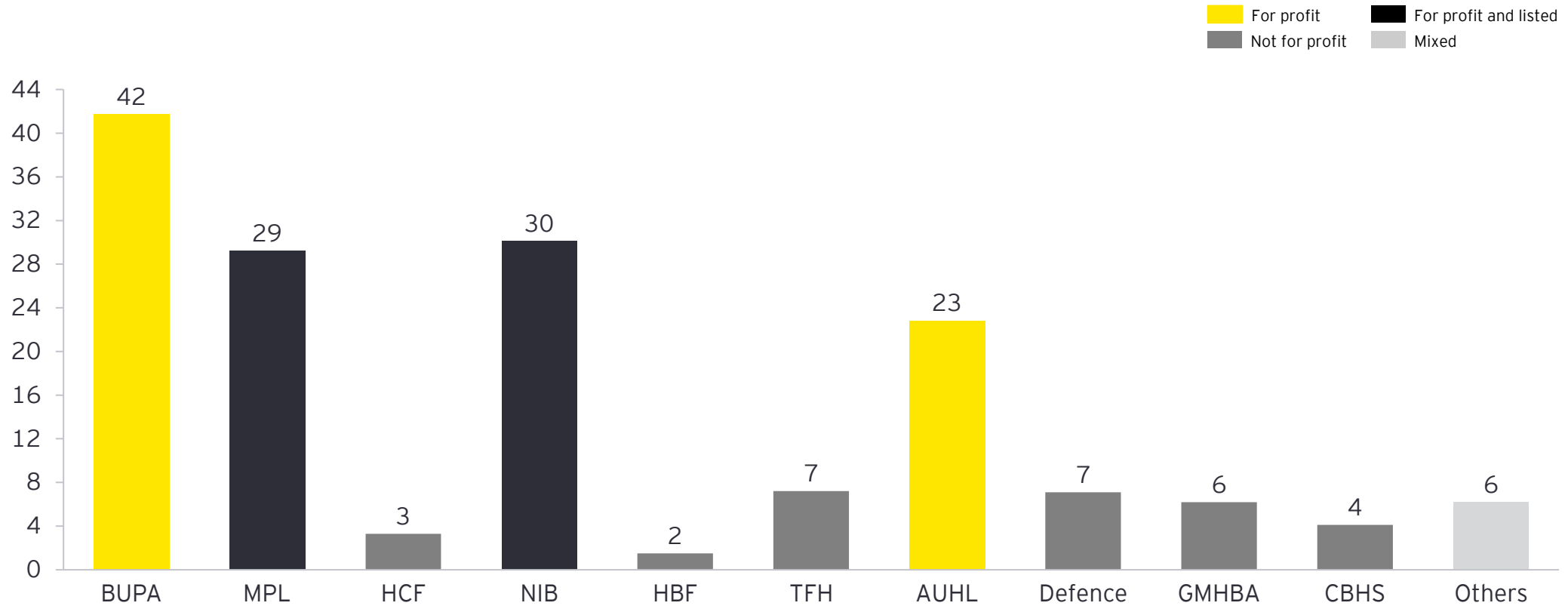


Source: APRA June 2022 PHI (Operations of PHIAC Annual Reports); EY PJP analysis

Larger for-profit funds delivered high ROE with Bupa outperforming - having an average ROE of 42 percent across the last 5 years

INDUSTRY RETURN ON EQUITY AVERAGE, FY18-22

Percent



Note: ROE the simple average of the last 5 years NPAT / year-end net assets; funds are ordered by market share by revenue

Source: APRA June 2022 PHI (Private Health Insurance operations Reports FY17-21); EY PJP analysis

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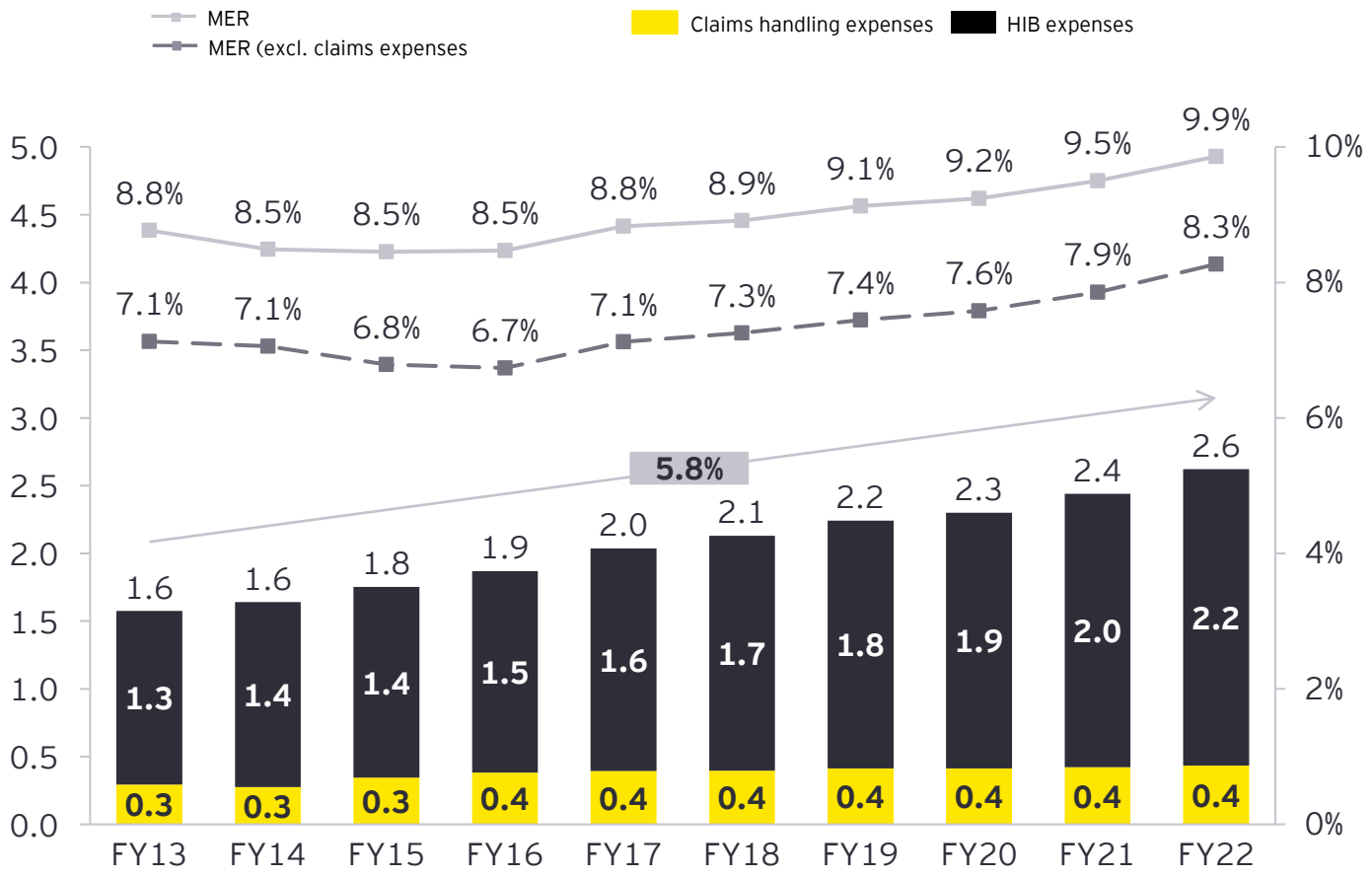
MER increased after 2018 due to a combination of system cost increases, technology investment and introduction of new services that cannot be charged as an HIB benefit

HEALTH INSURANCE BUSINESS EXPENSES

$ Billions



Source: APRA June 2022 PHI; EY PJP analysis

Key insights

- PHI business expenses consist of 2 types:
  - HIB expenses include commissions and fees, marketing, employee costs, operations, corporate overheads, and other management expenses. This excludes expenses directly related to claims handling
  - Claims handling expenses include the portion of expenses directly relating to claims handling including operations, employee costs, etc
  - There are two MER ratios – one excluding claims expenses. The primary measure MER includes both
- MER was flat between FY13 and FY17
- MER jumped from FY18 to FY22 due to various factors:
  - Higher technology expenses to modernise systems
  - Provisions for unpaid claims in the COVID era
  - Funds offering services that cannot be charged as a benefit in HIB so they are accounted for as HIB expenses. These include services like employee assistance programs for corporate clients
  - Labor government price controls from 2022 will motivate funds to further contain HIB expense growth

PHI community risk rating and risk equalisation impacts fund ability to price discriminate or select risks. This aims to ensure all Australians can access private health insurance and ensures portability of cover

PRIVATE HEALTH INSURANCE RISK RATING AND EQUALISATION

Community risk rating and risk equalisation

Private health insurance is community rated	• Everyone on the same product in the same State pays the same premium regardless of their expected claim costs • Rates are calculated based on the average claims costs • Health insurance is subject to universal acceptance (insurer cannot refuse to accept a risk that is part of a group to whom a product is offered) and 100% portability (insureds can move between insurers with no gap in coverage)
Risk equalisation means risk is shared amongst insurers	• Risk equalisation – funds are transferred from insurers with lower than average claims costs to insurers with higher than average claim costs • Insurers with heathier populations, i.e. better books like nib are net payers to insurers with inferior books having higher claim costs

Three risk equalisation calculations quarterly by State

Age-based pool (ABP)	• Age-based pool (ABP) calculation determines the sharing of the health claims of older policyholders (over age 55) and has a material bearing on insurer claims
High-cost claimant pool (HCCP)	• High-cost claimant pool (HCCP) calculation ensures that risks for the most expensive policy holders are shared (generally claims over $50,000 in a single year) – impacts only 3% of claims
Single equivalent unit (SEU)	• Market share calculations to determine customer base in terms of single equivalent unit (SEU). Sharing of above costs are done on this basis

Source: APRA June 2022 PHI; EY PJP analysis

45% of hospital and medical claims are risk equalised equalised amongst insurers through the risk equalisation trust

RISK EQUALISATION NET TRANSFERS FOR TOP-5 FUNDS, FY21

	Gross deficit*		Calculated deficit**		Net transfers		Risk equalisation trust
Bupa	$2,016m	−	$1,883m	=	$133m 4.1% of benefits	←	Net recipients
hbf	$546m	−	$426m	=	$120m 1.2% of benefits	←	
HCF	$968m	−	$943m	=	$25m 10.8% of benefits	←	
medibank	$1,858m	−	$1,885m	=	-$27m -20.1% of benefits	→	Net payers
All other funds	$1,553m	−	$1,586m	=	-$33m -14.6% of benefits	→	
nib	$475m	−	$694m	=	-$219m -0.8% of benefits	→	

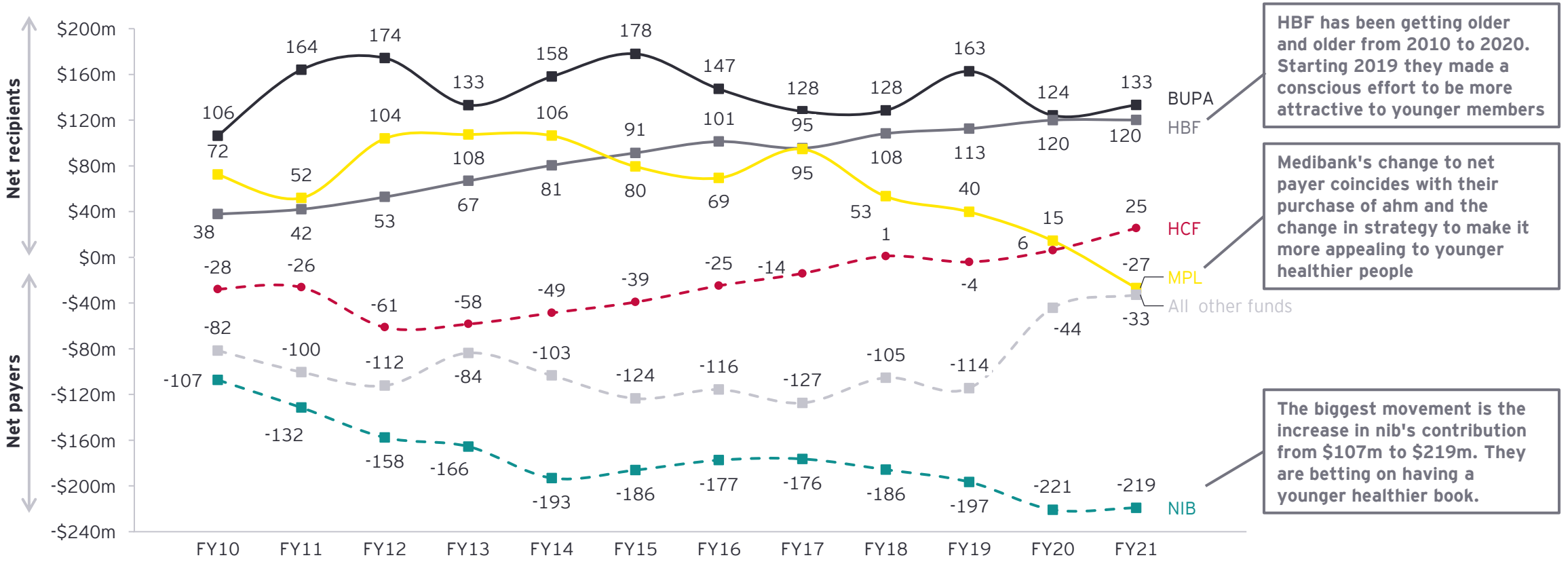
* Gross Deficits are calculated based on on average Single Equivalent Unit (SEU)
** Calculated Deficits are based on average Single Equivalent Unit (SEU) for each fund

Source: APRA June 2022 PHI; EY PJP analysis

MPL has moved to net payer while HCF has moved to a net recipient over the last 10 years. nib's payments have grown across the last 10 years

RISK EQUALISATION NET TRANSFERS FOR TOP-5 FUNDS, FY21

$ Millions



HBF has been getting older and older from 2010 to 2020. Starting 2019 they made a conscious effort to be more attractive to younger members

Medibank's change to net payer coincides with their purchase of ahm and the change in strategy to make it more appealing to younger healthier people

The biggest movement is the increase in nib's contribution from $107m to $219m. They are betting on having a younger healthier book.

Source: APRA June 2022 PHI; 2022 data for risk equalisation is expected to come out in March 2023; EY PJP analysis

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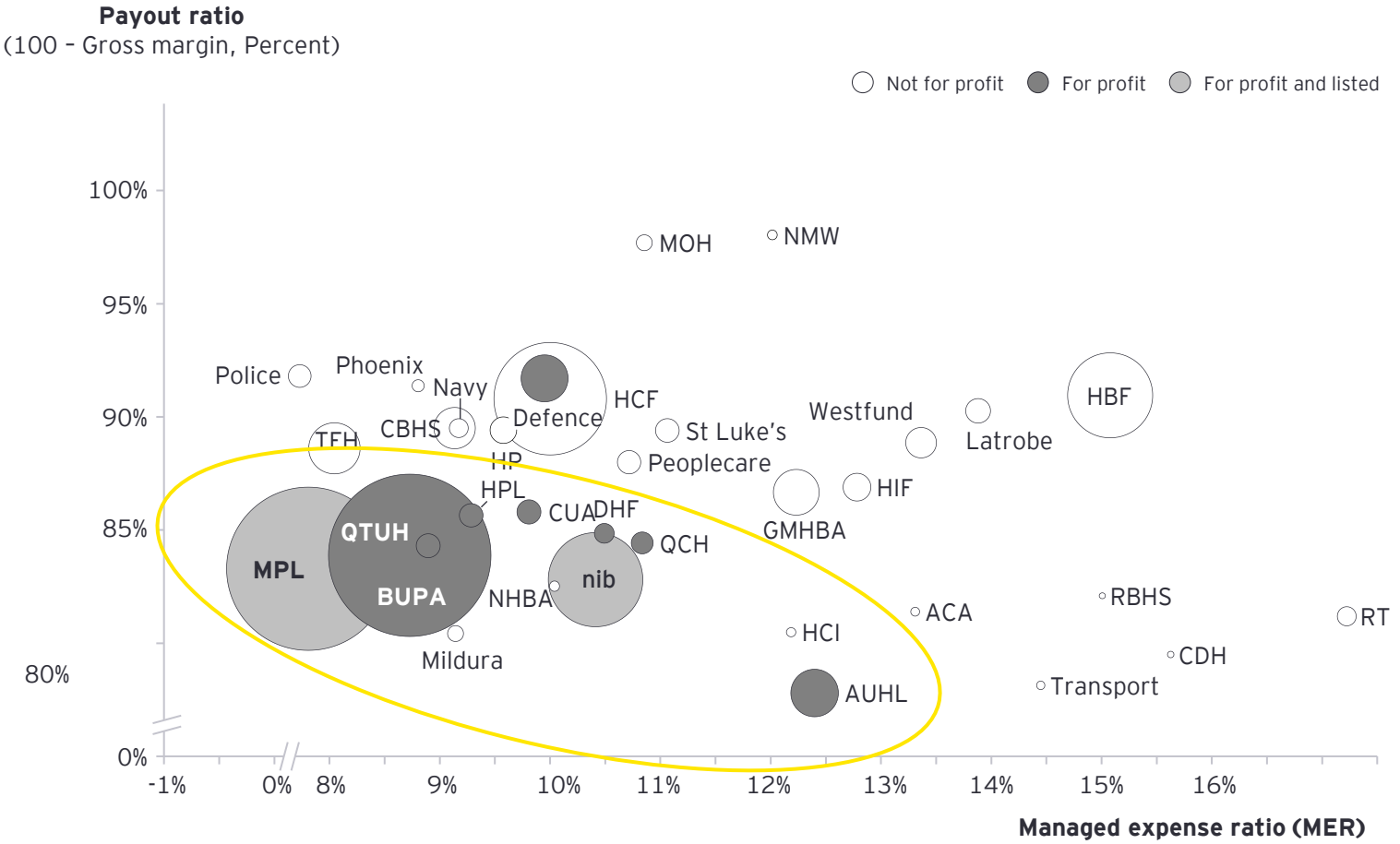
The for-profit funds have lower pay-out ratios and lower MER. Not-for-profit funds have higher pay-out ratios and the smaller funds have higher MER

FINANCIAL PERFORMANCE BY INSURER, FY22



Size of bubble corresponds to PHI industry market share (Average insured persons)

Source: APRA June 2022 PHI (Operations of PHIAC Annual Reports); EY PJP Analysis

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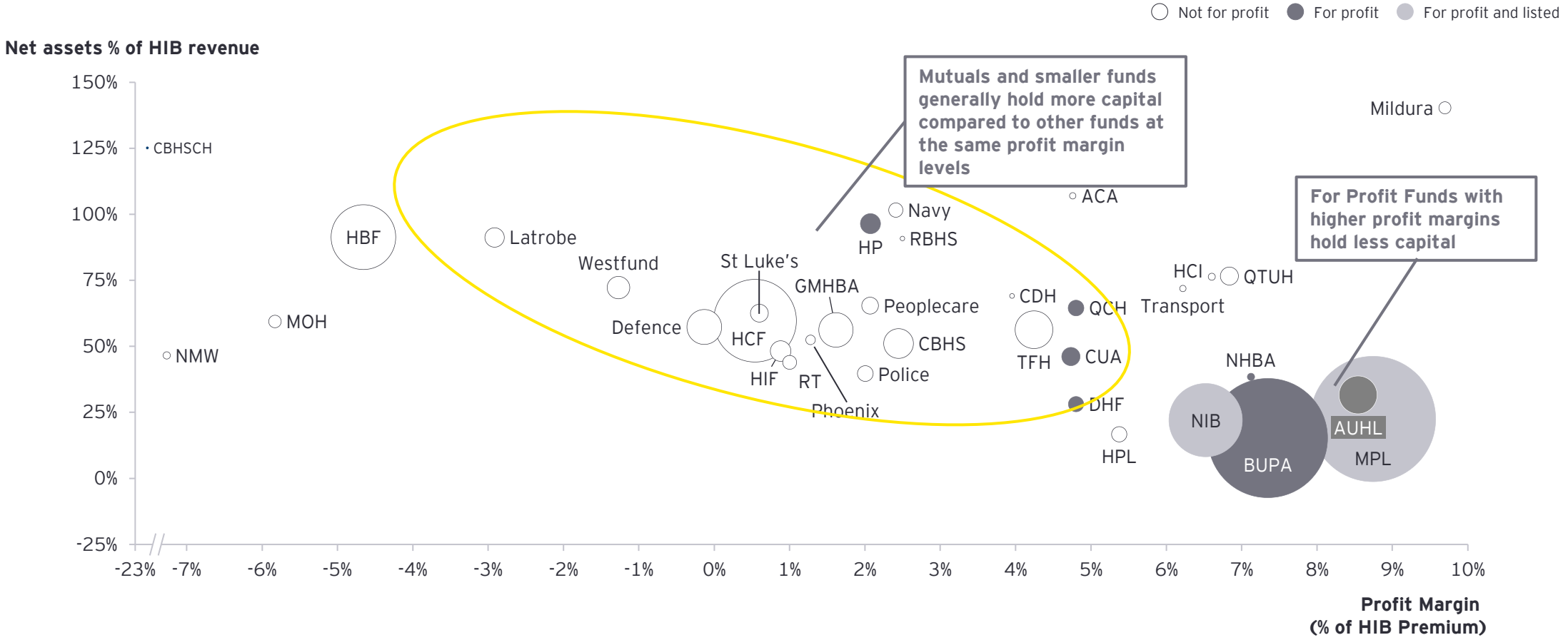
Mutuals and smaller funds generally hold excess capital relative to for profit funds. New APRA capital requirements will require larger funds to hold more capital

PROFIT MARGINS AND CAPITAL ADEQUACY, FY22



Note: Size of bubble corresponds to number of whole funds policies

Source: APRA June 2022 PHI (Operations of PHIAC Annual Reports); EY PJP Analysis

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CONTENTS

PHI leaders are embracing innovation and new business models that promise to significantly improve healthcare outcomes and value for PHI policyholders

INNOVATION AND FUTURE BUSINESS MODELS

- Funds are experimenting with joint ventures, new channels and ecosystem business models that combine primary and secondary health services, wellbeing services, and financial services together with advanced analytics to enable health analytics, reward loyalty and support customisation of experience and treatment pathways
- A care coordinator role would support the customer navigate through the treatment pathway, ensures all data follows the patient through the treatment journey, and that treatment options are transparent and evidence based. This role could provide an independent and unconflicted perspective on the clinical efficacy of the suggested treatment, the options available, and alternative providers that might be appropriate or available elsewhere
- Value-based payment mechanisms could incentivise higher-value care at lower cost – but the incentives need to be carefully designed
- Home care models are becoming attractive as a way to reduce healthcare costs and provide consumer choice but there are significant financial and other barriers to enabling it
- Other regulatory changes and healthcare innovation could create further incentives for PHI participation and improved healthcare choices, outcomes and value

Source: EY PJP analysis

PHI Funds and joint ventures are developing innovative new services and channels to market

EMERGING BUSINESS MODELS AND JOINT VENTURES

Medibank:
Short-stay no-gap hospital

- Medibank and more than 40 specialist doctors have formed a joint venture to develop a new short-stay surgical facility in Melbourne in 2023
- Will reduce out-of-pocket costs for eligible patients with procedures that can be done within day or short stay surgery and can recover at home with support
- Will reduce unnecessary time spent in hospital
- Expected to reduce costs, increase convenience and may also improve outcomes

AIA Amplify Health
Health technology and analytics

- AIA joint venture with Discovery (SA) Feb, 2022
- Will deploy a range of health technology assets, proprietary data analytics and extensive health expertise
- Accelerates AIA's Health & Wellness strategy
- Delivering financial benefits such as improved claims performance
- Transforms how individuals, corporates, payors and providers experience and manage health insurance and healthcare delivery, improving the health and wellness outcomes of patients and communities across Asia

Honeysuckle Health:
Health services and analytics

- nib and global health services company, Cigna established the Honeysuckle Health joint venture in December 2019, which is a joint venture providing tailored health services and health analytics
- Honeysuckle has focused mainly on corporate sponsored health funds and workers compensation personal injury rehabilitations programs.
  QBE recently announced a partnership to develop treatment pathways in personal injury cases

Qantas Assure:
Health loyalty

- Qantas partnered with nib to establish Qantas Assure health insurance
- Policyholders joining or switching can earn up to 110,000 points depending on the type and level of coverage
- Policyholders can earn up to 20,000 points per year using the Qantas well-being app, and completing activities like buying sports equipment, walking, going to the gym and participating in the Sleep Health Challenge
- These awards are supported by corporate partners like adidas, new balance, rebel, speedo, under armour

Eucalyptus:
Woolworths Telehealth

- Australian start-up Eucalyptus builds digital health opportunities for patients
- Its Pilot brand for men's healthcare includes treatments for weight loss, hair loss, erectile dysfunction and premature ejaculation
- Boasts over 200,000 customers with four brands; Pilot, Kin, Software and Normal
- Future step is to grow a digital super clinic

Flip:
Pay-as-you-go accident cover

- Offers pay-as-you-go insurance for $6 a day or $9 a week
- Provides cash payouts (up to $20,000) for accidental injuries
- Appeals to single people who don't own a home or have kids yet, and who are in pretty good health and cannot afford health insurance but want some protection – typically under 30 year old, Gen Z
- Helps cover gaps in basic health insurance and Medicare with immediate payments for medical invoices

Cabrini:
Care in the Home

- Strategic partnership between Bupa and Cabrini to introduce care in the home, while also ensuring Bupa customers will be covered with no additional out-of-pocket hospital costs from Cabrini
- This is a positive collaboration between a health fund and a hospital group working constructively together for the benefit of the policyholder and to their mutual benefits

HCF
Managed Care

- Supporting members with Healthy Weight for Life program, specifically designed for members with a BMI 28 and higher, and those living with osteoarthritis
- The program includes prevention care to help policyholders establish healthy habits and delay the development of various chronic conditions
- These programs are a pathway to HCF providing a holistic health management (and care coordination) service

Funds are also experimenting with ecosystem business models that combine primary and secondary health services, wellbeing services, and financial services together with advanced analytics to enable health analytics and customer experience

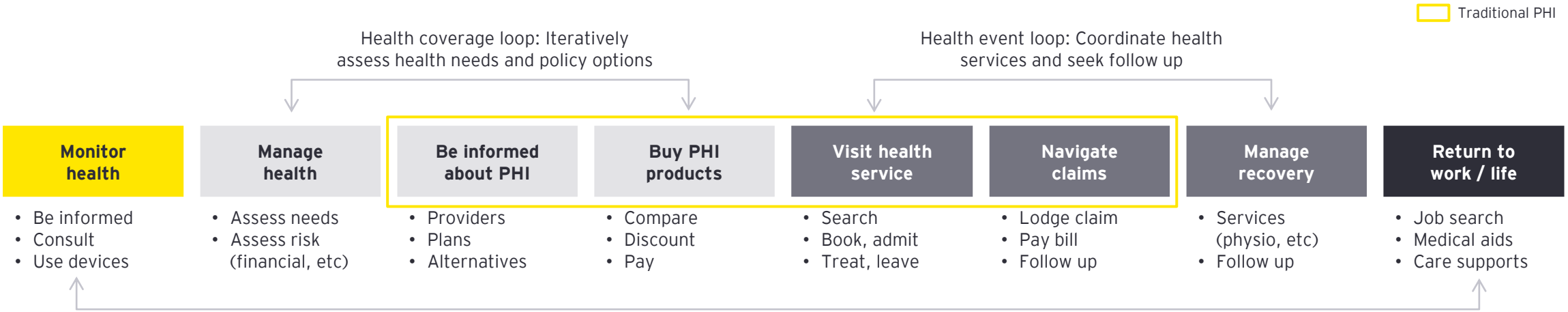
ECOSYSTEM BUSINESS MODELS

	Member focused PHI		Health services provider		Health and wellbeing provider		Health and FS marketplace provider		Ecosystem provider	
Portfolio	PHI	Community and aged care	PHI	Community and aged care	PHI	Community and aged care	PHI	Community and aged care	PHI	Community and aged care
	Wellbeing	General insurance	Wellbeing	General insurance	Wellbeing	General insurance	Wellbeing	General insurance	Wellbeing	General insurance
	Primary care	Life insurance	Primary care	Life insurance	Primary care	Life insurance	Primary care	Life insurance	Primary care	Life insurance
	Secondary care, chronic care	Wealth management	Secondary care, chronic care	Wealth management	Secondary care, chronic care	Wealth management	Secondary care, chronic care	Wealth management	Secondary care, chronic care	Wealth management
	Tertiary care	Banking	Tertiary care	Banking	Tertiary care	Banking	Tertiary care	Banking	Tertiary care	Banking
Customer value proposition	• Member-focused PHI provider • Range of HIB and extras covers • Offers limited primary care services such as dental and optical • Health management services		• Operate their own dental, optical, physio clinics. • Offer access to secondary and chronic care. • Some provide Community and Aged Care • Ability to operate as 'care coordinator' across patient health journey • No gap fee at network of primary care services		• Introduces prevention and wellbeing offerings (e.g. weight loss programs, mental health) • New alliances that integrate payers, providers and loyalty rewards to drive behavioural change focusing on health and wellbeing • Extends PHI, primary care and wellbeing into life insurance		• Extends PHI and primary care services into a financial services supermarket offering general insurance, life insurance, wealth management and banking • Leverages customer data across categories to improve underwriting and deepen customer engagement and retention • A complete health and financial services concierge		• Health and financial wellbeing across portfolio of related services • Integrated loyalty programs • Advanced analytics to customize experience, reward loyalty and understand life events and needs • Vertical integration into banking, wealth management and secondary/tertiary care • A complete health and financial services concierge	
Provider value proposition	• Simple • Clear value proposition • Feasible at smaller scale		• Convenient 'one-stop-shop' for most health needs • Enables end-to-end value chain across care pathways including care delivery • Ability to capture revenue across primary, secondary and chronic care providers • Advanced health analytics to support health management services		• Provides digital-enabled services around prevention and health • Life, health insurance together with wellbeing to improve health and reduce claims expenses • Rewarding health and wellness through reduced health and life insurance and discounts on 3rd party products and services		• Convenient 'one-stop-shop' for health and financial services needs • Advanced health analytics to support health management solutions • Deepen customer relationships and enable customised offers and health nudges through analytics across sectors		• Creates a network of services covering multiple aspects of the patient's life • Better data to evaluate customer needs, segments and pricing • Cross sell different services to customer and make customer journey more integrated • Integrated health management service and comprehensive care coordination service	

Source: APRA June 2022 PHI; EY PJP analysis

A care coordinator role would support the customer navigate through the treatment pathway, ensures all data follows the patient through the treatment journey, and that treatment options are transparent and evidence based

CARE COORDINATOR ROLE



Traditional model: Reactive

- Quick escalations to **high-cost** solutions
- Significant number of **emergencies** (non-elective)
- Hospital-based solution as the **norm**
- The patient journey is **more expensive** than required
- Patients are **dependent on the doctor**, a 'done to' model
- Outcomes **are not always optimal** for the consumer / patient

Future model: Proactive

- Reduced number of **unnecessary contacts**
- **Proactive** patient management
- Self-management enabled through **digital tools**
- Smart homes and **virtual care**
- Higher **reliability** across the health system
- Improved **outcomes**
- Reduced through life **cost of care**

Value-based payment mechanisms could incentivise higher-value care at lower cost – but the incentives need to be carefully designed

VALUE-BASED PAYMENT MECHANISMS

Lower risk sharing ← → **Greater risk sharing**

	Fee for service (current)	Data Sharing	Performance Pay	Episode of care	Partial or full capitation
Payment mechanism	• Single fee paid for each service provided by multiple providers engaging with the patient • Payers reimburse providers individually on a volume basis • Predominant current model	• Data sharing between payer and provider to enable improved care coordination	• Single fee for each service plus a quality bonus • Bonus may be based on health outcomes or process quality metrics	• Single fee for an entire 'episode' (diagnosis to treatment / return to work) • High care and cost coordination between payer and provider	• Single fee for healthcare services or type of service for a period of time • Care coordination managed by providers for set fee with reporting on quality metrics
	• Hospital, surgeon, and anaesthetist claim separately for services as part of back surgery	• Sharing of clinical data for non-acute back pain with GPs, physios, and surgeons	• Bonus if personal injury patient returns to work within certain timeframe, or recovers mobility	• Fixed payment for back-surgery and post-surgical rehabilitation	• Payment per patient for program of chiropractic / physio services for 6 months
Incentive	• Incentive is to increase the number and severity of services provided • Encourages overservicing and opens avenue for fraud, e.g. billing for services not provided	• Data would be shared between parties for the benefit of the patient (consistency, efficiency, reduction in intrusive tests and answering same questions) • Data enables funder to monitor service providers, benchmark service providers and hold them to account • Model can create conflict between stakeholders and has proved unpopular with medical providers	• If it's measured it gets done – will encourage quality • Needs to be closely aligned to patient outcomes to ensure gaming of the system (behaving to maximise bonus rather than best outcome of patient) is minimised • Has been difficult to agree due to range of severity, complexity, difficulty and hence agree the benchmark at which bonus is achieved could be achieved by selecting only the most simple cases within each category	• A significant challenge is defining categories of episodes of care and level of complexity and intensity • Is re-admission a new episode or under what circumstances? • Incentive is for more episodes of care, higher complexity and more add-ons	• Incentive is to minimise care over period contracted • Needs to be subject to patient outcomes and patient rating of service

Home care models are becoming attractive as a way to reduce healthcare costs and provide consumer choice but there are significant financial and other barriers

MOMENTUM AND BARRIERS TO CARE AT HOME

Momentum	**Rising demand for healthcare**	• Ageing population and increasing prevalence of chronic diseases is placing pressure on our health system, with some hospitals operating at full utilisation and unable to meet demand. Care at home can alleviate this pressure by freeing up hospital beds for people who can be treated at home (for example dialysis or chemo at home) and recovery options including discharge and support during the recovery period
	Rising healthcare costs	• Increased volume of people requiring healthcare, along with increasing input costs from rising wages and medical technology, is placing pressure on Government to fund the Australian healthcare industry. Care at home can reduce costs as treating a patient at home is less expenditure than the hospital
	Technology enhancements	• Advancements in wearable technologies, remote monitoring and video / telehealth are enabling more health services to be delivered at home
	Consumer preferences	• Consumers value choice, convenience and comfort. Improved customer experience in other industries is raising consumers expectations for how they receive health care
	PHI Support	• Medibank and nib CEOs have actively voiced their support for preventive health and care at home initiatives in the media. They both say that keeping customers healthy and out of hospital is the transformation required to stem rising health costs
Financial and other barriers	**Fragmented health funding**	• Multiple payers (Federal Gov, State / Territory Gov. PHI and self-pay) cover a range of services in Australia. The barrier is that the payer who invests in care at home may not reap the benefits
	Disparate technology systems and patent data	• Different technology systems are used across GPs, hospitals and allied health with little to no ability to share patient data across providers. Government investment in the My Health Record and electronic medical records in hospitals is trying to remove this barrier but will take time
	Geographic barriers	• Large distances for medical and care professionals to travel in rural and remote communities
	Low health literacy	• Australians (particularly the elderly) have low understanding of their health needs, including health prevention and management. According to the National Health Survey by ABS, only one-fifth (20%) of people aged 65 and older strongly agreed that they had social support for health
	Shortage in qualified staff	• Medical professionals are trained in a health discipline (e.g. surgery) rather than providing wholistic patient care to keep a patient well. There is a shortage in staff trained in core care at home services
	Private Hospitals	• Private hospitals and specialists working at private hospitals benefit from hospitalisation and inpatient care
	PHI restrictions	• On what out-of-hospital services they can cover
	Risk equalization	• PHI companies do not fully benefit from keeping patients out of hospital due to risk equalisation

Other regulatory changes and healthcare innovation could increases PHI adoption and improve healthcare choices, outcomes and value

ENCOURAGING OTHER CHANGE WITH PHI

Change	Description
Increasing public information on out-of-pocket costs	• Increasing publicly-available information on out-of-pocket costs and health outcomes to improve patient choice
Promoting the value of PHI	• Targeted marketing of needs at each life stage including case studies of the real differences in health and financial outcomes with and without PHI, i.e. itemised breakdown of the total costs
Creating incentives for healthier people to join PHI	• Providing benefits to healthier people, such as mental health benefits or other 'add-ons' and provide, where possible, selected discounts, i.e. no claims bonus or changing the Medicare Levy Surcharge arrangements to reward healthier people
Changing the risk equalisation system	• Changing to a prospective model would re-spread risk between insurers based on risk factors that indicate health status (rather than actual claim payments) – thereby increasing the incentive for health insurers to become more involved in managing treatment pathways
Community rating reform	• Relaxing some of the restrictions on community rating to allow innovative products and services, e.g. wellbeing, rewards for healthy behaviours
Chronic disease management programs	• Identification, risk stratification and management of multi-morbid, complex, and chronic members to reduce long-term cost pressures
Wearable technology	• Offering the use of wearables including Fitbit and Polar devices to generate new health data, engage members and reward healthy behaviour. These also support care at home initiatives
Pay-as-you-use private health insurance	• On-demand injury insurance. Agreed cash payouts if you get injured in an accident to cover gaps with Medicare or PHI and protect you from unexpected expenses
Peer-to-peer private health insurance	• Peer-to-peer (P2P) insurance is a risk-sharing network where a group of individuals pool their premiums together to insure against health risk and reduce long-term cost pressures. This encourages peers to closely manage health costs and outcomes

These innovations could generate benefits for policyholders, healthcare providers and funds

BENEFITS FROM FURTHER INNOVATION IN PHI

	Provide better services to policyholders	Create more trans-parency of costs, covers and gaps	Engage policy holders in health-care and choices	Reduce entry barriers to PHI	Reward healthy behaviour in private health insurance	Reduce long-term cost pressures for chronic care	Reduce cost of claims by keeping policyholders healthier	Reduce cost of claims by creating better treatment pathways	Reduce cost of claims by aligning incentives of providers	Capture data to enable advanced health analytics	Provide customisation, alignment and rewards across health, well-being and financial services
Ecosystem business models					✓			✓		✓	✓
Care coordinator role	✓	✓	✓				✓	✓	✓	✓	✓
Value-based payment mechanisms	✓	✓				✓			✓	✓	
Care at home	✓		✓			✓	✓	✓	✓	✓	
Increasing public information on out-of-pocket costs	✓	✓	✓	✓							✓
Changing the risk equalisation system								✓			
Community rating reform					✓		✓				✓
Chronic disease management programs			✓			✓		✓			
Wearable technology			✓		✓		✓			✓	✓
Promoting the value of PHI	✓	✓	✓	✓							
Creating incentives for healthier people to join PHI	✓	✓	✓	✓	✓		✓				
Pay-as-you-use private health insurance	✓	✓	✓	✓							
Peer-to-peer private health insurance	✓	✓	✓	✓	✓	✓	✓		✓		

Looking forwards, the environment will be tough for PHI with capped rate increases, strong inflation driving up costs and risks of recession impacting PHI adoption levels

ASSESSMENT OF SECTOR PERFORMANCE 2023-2028

Performance driver	Assessment	Rationale / comment
Regulatory environment	↘	• 2% rate caps will limit premium growth if extended • APRA capital adequacy changes will depress ROE for larger funds
Macroeconomic environment	↘	• High inflationary pressures including wages growth will increase hospital costs • Hospitals are pushing back on renewal of contracts with PHI funds due to intensifying cost pressures
Health insurance premium growth	↘	• Low premium growth due to rate caps
Health insurance benefits growth	↘	• Build-up in procedures delayed during COVID will increase HIB • Mental health claims may continue to escalate due to recession, pandemic and global geo-political tensions
PHI adoption	↘	• Inflationary pressure on homes will encourage families to move to basic cover or drop PHI altogether • Young people will delay moving into PHI and may explore lower cost alternatives like pay-as-you-go accident insurance models
Gross margin / ROE	↘	• Likelihood of HIB outpacing rate increases • Increase in APRA's capital adequacy requirements for larger funds will impact ROE • Catch up investment in technology modernisation and security following MPL cyber attack will increase HIB expenses
Health care innovation	→	• Tightening margins will discourage significant investment in innovation unless rate controls are eased and funds are able to include health innovations within HIB benefits

Source: EY PJP analysis

CONTENTS

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