Medibank Private
AMA enter the debate

Event
- In a National Press Club speech (22 July 2015) covering a broad range of health sector issues, Professor Brian Owler, AMA President, addressed the current negotiations between insurers and hospitals. We review the major issues addressed and summarise our expectations below.

Impact
- We expect patient and doctor pressure will see Calvary agree to MPL’s quality & service, terms & conditions and price terms.
- A negotiated outcome, with contracted price increases of <2%, is consistent with Medibank achieving moderating claims growth, industry competitive premium rate increases and expanding net margins. We don’t expect a noticeable impact on MPL volumes or profitability as a result of the negotiations and media coverage.
- A number of other health funds support the stance of MPL. We note that Calvary was recently in dispute with the Health funds holding ~17% of policyholder market share represented by AHSA, and other funds and hospital groups have been in contract dispute in the past. We expect that affordability and utilisation may result in more disputes in the future.
- Industry data supports expanding margins: 1) Premium growth per member in the 3 qtrs to March 2015 was +5.0 to +5.2% (following 8 qtrs of growth below 5%); 2) Claims growth per member has fallen below 5% in the 2 qtrs to March 2015 (following 6 qtrs where claims growth was above 5%). Claims growth per member in the March qtr was up only +3.9%.
  ⇒ Consistent with our MPL forecasts we expect industry net margins to improve in the June qtr (adjusting for the days claim effect from ANZAC day) following annual premium rate increases from 1 April.
- An issue raised in the Brian Owler speech was funds not paying for maternal death associated with childbirth. In such tragic circumstances industry practice is for the hospital not to bill the fund. Under no circumstances would a patient be billed. It would also be highly unusual for such an event to occur in a private hospital as high risk cases are managed in major public hospitals. Raising such highly emotive examples, where industry practice exists to manage the circumstance, does not support an informed public debate around funds and hospital contracting.

Earnings and target price revision
- No change to earnings or price target.

Price catalyst
- 12-month price target: A$2.65 based on a DCF methodology.

Action and recommendation
- Outperform: We expect MPL and Calvary will negotiate terms consistent with moderating claims growth and quality outcomes. Moderating claims growth will allow MPL to reduce premium rate of increases and expand margins.

Note: Recommendation timeline - if not a continuous line, then there was no Macquarie coverage at the time or there was an embargo period.

Source: FactSet, Macquarie Research, July 2015 (all figures in AUD unless noted)
Calvary Group and Medibank contract negotiation key points

- **Timing**: Medibank will go off-contract with Calvary Health Care from 31 August 2015, unless a negotiated outcome can be agreed and this may involve mediation with the Ombudsman.

- **What is under dispute**: The dispute arises as Medibank and Calvary have not been able to agree suitable quality (incl. re-admission rates and avoiding preventable, adverse events) and affordability criteria, terms and conditions and contract price increases.

- **What is unusual about the Calvary Group and Medibank dispute**: It is more usual for the Hospital to cancel an existing contract as this allows the Hospital to charge their own rates. In this case with Medibank signalling that it will end the current contract on 31 August 2015 we believe this shows Medibank will look to apply service quality and affordability standards, terms and conditions, and contract price increases to other contracts when necessary.

- **Which other hospital groups have entered agreements with Medibank?** Our understanding is that Healthe Care, StVincents and Epworth have all been able to agree terms (covering quality and service, terms and conditions and contract price increases) with Medibank recently. Each of these hospitals are similar in terms of hospital numbers with Healthe Care operating on a ‘for-profit’ basis and the other groups not ‘for-profit’.

**Fig 1** Premiums and Claims growth per policy member (YoY)

![Image of Premiums and Claims growth per policy member (YoY)]

Source: PHIAC, Macquarie Research, June 2015.

- **Fig 2** Australia’s Private hospital industry is relatively concentrated

![Image of Australia’s Private hospital industry is relatively concentrated]

Source: Company websites, Macquarie Research, January 2015.

- **How will policyholders react? We expect very limited switching impact.** Medibank will contact members impacted by the decision. Policyholders who are about to claim for upcoming procedures in Calvary hospitals may move health funds (without having to re-serve waiting periods given industry portability). While this would increase switching, MPL would avoid the non-risk equalised claims from these policyholders. This would be a small positive to net margin. Policyholders that don’t switch may face out-of-pocket fees not covered by their health insurance as Calvary will be able to charge their own rates.
Negotiated outcome: We expect pressure from patients and doctors will see Calvary agree to Medibank's terms. A negotiated outcome is consistent with Medibank achieving moderating claims growth and industry competitive premium rate increases with expanding net margins. Calvary were recently in contract dispute with the Health funds holding ~17% of policyholder market share represented by AHSA (Australian Hospital Service Alliance). This dispute ended in a negotiated outcome.

The Calvary Group hospital network

Where will this matter for doctors and patients? While Calvary is only ~5% of overnight hospitals in Australia, the 11 hospitals are concentrated in South Australia, ACT, Wagga Wagga and Tasmania. Doctors in South Australia may have flexibility to treat patients in alternative non-Calvary hospitals but there is less flexibility where Calvary is more concentrated such as Wagga and Tasmania. This will likely attract significant community attention.

The data below illustrates the share of beds in the Calvary Group network by state. On a regional basis Calvary operates the Riverina Hospital in Wagga Wagga (NSW) with this concentration under-represented in the table below.

Calvary group also operates two public hospitals in ACT and one in each of VIC and NSW.

Fig 3 Calvary estimated market share of Private and Public hospital operation by state

Availability of public and private hospital beds by state

Australian Health Institute of Health and Welfare data shows that on a combined public and private basis, South Australia, where Calvary is concentrated, is well served by bed capacity. Tasmania, with the second largest number of Calvary hospital beds, has less bed availability.

It is also important to note that the new Royal Adelaide Hospital (opening 2016) and the Royal Hobart Hospital revamp will boost the provision of high quality health care in South Australia and Tasmania, the two key states for Calvary.

Fig 4 Beds per 1,000 population in Australia by state (2013-14)
Review of… Professor Brian Owler, AMA President, speech at the National Press Club (22 July 2015) covering a broad range of health issues

- **Context:** Based on the relationship between Hospitals and Doctors we expect that the AMA would naturally support Hospitals in debates between health funds and hospitals.

**Introduction**

- **The speech highlighted**... universality, equity of access, the sanctity of the doctor–patient relationship, a balance between private and public medicine, and the high level of training of those within the system, especially doctors.
- **…and reminded** politicians, our doctors and healthcare workers, and our community that these foundations must be preserved and cannot be taken for granted.
- **Recapped** that...after the 2014 Budget, the Australian healthcare system was under enormous threat from an attack on general practice and a withdrawal of public hospital funding.
- **…noting** the GP co-payment proposals undermined the foundations of our healthcare system - both mark 1 and mark 2 were defeated.
- **Despite the AMA pressure**... the freeze on indexation of patients’ Medicare rebates is still in place and public hospital funding threats remain.
- **and threats remain**... as the leaders of State and Territory governments are meeting in Sydney with the Prime Minister to discuss, among other things, the future funding arrangements of our public hospital system.

**The body of the speech**... focused on strengthening our healthcare system.

**Part #1: MBS review**

- The MBS refers to the Medicare Benefits Schedule. The MBS details all benefits received from Medicare for medical services set by the Australian Government. The MBS lists a wide range of consultations, procedures and tests, and the Schedule fee for each of these items (for example, an appointment with your GP or blood tests to monitor your cholesterol level.)

- **With respect to the MBS speech highlighted**... some modern medical practices are not reflected in the MBS, so the AMA welcomes the opportunity to ensure the Schedule meets the needs of a modern healthcare system so long as this review is not being aimed at cutting the funding to health and cannot deprive patients of access to medical services.

  ⇒ **Macquarie view:** From the perspective of Private Health Insurers, outcomes of the MBS review are not yet clear. Private health insurance must pay services covered under the MBS which are in a policyholder’s policy coverage (e.g. ‘Top cover’ covers all MBS services).

**Part #2: Indexation freeze**

- **The speech highlighted that**... the freeze on indexation of patients' Medicare rebates is still Government policy.

- **and reminded us that**... the Medicare rebate is the rebate to the patient. Only in the case of bulk billing does that rebate go directly to the doctor.

  ⇒ **Macquarie clarification:** Medicare (and Private Health Insurance) is a patient insurance system not a doctor payment system. Doctors can charge a different fee for services versus the MBS fee. If the charge happens to be the same as the patient insurance system cover then the patient is not out of pocket = bulk billing or in the case of PHI that patient pays no gap.

  ⇒ Note that GPs are not covered by PHI and bulk billing (Medicare funded) occurs with GPs.

  ⇒ In private care the doctor charge their fee, and the patient gets back money from their different insurers, be they government (Medicare) or private insurers.

  ⇒ Patients in Public hospitals (being treated as Public patients) face no out of pocket or gap. Note that patients can elect to be treated as private patients in public hospitals with the level of care is unchanged. The patient may face a gap payment as the PHI fund will be billed for the service provided in the public hospital.

- **AMA consider that**... The freeze is a proposal based purely on reducing health expenditure, rather than investing in the health of patients.
- For patients, there will be a growing out-of-pocket cost to accessing quality health care.

- The freeze has meant that private health insurers have had to make a decision on whether they also freeze their schedules, or choose to index and absorb the extra costs of indexation.

- Some private health insurers, such as **Medibank Private**, have chosen not to index their known gap schedule. As a result doctors may charge a gap. It may lower the costs for the fund substantially, but it will mean that patients in that fund are likely to be subject to higher out-of-pocket expenses.

- **BUPA and many of the mutual funds** have indexed their schedules and will absorb the lack of Government indexation. These funds will carry increased costs, and this will put pressure on health insurance premiums.

- **HCF** has chosen to offer a known gap schedule as a direct result of the indexation freeze. This means that, in order to avoid both of the above scenarios, they are now offering a schedule whereby the doctor can charge an extra out-of-pocket expense of $500.

  - **Macquarie View:** We don’t believe that the position of health funds can be simply split into the freeze and indexed categories with some funds making adjustments depending on the service, level of clinical involvement and fee relative to the MBS fee.

- A key foundation of our health system – something lacking in many other nations – is a balance between our public and private systems.

- Government measures that reduce the value of private health insurance by increasing out of pocket expenses – or putting upward pressure on health insurance premiums – undermine our private sector.

- This puts more pressure on our public hospital system – and that’s not good for anyone.

- AMA believes the freeze should be lifted.

**Part #3: Private health insurers**

- **The speech highlights support for many of the features of Australia’s private health insurance system:** 1) Patients with pre-existing conditions have been able to join a health fund and receive treatment, after a waiting period of usually one year; 2) Patients cannot be denied coverage; and 3) Community rating ensures that patients with significant medical conditions continue to be covered.

- **The speech also raises the…dispute between Medibank and the Calvary Health group.**

  - **Macquarie View:** From 1 September, assuming mediation is not able to resolve the price, quality & service and terms & condition differences between MPL and Calvary Care, Medibank Private policyholders will no longer be fully covered for treatment in a Calvary Hospital.

  - **Should MPL and Calvary fail to agree terms,** under Second Tier Default Benefits arrangements Medibank is required to pay not less than 85% of the average charge for the equivalent episode of hospital treatment under that health insurer’s negotiated agreements in force on 1 August of the first year with comparable facilities in the State.

  - **This may see patients charged a gap by the hospital for care in a Calvary hospital.**

  - **We expect that while negative for the health fund brand if they are not able to convince policyholders they have valid quality and service issues that should be addressed and they are providing affordable coverage, the doctors who bring the patients to the hospital group will pressure the hospital to come to agreed terms with the fund or where possible provide care in alternative non-Calvary facilities.**

- Calvary Group hospitals are concentrated in ACT, Tasmania, Riverina and South Australia.

- Medibank Private has proposed that they will not pay for treatment in the instances of a number of ‘preventable complications’.

- The Medibank Private list includes 165 different ‘preventable’ clinical conditions or events.

- While private health insurers spend a lot on the marketing of extras and hype, the value of the products can be very different.
The AMA will be undertaking activities to ensure that members of the public are better educated about health insurance products.

Part #4: Sundry issues raised in the speech

- A) The private health insurance sector also needs regulation.
  - **Macquarie view**: Health funds are already very highly regulated. The government/regulator:
    1) approve annual premium increases; 2) have significant impact on product design and coverage; 3) regulate capital; 4) guarantee portability and coverage for pre-existing conditions; 5) ensure community rating and set the risk equalisation scheme. Some level of competition should remain and the process of negotiation between hospitals and health funds should be able to play out commercially.

- B) It is not only about the spectre of a US-style managed care system.
  - **Macquarie view**: We expect that PHI will increasingly fund initiatives in the primary care arena to help manage the best integrated health outcomes (quality and cost) not a US style managed care system.

- C) The speech states the AMA view that…Healthcare expenditure is not out of control.
  - **Macquarie view**: Access to relevant health information facilitated by information technology (ideally regulated by government and managed by private operators) would assist with better and more efficient health outcome. We believe PHI should participate.
  - While we expect that healthcare expenditure is not out of control, health funds are setting product design and entering into hospital contracting negotiations with affordability and access to PHI as a key factor (especially following the income testing and capping of the PHI premium rebate).

- D) Policies in health must be re-orientated - they must pivot to general practice given the growing burden of chronic disease.
  - **Potential efficiencies noted that**…7% of hospital admissions may be avoidable with timely and effective provision of non-hospital or primary health care… the AMA is working with private health insurers on ways that private health insurers can support our family doctors in the management of chronic disease.
  - **Macquarie view**: Increasing the role of the GP in effective provision of non-hospital or primary health care would support improved integrated health outcomes. We expect that PHI will increasingly fund initiatives in the primary care arena to help deliver integrated health outcomes (quality and cost).

- E) The speech noted a number of pressures on the health system with…1) The Treasury estimates that $57bn will be taken out of our public hospitals between 2017 and 2025; 2) doctors stop seeing patients because they don’t want to add any more to the waiting list; and 3) elective surgery is anything but ‘elective’ (it includes cancers and life-threatening conditions).
  - **Macquarie View**: The issues raised about the health system support our view that PHI will represent an increasing part of health funding in Australia over the long term as: 1) governments look to private health insurance to ease pressure on the public funding of health care; and 2) waiting lists continue to act as a rationing system for care in the public system and people utilise the private system to access the service levels and timeliness of care available in the private system.
## Medibank Private MPL-AU

### Share Price 2.05


### Valuation

- **Valuation as at today:** 5.981  
  Capital return: 29.0%  
  PER at Current share price (1 yr fwd): 13.0  
- **Valuation in 12m:** 7.338  
  Dividend Yield: 4.7%  
  PER at Price Target (2 yr fwd): 22.5  
- **Share price trend:** 2.65
  Total Return: 54.3%  
  Dividend Yield at Price Target (2 yr fwd): 3.4%

### Source
Company data, Macquarie Research, July 2015; price as of 23 July close
Macquarie Wealth Management

Macquarie Quant View

The quant model currently holds a marginally positive view on Medibank Private. The strongest style exposure is Earnings Momentum, indicating this stock has received earnings upgrades and is well liked by sell side analysts. The weakest style exposure is Price Momentum, indicating this stock has had weak medium to long term returns which often persist into the future.

176/242
Global rank in Insurance

% of BUY recommendations: 36% (5/14)
Number of Price Target downgrades: 3
Number of Price Target upgrades: 0

Macquarie Alpha Model ranking

A list of comparable companies and their Macquarie Alpha model score (higher is better).

Macquarie Earnings Sentiment Indicator

The Macquarie Sentiment Indicator is an enhanced earnings revisions signal that favours analysts who have more timely and higher conviction revisions. Current score shown below.

Factors driving the Alpha Model

For the comparable firms this chart shows the key underlying styles and their contribution to the current overall Alpha score.

Drivers of Stock Return

Breakdown of 1 year total return (local currency) into returns from dividends, changes in forward earnings estimates and the resulting change in earnings multiple.

How it looks on the Alpha model

A more granular view of the underlying style scores that drive the alpha (higher is better) and the percentile rank relative to the sector and market.

Source (all charts): FactSet, Thomson Reuters, and Macquarie Research. For more details on the Macquarie Alpha model or for more customised analysis and screens, please contact the Macquarie Global Quantitative/Custom Products Group (cpg@macquarie.com)
Recommendation definitions:

**Macquarie - Australia/New Zealand**
- Outperform – return >3% in excess of benchmark return
- Neutral – return within 3% of benchmark return
- Underperform – return <3% below benchmark return

**Volatility index definition**

This is calculated from the volatility of historical price movements.

**Very high–highest risk** – Stock should be expected to move up or down 60–100% in a year – investors should be aware this stock is highly speculative.

**High** – stock should be expected to move up or down at least 40–60% in a year – investors should be aware this stock could be speculative.

**Medium** – stock should be expected to move up or down at least 30–40% in a year.

**Low-medium** – stock should be expected to move up or down at least 15–25% in a year.

**Low** – stock should be expected to move up or down at least 10% to +10% in a year.

Recommendations – 12 months

**Note:** Quant recommendations may differ from Fundamental Analyst recommendations.

Financial definitions

All "Adjusted" data items have had the following adjustments made:

- Added back: goodwill amortisation, provision for catastrophe reserves, IFRS derivatives & hedging, IFRS impairments & IFRS interest expense.
- Excluded: non recurring items, asset sales, property revamps, realised value uplift, preference dividends & minority interests.

- **EPS** – adjusted net profit / epsowa*
- **ROA** – adjusted ebit / average total assets
- **ROA Banks/Insurance** – adjusted net profit /average total assets
- **ROE** – adjusted net profit / average shareholders funds
- **Gross cashflow** – adjusted net profit + depreciation (equivalent fully paid ordinary weighted average number of shares)

All Reported numbers for Australian/NZ listed stocks are modelled under IFRS (International Financial Reporting Standards).

**Recommended risk disclosures**:

- **MPL AU**: The PHI sector in Australia is highly regulated. MPL does not control the enactment or content of new legislation and regulations. Product design and inadequate premium rate approvals may impact the net margin that MPL’s PHI products generate. Complementary Services operations are subject to contract execution and renewal risk. IT renewal: MPL is undertaking a major IT project to replace its core policy and CRM systems. Failure to deliver the project as expected could impact performance.

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- **Macquarie First South - South Africa**
- **Macquarie - Canada**
- **Macquarie - USA**

- **Outperform** – return >5% in excess of benchmark return
- **Neutral** – return within 5% of benchmark return
- **Underperform** – return <5% below benchmark return

**Recommendation proportions – For quarter ending 30 June 2015**

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*for US coverage by MCUSA, 9.68% of stocks followed are investment banking clients*

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*for US coverage by MCUSA, 5.53% of stocks followed are investment banking clients*

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*for US coverage by MCUSA, 1.38% of stocks followed are investment banking clients*
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