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Further Adventures in Health Risk:
An updated history of Australian Health Insurance

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1. The adventure continues…

2017 marks ten years since the publication of *Adventures in Health Risk: A History of Australian Private Health Insurance* at the 2007 Actuaries Institute Biennial Convention. The 2007 Convention Paper presented an historical analysis of private health insurance in Australia, including the origins of each health insurer, major regulatory developments in the market, and merger and acquisition activity,

Over the past decade the private health insurance industry has continued to change and evolve; this paper documents some of the important changes and trends in the private health insurance industry over the past ten years.

2017 also marks a number of other anniversaries in private health insurance:

- 10 years since the commencement of the Private Health Insurance Act
- 10 years since the renaming of and changes to the Risk Equalisation arrangements
- 20 years since the Industry Commission Report into Private Health Insurance Industry, which led to the introduction of Lifetime Health Cover in 2000
- 20th year of the Private Health Insurance newsletter published by the Health Practice Committee of the Actuaries Institute, providing actuaries and others interested in the Australian private health insurance industry with regular updates, with almost 300 issues so far
- 20th year of the Industry Risk Equalisation survey, a quarterly informal sharing of claims and membership data between insurers to enable risk equalisation receipts and payments to be estimated prior to formal APRA assessment.

The past 10 years has been an eventful period for the private health insurance industry, involving changes to the regulatory environment, continued demographic change, pressure on premiums and changes to the insurers operating in the market.

2. Regulatory environment

There have been a number of major changes to the private health insurance regulatory environment over the past decade, including the commencement of the Private Health Insurance Act, changes to Risk Equalisation arrangements, changes to the Government Rebate and Medicare Levy Surcharge and transfer of regulatory supervision from PHIAC to APRA. A timeline of major regulatory changes over the past ten years is included in Appendix A.

2.1 Private Health Insurance Act

The Private Health Insurance Act commenced on 1 April 2007. The intention of the new act was to separate and simplify the regulatory framework compared to the previous arrangements, which were part of the National Health Act and regulations which had developed in an ad-hoc manner over many years.

There are a number of rules supporting the Private Health Insurance Act, including:

Complying Product Rules specifying requirements for minimum benefits, product information statements and a number of other matters (discounts, waiting periods, transfers certificates and performance indicators).

Prostheses Rules specifying benefits for prostheses.

Health Insurance Business Rules which specify exclusions from the definition of health insurance business.

Risk Equalisation Policy Rules which specify how the Risk Equalisation calculations will be made.

Health Benefits Fund Policy Rules including maximum discounts and rules for Overseas Visitors Health Cover.

Insurer Obligation Rules including Appointed Actuary requirements, reporting and notifications.

The **Private Health Insurance Prudential Supervision Act** commenced on 1 July 2015 with the transfer of regulatory responsibilities for private health insurance to the Australian Regulation Authority (APRA). It includes requirements governing expenditure and application of monies in Health Benefits Funds, solvency and capital adequacy requirements, the role of the Appointed Actuary, and rules for restructures, mergers and acquisitions, which were formerly contained in the **Health Benefit Fund Administration Rules.**

All health insurers were required to be corporations law entities and seek re-registration under the new Private Health Insurance Act prior to 1 July 2008.

The introduction of the Private Health Insurance Act generally reflected the prevailing regulatory requirements. Some of the more significant changes are described below.

2.1.1 Premium Change Approval

Every year, private health insurers review premium rates for their products. Since 1997, contribution rate increases have been effective from a common date for all private health insurers, typically 1st April each year.

Under section 66-10 of the *Private Health Insurance Act*, private health insurers must apply to the Minister for Health for approval of premium changes. The Minister must approve the proposed changes unless satisfied that a change would be contrary to the public interest.

The term 'public interest' is not defined in the Private Health Insurance Act. The Minister for Health has interpreted this public interest test to mean that premium increases are the minimum necessary to ensure insurer solvency, support benefits outlays, and meet prudential standards concerning capital adequacy, while also ensuring the affordability and value of private health insurance as a product. Consideration is also given to a private health insurer's management expenses ratio, which measures the relationship between the operating expenses incurred in the course of an insurer's normal operations and its contribution income.

This definition of public interest involves multiple, potentially competing, objectives.

These requirements are in contrast to the previous requirements under the National Health Act that the Minister of Health could refuse to approve a premium change if it imposed any unreasonable or inequitable condition affecting the rights of contributors or adversely affected the financial stability of the health insurer.

2.1.2 Discounts

From 20 October 1999, health insurers were permitted to provide premium discounts of up to 12%, representing the average industry management expense ratio, where they were satisfied that the discount did not exceed the savings made as a result of the contributor paying either 6 months or more in advance, through payroll deduction or direct debit or being a part of a contribution group. (HBF circular 601, Department of Health, 2/11/1999)

Before introducing a discount, health funds needed to submit a rule change for the discount to the Department of Health at least 60 days before coming into effect providing details of the discount. All discount arrangements needed to be reported to the Department and renewed on an annual basis. (HBF circular 629, Department of Health, 18/4/2000)

The annual report on discounting arrangements required a listing of each discount arrangement, showing:

- name of the contribution group
- discount start date
- discount end date
- the average percentage discount to contributors in the contribution group

- the cost to the fund in reduced premium income attributable to the discount arrangement
- a reasonable assessment of the savings in management expenses attributable to that discount arrangement
- a statement from the Public Officer that the health insurer does not have any discount arrangements that offer discounts to individual contributors greater than 12%
  (HBF circular 712, 30/5/2001)

Health insurers could be requested to provide evidence indicating how the insurer satisfied itself that the revenue forgone by providing the discount will not be more than the reduction in management expenses attributable to the payment. Commissions, brokerage fees, inducements or other sums paid as an incentive for a contributor or group of contributors to take out a product were included in calculating the percentage discount. Any indirect inducements such as the waiver of an excess or copayment was also included in the discount calculation by taking into account the difference between the premium paid for the product with an excess or copayment and the premium that would be paid for a comparable product with no excess or copayment, as well as any difference between the premium paid by the contribution group and the premium paid by other contributors for a substantially similar product.

With the commencement of the Private Health Insurance Act in 2007, the discounting arrangements were simplified in section 6 of the Private Health Insurance (Complying Product) Rules:

- Maximum discount of 12% compared to the full premium for a policy in the same product subgroup
- Discounts extended to quarterly premium payments
- Discounts exclude brokerage and commission
- Discounts exclude any promotion offered upon purchase in the first year of a policy, which is subject to a separate limit of 12% of premium

The requirement for health insurers to report or justify the discounts provided to the Department of Health is no longer in force.

2.1.3 Lifetime Health Cover

Lifetime Health Cover commenced on 15 July 2000. Premium loadings were applied for people who took out hospital cover after age 30. The Private Health Insurance Act modified the Lifetime Health Cover arrangements to remove these loadings once a person has been subject to them for a period of ten years. The first loadings were removed from 15 July 2010 following ten years of the Lifetime Health Cover arrangements.

2.1.4 Other PHI Act changes

The introduction of the Private Health Insurance Act resulted in a number of other minor changes to product regulations:

Broader Health Cover
The range of services that could be covered by private health insurance was broadened to include out-of-hospital services that substitute for or prevent hospital care.

Members in arrears
The requirement for health insurers to maintain continuity of cover for contributors who fall up to two months in arrears [National Health Act Schedule 1(d)] was removed. However, most health insurers still include this feature as part of their fund rules.

Mandatory full cover hospital product
The requirement for health insurers to provide a least one hospital product that covered all treatments [National Health Act Schedule 1(bd)] was removed.

Ambulance Levy Discounts
The requirement for health insurers to discount the hospital premium paid by people exempt from the NSW and ACT ambulance levy (eg. holders of pension cards) was removed. Any discount given is now included in the general discounting provisions described in section 2.1.2.

2.2 Risk Equalisation Arrangements

From 1 April 2007, the Reinsurance Trust Fund was renamed the Risk Equalisation Trust Fund (and then from 1 July 2015 changed to Risk Equalisation Special Account), more accurately describing its function, and a number of changes were implemented:

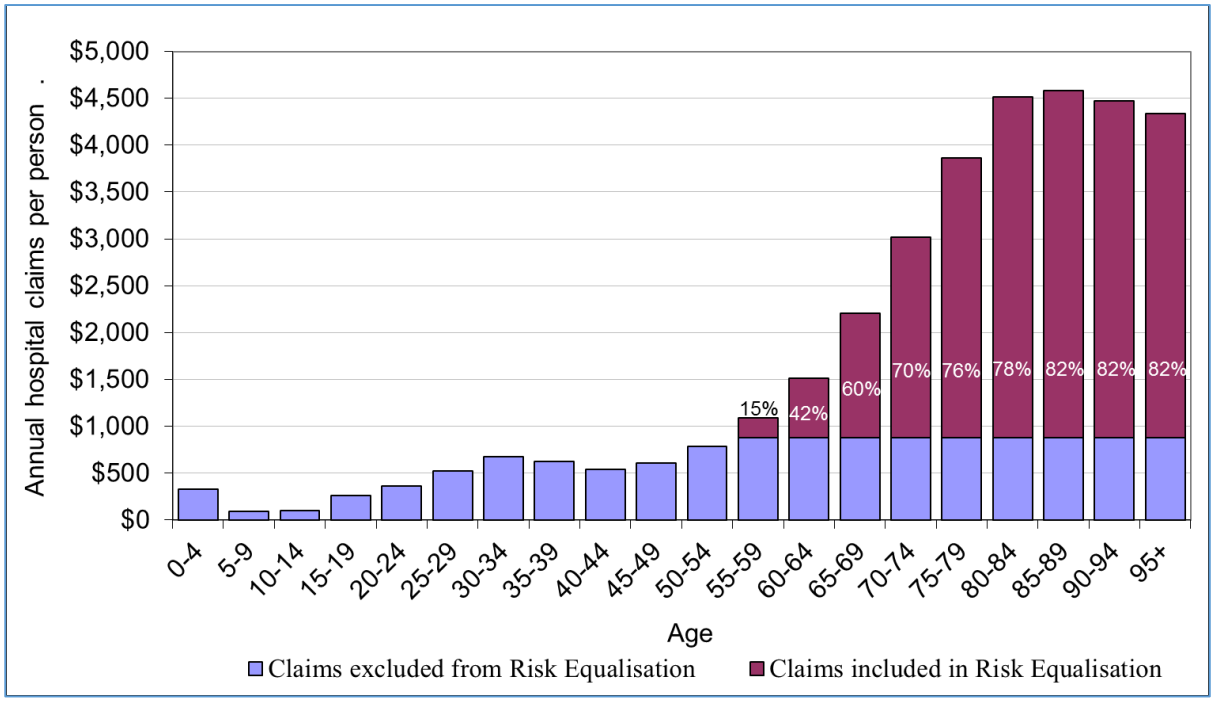
	Previous	Current
Ineligible benefits	The following benefits were excluded: • medical benefits over 16% above the Medicare Benefit Schedule. • Out-of-hospital services are generally excluded unless they have been assessed as approved outreach services	All hospital treatment benefits eligible for pooling.
high cost claims	Benefits paid for memberships experiencing long stays in hospital are eligible for pooling. Hospital benefits in excess of 35 days in the past 12 months for a membership are pooled.	Replaced by compulsory scheme covering benefits paid (after age-based pooling) in excess of $50,000 per person over four rolling quarters.
SEU Definition	Single memberships count as 1 SEU, other memberships (families, couples, single parents) count as 2 SEU's.	Single parents will be counted as 1 SEU instead of 2.

Pooling factors

The proportion of benefits pooled was changed to be tiered by age bands, compared to the previous fixed percentage of eligible benefits for persons aged 65 or older:

Age	Previous	Current
0–54	0.0%	0.0%
55–59	0.0%	15.0%
60–64	0.0%	42.5%
65–69	79.0%	60.0%
70–74	79.0%	70.0%
75–79	79.0%	76.0%
80–84	79.0%	78.0%
85–89	79.0%	82.0%
90–94	79.0%	82.0%
95+	79.0%	82.0%

The reason for varying percentages by age band was to smooth the costs across successive age bands. Under the previous arrangements, the costs of the 60-64 year old age group was significantly higher than the 65-69 year old age group after risk equalisation is taken into account. The current arrangements have reduced such distortions as illustrated below:



The pooling percentages were chosen to keep the size of the claims equalisation pool unchanged at the point of transition.

A history of changes to the risk equalisation arrangements in documented in *One Size Fits All: a review of community rated private health insurance*.

2.3 Government Rebate and Medicare Levy Surcharge

The 30% Government rebate on private health insurance premiums commenced in 1999. The Medicare Levy Surcharge for persons without private hospital cover commenced in 1997. The following tables set out the various income levels applying to the rebate and Medicare Levy Surcharge:

Financial Year	Income Tiers		
	A	B	C
Jan99-Jun08	$50,000	-	-
2008/09	$70,000	-	-
2009/10	$73,000	-	-
2010/11	$77,000	-	-
2011/12	$80,000	-	-
2012/13	$84,000	$97,000	$130,000
2013/14	$88,000	$102,000	$136,000
14/15 to 20/21	$90,000	$105,000	$140,000

Income range	Single	Non-Single	Medicare Levy Surcharge
Base	up to A	2 x Single level + $1,500 for 2nd and subsequent dependent child	Nil
Tier 1	between A and B		1.00%
Tier 2	between B and C		1.25%
Tier 3	over C		1.50%

Means testing of the rebate commenced from 1 July 2012. Each year a rebate adjustment factor is calculated to reduce the percentage rebate to apply for the following year, as a proxy to capping the growth in the Government Rebate to the increase in the Consumer Price Index, as follows:

Year commencing	Average premium increase	Consumer Price Index increase	Rebate Adjustment Factor
01 Apr 2014	6.20%	2.75%	0.968
01 Apr 2015	6.18%	1.72%	0.958
01 Apr 2016	5.59%	1.69%	0.963
01 Apr 2017	4.84%	1.48%	0.968

CPI = All Groups Australia, December annual percentage change to 2 decimal places
PHI Premium Increase = average industry percentage change published by DHA to 2 decimal places
Rebate Adjustment Factor = (1+ CPI) / (1 + PHI premium increase) rounded to three decimal places

The application of these rebate adjustment factors gives the following rebate levels:

Year commencing	Base			Tier 1			Tier 2			Tier 3
	age<65	age 65-69	age 70+	age<65	age 65-69	age 70+	age<65	age 65-69	age 70+	
	30.000%	35.000%	40.000%	20.000%	25.000%	30.000%	10.000%	15.000%	20.000%	0%
01 Apr 2014	29.040%	33.880%	38.720%	19.360%	24.200%	29.040%	9.680%	14.520%	19.360%	0%
01 Apr 2015	27.820%	32.457%	37.094%	18.547%	23.184%	27.820%	9.273%	13.910%	18.547%	0%
01 Apr 2016	26.791%	31.256%	35.722%	17.861%	22.326%	26.791%	8.930%	13.395%	17.861%	0%
01 Apr 2017	25.934%	30.256%	34.579%	17.289%	21.612%	25.934%	8.644%	12.966%	17.289%	0%

From 1 July 2013, the Lifetime Health Cover loading applied to hospital premiums does not attract a Government Rebate.

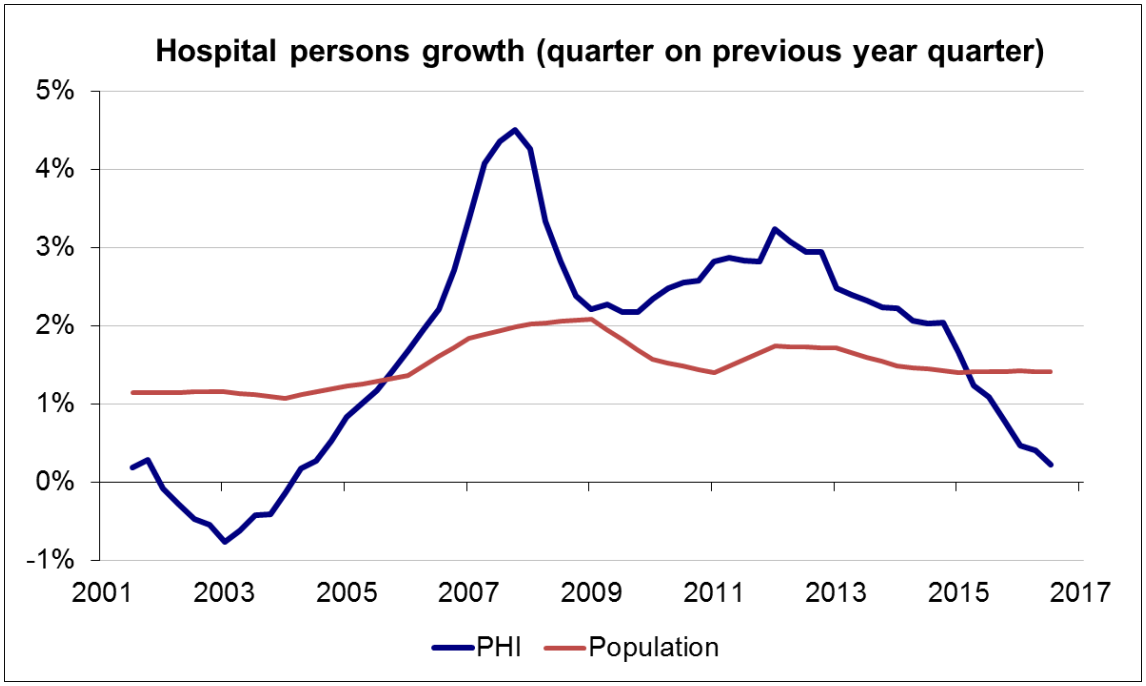
2.4 Prudential Regulation

Changes to the prudential capital standards came into effect on 1 March 2014, replacing those introduced on 1 January 2001.

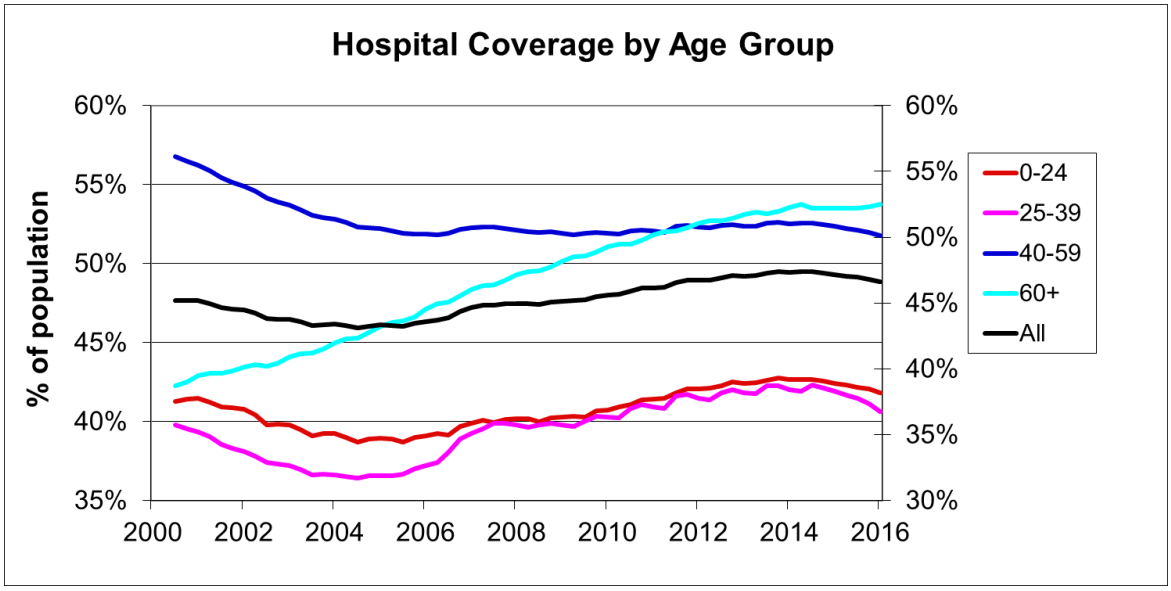
The Private Health Insurance Administration Council (PHIAC) was established on 28 June 1989 as the prudential regulator of the private health insurance industry. These responsibilities were transferred to the Australian Prudential Regulation Authority (APRA) from 1 July 2015. Administrative functions were transferred from Canberra to Sydney, Melbourne and Brisbane, with some ex-PHIAC staff transferring to APRA.

3. Membership trends

Private health insurance membership has been growing since 2004, however growth rates have reduced significantly over the past two years:

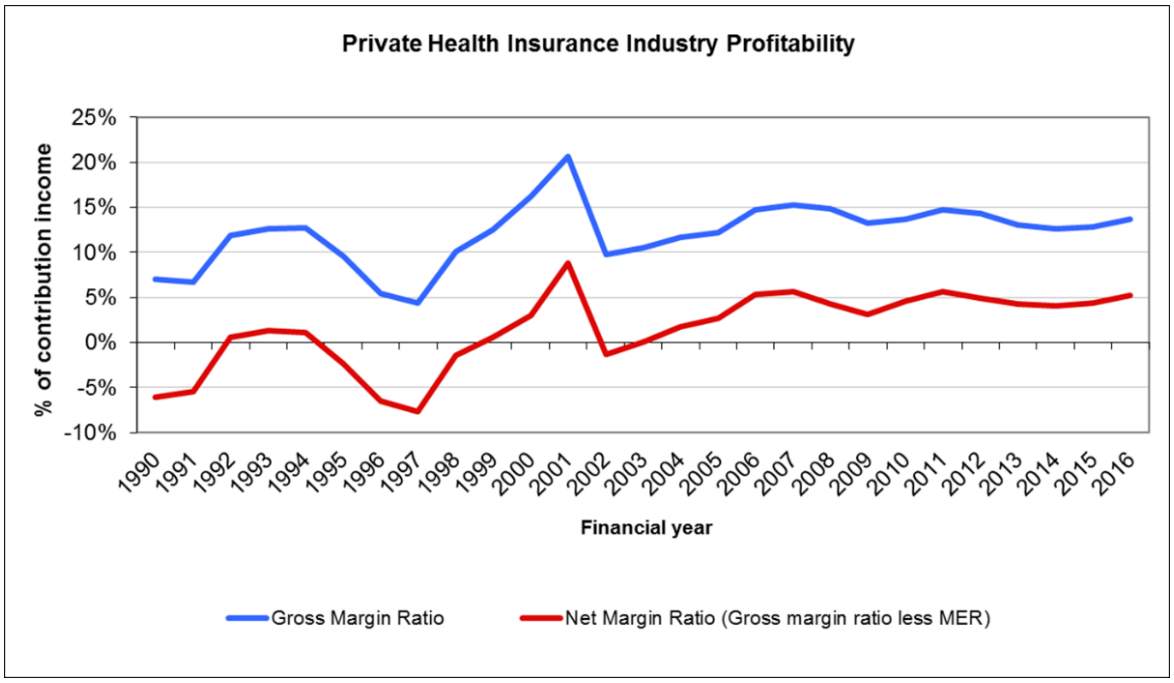


Population coverage has grown in most age groups over the past decade, with the exception of the 40-59 age group. The highest level of growth has been experienced in the over 60 age group.



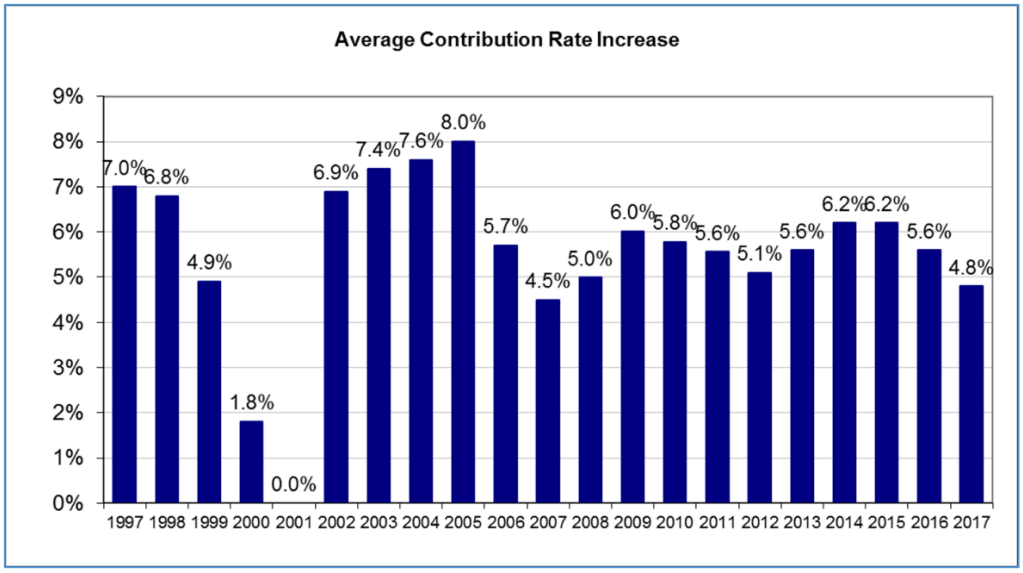
4. Financial performance

The past decade has seen relatively stable financial performance, with industry net margins averaging 4-5% of contribution income, in sharp contrast to the losses of the 1990's:



5. Premiums

Since 1997, private health insurers have generally increased their premiums each April. Section 66-10 of the Private Health Insurance Act requires private health insurers to apply to the Minister for Health for approval of premium changes. The Department of Health publishes a list with the average premium increase for each insurer and the industry average weighted by the number of persons covered by each insurer. The following chart shows the industry average premium increase since 1997:



The average premium increase for each insurer is calculated as:

$$\frac{\text{(FCI with premium changes – FCI without premium changes) x 100}}{\text{FCI without premium changes}}$$

where FCI is the forecast contribution income for the insurer for the 12 month period following the implementation of the changes, excluding forecast changes in membership, and including rate protection.

Health insurers generally offer rate protection, which protects contributors from the forthcoming premium increase provided they have paid prior to the effective date.

5.1 Premium Increases and the Consumer Price Index

It is possible to estimate the impact of rate protection from APRA's private health insurance statistical publications to derive the effective average increase in the price of private health insurance. This can then be converted into an average increase net of the PHI rebate, recognising that the annual reduction in the percentage rebate translates to a higher increase to the consumer. The following table compares these measures of the increase in private health insurance premiums to other CPI and AIHW inflation measures:

Year ended	Unearned Premium Liability $m	Premium Income $m	UPL%	Standard PHI Rebate	PHI Average Premium Increase after rate protection	PHI Average Premium Increase before rate protection	PHI Average Premium Increase net of PHI rebate	CPI	Health CPI	Medical & Hosp Serv CPI	AIHW Health Expenditure per person
Mar 08	1,342	11,896	11.3%	30.0%	5.0%	5.6%	5.6%	4.3%	4.4%	5.6%	7.1%
Mar 09	1,488	12,852	11.6%	30.0%	6.0%	6.8%	6.8%	2.4%	5.3%	6.7%	8.1%
Mar 10	1,573	13,893	11.3%	30.0%	5.8%	6.5%	6.5%	2.9%	5.1%	6.6%	4.5%
Mar 11	1,693	15,092	11.2%	30.0%	5.6%	6.3%	6.3%	3.3%	4.2%	6.0%	6.6%
Mar 12	1,761	16,401	10.7%	30.0%	5.1%	5.7%	5.7%	1.6%	4.2%	5.1%	6.2%
Mar 13	2,264	17,633	12.8%	30.0%	5.6%	6.4%	6.4%	2.5%	6.1%	9.3%	1.7%
Mar 14	2,346	18,962	12.4%	29.0%	6.2%	7.1%	8.5%	2.9%	4.0%	5.4%	3.6%
Mar 15	2,643	20,373	13.0%	27.8%	6.2%	7.1%	8.9%	1.3%	4.4%	6.5%	3.0%
Mar 16	2,894	21,758	13.3%	26.8%	5.6%	6.4%	8.0%	1.3%	4.6%	6.2%	na
Mar 17	na	na	13.3%	25.9%	4.8%	5.6%	6.8%	2.1%	3.8%	5.4%	na
10 year average					5.6%	6.4%	7.0%	2.5%	4.6%	6.3%	5.4%

Many commentators like to compare the annual private health insurance industry average increase published by the Department of Health to the increase in the Consumer Price Index. The Consumer Price Index is comprised of 11 major groups, 33 sub–groups, and 87 expenditure classes. Appendix 1 of *A Guide to the Consumer Price Index* contains a full list of groups, sub–groups and expenditure classes and weights. The Household Expenditure Survey conducted by the Australian Bureau of Statistics is the primary source of information for the expenditure weights for the Consumer Price Index.

5.2 Disaggregating the Consumer Price Index

The following table shows the CPI increase for selected expenditure classes:

Group	**Expenditure class**	**Year ended March 2017 %pa**	**10 years to March 2017 %pa**	**Weighting in total CPI**
All groups	All	2.1%	2.5%	100.00%
Health	All	3.8%	4.6%	5.29%
Education	All	3.3%	5.0%	3.18%
Alcohol & Tobacco	All	6.1%	5.5%	7.06%
Health	Medical & hospital services	5.4%	6.3%	3.42%
Education	Secondary education	4.1%	5.9%	1.26%
Alcohol & Tobacco	Tobacco	13.3%	10.4%	2.32%
Housing	Utilities (Electricity,Gas,Water)	4.3%	7.4%	3.61%
Household Equipment	Household appliances & tools	-2.3%	-0.6%	1.43%
Recreation & Culture	Audio,visual,computing equip	-7.2%	-12.2%	1.56%

This table shows that the three CPI Groups of Health, Education, and Alcohol & Tobacco have increased at around twice the rate of the overall CPI over the past ten years. There are expenditure classes within each of these groups that have increased at rates similar to the Medical & hospital services expenditure class of 2.5 times the overall CPI or higher.

The items and weights which comprise the Health Group in the CPI are:

Sub-group	Expenditure class	Items included	CPI Index weighting
Medical products, appliances and equipment	Pharmaceutical products	Prescription medicines, vaccines and treatments, cold-relief products, vitamins, band-aids, antiseptic, sunscreen and skin treatment	1.17%
	Therapeutic appliances and equipment	Corrective eyeglasses and contact lenses, hearing aids, neck braces, crutches and electronic and other devices for monitoring blood pressure etc., repair of such articles, includes dentures but not fitting costs	0.14%
Medical, dental and hospital services	Medical and hospital services	Consultations of physicians in general or specialist practice and hospital charges, medical insurance	3.42%
	Dental services	Services of dentists, oral hygienists and other dental auxiliaries including fitting costs of dentures	0.56%
Health Group			5.29%

So it is clear that the price of health insurance policies is included in the Consumer Price Index in the Medical and Hospital Services expenditure class in the Health group of the CPI. These health insurance prices are surveyed by the Australian Bureau of Statistics annually. The prices collected for subsidised services are recorded as net of any subsidy or assistance provided by government. This means that the health insurance component of the medical and hospital services expenditure class includes the impact of the reduction of the government rebate. There is no detail on the specific products that are surveyed by the ABS for the purposes of the CPI index.

Further detail of the relative weighting of the components within the Hospital and Medical Services expenditure class can be obtained from the Household Expenditure Survey:

Hospital and Medical Services components	**Weighting**	**Item code**
Counselling services	0.2%	13029 99901
Hospital, medical and dental insurance	*56.9%*	*09010 10101*
Ambulance insurance	*0.8%*	*09010 10201*
Sickness and personal accident insurance	10.4%	09010 10301
General practitioner doctor's fees	4.2%	09020 10101
Specialist doctor's fees	16.0%	09020 10201
Physiotherapy and chiropractic fees	3.3%	09020 10501
Health practitioner's fees	2.7%	09020 19999
Hospital and nursing home charges	4.7%	09999 90101
Other medical care and health expenses	0.8%	09999 99999
	100.0%	

Source: Table 27A, Household Expenditure Survey, Detailed Expenditure Items, ABS

The two items in italics represent the private health insurance expenditure components of the Hospital and Medical Services expenditure class of the CPI. This analysis of the construction of the Consumer Price Index shows that private health insurance product prices comprise:

- 57.7% of the Medical and Hospital Services expenditure class of the CPI,
- giving PHI premiums an overall weighting of 57.7% x 3.42% = 1.98% of the overall CPI Index, or
- 1.98%/5.29% = 37% of the Health CPI.

As the largest component of the Health CPI is increases in private health insurance premiums, it is therefore not a valid comparison benchmark, as it does not directly measure underlying provider costs.

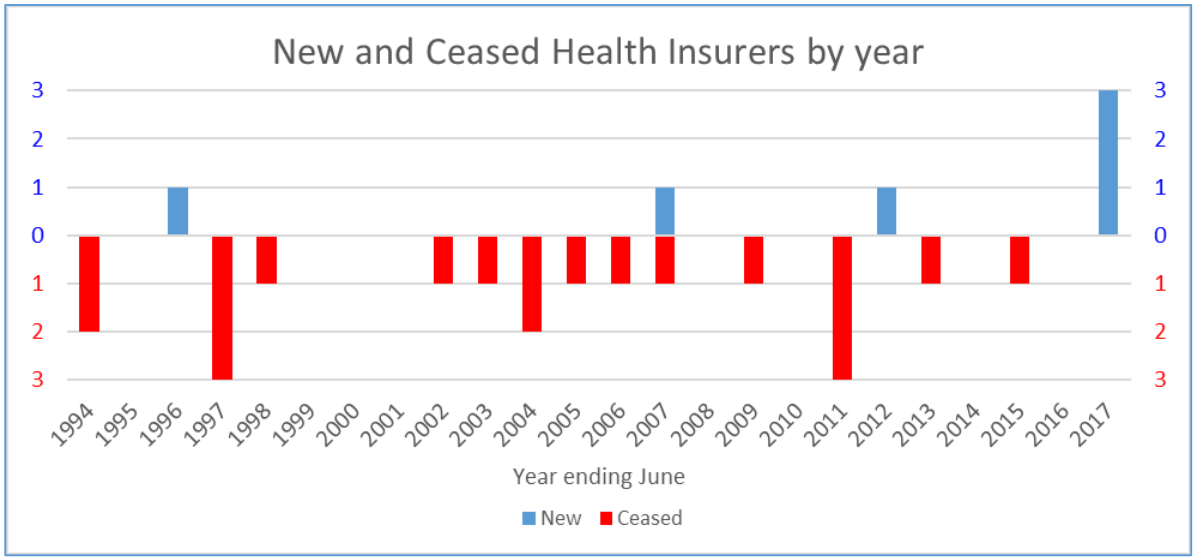
6. Insurers

At April 2017, there are 36 private health insurers operating in Australia. The following table shows the change in the number of insurers, split by open vs restricted access, and for profit vs not for profit, over the past ten years:

		Jun 07	Jun 08	Jun 09	Jun 10	Jun 11	Jun 12	Jun 13	Jun 14	Jun 15	Jun 16	Apr 17
Open Funds	For Profit	5	7	9	10	7	8	7	7	9	10	11
	Not for Profit	20	18	15	14	14	14	15	15	14	13	13
	Total	25	25	24	24	21	22	22	22	23	23	24
Restricted Funds	For Profit	0	0	0	0	0	1	1	2	1	1	1
	Not for Profit	13	13	13	13	13	12	11	10	9	9	11
		13	13	13	13	13	13	12	12	10	10	12
TOTAL		38	38	37	37	34	35	34	34	33	33	36

A timeline of major health insurer events in included in Appendix B.

Over the past 24 years, there have been 6 new and 19 ceased health insurers:



7. New Entrants

New entrants to the Australian Private Health Insurance industry have been rare over the past 30 years. Between 1989 and 2011, only two new health insurers were registered.

Transition Benefits Health Fund commenced in 1996 to take over BHP's previously unregistered employer funded health insurance arrangements, which were then transferred to Lysaght Peoplecare in 2002.

National Health Benefits Australia, trading as onemedifund, commenced in 2007 and currently has less than 6,000 contributors.

Health.com.au commenced in April 2012 and represented the most significant new startup health insurer since Health Australia in September 1986. The following table lists its financial and membership outcomes since inception:

Financial Year	Premiums $m	Gross Margin % of premium	Contributors
2011/12	0.7	-13.7%	3,456
2012/13	25.3	14.7%	15,863
2013/14	59.4	9.4%	31,656
2014/15	108.7	7.4%	39,489
2015/16	117.3	3.7%	40,350

Health.com.au primarily sourced its contributors through the iSelect intermediary. Health.com.au was purchased by GMHBA for $46.2m on 31 July 2015 as part of a recapitalisation and repayment of $42.1 million of loans from iSelect.

Three new health insurers commenced operations in the second half of 2016, equalling the number of new entrants in the previous quarter of a century. All three recent new entrants have been established by an existing health insurer to focus on particular target markets.

CBHS Corporate Health was registered on 1 July 2016 and has been established as a for-profit open access insurer focussing on working with employers to provide private health insurance and promote improved wellbeing for employees. It is part of the CBHS Health group.

Emergency Services Health was registered on 4 November 2016 and has been established as a not-for-profit restricted access insurer with membership open to employees, volunteers and families of the emergency response and recovery sector, including fire, ambulance, medical, state emergency, water and surf lifesaving response and recovery. It is backed by Police Health.

Nurses and Midwives Health was registered on 2 December 2016 and has been established as a not-for-profit restricted access insurer with membership open to nursing and midwifery union members and their families. It was established by Teachers Health Fund.

While not strictly new entrants, some companies (including Qantas, Suncorp and APIA) have recently entered into agreements to distribute private health insurance products.

8. Status Changes

Since 2012, there have been four insurers convert from Not For Profit to For Profit, and three insurers convert from restricted access to open access:

Not For Profit to For Profit
Doctors Health
Transport Health
CUA Health
Queensland Country Health

Restricted to Open Access
Health Care Insurance
Transport Health
Phoenix Health Fund

The conversions from restricted access to open access are a continuation of a longer term trend that has seen the number of restricted access insurers halve over the past 20 years, reversed slightly by the commencement of two new restricted access insurers in late 2016, Emergency Services Health and Nurses and Midwives Health.

Two of the for profit conversions, Doctors Health and Transport Health, were associated with the acquisition of those insurers.

9. Mergers and Acquisitions

The following table sets out the merger and acquisition activity over the past 15 years:

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
2016	Transport Health	rt health	25.3	10.5	9.5	24.8	$1,562	60%	Jun-16
2015	Health.com.au	GMHBA	46.2	14.7	38.9	108.7	$808	29%	Jun 15
2014	Medibank Private	ASX listing	5,673.2 [1]	1,155.1	1,830.0	5,499.9	$2,469	82%	Jun 14
2014	Transport Health	Primary Health Care	18.0	10.3	4.6	15.6	$1,662	49%	Jun 13
2012	Doctors Health	Avant Mutual	30.0	19.9	7.5	25.0	$1,350	40%	Jun 11
2009	AHM	Medibank Private	367.0	215.0	155.4	377.1	$979	40%	Jun 08
2008	Manchester Unity	HCF	188.0 [2]	85.2	79.1	225.1	$1,299	46%	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 [3]	336.3	328.8	666.0	$836	41%	Jun 07
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

1. Excludes dividend of $238.8m paid prior to listing
2. Excludes $68m for non-health insurance business from Information Memorandum valuation
3. Shares issued to members on demutualisation valued at closing price on day of ASX listing of $1.18

The table excludes a number of transactions where the purchase price was nil or net asset value (eg. IOR, Goldfields, Federation Health, Druids NSW, Druids Vic). A number of the transactions listed in the table involved for-profit conversion and demutualisation, with payments made to the health insurance contributor owners, (including NIB, MBF, Manchester Unity, AHM and Transport Health). The detailed implementation of some of these demutualisations were explored in more detail in *Pennies from Heaven: Health Insurance Demutualisations*.

The table shows that acquirers have paid a wide range of prices to acquire health insurance business, valuing goodwill (excess of purchase price over net assets) as a percentage of annual contribution income in the range 29% to 82%.

10. Concluding Remarks

Adventures in Health Risk concluded with the remark that 2007 was undoubtedly a watershed year for the private health insurance industry, with the demutualisations of NIB and MBF announced, BUPA proposing the acquire MBF, the Federal Government preparing to sell Medibank Private, and Australian Unity considering and dismissing demutualisation.

The list of major regulatory events in Appendix A, the table of mergers and acquisitions in section 9, and the health fund activity timeline in Appendix B is testament to the fact that the private health insurance industry is continually changing and no doubt the future holds plenty of further adventures in store.

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APPENDIX A – Major Regulatory Events since 2007

2007

1 April	Private Health Insurance Act takes effect
	Changes to Risk Equalisation arrangements commence

2008

1 July	Medicare Levy Surcharge income thresholds increased from $50,000 to $70,000 (single) and indexation of income thresholds introduced
1 July	Deadline for all private health insurers to be corporations law entities and re-register under the Private Health Insurance Act

2012

1 July	Private Health Insurance Rebate means testing commences

2013

1 July	Lifetime Health Cover Loadings excluded from the Private Health Insurance Rebate

2014

31 March	New regulatory capital standards take effect
1 April	Reduction in Private Health Insurance Rebate percentage commences

2015

1 July	PHIAC's regulatory responsibilities transferred to APRA
1 July	The Private Health Insurance Supervision Act commences

APPENDIX B - Health Fund Activity Timeline since 2007

2007

29 May	United Ancient Order of Druids Friendly Society changed name to Druids Friendly Society
18 June	National Health Benefits Australia Pty Ltd commences operations
1 October	NIB Health Funds Ltd converted to for profit
1 November	NIB issues shares to members and lists on Australian Securities Exchange

2008

1 April	Credicare Health Fund Ltd changed name to CUA Health Limited
	Health Partners Inc health fund transferred to Health Partners Ltd
	Australasian Conference Association Ltd health fund transferred to ACA Health Benefits Fund Limited
17 June	MBF Australia converted to a for profit fund, demutualised and purchased by BUPA for $2,410 million
1 October	Health insurance business of Druids Friendly Society Ltd transferred to GMHBA
October	NIB rejects takeover offer, believed to be from South African health insurer Discovery Health, of $1.15 to $1.20 per share
24 December	MU converted to a for profit fund, demutuailsed and purchased by HCF for $256 million

2009

15 January	AHM converted to a for profit fund, demutuailsed and purchased by Medibank Private for $367 million
1 October	Medibank Private converted to a for profit fund

2010

30 March	MBF Australia Pty Ltd changed name to BUPA Australia Pty Ltd
1 July	BUPA Australia Health, BUPA Australia and MBF Alliances merged

November	GMHBA rejects NIB $180 million takeover offer
2011	
30 June	Manchester Unity merged with HCF
2012	
31 May	Doctors Health Fund converted to a for profit fund, demutualised and purchased by Avant Group Holdings Ltd for $30 million
16 April	health.com.au commences operations
1 July	Australian Health Management merged with Medibank Private
2013	
27 May	HCI converted from a restricted fund to an open fund
2014	
30 June	Transport Health converted to a for profit fund and demutualised
18 September	Transport Health purchased by Primary Health Care for $18 million
1 July	CUA Health Ltd converted to a for profit fund
10 November	Transport converted from a restricted fund to an open fund
25 November	Medibank Private listed on the Australian Securities Exchange
2015	
18 May	Phoenix converted from a restricted fund to an open fund
30 June	Healthguard merged with HBF
31 July	health.com.au purchased by GMHBA for $46.2 million
2016	
1 January	Queensland Country Health converted to a for profit fund
1 July	Transport Health purchased by rt health for $25.3 million
1 July	CBHS Corporate Health Pty Ltd registered
4 November	Emergency Services Health Pty Ltd registered
2 December	Nurses and Midwives Health Pty Ltd registered