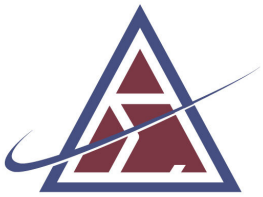

Institute of Actuaries of Australia

Pennies from Heaven

Health Insurance Demutualisations

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1. Catching the Demutualisation Wave

In the past 18 months there have been four significant demutualisations in the private health insurance industry. This paper reviews and compares these recent demutualisations and the associated actuarial issues.

According to Wikipedia, *"A mutual organisation is based on the principle of mutuality. Members do not contribute to the capital of the company by direct investment, but derive their right to profits and votes through their customer relationship. A mutual is therefore owned by, and run for the benefit of, its members - it has no external shareholders to pay in the form of dividends. Profits made will usually be re-invested in the mutual for the benefit of the members, although some profit may also be necessary in the case of mutuals to sustain or grow the organisation, and to make sure it remains safe and secure."*

"Demutualisation is the process by which a customer-owned mutual organisation changes legal form to a joint stock company. As part of the demutualisation process, members of a mutual usually receive a "windfall" payout, in the form of shares in the successor company, a cash payment, or a mixture of both. In a mutual organisation the legal roles of customer and owner are combined whereas in the joint stock company the roles are distinct."

Demutualisation activity in Australia has moved though the financial services sector in waves: building societies and credit unions in the 1980's/90's, life insurers in the 1990's, friendly societies in the early 2000's and health insurers in the late 2000's as illustrated in the following table:

Sector	Year	Organisation
Building Societies and Credit Unions	1985	NSW Building Society
	1986	Civic Co-op Permanent Building Society
	1987	Perth Building Society & Hotham Permanent Building Society
	1987	St George Building Society
	1987	Tasmanian Permanent Building Society
	1987	United Permanent Building Society
	1988	Metropolitan Permanent Building Society (Metway)
	1989	Illawarra Mutual Building Society
	1989	RESI-Statewide Building Society
	1990	Canberra Permanent Building Society
	1992	The Rock Building Society
	1992	Wide Bay Capricorn Building Society
	1993	First Provincial Building Society
	1993	Ipswich & West Moreton Building Society
	1993	Mackay Permanent Building Society
	1993	Northern Building Society
	1993	Pioneer Permanent Building Society
	1994	Co-operative Building Society of SA
	1997	Sunstate Credit Union
Life Insurers	1990	Capita
	1995	National Mutual
	1996	Colonial Mutual
	1997	AMP
Other	1998	ASX
	2000	NRMA Insurance
Friendly Societies	2001	Over 50s Mutual Friendly Society
	2002	IOOF
	2002	Hibernian Friendly Society
Health Insurers	2007	NIB
	2008	MBF
	2008	Manchester Unity
	2009	AHM

Source: www.delisted.com.au/Demutualised.aspx

Similar demutualisation activity has occurred overseas. In the last two decades a number of large mutuals have demutualised, including Prudential, MetLife, John Hancock, Mutual of New York, Manufacturers Life, Sun Life, Principal, and Phoenix Mutual in the US; Prudential, Friends Provident, Scottish Amicable and Standard Life in the UK and Old Mutual in South Africa.

In Britain, some mutual building societies have changed their rules to guard against demutualisation by requiring new members to agree that any windfall gains from a future demutualisation will be paid to an agreed charity. A credit union in Western Australia has introduced a one year waiting period before new members can qualify for any future demutualisation windfall.

Prior to 1985, all Australian health insurers operated on a 'not for profit' basis. 'Not for profit' health insurers are exempt from income tax under section 50-30 item 6.3 of the Income Tax Assessment Act 1997. The National Health Act was amended in 1985 to respond to the rise of risk rated health insurance by organisations not registered under the National Health Act. To accommodate the inclusion of these non-registered organisations, the Act was amended to allow for registration on a 'for profit' basis, allowing payment of dividends to shareholders.

There are presently nine health insurers operating on a 'for profit' basis:

Insurer	For Profit status commenced	Description
Grand United Corporate	1986	Commenced operations as FAI Health
BUPA Australia	1986	Commenced operations in 1986, HBA and Mutual Community acquired in 1995
MBF Alliances	1997	Conversion to 'for profit' status as SGIO Health
Australian Unity	2001	Conversion to 'for profit' status
National Health Benefits	2007	Commenced operations
NIB	2007	Demutualisation and listing on ASX
MBF	2008	Demutualisation and acquisition by BUPA (UK)
Manchester Unity	2008	Demutualisation and acquisition by HCF
AHM	2009	Demutualisation and acquisition by Medibank Private

There have been a large number of health insurance mergers and acquisitions. A history of industry activity is documented in *Adventures in Health Risk: A history of health insurance in Australia*. Many consolidations have occurred through merger of 'not for profit' health insurers. However recent consolidations have occurred via demutualisation, releasing value for members of the demutualised insurer.

The following table summarises recent health insurance transactions:

Year	Target	Acquirer	Purchase Price $m	Net Assets $m	Contributors 000's	Contribution Income $m	Goodwill Paid per Contributor	Goodwill Paid % of Contributions	Data date
2009	AHM	Medibank Private	367.0	215.0	155.4	377.1	$979	40%	Jun 08
2008	Manchester Unity	HCF	188.0 [1]	85.2	79.1	225.1	$1,299	46%	Jun 08
2008	Druids VIC	GMHBA	4.7	4.7	6.2	15.1	$0	0%	Jun 08
2008	MBF	BUPA	2,410.0	1,182.1	819.2	1,988.4	$1,499	62%	Jun 08
2007	NIB	ASX listing	611.1 [2]	336.3	328.8	666.0	$836	41%	Jun 07
2006	Druids NSW	AHM	2.5	2.5	1.5	4.2	$0	0%	May 06
2004	IOOF	NIB	15.0	6.4	10.6	17.2	$812	50%	Jun 03
2003	NRMA Health	MBF	100.0	46.3	95.7	170.6	$561	31%	Jun 03
2002	AXA Health	BUPA	595.0	117.6	453.4	821.0	$1,053	58%	Jun 02

Notes:

1. Manchester Unity: Purchase price of $256 million reduced by $68m for value of non-health insurance business also acquired as per Information Memorandum
2. NIB: shares issued to members on demutualisation valued at volume weighted average price in first four months of ASX listing of $1.18 per share

The above table compares the transactions in terms of goodwill paid per contributor and as a percentage of contribution income. There are many other valuation methods and measures that can be used, for example, multiples of earnings, net tangible assets or discounted cashflow models. Adjustments can be made to incorporate the regulatory capital requirements. The independent expert reports contained in the demutualisation documents include detailed valuation methods and calculations.

Some acquisitions have resulted in the ultimate merger of the target and acquirer. IOOF was merged with NIB (ie. a 'for profit' health insurer was acquired then merged with its 'not for profit' parent).

Other acquisitions by way of merger involved no consideration being paid, following PHIAC intervention:

- Goldfields was merged with Healthguard in 2002
- IOR was acquired by, then merged with, HCF in 2002
- Federation Health was merged with Latrobe Health in 2005

Health insurance mergers were historically (but not always) marriages of necessity where one party was in a weakened state following a financial crisis. There was little, if any, value available to be distributed to members. With most health insurers presently in good financial health, the question of distributing value to members is more pertinent, particularly if the acquirer is not a mutual organisation. It would appear that mergers have given way to demutualisations as the acquisition method of choice.

2. Why Demutualise?

Demutualisation crystallises value by releasing a windfall gain to the present generation of members, which at least partly represents accumulated value that has been built by past generations of members.

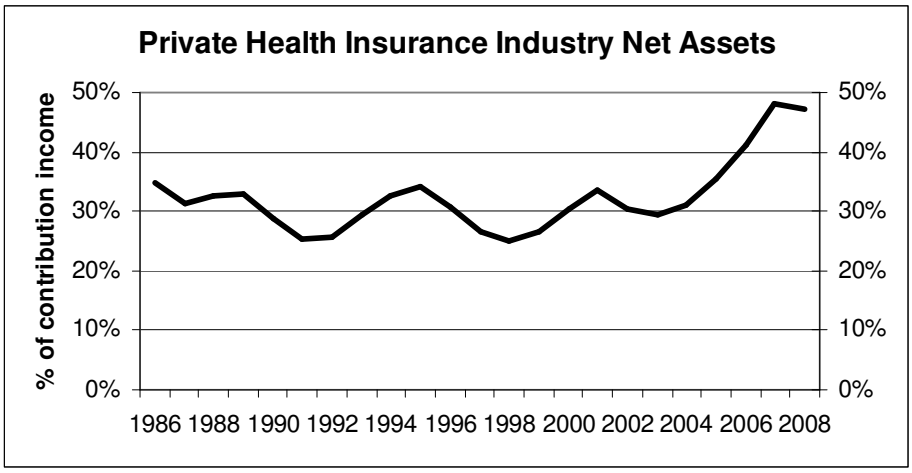
Arguments in support of recent demutualisations include:

- increased security of member benefits
- greater capital resources as part of a larger organisation
- creation of a stronger group
- fair and reasonable purchase price
- allows members to share in the value locked in the health insurer
- combined group will be better positioned to limit premium increases
- combining with a like-minded organisation
- improved product offerings and service delivery
- economies of scale and synergies
- enhances strategic and capital flexibility
- superior to return of surplus capital via reduced premiums and/or increased benefits
- separation of shareholder and policyholder rights
- increased board and management accountability
- response to structural changes in the private health insurance industry

Arguments against demutualisations include:

- consider allocation rules are not fair and reasonable
- concern about loss of company membership rights
- concern that the acquirer will have a different culture
- do not believe that the health insurer needs to change
- concerned about possible adverse impacts on benefits or premiums due to the need to finance tax and dividends
- concern that the health insurer will no longer be a mutual
- costs associated with demutualisation (and ASX listing)
- shareholders and policyholders may have competing interests
- concern about having a foreign owner
- alternative options should have been pursued
- disagree with the views of the Board and the independent expert

Recent health insurer demutualisations have not been triggered by financial crises, but by pre-emptive activity or approaches from competitors. Since demutualisation releases a windfall gain to members, many Boards may feel a responsibility to present any offers received to members or to proactively explore the merits of demutualisation. Demutualisation activity has also occurred after a period of good industry financial performance and accumulation of significant reserves, illustrated by the following graph:



3. Ownership Considerations

In any health insurer transaction where a change of ownership occurs it is essential to determine who has an ownership interest in the target health insurer.

The Constitutions of each health insurer contain provisions relating to wind-up, and most 'not for profit' health insurers provide that in these circumstances there is to be no distribution of surplus assets to members. Many health insurers provide that any surplus would be paid to an institution having similar objectives and distribution restrictions, paid to a charity, or paid to PHIAC. Section 149-45 of the Private Health Insurance Act requires that any residual assets after termination to be paid to PHIAC (essentially the Risk Equalisation Trust Fund).

However a demutualisation does not involve a wind-up, and recent demutualisations have occurred despite their Constitutions including provisions prohibiting members from receiving any surplus on wind-up. Members of mutual organisations generally have two sets of rights: contractual rights through a policy, and rights as a member under the health insurer's Constitution. Regardless of the winding up provisions in the Constitution, the key ownership right of members derives from their right to vote to change the Constitution. While membership generally does not provide a right to receive distributions, a change in the Constitution would permit a demutualisation to occur and give rise to membership acquiring a financial value.

As a result of demutualisation, members have their membership rights cancelled and therefore lose their voting rights as members, however they retain their rights as customers (policy owners). The process of demutualisation separates out and crystallises a value for mutual membership rights. It is important to note that the Constitutions of most health insurers define a member for voting purposes to be the principal policyholder, and do not include other persons covered by the policy.

In some transactions where the health insurance business was operated by a friendly society, the purchase price was paid to the friendly society but with health insurance members able to retain a continuing financial interest in the friendly society.

In 2006 AHM paid $2.5 million to United Ancient Order of Druids Registered Friendly Society NSW to acquire their health insurance business. Half of the purchase price was used to subsidise premiums payable by ex-Druids members for a period of 2 years and the other half was retained by the friendly society in the form of an investment bond for each member which could be withdrawn after three years.

In 2008 GMHBA paid $4.7 million to United Ancient Order of Druids Friendly Society (Victoria) to acquire their health insurance business. While the health insurance members were not entitled to the proceeds of the sale, transferring Druids members were allowed to retain membership of the friendly society for an annual fee of $10 which was waived for the first year. This provided these members with a right to participate in the case of a future distribution or wind-up of the friendly society.

4. Regulatory Requirements

Demutualisation involves changing registration status to a 'for profit' private health insurer under the Private Health Insurance Act. This enables the health insurer to make distributions to its owners. Converting to 'for profit' means the health insurer is no longer exempt from income tax.

Changing registration status

Section 126-40 of the Private Health Insurance Act sets out the requirements for changing registration status.

'For Profit' Conversion

Section 126-42 of the Private Health Insurance Act sets out the requirements for a conversion to 'for profit' status. The insurer is required to provide the Private Health Insurance Administration Council (PHIAC) with a conversion scheme. PHIAC must approve the application if it is satisfied that it would not in substance involve the demutualisation of the insurer. If it involves a demutualisation, PHIAC must approve the application if:

- it only provides financial benefits to policyholders or other insured persons, and
- PHIAC is satisfied that the conversion scheme would not result in financial benefits from the scheme being distributed inequitably between such policyholders and insured persons.

PHIAC has issued a practice note for applications to convert to 'for profit' status. PHIAC is required to consider whether the application involves a process, or series of processes, wherein a corporation with a mutual structure, usually limited by guarantee, becomes a corporation limited by shares, with its dominant purposes being to generate profit and yield returns to shareholders. The circumstances of each demutualisation will vary, however they often involve a scheme of arrangement approved by a Court under part 5.1 of the *Corporations Act 2001* and constitutional amendment. The demutualisation application must be published in a national newspaper to provide interested parties with an opportunity to submit comment to PHIAC.

Demutualisation

The Private Health Insurance Act requires that only policyholders and insured persons may benefit financially from a demutualisation. The Private Health Insurance Act requires PHIAC to consider the financial interest of all individuals who are covered by an insurance policy of the insurer, to be satisfied that the distribution of financial benefits is only to policyholders or insured persons, and that the distribution is not inequitable between policyholders and other insured persons.

Restructures, mergers, acquisitions and terminations of health benefit funds

The Private Health Insurance Act also provides for the restructure (section 146-1), merger and acquisition (section 146-5) and termination (section 149) of health benefits funds conducted by private health insurers.

Restructures

A private health insurer may restructure its health benefits funds so that insurance policies that are referable to a health benefits fund of the insurer become referable to one or more other health benefits funds of the insurer.

An application to PHIAC for approval of a restructure proposal must include a business plan for the receiving fund and a report from the insurer's appointed actuary.

The business plan must cover a three year period from the restructure date and include details of:

- assets and liabilities of the fund at the restructure date
- monthly budget showing income, expenditure, assets, liabilities, solvency and capital adequacy position, management expense ratio and number of policyholders
- proposed marketing plan
- proposed changes to procedures and arrangements with health service providers and other service providers
- proposed changes to benefits or premiums
- arrangements or processes necessary for the restructure to occur

The appointed actuary's report must provide an opinion on:

- whether the business plan submitted is well-founded
- whether the assets and liabilities to be transferred are a reasonable estimate of the position of the transferring funds
- whether the restructure will affect the ability of the insurer to comply with solvency and capital adequacy requirements at the restructure date and at any time over the following three years and within the foreseeable future
- the likely effect of the restructure on premiums and benefits for both policies being transferred and not being transferred at the restructure date and at any time over the following three years and within the foreseeable future

Mergers and Acquisitions

A private health insurer may enter into an arrangement with one or more other private health insurers under which insurance policies that are referable to a health benefits fund or funds of the transferring insurer become referable to a health benefits fund or funds of the receiving insurer.

If the proposed transfer of policies involves any form of financial benefit to any person, the arrangement must state the details of the financial benefit, whether or not the person to benefit is a party to the arrangement.

If the proposed transfer of policies involves the transfer of policies referable to the health benefits fund of a 'not for profit' insurer to the health benefits fund of a 'for profit' insurer, and the transferring insurer has (or will have) any interest in the receiving insurer, the application for approval must provide an independent expert's valuation of the market value of the transferring insurer's health insurance business.

An application to PHIAC for approval of a merger or acquisition proposal must include a business plan for the receiving fund and a report from the appointed actuaries of both the receiving fund and the transferring fund.

The business plan must cover a three year period from the restructure date and include details of:

- assets and liabilities of the fund at the restructure date
- monthly budget showing income, expenditure, assets, liabilities, solvency and capital adequacy position, management expense ratio and number of policyholders
- proposed marketing plan
- proposed changes to procedures and arrangements with health service providers and other service providers
- proposed changes to benefits or premiums

The receiving insurer appointed actuary's report must provide an opinion on:

- whether the business plan submitted is well-founded
- whether the assets and liabilities to be transferred are a reasonable estimate of the position of the transferring fund
- whether the restructure will affect the ability of the insurer to comply with solvency and capital adequacy requirements at the restructure date and at any time over the following three years and within the foreseeable future
- the likely effect of the restructure on premiums and benefits for both policies being transferred and not being transferred at the restructure date and at any time over the following three years and within the foreseeable future

The transferring insurer appointed actuary's report must provide an opinion on:

- whether the assets and liabilities to be transferred are a reasonable estimate of the position of the transferring fund
- whether the net asset position of the fund immediately after the transfer takes effect will not be greater than zero
- whether the restructure will affect the ability of the insurer to comply with solvency and capital adequacy requirements at the restructure date and at any time over the following three years

Terminations

Section 149-45 of the Private Health Insurance Act provides that any assets remaining following the termination of a health benefits fund are to be paid to PHIAC for payment to the Risk Equalisation Trust Fund.

5. Demutualisation Principles

An allocation basis must be determined to distribute the proceeds of the demutualisation.

In NIB's case, the Federal Court noted that:

"The fairest demutualisation designed to distribute stored-up profits would engage in an historical investigation to determine which policyholders, both present and former, have contributed to such profits and to what extent. However, from a practical point of view, such an inquiry is almost impossible."

PHIAC is required to make an assessment of whether the proposed allocation basis is not inequitable between policyholders and insured persons. In taking a decision on the share allocation methodology proposed, PHIAC has established the following principles to assess allocation bases.

Value and Rights
The allocation should recognize the past value contributed, the future value given up by policyholders and insured persons in the demutualisation, and rights given up.

Equality
Policyholders and insured persons should be treated equally as far as possible. There should be minimal discrimination against groups or individuals, unless it can be demonstrated that they have forfeited a financial benefit.

Persons should not receive a financial benefit unless the person is either a policyholder or other insured person.

Persons that are neither policyholders nor insured persons, regardless of their role in the demutualisation, may not receive any allocations.

Entitlements should generally be allocated only to contributors, who have the primary contractual relationship with the insurer.

Eligible policyholders should be allocated a specified entitlement in proportion to length of membership.

Transparency
The allocation basis should be understandable, readily calculated and verifiable as accurate.

Efficiency
The allocation should not waste resources that would otherwise have been distributed to members.

Process
The process giving rise to the allocation decision should:

- be performed without bias
- include consideration of possible alternatives and why those alternatives were not chosen
- have some consistency with other demutualisations
- be compliant with laws, regulation and the company's constitution
- ensure that every affected person has a means to be heard.

Reasonable Benefit Expectations
To the extent that policyholder expectations cannot be protected in the demutualisation, they may be compensated for by a share allocation.

Needs
The allocation must satisfy stakeholder needs – for example, policyholders should understand the basis, process and have a say in the distribution – eg via a vote.

Access
It should be easy for policyholders to understand and access their entitlement. It would be inequitable if participants had to go through a difficult or unnecessary process or administration in order to determine and receive their entitlement.

These PHIAC principles are similar to the principles adopted in several of the demutualisations to guide the development of allocation rules:

1. Membership should be rewarded. The principle of mutuality suggests that people that are not members should not be rewarded.
2. The allocation should try to avoid "double dipping".
3. The cut off date should be selected to avoid allocation to those customers joining to take advantage of the announced allocation.
4. Rights being given up are not significant or material to the overall financial benefit.
5. The financial benefit can be considered to be in the nature of a windfall gain.
6. The allocation basis should take into account contribution to value but should not be driven by it.
7. The allocation basis should recognise that contribution to value cannot be accurately determined.
8. The allocation basis should clearly recognise the different contribution to value between health insurance business and any other business.
9. The allocation basis should be simple and based on data that can be verified by the organisation.
10. The allocation basis should have a mechanism for dealing with issues that may take time to be resolved.
11. The allocation rules should represent a normal view of fairness where loyalty to the organisation is recognised and valued.
12. The allocation basis should take into consideration past demutualisations and should not be radically out of step with the allocation bases that have previously been adopted.

6. Comparison of Allocation Bases

This section briefly outlines the specific demutualisations of NIB, MBF, Manchester Unity and AHM, comparing the allocation bases used and highlighting some of the issues raised during the demutualisation process.

The members of each health insurer overwhelmingly voted in favour of the demutualisation proposals as shown in the following table:

Health Insurer	Resolution	Required Threshold	Outcome
NIB	Votes cast	nil	33.7%
	Votes in favour	75%	94.7%
MBF	Votes cast	nil	41%
	Votes in favour	50%	98.3%
Manchester Unity	Votes cast	40%	77.8%
	Votes in favour	80%	99.1%
AHM	Votes cast	25%	58.4%
	Votes in favour	75%	95.2%

The Australian Competition and Consumer Commission (ACCC) reviewed each of the proposed demutualisations of MBF, Manchester Unity and AHM. It concluded that each transaction was unlikely to give rise to a substantial lessening of competition in any relevant market.

NIB

In response to an extensive review of possible options, NIB determined that demutualisation and ASX listing was the most appropriate strategy to support its ongoing sustainability and future growth. It demutualised and listed on the Australian Securities Exchange in November 2007. Shares were allocated to contributors as follows:

Share allocation per year (rounded up to next year)

Policy Type	Shares per year	Minimum	Maximum
Ambulance Only Policy	10	100	300
Single Policy	100	300	3000
Family Policy	200	600	6000

based on single/family status at 20 March 2007

The volume weighted average share price over the first four months of listing was $1.18. Since listing NIB's share price has traded as high as $1.40 and as low as $0.55, and was $0.80 on 27 March 2009.

Share entitlements were based on length of membership (less valid periods of suspension), product type and family type on 8 November 2007. A minimum number of shares was allocated to avoid negligible allocations.

NIB commenced operations as the Newcastle Industrial Benefits fund in 1953. NIB merged with South Coast Medical Benefits in June 1975, Hunter Medical Benefits in November 1978, and Newcastle & Hunter Medicare Health Fund (formerly Store Hospital & Medical Fund) in June 1981. NIB acquired Grand United in September 1994 and IOOF (Victoria) in 2003. A maximum membership duration of 30 years was imposed to recognise that verification of historical membership records was difficult prior to this date. For Ex-IOOF Members, membership duration was only counted from the transfer date of 1 May 2003, as they were previously members of a 'for profit' health insurer.

Allocations were based on the family type at 20 March 2007. Policyholders with family policies received double the benefit of single policies, reflecting historical practice for contribution rates for family policies being double that for single policies.

No differentiation was made for different product types (except for Ambulance Only products) or for minor differences in benefits such as excess levels, as the nature of health products has changed over time. Ambulance Only policyholders received a smaller allocation due to the significant difference in contribution rates and benefits relative to hospital or ancillary products. Policyholders holding multiple policies (eg. separate hospital and ancillary policies) were treated as having only one policy based on the product that provides the greatest allocation.

MBF

Following a strategic review, MBF proposed a demutualisation and ASX listing. It rejected a proposal from BUPA Australia to combine the two businesses and in August 2007 recommended that MBF proceed with ASX listing.

In November 2007, BUPA Australia presented a revised merger proposal. In December 2007, MBF and BUPA Australia entered into an agreement to combine the business operations of MBF and BUPA Australia. BUPA (UK) paid $2.41 billion to be distributed to MBF members. MBF demutualised in June 2008.

Following the acquisition, in October 2008 MBF made a capital payment of $500 million to its parent, BUPA Australia Holdings. In the longer term, the BUPA Australia Group intends to seek to merge the health funds of MBF and the BUPA Australia into a single health insurer.

Units were allocated to contributors as follows:

Fixed allocation per member

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	15	125	250	375
Family Policy	30	250	500	750

Tenure allocation - per complete year, maximum 30 years

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	5	25	50	75
Family Policy	10	50	100	150

based on single/family status in the relevant year

Entitlements were based on length of membership (less valid periods of suspension) and product type held on 8 November 2007. Historical changes in family status were taken into account.

MBF commenced operations 1946. It acquired MBF Alliances (formerly NRMA Health) in 2003. The earliest date for membership duration purposes was 1 November 1978. Members with continuous membership since this date were allocated a maximum duration of 30 years to recognise that verification of historical membership records was difficult prior to this date. Members of MBF Alliance were excluded from the allocation as they were members of a 'for profit' health insurance subsidiary of MBF.

Each unit allocated was worth $1.44. $25 million of the $2.41bn proceeds were held back to deal with errors and disputes in the allocation process, with the residual balance distributed in proportion to the initial payments made.

Manchester Unity

In late 2007, Manchester Unity received an unsolicited approach from another private health insurer. Manchester Unity commenced a process to identify the most suitable merger partner, culminating in a bidding process and announcement in August 2008 of a recommendation for a merger between Manchester Unity and HCF.

Following acquisition, HCF intends that Manchester Unity will make a capital payment to HCF of surplus capital in excess of the target surplus level. HCF intends to merge the health benefits funds of Manchester Unity and HCF into one fund operated by HCF on a 'not for profit' basis.

Units were allocated to contributors as follows:

Fixed allocation per member

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	18.5	185	185	370
Family Policy	37	370	370	740

Tenure allocation - per year (rounded up to next year), maximum 23 years

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	7.5	75	75	150
Family Policy	15	150	150	300

based on single/family status in the relevant year

Entitlements were based on length of membership (less valid periods of suspension) and product type held on 27 August 2008. Historical changes in family status were taken into account.

Each unit allocated was worth $1.00. A minimum allocation of $250 applied to each member. Members also received allocations in respect of the financial services business of Manchester Unity. Of the $256m proceeds, $5 million was held back to deal with errors and disputes in the allocation process, with the residual balance distributed in proportion to the initial payments made.

Manchester Unity commenced operations in 1843. In respect of health insurance business policies, the earliest possible date joined was 2 December 1985, which was when Manchester Unity was re-registered under the then National Health Act. Manchester Unity had wound up its health fund on 31 January 1984 after coming to the view that it would no longer be viable, and instead registered a hospital benefit fund under the NSW Friendly Societies Act to avoid certain regulatory requirements. Manchester Unity re-commenced operations under the National Health Act when legislative changes were made requiring organisations carrying on health insurance business to register under the National Health Act.

Once the merger is completed, Manchester Unity will become only the third 'for profit' health insurer to have merged with a 'not for profit' health insurer (after Health Australia merged with Medibank Private in 1990 and IOOF merged with NIB in 2004). HCF will need to consider the future membership rights of Manchester Unity members (given they have received a payment for extinguishing their former Manchester Unity membership rights) in comparison to continuing HCF members. This will be important for the equitable treatment of these two groups of members in any future transactions.

AHM

In 2006 AHM conducted a review of strategic options that included merging with another company or demutualisation. A survey of AHM members found that 65% were against demutualisation, however only 44% opposed demutualisation under friendly circumstances where the Board recommended the offer.

In late 2007, AHM received unsolicited approaches from two private health insurers expressing interest in merging with or making an investment in AHM. In July 2008 AHM announced that it had accepted an offer from Medibank Private.

Units were allocated to contributors as follows:

Fixed allocation per member

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	20	200	200	400
Family Policy	40	400	400	800

Tenure allocation - per year (rounded up to next year), maximum 32 years

Policy Type	Ambulance Only policy	Extras Only policy	Hospital Only policy	Combined policy
Single Policy	6.5	65	65	130
Family Policy	13	130	130	260

based on single/family status in the relevant year

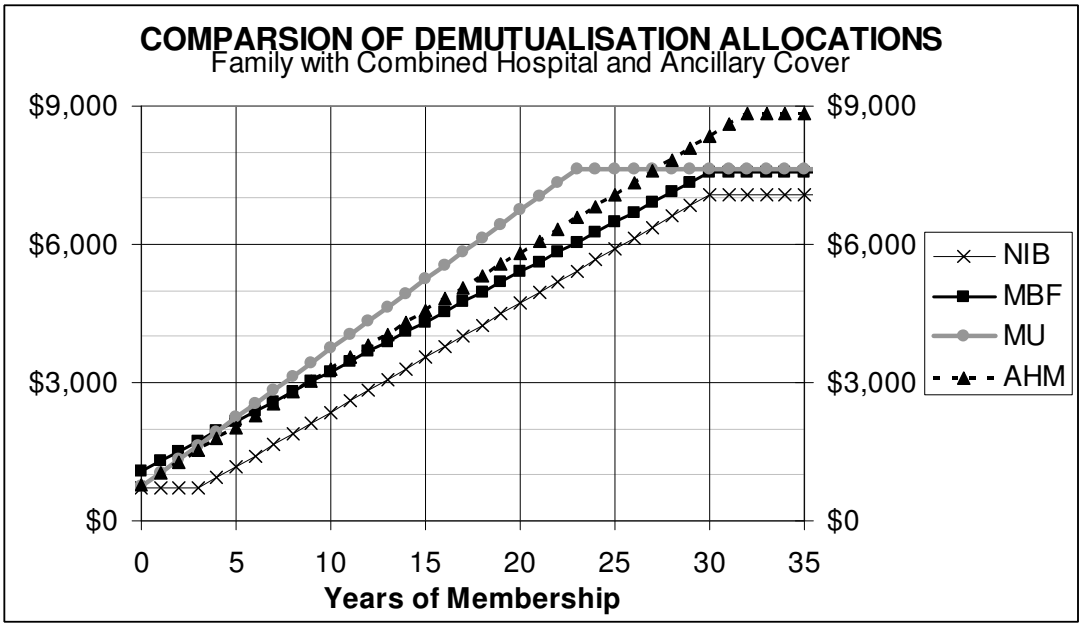
Entitlements were based on length of membership (less valid periods of suspension) and product type held on 13 July 2008. AHM had its origins in the Local Government Employees' Medical and Hospital Club which commenced in January 1971 and the Wollongong Hospital and Medical Benefits Contribution Fund and the Bulli District Hospital Contribution Fund (later becoming Illawarra Health Fund) which commenced prior to 1952. It acquired the members of Mercantile Mutual Health in 1999 and acquired the health insurance business of United Ancient Order of Druids Registered Friendly Society NSW in 2006.

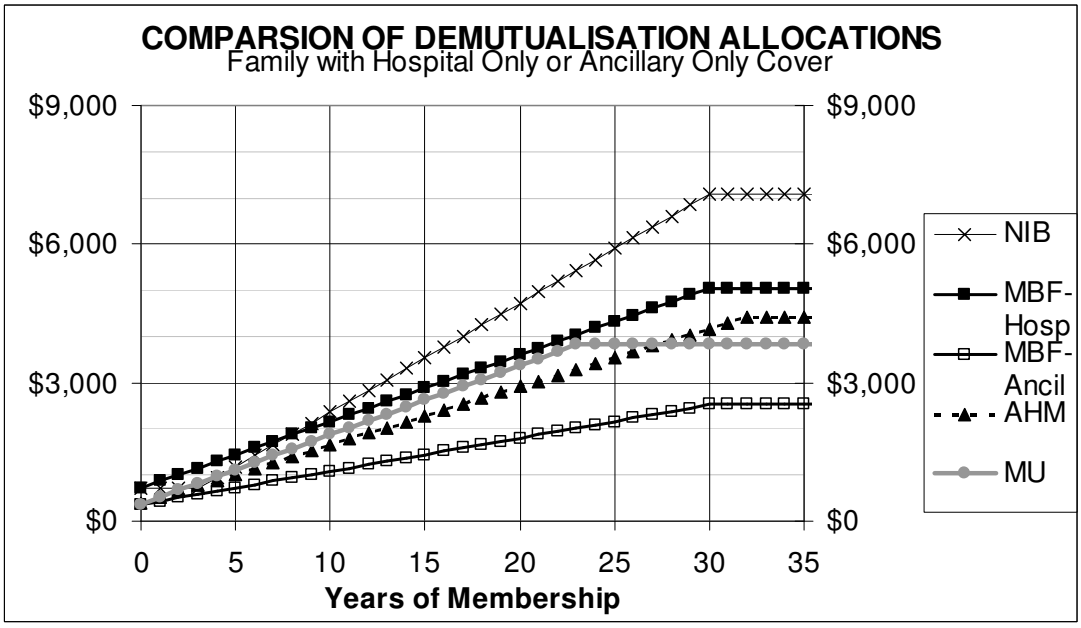
The earliest date for membership duration purposes was 3 October 1976, imposing a maximum of 32 years to recognise that verification of historical membership records was difficult prior to this date. Ex-Mercantile Mutual members had their membership limited to the date they joined AHM on or after 1999. Ex-Druids members had their historical membership count up to the maximum duration. Historical changes in family status were taken into account.

Each unit allocated was worth $0.97. Of the $367 million proceeds, $5 million was held back to deal with errors and disputes in the allocation process, with the residual balance distributed in proportion to the initial payments made.

Comparison of Allocation Bases

The following charts compare policyholder allocations under the four demutualisations. The first graph compares allocations for families continuously holding both hospital and ancillary cover. The second graph compares allocations for families continuously holding either hospital or ancillary cover.





NIB's allocation rules gave more value to those with hospital only or ancillary only cover than the other demutualisations since they did not distinguish between product holdings. MBF's allocation rules gave more value to hospital cover compared to ancillary cover, on the basis that hospital cover has higher contribution rates and has made a larger contribution to value. This only impacts the minority of members who do not have both hospital and ancillary cover.

7. Allocation Issues

The allocation bases adopted gave rise to a number of design and practical issues in specific circumstances that warrant further discussion. In each demutualisation, an allocation review committee was established to respond to member concerns regarding their allocations. The role of this committee was to establish that the allocation rules had been applied correctly. Some of the consideration was held back to provide sufficient funds to deal with any incorrect allocations.

Important Dates

Each demutualisation had a cut-off date for entitlement purposes. In some cases, policies had to still be in force at a future date (record date) in order to be eligible to receive entitlements.

Contributors who were in arrears at the cut-off date were given a period of time to pay up arrears to be eligible. Contributors who were suspended at the cut-off date were also given a period of time to reactivate their policy to be eligible.

Transactions just prior to the cut-off date or record date could affect entitlements, for example downgrading (eg. dropping hospital or ancillary cover), transferring from family to single or ceasing cover.

Beneficiaries

The only persons who received entitlements in each demutualisation were contributors. This meant that children and spouses received no allocations. Periods of cover while not a contributor were of no relevance in determining length of membership. Therefore any historical changes in the person named as contributor were important in determining the appropriate allocation. It is of note that the majority of contributors are male.

Many funds use the word 'member' in a general sense refer to all insured persons, and the period of time a person has been insured may have been used for benefit eligibility or member recognition purposes, however have no impact on contributor entitlements.

Membership Data Quality

The quality of membership history data was a major consideration in determining the allocation basis. All health insurers set an earliest membership date for the purposes of the allocation, recognising that the insurer's historical membership data was probably not of sufficient quality and accuracy to be used for a purpose that probably was not contemplated.

In MBF's case, the Federal Court noted that:
"*A person who had held a policy prior to 1 November 1978 had his or her cash entitlement calculated on the basis that he or she had held a policy for a maximum of 30 years. The reason for that ceiling concerns a lack of reliable records going back prior to 1 November 1978. Apparently, MBF's first computer system was installed in late 1976. Previously, membership data had existed only in hard copy form. While some Participating Contributors who had held policies for longer than 30 years continued to hold documentary evidence showing this, others did not. The Board of MBF did not consider it fair or appropriate to treat those Participating Contributors who had documentary evidence differently from those who did not." (MBF Federal Court judgement)*

Membership changes

Product and Family type changes
Given data quality limitations and changes to product offerings over time, all health insurers decided not to take into account historical product changes, and only recognised the current product type (eg. hospital, ancillary or combined cover). Some members were concerned that they were not being given recognition for their long membership on top level covers.

NIB did not take into account historical changes between single and family status. This had a significant impact on elderly members more likely to be single after many years of family membership. In the other demutualisations historical family status changes were taken into account.

The Federal Court commented on NIB's approach of only recognising current family type:

"For many years, some members of NIB were Family Members, but subsequently converted to being Single Members. Such Members receive an allocation on the basis of their current status rather than on their past status." The Independent Actuary "confirms his opinion that the share allocation rules, in selecting policy status on the cut-off date, are consistent with the approach adopted in several other demutualisations that have been approved in Australia in recent years. He observed that it is generally not possible to take into account the historic personal circumstances of all individual participants in a demutualisation because the organisation will not have all of the necessary personal information to enable such an exercise to be undertaken." Based on "the extent, quality and reliability of the records held by NIB, it would not be possible to allocate shares by taking into account changes in individual circumstances or policy type held over the 30 year period adopted by the share allocation rules." (NIB Federal Court judgement)

Suspension and lapse
Health insurers allow members to suspend cover in limited circumstances (eg. overseas travel). Valid periods of suspension in accordance with the fund rules were deducted from length of membership for allocation entitlement purposes. However a short period of lapse meant loss of all historic entitlements for the period prior to lapse. Some members complained about strict adherence to fund rules in determining entitlements around the cut-off date which differed from usual fund practice.

Membership mergers and splits
Over long periods of time, many changes are possible to a person's health insurance coverage. Persons covered can join and leave policies as family circumstances change with family formations, separations and death. These major family events will have an impact on allocation entitlements. In some cases policy changes may have been induced by the health insurer in a well-intentioned effort to maximise benefits for members as a result of certain product features (excesses and limits). While generally it was the history of the current contributor that determined the allocation entitlement, in some circumstances longer membership length may be granted depending on the policy history.

Where there was a change in contributor within a policy, or the contributor dies, the substituted contributor may be given credit for the previous contributor's membership.

Where a person covered (not a current contributor) was previously a contributor on another policy (such as for a family formation), that ex-contributor has no entitlement under the allocation rules. Where a person covered (not a contributor) left a policy to become a contributor on their own policy (eg. family separation), they are only eligible for an allocation for the period of membership as a contributor. The continuing contributor on the former policy received the entitlement for the prior period of family membership.

Other involuntary membership changes may have occurred if contributors no longer require cover, such as Defence Force personnel or Veteran Gold Card arrangements.

Prior mergers and acquisitions

It is important to establish the impact of prior merger and acquisition activity on allocation entitlements. Where members were originally part of a 'for profit' health insurer or have previously received a payment for their membership rights, it is sensible to establish an earliest date for the purpose of determining membership length in the demutualisation process. This will avoid "double dipping" of entitlements by previously acquired members. However the treatment of these members must be in accordance with contractual arrangements.

The Federal Court commented in relation to AHM that:

"*A query was raised as to why the years of membership are recognized by the allocation rules only as far back as 3 October 1976. The duration of a policy prior to that date had not been recognized because the Company's records prior to that date are not considered by the directors to be sufficiently complete and accurate for the purposes of verifying the date on which a policyholder joined the Company or its predecessor funds. AHM acquired all of the shares and the capital of Mercantile Mutual Health in 1999 from Mercantile Mutual Holdings Limited. Mercantile Mutual Health was a public company limited by shares, and was not a company that could fairly be described as a mutual company. Accordingly, the former policyholders of Mercantile Mutual Health were only holders of policies issued by Mercantile Mutual Health; they were not members of a mutual organization and had no ownership interests in the assets of funds maintained by Mercantile Mutual Health.*

This is in contrast with the position in relation to the Illawarra Health Fund and United Ancient Order of Druids Friendly Society NSW Limited whose members became members of the Company. In the former case, the Company paid no consideration for the merger. In the latter case, the Company undertook a contractual obligation to recognize the prior membership of members of the Druids' Health Fund" (AHM Federal Court judgement)

Member expectations

The arrangements should be simple to understand and explain. Members will discuss and compare their demutualisation allocations.

Base Allocation versus Tenure Allocation

A base allocation reflects the fact that some of the value of the organisation is referable to past contributors rather than current contributors. In MBF's case this was estimated to be around 25% of value. It also recognises that all contributors have equal voting entitlements.

Considerations for future demutualisations

While there in no one correct answer, and all allocation methods involve some degree of subjectivity and are subject to contention, the experiences with demutualisation allocations suggest a few areas for careful consideration in any future demutualisations:

- **Lapses:** short periods of lapse can result in loss of significant value
- **Product changes:** data may be accurate enough to consider product history
- **Family formations and separations:** can a better outcome be achieved?
- **Maximum duration due to data limitations:** consider additional allocation to longest serving members

8. Actuarial Advice

Actuaries have key advisory roles in health insurance demutualisations and mergers. A number of actuaries provided advice in relation to recent transactions:

Health Insurer	Appointed Actuary	Independent Reviewing Actuary
NIB	Mark Bishop	David Goodsall
MBF	Ian Burningham	Duncan Rawlinson & Rob Paton
Manchester Unity	Warrick Gard	-
AHM	Warrick Gard	Geoff Atkins & Jamie Reid
Druids NSW GMHBA	Allen Truslove Michael Howard	-

Demutualisations

The demutualisations have included reports from the appointed actuary and (in the case of NIB, MBF and AHM) an independent actuary. These reports have generally expressed an opinion on:

- the fairness and reasonableness of the allocation rules
- whether the reasonable benefit expectations of policy owners are materially adversely impacted by the proposal
- whether the outlook for future contribution rate increases is materially adversely impacted by the proposal
- whether the security of benefits provided to policy owners is materially adversely impacted by the proposal

Recommended allocation basis

Actuaries have a major role in recommending an appropriate allocation basis. The allocation bases adopted in recent demutualisations were considered in detail in section 6.

Impact on reasonable benefit expectations

The actuarial opinions concluded that demutualisation would not adversely impact policyholders' reasonable benefit expectations for the following reasons:

- there was no impact on current benefits offered or ability to amend these benefits in the normal course of business
- there were no plans to amend fund rules to reduce any policy features or benefits
- significant competition exists in the private health insurance market
- any changes to benefit entitlements are required to be notified to policyholders and the Department of Health & Ageing
- policyholders have the ability to switch insurers with continuity of cover without being required to serve additional waiting periods
- significant reductions in benefits would impact the competitiveness of products and place the insurer at a commercial disadvantage.

Impact on future contribution rates

The actuarial opinions concluded that demutualisation would not adversely impact future contribution rates for the following reasons:

- the proposed pricing policy following demutualisation is based upon target margins within the range already contemplated under the current pricing policy, and so will not put greater pressure on premium rates than the current pricing policy

- the intended gross margin target should be sufficient, for the reasonably foreseeable future, to meet expectations for a return on investment
- synergies from the transaction are likely to largely offset any requirement to pay tax and dividends on an ongoing basis
- health insurance is a competitive industry where it is relatively simple to change providers because of the legislative requirement of full portability between health insurers, and premium rates must be set having regard to the health insurer's competitive position and the response of customers and competitors to price changes
- all changes in premium rates are subject to regulatory review and must be approved by the Minister for Health and Ageing
- the combined purchasing power and increased business opportunities from the transaction will provide cost advantages which will benefit members and reduce pressure on premium increases
- there are imperatives for improvements in costs in a range of controllable areas.

Impact on security of benefits

The actuarial opinions concluded that demutualisation would not adversely impact policyholders' security of benefits for the following reasons:

- it is intended that the insurer continue to maintain a target level of capital in excess of the capital adequacy requirement set by PHIAC. Any surplus capital in excess of this amount will be accessible to shareholders
- the PHIAC solvency and capital adequacy standards require sufficient capital that any marginal increase in the level of capital maintained above that required by these standards, provides an ever-reducing marginal increase in policyholder security
- while there may be a reduction in the current level of capital as a result of payment of tax, dividends and capital payments, this is not material in respect of the level of cover likely to remain and the security of policy owners' benefits
- the insurer may be able to access external capital reserves from the parent or from capital markets (or as a result of future merger plans).

Restructure, merger and acquisition of health benefits funds

Actuaries also have a specific legislative role in relation to restructure, merger and acquisition of health benefits funds under section 146 of the Private Health Insurance Act.

On 1 October 2008, Ancient Order of Druids Friendly Society (Victoria) transferred its health insurance business to GMHBA. Druids members were allocated to products with benefits similar to their previous Druids policies. This was the first transfer of health insurance business under section 146-5 of the Private Health Insurance Act.

Actuarial reports were prepared by the appointed actuaries of Druids NSW and GMHBA as part of the transfer. The appointed actuaries concluded that the transfer should not adversely affect the longer term capital adequacy requirements of either insurer and in the case of Druids its capital adequacy position would be improved immediately following the transfer of the health insurance business to GMHBA. The financial security of the health insurance benefits of Druids members would be improved by transfer to GMHBA.

9. Other Corporate Activity

NIB

In October 2008, NIB received a proposal from a third party to acquire a controlling stake in NIB and establish a strategic alliance at $1.15 to $1.20 per share. The bidder was believed to be Discovery Health, a major South African health insurer (*The Australian, 1/11/08*). NIB rejected the proposal, saying that the proposed price was inadequate. NIB is presently undertaking an on-market buyback of up to 10% of its shares.

Australian Unity

Australian Unity has previously considered and dismissed the demutualisation option. In December 2005, Australian Unity published a report to members '*Australian Unity Our Future',* outlining the advantages and disadvantages to its members of either remaining a mutual or demutualising. The report contained independent valuation assessments, indicative share allocation outcomes and taxation implications. Member consultation via discussion meetings, questionnaires and telephone surveys resulted in 52% saying they wanted the company to stay as it was, 30% favouring demutualisation and 18% being undecided.

GMHBA

In 2008, GMHBA undertook a detailed review of operations to see if a change to structure and method of business was warranted. As a result of this process, the Board resolved to remain a mutual 'not for profit' organisation for the following reasons:

- a majority of members surveyed said they did not want to change
- a 'for profit' insurer would need to pay income tax
- there would be significant initial and ongoing ASX listing costs
- the requirement to pay dividends could be seen as being in conflict with keeping premiums as affordable as possible
- There is no current pressing need to demutualise.

Medibank Private

The Medibank Private Sale Act was passed in 2007 enabling the Commonwealth Government to sell its interest in Medibank Private. The Labor Government was elected in November 2007 and has reiterated its policy that Medibank Private remain a Government Business Enterprise, reporting to the Minister for Finance and Deregulation.

10. Acknowledgements

I acknowledge the valuable assistance and feedback I received from David Watson and Peter Lurie in the preparation of this paper.

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