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Private Health Insurance Bill 2006

No. , 2006

(Health and Ageing)

**A Bill for an Act to regulate private health
insurance, and for related purposes**

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1 **A Bill for an Act to regulate private health**
2 **insurance, and for related purposes**

3 The Parliament of Australia enacts:
4 **Chapter 1—Introduction**

5 **Part 1-1—Introduction**

6 **Division 1—Preliminary**

7 **1-1 Short title**

8 This Act may be cited as the *Private Health Insurance Act 2006*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **1-5 Commencement**

2 This Act commences on 1 April 2007.

3 **1-10 Identifying defined terms**

4 (1) Many of the terms in this Act are defined in the Dictionary in
5 Schedule 1.

6 (2) Most of the terms that are defined in the Dictionary are identified
7 by an asterisk appearing at the start of the term: as in “*health
8 benefits fund”. The footnote with the asterisk contains a signpost to
9 the Dictionary.

10 (3) An asterisk usually identifies the first occurrence of a term in a
11 section (if not divided into subsections), subsection, definition,
12 table item or diagram. Later occurrences of the term in the same
13 provision are not usually asterisked.

14 (4) Terms are not asterisked in headings, notes, examples or guides.

15 (5) If a term is not identified by an asterisk, disregard that fact in
16 deciding whether or not to apply to that term a definition or other
17 interpretation provision.

18 (6) The following basic terms used throughout the Act are not
19 identified with an asterisk:

20

Terms that are not identified with an asterisk

Item	This term ...	is defined in ...
1	Council	the Dictionary in Schedule 1
2	Federal Court	the Dictionary in Schedule 1
3	insurance	section 5-1
4	Medicare Australia CEO	the Dictionary in Schedule 1
5	Private Health Insurance Ombudsman	the Dictionary in Schedule 1
6	private health insurer	the Dictionary in Schedule 1

21

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 3—Overview of this Act**

3 **3-1 What this Act is about**

4 This Act is about private health insurance. It:

- 5 (a) provides incentives to encourage people to have private
6 health insurance; and
7 (b) sets out rules governing private health insurance *products;
8 and
9 (c) imposes requirements about how insurers conduct *health
10 insurance business.

11 **3-5 Incentives (Chapter 2)**

12 Chapter 2 provides the following incentives:

- 13 (a) reductions in premiums for *complying health insurance
14 policies;
15 (b) payments by the Commonwealth in relation to premiums
16 paid for complying health insurance policies;
17 (c) a lifetime health cover scheme, under which premiums may
18 rise for people who do not maintain private health insurance
19 from an early age.

20 **3-10 Complying health insurance products (Chapter 3)**

21 Chapter 3 requires insurers who make private health insurance
22 available to people to do so in a non-discriminatory way, to offer
23 *products that comply with this Act, and to meet certain other
24 obligations imposed by this Act in relation to those products.

25 **3-15 Private health insurers (Chapter 4)**

26 Chapter 4 requires registration of anyone carrying on *health
27 insurance business, and imposes obligations aimed at ensuring
28 health insurance businesses, and in particular *health benefits
29 funds, are conducted appropriately.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **3-20 Enforcement (Chapter 5)**

2 Chapter 5 provides for a range of enforcement mechanisms aimed
3 at monitoring and ensuring compliance with this Act and
4 protecting the interests of *policy holders.

5 **3-25 Administration (Chapter 6)**

6 Chapter 6 contains administrative and machinery provisions
7 relating to the operation of this Act.

8 **3-30 Dictionary (Schedule 1)**

9 The Dictionary in Schedule 1 contains definitions of terms used
10 throughout this Act.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 5—Constitutional matters**

3 **5-1 Meaning of *insurance***

4 In this Act:

5 *insurance* means insurance to which paragraph 51(xiv) of the
6 Constitution applies.

7 **5-5 Act not to apply to State insurance within that State**

8 This Act does not apply with respect to State insurance that does
9 not extend beyond the limits of the State concerned.

10 **5-10 Compensation for acquisition of property**

11 (1) If the operation of this Act would result in an acquisition of
12 property from a person otherwise than on just terms, the
13 Commonwealth is liable to pay a reasonable amount of
14 compensation to the person.

15 (2) If the Commonwealth and the person do not agree on the amount
16 of the compensation, the person may institute proceedings in the
17 Federal Court for the recovery from the Commonwealth of such
18 reasonable amount of compensation as the court determines.

19 (3) In this section:

20 *acquisition of property* has the same meaning as in paragraph
21 51(xxxi) of the Constitution.

22 *just terms* has the same meaning as in paragraph 51(xxxi) of the
23 Constitution.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Chapter 2—Incentives**

3 **Part 2-1—Introduction**

4 **Division 15—Introduction**

5 **15-1 What this Chapter is about**

6 This Chapter contains the following incentives to encourage people
7 to have private health insurance:

- 8 (a) reductions in premiums (see Division 23);
- 9 (b) payments in return for payments of premiums
10 under complying health insurance policies (see
11 Division 26);
- 12 (c) lifetime health cover (see Part 2-3).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Part 2-2—Premiums reduction and incentive payments schemes

3

4

Division 20—Introduction

5

20-1 What this Part is about

6

To encourage people to take out, and continue to hold, private health insurance, this Part provides that people may either:

7

8

(a) reduce the premiums payable for their complying health insurance policies by participating in the premiums reduction scheme in Division 23; or

9

10

11

(b) receive a payment from the Commonwealth under Division 26 in partial reimbursement for a payment of premiums under a complying health insurance policy.

12

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14

15

Note: The premiums reduction scheme and the incentive payments scheme are complemented by the private health insurance offset provided for by Subdivision 61-H of the *Income Tax Assessment Act 1997*.

16

17

18

20-5 Private Health Insurance (Incentives) Rules

19

Matters relating to the *premiums reduction scheme and the *incentive payments scheme are also dealt with in the Private Health Insurance (Incentives) Rules. The provisions of this Part indicate when a particular matter is or might be dealt with in these Rules.

20

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Note: The Private Health Insurance (Incentives) Rules are made by the Minister under section 333-20.

25

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 23—Premiums reduction scheme**

3 **Subdivision 23-A—Amount of reduction**

4 **23-1 Reduction in premiums**

- 5 (1) The amount of premiums payable under a *complying health
6 insurance policy in respect of a financial year is reduced in
7 accordance with this section if a person is a *participant in the
8 *premiums reduction scheme in respect of the policy.
- 9 (2) The amount of the reduction is the sum of:
- 10 (a) 30% of the amount of premiums payable under the policy in
11 respect of days in the financial year on which no person
12 covered by the policy was aged 65 years or over; and
- 13 (b) 35% of the amount of premiums payable under the policy in
14 respect of days in the financial year on which:
- 15 (i) at least one person covered by the policy was aged 65
16 years or over; and
- 17 (ii) no person covered by the policy was aged 70 years or
18 over; and
- 19 (c) 40% of the amount of premiums payable under the policy in
20 respect of days in the financial year on which at least one
21 person covered by the policy was aged 70 years or over.
- 22 (3) However, if, before 1 January 1999, a person was registered or
23 eligible to be registered under the *Private Health Insurance*
24 *Incentives Act 1997* in respect of the policy, the amount of the
25 reduction is the greater of:
- 26 (a) the amount worked out under subsection (2); and
27 (b) the *incentive amount for the policy for the financial year.
- 28 (4) If the amount of premiums is payable in respect of only part of a
29 financial year, the amount of the reduction is worked out using this
30 formula:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 Whole year reduction $\times \frac{\text{Part of year}}{365}$

2 where:

3 ***part of year*** means the number of days in the part of the financial
 4 year.

5 ***whole year reduction*** means the amount that would have been the
 6 reduction if the premium had been payable in respect of the whole
 7 financial year.

8 **23-5 Meaning of *incentive amount***

9 (1) The ***incentive amount*** for a *complying health insurance policy for
 10 a financial year is the amount worked out under this table:

11

Incentive amount				
Item	Number and kinds of people covered by the policy	Policy covers *hospital treatment but not *general treatment	Policy covers *general treatment but not *hospital treatment	Policy covers *hospital treatment and *general treatment
1	3 or more people	\$350	\$100	\$450
2	One *dependent child and one other person	\$350	\$100	\$450
3	2 people neither of whom is a *dependent child	\$200	\$50	\$250
4	One person	\$100	\$25	\$125

12

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2 Incentives

Part 2-2 Premiums reduction and incentive payments schemes

Division 23 Premiums reduction scheme

Section 23-10

- 1 (2) If the amount of premiums is payable in respect of only part of a
2 financial year, the incentive amount is worked out using this
3 formula:

4
$$\text{Amount worked out under subsection (1)} \times \frac{\text{Number of days in that part of the financial year}}{365}$$

5 **23-10 Reduction after a person 65 years or over ceases to be covered**
6 **by policy**

- 7 (1) If:
- 8 (a) at any time, premiums under an insurance policy (the
9 *original policy*) were reduced by 35% or 40% because a
10 person aged 65 years or over (the *entitling person*) was
11 insured under the original policy; and
- 12 (b) at that time, another person (other than a *dependent child)
13 was also insured under the original policy; and
- 14 (c) the entitling person subsequently ceases to be insured under
15 the original policy;
- 16 subsections 23-1(2) and (3) apply in relation to a *complying
17 health insurance policy (whether or not the original policy) under
18 which the other person is insured (other than for the purposes of
19 working out the *incentive amount) as if:
- 20 (d) the entitling person were also insured under that policy; and
21 (e) the entitling person were the same age as the age at which he
22 or she ceased to be insured under the original policy.
- 23 (2) Subsection (1) ceases to apply if a person (other than a *dependent
24 child) who was not insured under the original policy at the time the
25 entitling person ceased to be insured under it becomes insured
26 under the policy to which subsection (1) applied.
- 27 (3) Subsection (1) does not apply if its application would result in the
28 amount payable under subsection 23-1(2) or (3) being less than it
29 would otherwise have been.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (4) Paragraph (1)(a) applies in relation to premiums reduced by 35%
2 or 40% whether the reduction was under this Part or under
3 Chapter 3 of the *Private Health Insurance Incentives Act 1998*.

4 **Subdivision 23-B—Participation in the premiums reduction**
5 **scheme**

6 **23-15 Registration as a participant in the premiums reduction**
7 **scheme**

- 8 (1) A person may apply to a private health insurer, in the *approved
9 form, to become a *participant in the *premiums reduction scheme
10 in respect of a *complying health insurance policy issued by the
11 insurer if:
12 (a) the insurer is a *participating insurer; and
13 (b) either or both of the following apply:
14 (i) the person has paid, or the person's employer has paid
15 as a *fringe benefit on the person's behalf, a premium
16 under the policy in respect of a financial year;
17 (ii) the person is insured under the policy (and is not a
18 *dependent child); and
19 (c) the person meets any requirements specified in the Private
20 Health Insurance (Incentives) Rules for the purposes of this
21 paragraph.
- 22 (2) A private health insurer that receives an application under
23 subsection (1) must notify the Medicare Australia CEO of the
24 application, in the *approved form, no more than 14 days (or any
25 other period determined by the Medicare Australia CEO) after
26 receiving the application.
- 27 (3) If notified of an application and satisfied that paragraphs (1)(a), (b)
28 and (c) apply, the Medicare Australia CEO must register the
29 applicant as a *participant in respect of the policy.
- 30 (4) The Medicare Australia CEO must notify the private health insurer
31 that issued the policy if the Medicare Australia CEO registers a

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2 Incentives

Part 2-2 Premiums reduction and incentive payments schemes

Division 23 Premiums reduction scheme

Section 23-20

1 person as a *participant in the *premiums reduction scheme in
2 respect of the policy.

3 **23-20 Refusal to register**

4 (1) If the Medicare Australia CEO refuses to register the applicant in
5 respect of a policy, the Medicare Australia CEO must give the
6 applicant, and the private health insurer that issued the policy,
7 notice of the refusal together with reasons for the refusal.

8 Note: Refusals to register are reviewable under Part 6-9.

9 (2) The applicant is taken to be registered as a *participant in respect
10 of the policy if the Medicare Australia CEO does not give notice of
11 refusal within 14 days after receiving the notice under subsection
12 23-15(2) from the private health insurer to which the applicant
13 applied for registration.

14 **23-25 Pre-1999 participants must keep information up to date**

15 (1) If, before 1 January 1999, a person was registered or eligible to be
16 registered under the *Private Health Insurance Incentives Act 1997*
17 in respect of the policy, a *participant in respect of the policy must
18 notify the private health insurer that issued the policy if there is a
19 change in a detail:

20 (a) stated in an application under subsection 23-15(1); or

21 (b) relating to the number of people insured under the policy, or
22 to whether any of those people are *dependent children;

23 that the participant should reasonably expect will affect the
24 *incentive amount for the policy for a financial year. The
25 participant must give the notice no more than 30 days after the
26 change occurs.

27 (2) A person commits an offence if:

28 (a) the person is required by subsection (1) to give a notice to a
29 private health insurer if a detail mentioned in that subsection
30 changes as mentioned in that subsection; and

31 (b) the person fails to comply with the requirement.

32 Penalty: 60 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (3) Subsection 4K(2) of the *Crimes Act 1914* does not apply to the
2 obligation to provide information under subsection (1).
- 3 (4) A private health insurer must notify the Medicare Australia CEO of
4 each notice the insurer receives under subsection (1), in the
5 *approved form and no more than 14 days (or any other period
6 determined by the Medicare Australia CEO) after receiving the
7 notice.

8 **23-30 Participants who want to withdraw from scheme**

- 9 (1) A *participant must notify the private health insurer that issued the
10 policy in respect of which a person is a participant if the person no
11 longer wishes to be registered in respect of the policy.
- 12 (2) A private health insurer must notify the Medicare Australia CEO of
13 each notice the insurer receives under subsection (1), in the
14 *approved form and no more than 14 days (or any other period
15 determined by the Medicare Australia CEO) after receiving the
16 notice.
- 17 (3) If notified under subsection (2), the Medicare Australia CEO must
18 revoke the person's registration in respect of the policy.

19 **23-35 Revocation of registration**

- 20 (1) The Medicare Australia CEO must revoke a person's registration
21 in respect of a *complying health insurance policy if the Medicare
22 Australia CEO is satisfied that the person is not eligible to
23 participate in the *premiums reduction scheme in respect of the
24 policy.
- 25 Note: Revocations of registration are reviewable under section Part 6-9.
- 26 (2) Revocation of registration under subsection (1) does not affect a
27 person's right to make another application for registration under
28 section 23-15.
- 29 (3) The Medicare Australia CEO must give notice of the revocation of
30 a person's registration in respect of a *complying health insurance
31 policy to the person, and to the private health insurer that issued

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2 Incentives

Part 2-2 Premiums reduction and incentive payments schemes

Division 23 Premiums reduction scheme

Section 23-40

1 the policy, within 28 days after the day on which the revocation
2 occurs.

3 **23-40 Variation of registration**

4 (1) A private health insurer must notify the Medicare Australia CEO if
5 the treatments *covered by a *complying health insurance policy,
6 issued by the private health insurer and in respect of which a
7 person is a *participant, are varied.

8 (2) On receiving such a notice, the Medicare Australia CEO must vary
9 the details of the registration accordingly and give notice of the
10 variation to the private health insurer.

11 **23-45 Retention of applications by private health insurers**

12 (1) A private health insurer must retain an application made to it under
13 subsection 23-15(1) for the period of 5 years beginning on the day
14 on which the application was made.

15 (2) The private health insurer may retain the application in any form
16 approved in writing by the Medicare Australia CEO.

17 (3) An application retained in such a form must be received in all
18 courts or tribunals as evidence as if it were the original.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Division 26—The incentive payments scheme

Subdivision 26-A—Amount of incentive payment

26-1 Payment in relation to premiums

- (1) A person is entitled to a payment under this Division if:
- (a) the person has paid, or a person's employer has paid as a *fringe benefit for the person, premiums under a *complying health insurance policy for the whole or a part of a financial year; and
 - (b) the amount of premiums was not reduced under Division 23; and
 - (c) the person meets any requirements specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph.
- (2) The amount of the payment is the sum of:
- (a) 30% of the amount of the premium paid by a person, or by a person's employer as a *fringe benefit for the person, under the policy in respect of days in the financial year on which no person covered by the policy was aged 65 years or over;
 - (b) 35% of the amount of the premium paid by a person, or by a person's employer as a fringe benefit for the person, under the policy in respect of days in the financial year on which:
 - (i) at least one person covered by the policy was aged 65 years or over; and
 - (ii) no person covered by the policy was aged 70 years or over;
 - (c) 40% of the amount of the premium paid by a person, or by a person's employer as a fringe benefit for the person, under the policy in respect of days in the financial year on which at least one person covered by the policy was aged 70 years or over.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2 Incentives

Part 2-2 Premiums reduction and incentive payments schemes

Division 26 The incentive payments scheme

Section 26-5

- 1 (3) However, if, before 1 January 1999, a person was registered, or
2 eligible to be registered, under the *Private Health Insurance*
3 *Incentives Act 1997* in respect of the policy, the amount of the
4 payment is the greater of:
5 (a) the amount worked out under subsection (2); and
6 (b) the *incentive amount for the policy for the financial year.
- 7 (4) The total amount payable under this Division for a policy for a
8 financial year is reduced by the amount of any tax offset received
9 under Subdivision 61-H of the *Income Tax Assessment Act 1997*
10 for the total amount of the premium paid by a person, or by a
11 person's employer as a *fringe benefit for the person, under the
12 policy for that financial year.
- 13 (5) A private health insurer must give a person a receipt, in the
14 *approved form, for a payment of an amount of premiums (other
15 than an amount that has been reduced under Division 23) if the
16 person requests it.

17 **26-5 Payment after a person 65 years or over ceases to be covered by**
18 **policy**

- 19 (1) If:
20 (a) at any time, a payment of an amount of 35% or 40% of the
21 premiums payable under an insurance policy (the *original*
22 *policy*) was made to a person because a person aged 65 years
23 or over (the *entitling person*) was insured under the original
24 policy; and
25 (b) at that time, another person (other than a *dependent child)
26 was insured under the original policy; and
27 (c) the entitling person subsequently ceases to be insured under
28 the original policy;
29 subsections 26-1(2) and (3) apply in relation to a *complying
30 health insurance policy (whether or not the original policy) under
31 which the other person is insured (other than for the purposes of
32 working out the *incentive amount) as if:
33 (d) the entitling person were also insured under that policy; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (e) the entitling person were the same age as the age at which he
2 or she ceased to be insured under the original policy.
- 3 (2) Subsection (1) ceases to apply if a person (other than a *dependent
4 child) who was not insured under the original policy at the time the
5 entitling person ceased to be insured under it becomes insured
6 under the policy to which subsection (1) applied.
- 7 (3) Subsection (1) does not apply if its application would result in the
8 amount payable under subsection 26-1(2) or (3) being less than it
9 would otherwise have been.
- 10 (4) Paragraph (1)(a) applies in relation to a payment of an amount of
11 35% or 40% of the premiums payable under an insurance policy
12 whether the payment was made under this Part or under Chapter 2
13 of the *Private Health Insurance Incentives Act 1998*.

14 **Subdivision 26-B—Claiming payments under the incentive**
15 **payments scheme**

16 **26-10 Claim for payment under incentive payments scheme**

- 17 (1) To be paid an amount to which a person is entitled under
18 section 26-1, the person must make a claim in the *approved form.
- 19 (2) The claim must be sent to or lodged at an office of Medicare
20 Australia, or a place approved by the Medicare Australia CEO, in:
21 (a) the financial year in which the payment of premiums to
22 which the claim relates was made; or
23 (b) the next financial year.

24 **26-15 Withdrawal of claim**

25 A claimant may at any time, by writing sent to or lodged at an
26 office of Medicare Australia, or a place approved by the Medicare
27 Australia CEO, withdraw a claim.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **26-20 Determination of claim and payment of amount**

- 2 (1) The Medicare Australia CEO must make a decision granting or
3 refusing the claim within 14 days after the day on which the claim
4 is made.
- 5 (2) If the claim is granted, the Medicare Australia CEO must pay to
6 the claimant the amount to which the claimant is entitled.
- 7 (3) If the claim is refused, the Medicare Australia CEO must give the
8 claimant a notice stating that the claim has been refused and setting
9 out the reasons for the refusal.

10 **26-25 Reconsideration of decision refusing a claim**

- 11 (1) If a claim is refused, the claimant may apply to the Medicare
12 Australia CEO for the Medicare Australia CEO to reconsider the
13 decision.
- 14 (2) The application must:
15 (a) be in writing; and
16 (b) set out the reasons for the application.
- 17 (3) The application must be made within:
18 (a) 28 days after the day on which the claimant was notified of
19 the decision; or
20 (b) if, either before or after the end of that period of 28 days, the
21 Medicare Australia CEO extends the period within which the
22 application may be made—the extended period for making
23 the application.
- 24 (4) The Medicare Australia CEO must:
25 (a) reconsider the decision; and
26 (b) either affirm or revoke the decision;
27 within 28 days after receiving the application for reconsideration.
- 28 Note: Decisions affirming original decisions are reviewable under Part 6-9.
- 29 (5) If the Medicare Australia CEO revokes the decision, the revocation
30 is taken to be a decision granting the claim.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (6) The Medicare Australia CEO must give the claimant a notice
2 stating his or her decision on the reconsideration together with a
3 statement of his or her reasons for the decision.
- 4 (7) The Medicare Australia CEO is taken, for the purposes of this
5 Subdivision, to have made a decision affirming the original
6 decision if the Medicare Australia CEO has not told the claimant of
7 the decision on the reconsideration before the end of the period of
8 28 days.

9 **26-30 Claimants to keep information up to date**

- 10 (1) If, after a claimant has made a claim under section 26-10 for a
11 payment of an amount:
12 (a) a matter, event or circumstance occurs that affects the
13 claimant's entitlement to the payment; or
14 (b) a change occurs in the premium, or in the amounts or
15 frequency of the payments in respect of the premium, under
16 the policy;
17 the claimant must, within 30 days after the occurrence of the
18 matter, event, circumstance or change, notify the Medicare
19 Australia CEO of the details of the matter, event, circumstance or
20 change.
- 21 (2) A person commits an offence if:
22 (a) the person is required by subsection (1) to notify the
23 Medicare Australia CEO of the details of a matter, event,
24 circumstance or change mentioned in that subsection; and
25 (b) the person fails to comply with the requirement.
- 26 Penalty: 60 penalty units.
- 27 (3) Subsection 4K(2) of the *Crimes Act 1914* does not apply to the
28 obligation to provide information under subsection (1).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 2-3—Lifetime health cover**

3 **Division 31—Introduction**

4 **31-1 What this Part is about**

5

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9

People are encouraged to take out hospital cover by the time they turn 30. A person who is older than 30 when he or she takes out hospital cover for the first time, or who drops hospital cover for a period after having turned 30, may have to pay higher premiums for hospital cover. This scheme is known as lifetime health cover.

10 **31-5 Private Health Insurance (Lifetime Health Cover) Rules**

11

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14

Matters relating to lifetime health cover are also dealt with in the Private Health Insurance (Lifetime Health Cover) Rules. The provisions of this Part indicate when a particular matter is or might be dealt with in these Rules.

15

16

Note: The Private Health Insurance (Lifetime Health Cover) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 34—General rules about lifetime health cover**

3 **34-1 Increased premiums for person who is late in taking out**
4 **hospital cover**

5 (1) A private health insurer must increase the amount of premiums
6 payable for *hospital cover in respect of an *adult if the adult did
7 not have hospital cover on his or her *lifetime health cover base
8 day.

9 (2) The amount of the increase is worked out as follows:

10
11
$$\left(\text{Lifetime health cover age} - 30 \right) \times 2\% \times \text{*Base rate}$$

12 where:

13 **base rate**, for *hospital cover, is the amount of premiums that
14 would be payable for the cover if:

- 15 (a) the premiums were not increased under this Part; and
16 (b) there was no discount of the kind allowed under subsection
17 66-5(2).

18 **lifetime health cover age**, in relation to an *adult who takes out
19 *hospital cover after his or her *lifetime health cover base day,
20 means the adult's age on the 1 July before the day on which the
21 adult took out the hospital cover.

22 **34-5 Increased premiums for person who ceases to have hospital**
23 **cover after his or her lifetime health cover base day**

24 (1) A private health insurer must increase the amount of premiums
25 payable for *hospital cover in respect of an *adult if, after the
26 adult's *lifetime health cover base day, the adult ceases to have
27 hospital cover.

28 (2) The amount of the increase is worked out as follows:
29

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 34-10

1 Years without hospital cover \times 2% \times *Base rate

2 where:

3 **base rate** is the *base rate for the *hospital cover.

4 **years without hospital cover** is the number obtained by:

- 5 (a) dividing by 365 the number of days (other than *permitted
6 days without hospital cover), after the first day on which
7 subsection (1) applied to the *adult, on which he or she did
8 not have *hospital cover; and
9 (b) rounding up the result to the nearest whole number.

- 10 (3) Any increase under this section in the amount of premiums payable
11 for *hospital cover is in addition to any increase under section 34-1
12 in the amount of premiums payable for that hospital cover.

13 **34-10 Increased premiums stop after 10 years' continuous cover**

14 (1) A private health insurer must stop increasing the amount of
15 premiums payable for *hospital cover in respect of an *adult under
16 this Part if the adult has had hospital cover (including under an
17 *applicable benefits arrangement), the premiums for which have
18 been increased under this Part or *old Schedule 2:

- 19 (a) for a continuous period of 10 years; or
20 (b) for a period of 10 years that has been interrupted only by
21 *permitted days without hospital cover or periods during
22 which the adult was taken to have had hospital cover
23 otherwise than because of paragraph 34-15(2)(a) (none of
24 which count towards the 10 years).

25 (2) The amount must stop being increased on the day after the last day
26 of the 10 year period.

27 (3) The amount of premiums payable for *hospital cover in respect of
28 the *adult must start to be increased under this Part again if:

- 29 (a) after the end of the 10 year period, the adult ceases to have
30 hospital cover; and
31 (b) the adult later takes out hospital cover again; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (c) the days in the period between ceasing to have the cover and
2 taking it out again are not all *permitted days without hospital
3 cover in respect of the adult.

4 (4) Subsection (3) does not prevent this section applying again in
5 respect of any later 10 year period.

6 (5) In subsection (1):

7 *old Schedule 2* means Schedule 2 to the *National Health Act 1953*
8 as in force before 1 April 2007.

9 **34-15 Meaning of *hospital cover***

10 (1) ***Hospital cover*** is so much of a *complying health insurance policy
11 as *covers *hospital treatment. An *adult has hospital cover if he or
12 she is insured under a complying health insurance policy that
13 covers hospital treatment.

14 (2) An *adult is taken to have *hospital cover:

15 (a) at any time during which the adult was covered by an
16 *applicable benefits arrangement; or

17 (b) at any time during which the adult holds a *gold card; or

18 (c) at any time during which the adult is in a class of adults
19 specified in the Private Health Insurance (Lifetime Health
20 Cover) Rules for the purposes of this paragraph.

21 (3) In this section:

22 ***gold card*** means a card that evidences a person's entitlement to be
23 provided with treatment:

24 (a) in accordance with the Treatment Principles prepared under
25 section 90 of the *Veterans' Entitlements Act 1986*; or

26 (b) in accordance with a determination made under section 286
27 of the *Military Rehabilitation and Compensation Act 2004* in
28 respect of the provision of treatment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **34-20 Meaning of *permitted days without hospital cover***

2 (1) Any of the following days that occur after an *adult ceases, for the
3 first time after his or her *lifetime health cover base day, to have
4 *hospital cover are ***permitted days without hospital cover*** in
5 respect of that adult:

6 (a) days on which the cover was suspended by the private health
7 insurer in accordance with the rules for suspensions set out in
8 the Private Health Insurance (Lifetime Health Cover) Rules;

9 (b) days (not counting days covered by paragraph (a)) on which
10 the adult is *overseas that form part of a continuous period
11 overseas of more than one year;

12 (c) the first 1,094 days (not counting days covered by
13 paragraph (a) or (b)) on which the adult did not have hospital
14 cover.

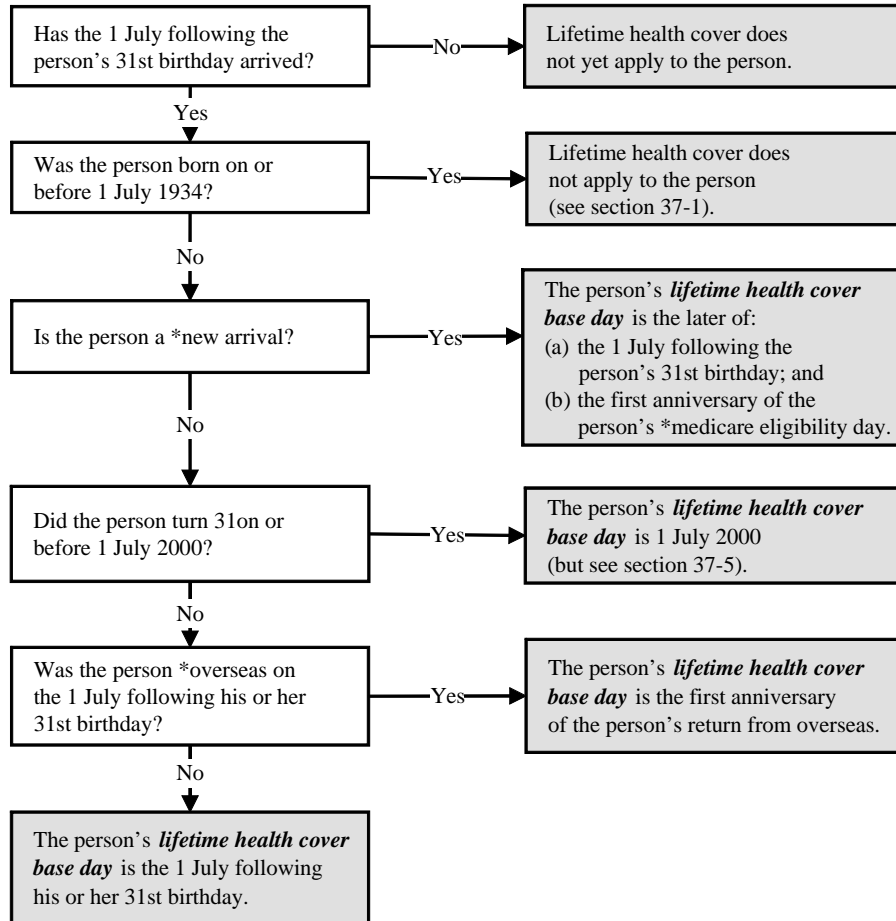
15 (2) The Private Health Insurance (Lifetime Health Cover) Rules may
16 specify days that, despite subsection (1), are taken not to be
17 *permitted days without hospital cover.

18 **34-25 Meaning of *lifetime health cover base day***

19 (1) A person's ***lifetime health cover base day*** is the day worked out by
20 using this diagram:
21

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Working out a person's lifetime health cover base day



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- (2) A person is a *new arrival* if:
- (a) the person entered Australia for the first time on or after 1 July 2000; and
 - (b) the person was not an Australian citizen or permanent resident of Australia at the time of the entry.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2 Incentives

Part 2-3 Lifetime health cover

Division 34 General rules about lifetime health cover

Section 34-30

- 1 (3) A person's *medicare eligibility day* is the day on which the person
2 is registered by the Medicare Australia CEO as an eligible person
3 within the meaning of section 3 of the *Health Insurance Act 1973*.
- 4 (4) Despite subsection (1), if:
- 5 (a) on or before 1 April 2007, a person's Schedule 2 application
6 day had arrived for the purposes of the *National Health Act*
7 *1953*; and
- 8 (b) the person had *hospital cover on 1 April 2007; and
- 9 (c) the person has had hospital cover continuously since that day;
- 10 the person's *lifetime health cover base day* is the person's
11 Schedule 2 application day. For this purpose, a day on which the
12 person has hospital cover does not include a *permitted day
13 without hospital cover or a day on which the person would
14 otherwise be taken to have hospital cover because of subsection
15 34-15(2).

16 **34-30 When a person is overseas**

- 17 Without limiting when a person is taken to be *overseas for the
18 purposes of this Part:
- 19 (a) a person who lives on Norfolk Island is taken, while the
20 person is living there, to be overseas; and
- 21 (b) any period in which a person returns to Australia for less than
22 90 days counts as part of a continuous period overseas; and
- 23 (c) a person is taken to have returned from overseas if the person
24 returns to Australia for a period of at least 90 days.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 37—Exceptions to the general rules about lifetime**
3 **health cover**

4 **37-1 People born on or before 1 July 1934**

- 5 (1) The amount of premiums payable for *hospital cover in respect of
6 an *adult does not increase under this Part if the adult was born on
7 or before 1 July 1934.
- 8 (2) However, this section does not prevent section 37-20 applying to
9 the *hospital cover in respect of any *adults who were born after
10 1 July 1934.

11 **37-5 People over 31 and overseas on 1 July 2000**

12 A person:

- 13 (a) who turned 31 on or before 1 July 2000; and
14 (b) who was *overseas on 1 July 2000;

15 is taken, for the purposes of section 34-1, to have had *hospital
16 cover on the person's *lifetime health cover base day.

17 **37-10 Hardship cases**

18 A person is treated for the purposes of this Part as if he or she had
19 *hospital cover on 1 July 2000 if a determination under clause 10
20 of Schedule 2 to the *National Health Act 1953* (as in force
21 immediately before 1 April 2007) had effect in relation to the
22 person immediately before 1 April 2007.

23 **37-15 Increases cannot exceed 70% of base rates**

24 The maximum amount of any increase under this Part in the
25 amount of premiums payable for *hospital cover in respect of an
26 *adult is an amount equal to 70% of the *base rate for the hospital
27 cover.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 37-20

1 **37-20 Joint hospital cover**

2 (1) If:

3 (a) more than one *adult is covered under the same *hospital
4 cover; and

5 (b) the amount of premiums payable for the cover in respect of at
6 least one of those adults is increased under this Part;

7 the amount of the premiums payable for the cover in respect of all
8 of the adults is increased.

9 (2) The amount of the increase in the premiums payable for the cover
10 is worked out by:

11 (a) dividing the *base rate for the cover by the number of *adults
12 it covers; and

13 (b) using that rate to work out for each adult what the amount of
14 the increase for that adult (if any) would be; and

15 (c) adding together the results of paragraph (b).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 40—Administrative matters relating to lifetime**
3 **health cover**

4 **40-1 Notification to insured people etc.**

- 5 (1) A private health insurer must comply with any requirements
6 specified in the Private Health Insurance (Lifetime Health Cover)
7 Rules relating to providing information to:
8 (a) *adults in respect of *hospital cover with the private health
9 insurer; and
10 (b) other adults who apply for, or inquire about, that hospital
11 cover;
12 about increases under this Part in the amounts of premiums payable
13 for hospital cover in respect of those adults.
- 14 (2) A private health insurer must comply with any requirements
15 specified in the Private Health Insurance (Lifetime Health Cover)
16 Rules relating to providing information to other private health
17 insurers about increases under this Part in the amounts of
18 premiums payable for *hospital cover with the private health
19 insurer.
- 20 (3) The Private Health Insurance (Lifetime Health Cover) Rules may
21 require or permit a private health insurer to provide information of
22 a kind referred to in this section in the form of an age notionally
23 attributed, to an *adult or other person, as the age from which the
24 adult or other person will be treated as having had continuous
25 *hospital cover.
- 26 (4) A private health insurer must keep separate records in relation to
27 each *adult who has *hospital cover.
- 28 (5) When an *adult ceases to be *covered by *hospital cover under
29 which more than one adult was covered, the private health insurer
30 must notify each other adult that the adult has ceased to be covered
31 by the cover.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **40-5 Evidence of having had hospital cover, or of a person's age**

2 A private health insurer must comply with any requirements
3 specified in the Private Health Insurance (Lifetime Health Cover)
4 Rules relating to whether, and in what circumstances, particular
5 kinds of evidence are to be accepted, for the purposes of this Part,
6 as conclusive evidence of:

- 7 (a) whether a person had *hospital cover at a particular time, or
8 during a particular period; or
9 (b) a person's age.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Chapter 3—Complying health insurance**
3 **products**

4 **Part 3-1—Introduction**

5 **Division 50—Introduction**

6 **50-1 What this Chapter is about**

7 Broadly, health insurance that is made available to the public must
8 meet the requirements in this Chapter. This means that:

- 9 (a) the insurance must be community-rated (that is,
10 made available in a way that does not discriminate
11 between people) (see Part 3-2); and
- 12 (b) the insurance must be in the form of a complying
13 health insurance product (see Part 3-3); and
- 14 (c) the private health insurers who make the products
15 available must meet certain obligations to people
16 insured or seeking to be insured under the products
17 (see Part 3-4).

18 **50-5 Private Health Insurance (Complying Product) Rules, Private**
19 **Health Insurance (Prostheses) Rules and Private Health**
20 **Insurance (Accreditation) Rules**

21 Matters relating to *complying health insurance products are also
22 dealt with in the Private Health Insurance (Complying Product)
23 Rules, the Private Health Insurance (Prostheses) Rules and the
24 Private Health Insurance (Accreditation) Rules. The provisions of
25 this Chapter indicate when a particular matter is or may be dealt
26 with in these Rules.

27 Note: These Rules are all made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 3-2—Community rating**

3 **Division 55—Principle of community rating**

4 **55-1 What this Part is about**

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To ensure that everybody who chooses has access to health insurance, the principle of community rating prevents private health insurers from discriminating between people on the basis of their health or for any other reason described in this Part.

9

55-5 Principle of community rating

10

(1) A private health insurer must not:

11

(a) take or fail to take any action; or

12

(b) in making a decision, have regard or fail to have regard to any matter;

13

14

that would result in the insurer *improperly discriminating between people who are or wish to be insured under a *complying health insurance policy of the insurer.

15

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(2) **Improper discrimination** is discrimination that relates to:

18

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

19

20

21

(b) the gender, race, sexual orientation or religious belief of a person; or

22

23

(c) the age of a person, except to the extent allowed under Part 2-3 (lifetime health cover); or

24

25

(d) where a person lives, except to the extent allowed under paragraph 66-10(2)(a) or section 66-20; or

26

27

(e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to

28

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 result in an increased need for *hospital treatment or *general
2 treatment; or
3 (f) the frequency with which a person needs hospital treatment
4 or general treatment; or
5 (g) the amount or extent of the benefits to which a person
6 becomes entitled during a period under a *complying health
7 insurance policy, except to the extent allowed under
8 section 66-15; or
9 (h) any matter set out in the Private Health Insurance
10 (Complying Product) Rules for the purposes of this
11 paragraph.
- 12 (3) Despite subsection (2), discrimination by a *restricted access
13 insurer is not improper discrimination to the extent to which the
14 insurer:
15 (a) takes or fails to take an action; or
16 (b) in making a decision, has regard or fails to have regard to a
17 matter;
18 only to ensure that its *complying health insurance products are not
19 made available to persons to whom its constitution prohibits it
20 from making the products available.

21 **55-10 Closed products**

22 The principle of community rating in section 55-5 does not prevent
23 a private health insurer from refusing to make available to a person
24 a *complying health insurance product that the insurer is no longer
25 making available to anyone.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Part 3-3—Requirements for complying health**
3 **insurance products**

4 **Division 60—Introduction**

5 **60-1 What this Part is about**

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Complying health insurance products (which are made up of complying health insurance policies) are the only kind of insurance that private health insurers are allowed to make available as part of their health insurance business (see section 63-1 and Division 84). This Part sets out the requirements that an insurance policy must meet in order to be a complying health insurance policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 63—Basic rules about complying health insurance**
3 **products**

4 **63-1 Obligation to ensure products are complying products**

5 A private health insurer must ensure that the only kind of insurance
6 that it makes available as part of its *health insurance business is
7 insurance in the form of *complying health insurance products.

8 **63-5 Meaning of *complying health insurance product***

- 9 (1) A ***complying health insurance product*** is a *product made up of
10 *complying health insurance policies.
- 11 (2) A ***product*** is all the insurance policies issued by a private health
12 insurer:
13 (a) that *cover the same treatments; and
14 (b) that provide benefits that are worked out in the same way;
15 and
16 (c) whose other terms and conditions are the same as each other.
- 17 (3) Different premiums may be payable under policies in the same
18 *product.

19 **63-10 Meaning of *complying health insurance policy***

20 A ***complying health insurance policy*** is an insurance policy that
21 meets:

- 22 (a) the community rating requirements in Division 66; and
23 (b) the coverage requirements in Division 69; and
24 (c) if the policy *covers *hospital treatment—the benefit
25 requirements in Division 72; and
26 (d) the waiting period requirements in Division 75; and
27 (e) the portability requirements in Division 78; and
28 (f) the quality assurance requirements in Division 81; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products

Part 3-3 Requirements for complying health insurance products

Division 63 Basic rules about complying health insurance products

Section 63-10

- 1 (g) any requirements set out in the Private Health Insurance
- 2 (Complying Product) Rules for the purposes of this
- 3 paragraph.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 66—Community rating requirements**

3 **66-1 Community rating requirements**

- 4 (1) An insurance policy meets the community rating requirements in
5 this Division if:
- 6 (a) the policy prohibits the private health insurer that issued the
7 policy from breaching the principle of community rating in
8 section 55-5 in relation to a person insured under the policy;
9 and
 - 10 (b) the policy has no terms or conditions that would allow the
11 insurer to *improperly discriminate against a person insured
12 under the policy; and
 - 13 (c) the only discounts (if any) available under the policy are
14 discounts allowed under subsection 66-5(2); and
 - 15 (d) unless the policy is issued under a new *product (see
16 subsection (2))—the premiums payable under the policy meet
17 the premium requirement in section 66-5.
- 18 (2) For the purposes of paragraph (1)(d), an insurance policy is issued
19 under a new *product if the amount of premiums charged under
20 policies in the product has not changed since the first policy in the
21 product was issued.

22 **66-5 Premium requirement**

- 23 (1) For the purposes of paragraph 66-1(d), the premiums payable
24 under an insurance policy for a period meet the premium
25 requirement in this section if the amount of premiums payable
26 under the policy for the period:
- 27 (a) is the amount specified in the most recent approval under
28 section 66-10 as the *relevant amount for that kind of policy;
29 or
 - 30 (b) is the proportion, for the period, of that amount; or
 - 31 (c) would be the amount mentioned in paragraph (a) or (b)
32 except that a different amount is payable:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 66-10

- 1 (i) because of the application of Part 2-3 (lifetime health
2 cover); or
3 (ii) because of a discount allowed under subsection (2); or
4 (iii) because of a combination of subparagraphs (i) and (ii).
- 5 (2) A discount is allowed if it is available for people:
6 (a) who pay a premium at least 3 months in advance; or
7 (b) who pay a premium by payroll deduction; or
8 (c) who pay a premium by pre-arranged automatic transfer from
9 an account at a bank or other financial institution; or
10 (d) who are, under the *rules of the private health insurer, treated
11 as belonging to a contribution group; or
12 (e) in relation to whom the insurer is not required to pay a levy
13 under a law of a State or Territory;
14 as long as:
15 (f) the same discount is available for the same reason under
16 every policy in the *product; and
17 (g) the percentage discount does not exceed the percentage
18 specified in the Private Health Insurance (Complying
19 Product) Rules as the maximum percentage discount allowed.

20 **66-10 Minister's approval of premiums**

- 21 (1) A private health insurer that proposes to change the premiums
22 charged under a *complying health insurance product must apply to
23 the Minister for approval of the change:
24 (a) in the *approved form; and
25 (b) at least 60 days before the day on which the insurer proposes
26 the change to take effect.
- 27 (2) The application may propose different changes for policies in the
28 *product, but the proposed changed amount must be the same for
29 each policy in the product:
30 (a) issued to people living in a particular *risk equalisation
31 jurisdiction; and
32 (b) under which:
33 (i) only one person is insured; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (ii) 2 *adults are insured (and no-one else); or
2 (iii) 2 or more people are insured, none of whom is an adult;
3 or
4 (iv) 2 or more people are insured, only one of whom is an
5 adult; or
6 (v) 3 or more people are insured, only 2 of whom are
7 adults; or
8 (vi) 3 or more people are insured, at least 3 of whom are
9 adults.
- 10 (3) The Minister must, by written instrument, approve the proposed
11 changed amount or amounts, unless the Minister is satisfied that a
12 change that would increase the amount or amounts would be
13 contrary to the public interest.
- 14 (4) If the Minister approves the proposed changed amount or amounts,
15 the approval has effect:
16 (a) from the day specified in the approval as the day the change
17 takes effect; and
18 (b) until replaced by another approval for the *product under this
19 section.
- 20 (5) For the purposes of subsection 66-5(1), the amount approved for
21 each kind of policy described in subsection (2) is the *relevant*
22 *amount* for that kind of policy.
- 23 (6) If the Minister refuses to approve the proposed changed amount or
24 amounts, the Minister must table the Minister's reasons for refusal
25 in each House of the Parliament no later than 15 sitting days of that
26 House after the refusal.
- 27 (7) An instrument made under subsection (3) is not a legislative
28 instrument.

29 **66-15 Entitlement to benefits for general treatment**

- 30 Neither:
31 (a) the community rating principle in section 55-5; nor
32 (b) the community rating requirement in paragraph 66-1(b);

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 66-20

1 prevents a private health insurer from determining a person's
2 entitlement under a *complying health insurance policy to a benefit
3 for *general treatment (other than *hospital-substitute treatment) in
4 respect of a period by having regard to the amount of benefits for
5 that kind of treatment already claimed for the person in respect of
6 the period.

7 **66-20 Different amount of benefits depending on where people live**

8 Neither:
9 (a) the community rating principle in section 55-5; nor
10 (b) the community rating requirements in section 66-1;
11 prevents the amount of a benefit for a treatment under a
12 *complying health insurance policy from being different from the
13 amount of a benefit for the same treatment under another policy
14 that is in the same *product, if the difference is only because the
15 persons insured under the policies live in different *risk
16 equalisation jurisdictions.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 69—Coverage requirements**

3 **69-1 Coverage requirements**

- 4 (1) An insurance policy meets the coverage requirements in this
5 Division if the only things the policy *covers are:
6 (a) specified treatments that are *hospital treatment; or
7 (b) specified treatments that are hospital treatment and specified
8 treatments that are *general treatment; or
9 (c) specified treatments that are general treatment but none that
10 are *hospital-substitute treatment.
- 11 (2) Despite subsection (1), the policy must also *cover any treatment
12 that a policy of its kind is required by the Private Health Insurance
13 (Complying Product) Rules to cover.
- 14 (3) Despite subsection (1), the policy must not *cover any treatment
15 that a policy of its kind is not allowed under the Private Health
16 Insurance (Complying Product) Rules to cover.

17 **69-5 Meaning of cover**

- 18 (1) An insurance policy *covers* a treatment if, under the policy, the
19 insurer undertakes liability in respect of some or all loss arising out
20 of a liability to pay fees or charges relating to the provision of
21 goods or a service that is or includes that treatment.
- 22 (2) An insurance policy also *covers* a treatment if the insurer provides
23 an insured person, or arranges for an insured person to be provided
24 with, goods or a service that is or includes that treatment.
- 25 (3) If an insurance policy *covers a treatment in the way described in
26 subsection (2), this Part applies as if the provision of the goods or
27 service were a benefit provided under the policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 72-1

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**Division 72—Benefit requirements for policies that cover
hospital treatment**

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72-1 Benefit requirements

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(1) An insurance policy that *covers *hospital treatment meets the benefit requirements in this Division if:

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(a) the policy meets the requirements in the table in subsection (2); and

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9

(b) the policy meets any requirements specified in the Private Health Insurance (Complying Product) Rules to be benefit requirements; and

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(c) the policy does not provide benefits for:

13

(i) the cost of care and accommodation in an aged care service (within the meaning of the *Aged Care Act 1997*); or

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16

(ii) a charge for a pharmaceutical benefit supplied under Part VII of the *National Health Act 1953*, unless the circumstances of the charge are covered by section 92B of that Act; or

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19

(iii) any other treatment specified in the Private Health Insurance (Complying Product) Rules as a treatment for which benefits must not be provided; and

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(d) the *rules of the private health insurer that issues the policy meet the rules requirement in section 72-5.

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(2) These are the requirements that a policy must meet for the purposes of paragraph (1)(a):

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Requirements that a policy that *covers *hospital treatment must meet

Item	There must be a benefit for ...	The amount of the benefit must be ...
1	any part of *hospital treatment that is one or more of the following: (a) psychiatric care; (b) rehabilitation; (c) palliative care; if the treatment is provided in a *hospital and no *medicare benefit is payable for that part of the treatment.	at least the amount set out in the Private Health Insurance (Complying Product) Rules as the minimum benefit for that treatment.
2	*hospital treatment *covered under the policy for which a *medicare benefit is payable.	(a) if the charge for the treatment is less than the *schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) otherwise—at least 25% of the schedule fee for the treatment.
3	if the policy *covers *hospital-substitute treatment—hospital-substitute treatment covered under the policy for which a *medicare benefit is payable.	(a) if the charge for the treatment is less than the *schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) otherwise—at least 25% of the schedule fee for the treatment; but the benefit must not be provided if a medicare benefit of an amount that is at least 85% of the schedule fee is claimed for the treatment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products

Part 3-3 Requirements for complying health insurance products

Division 72 Benefit requirements for policies that cover hospital treatment

Section 72-5

Requirements that a policy that *covers *hospital treatment must meet

Item	There must be a benefit for ...	The amount of the benefit must be ...
4	(a) *hospital treatment *covered under the policy; and (b) if the policy covers *hospital-substitute treatment— hospital-substitute treatment covered under the policy; that is the provision of a prosthesis of a kind listed in the Private Health Insurance (Prostheses) Rules in circumstances: (c) in which a *medicare benefit is payable; or (d) set out in the Private Health Insurance (Prostheses) Rules for the purposes of this table item.	(a) at least the amount set out in the Private Health Insurance (Prostheses) Rules as the minimum benefit for the prosthesis; and (b) no more than the amount (if any) set out in the Private Health Insurance (Prostheses) Rules as the maximum benefit for the prosthesis.
5	any treatment for which the Private Health Insurance (Complying Product) Rules specify there must be a benefit.	at least the amount set out in the Private Health Insurance (Complying Product) Rules as the minimum benefit for that treatment.

1 Note: If a private health insurer provides a policy holder with, or arranges
2 for a policy holder to be provided with, treatment, it is treated as a
3 benefit for the purposes of this Division (see subsection 69-5(3)).

4 **72-5 Rules requirement in relation to provision of benefits**

- 5 (1) For the purposes of paragraph 72-1(1)(d), the *rules of the private
6 health insurer that issues the policy meet the rules requirement in
7 this section if the rules have the effect required by subsection (2).
- 8 (2) The effect required is that if, under an agreement or arrangement
9 with a private health insurer, a particular *health care provider
10 (other than a *medical practitioner) provides particular *hospital
11 treatment or *hospital-substitute treatment to people insured under

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 the same *complying health insurance product of the insurer, any
2 charge for the treatment:
- 3 (a) that is payable by an insured person; and
4 (b) which is not recoverable by a benefit under the product;
5 must be the same for all of the people insured under the product,
6 irrespective of:
- 7 (c) the frequency with which that provider provides that
8 particular treatment to people insured under that product; or
9 (d) any other matter.
- 10 (3) The Private Health Insurance (Complying Product) Rules may
11 modify the effect required by subsection (2) in relation to all or
12 particular kinds of *complying health insurance products, benefits,
13 treatments or *health care providers. To the extent the Rules do so,
14 the rules requirement is taken to be met if the conditions in the
15 Rules are met.

16 **72-10 Minimum benefits for prostheses**

- 17 (1) Private Health Insurance (Prostheses) Rules made for the purposes
18 of item 4 of the table in subsection 72-1(2) must only list a kind of
19 prosthesis if:
- 20 (a) an application has been made under subsection (2) in relation
21 to that kind of prosthesis; and
22 (b) the Minister has granted the application.
- 23 (2) A person may apply to the Minister to have the Private Health
24 Insurance (Prostheses) Rules list a prosthesis of the kind to which
25 the application relates.
- 26 (3) The application must be:
- 27 (a) in the *approved form; and
28 (b) accompanied by any application fee imposed under the
29 *Private Health Insurance (Prostheses Application and*
30 *Listing Fees) Act 2006*.
- 31 (4) The Minister must inform the applicant in writing of the Minister's
32 decision whether or not to grant the application. If the Minister

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products

Part 3-3 Requirements for complying health insurance products

Division 72 Benefit requirements for policies that cover hospital treatment

Section 72-15

1 decides not to grant the application, the Minister must also inform
2 the applicant of the reason for that decision.

3 (5) If:

- 4 (a) the Minister grants the application; and
5 (b) the applicant pays to the Commonwealth any initial listing
6 fee imposed under the *Private Health Insurance (Prostheses*
7 *Application and Listing Fees) Act 2006* within 14 days of
8 being informed of the Minister's decision to grant the
9 application;

10 the Minister must, on the next occasion when the Minister makes
11 or varies the Private Health Insurance (Prostheses) Rules:

- 12 (c) list the kind of prosthesis to which the application relates in
13 those Rules; and
14 (d) set out in those Rules a minimum benefit for the prosthesis;
15 and
16 (e) if the Minister considers it appropriate—set out in those
17 Rules a maximum benefit for the prosthesis.

18 **72-15 Ongoing listing fee for prostheses**

- 19 (1) This section applies if the Minister lists a kind of prosthesis in the
20 Private Health Insurance (Prostheses) Rules as a result of an
21 application under subsection 72-10(2).
22 (2) The applicant must pay to the Commonwealth the ongoing listing
23 fee for which the applicant is liable under the *Private Health*
24 *Insurance (Prostheses Application and Listing Fees) Act 2006*,
25 within 14 days of each day specified under that Act as an ongoing
26 listing fee imposition day.
27 (3) If the applicant fails to pay an ongoing listing fee in accordance
28 with subsection (2), the Minister may remove the kind of
29 prosthesis from the list in the Private Health Insurance (Prostheses)
30 Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 75—Waiting period requirements**

3 **75-1 Waiting period requirements**

4 (1) An insurance policy meets the waiting period requirements in this
5 Division if the *waiting period that applies to a person who did not
6 *transfer to the policy is no longer than:

- 7 (a) for a benefit for *hospital treatment or *hospital-substitute
8 treatment that is obstetric treatment or treatment for a
9 *pre-existing condition (other than treatment covered by
10 paragraph (b))—12 months; and
11 (b) for a benefit for hospital treatment or hospital-substitute
12 treatment that is psychiatric care, rehabilitation or palliative
13 care (whether or not for a pre-existing condition)—2 months;
14 and
15 (c) for any other benefit for hospital treatment or
16 hospital-substitute treatment—2 months.

17 (2) The Private Health Insurance (Complying Product) Rules may
18 modify the requirements in subsection (1) in relation to all or
19 particular kinds of private health insurers, benefits or insured
20 persons. To the extent the Rules do so, the waiting period
21 requirements in this Division are taken to be met if the conditions
22 in the Rules are met.

23 Note: If a private health insurer provides a policy holder with, or arranges
24 for a policy holder to be provided with, treatment, it is treated as a
25 benefit for the purposes of this Division (see subsection 69-5(3)).

26 **75-5 Meaning of *waiting period***

27 The *waiting period* that applies to a person for a benefit under an
28 insurance policy is the period:

- 29 (a) starting at the time the person becomes insured under the
30 policy; and
31 (b) ending at the time specified in the policy;
32 during which the person is not entitled to the benefit.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 75-10

1 **75-10 Meaning of *transfers***

2 A person *transfers* to a policy (the *new policy*) from another policy
3 (the *old policy*) if:

4 (a) either:

5 (i) the person is insured under the old policy at the time the
6 person becomes insured under the new policy; or

7 (ii) the person ceased to be insured under the old policy no
8 more than 7 days, or a longer number of days allowed
9 by the new policy's insurer for this purpose, before
10 becoming insured under the new policy; and

11 (b) the old policy is a *complying health insurance policy; and

12 (c) the person's premium payments under the old policy were up
13 to date at the time the person became insured under the new
14 policy.

15 Note: See section 99-1 about transfer certificates.

16 **75-15 Meaning of *pre-existing condition***

17 (1) A person insured under an insurance policy has a *pre-existing*
18 *condition* if:

19 (a) the person has an ailment, illness or condition; and

20 (b) in the opinion of a *medical practitioner appointed by the
21 insurer that issued the policy, the signs or symptoms of that
22 ailment, illness or condition existed at any time in the period
23 of 6 months ending on the day on which the person became
24 insured under the policy.

25 (2) In forming an opinion for the purposes of paragraph (1)(b), the
26 *medical practitioner must have regard to any information in
27 relation to the ailment, illness or condition that the medical
28 practitioner who treated the ailment, illness or condition gives him
29 or her.

30 (3) If:

31 (a) a private health insurer replaces a *complying health
32 insurance product with another complying health insurance
33 product; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (b) a person who was insured under a policy that was in the
2 replaced *product is *transferred by the insurer to a policy
3 that is in the replacement product;
4 the reference in paragraph (1)(b) to the day on which the person
5 became insured under the policy is taken to be a reference to the
6 day on which the person became insured under the replaced policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 78-1

1

2 **Division 78—Portability requirements**

3 **78-1 Portability requirements**

4

(1) An insurance policy meets the portability requirements in this
5 Division if the policy meets the requirements in subsections (2), (3)
6 and (4).

7

(2) An insurance policy meets the requirement in this subsection if the
8 *waiting period that applies to a person who *transferred to the
9 policy (the *new policy*) from another policy (the *old policy*) is no
10 longer than:

11

(a) for a benefit for *hospital treatment or *hospital-substitute
12 treatment that was not *covered under the old policy—the
13 period allowed under section 75-1; and

14

(b) for a benefit for hospital treatment or hospital-substitute
15 treatment that was covered under the old policy—the balance
16 of any unexpired waiting period for that benefit that applied
17 to the person under the old policy.

18

(3) An insurance policy meets the requirement in this subsection if the
19 policy does not impose on a person who *transferred to the policy
20 any period (other than a *waiting period allowed under
21 subsection (2)) during which the amount of a benefit in relation to
22 any particular *hospital treatment or *hospital-substitute treatment
23 is less than the amount the person would be eligible for during any
24 other period.

25

(4) An insurance policy meets the requirement in this subsection if, in
26 relation to a benefit for *hospital treatment or *hospital-substitute
27 treatment:

28

(a) that was *covered under the old policy; and

29

(b) in respect of which a higher excess or higher co-payment
30 applied under the old policy than is the case under the new
31 policy;

32

any period during which the higher excess or higher co-payment
33 continues to apply under the new policy to a person who

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 *transferred to the policy is no longer than the *waiting period
2 allowed under section 75-1 for a benefit for that treatment.
- 3 (5) In working out:
- 4 (a) for the purposes of subsection (2) or (4), whether a treatment
5 was *covered under an old policy; or
- 6 (b) for the purposes of subsection (3), whether the amount of a
7 benefit under a new policy during a period is less than the
8 amount it would be during another period;
- 9 disregard the existence or otherwise of contracts between the
10 insurer in relation to either of the policies and particular *health
11 care providers or groups of health care providers.
- 12 (6) The Private Health Insurance (Complying Product) Rules may
13 modify the requirements in this section in relation to all or
14 particular kinds of private health insurers, benefits or insured
15 persons. To the extent the Rules do so, the portability requirements
16 in this Division are taken to be met if the conditions in the Rules
17 are met.
- 18 Note: If a private health insurer provides a policy holder with, or arranges
19 for a policy holder to be provided with, treatment, it is treated as a
20 benefit for the purposes of this Division (see subsection 69-5(3)).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 81—Quality assurance requirements**

3 **81-1 Quality assurance requirements**

4 An insurance policy meets the quality assurance requirements in
5 this Division if the policy prohibits the payment of benefits for a
6 treatment that does not meet the standards in the Private Health
7 Insurance (Accreditation) Rules.

8 Note: The Private Health Insurance (Accreditation) Rules are made by the
9 Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 84—Enforcement of this Part**

3 **84-1 Offence: advertising, offering or insuring under non-complying**
4 **policies**

5 (1) A person commits an offence if:

6 (a) the person:

7 (i) advertises a *product; or

8 (ii) offers a person insurance under a policy; or

9 (iii) insures a person under a policy; or

10 (iv) arranges for another person to do a thing mentioned in
11 subparagraph (i), (ii) or (iii); and

12 (b) the policy, or a policy in the product, *covers *hospital
13 treatment or *general treatment or both (whether or not it
14 covers any other treatment); and

15 (c) the policy is not a *complying health insurance policy.

16 Penalty: 1,000 penalty units or imprisonment for 5 years, or both.

17 (2) In imposing a penalty on a private health insurer for an offence
18 under subsection (1), the court:

19 (a) must have regard to the possible impact of a penalty on the
20 insurer's capital adequacy, solvency and the level of
21 premiums for its *complying health insurance products; and

22 (b) must not impose a penalty if satisfied that doing so would
23 adversely affect the insurer's capital adequacy or solvency, or
24 be likely to lead to an increase in premiums for its products.

25 **84-5 Offence: directors and chief executive officers liable if systems**
26 **not in place to prevent breaches**

27 A person commits an offence if:

28 (a) the person is a *director or *chief executive officer of a
29 private health insurer; and

30 (b) the insurer commits an offence under section 84-1; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 84-10

- 1 (c) the person failed to exercise due diligence to ensure that
2 adequate systems were in place to prevent the insurer from
3 committing the offence.

4 Penalty: 1,000 penalty units or imprisonment for 5 years, or both.

5 **84-10 Injunction in relation to non-complying policies**

- 6 (1) If a private health insurer has engaged, is engaging, or is proposing
7 to engage, in conduct:
8 (a) that contravenes or would contravene section 63-1; or
9 (b) that is or that would be an offence against section 84-1;
10 the Federal Court may, on application by a person mentioned in
11 subsection (3), grant an injunction restraining the insurer from
12 engaging in the conduct.
- 13 (2) If:
14 (a) a private health insurer has refused or failed, is refusing or
15 failing, or is proposing to refuse or fail, to do a thing; and
16 (b) the refusal or failure:
17 (i) contravenes or would contravene section 63-1; or
18 (ii) is or would be an offence against section 84-1;
19 the Federal Court may, on application by a person mentioned in
20 subsection (3), grant an injunction requiring the insurer to do the
21 thing.
- 22 (3) For the purposes of subsections (1) and (2), an application may be
23 made by:
24 (a) the Minister; or
25 (b) the Council; or
26 (c) any other person.
- 27 (4) The court may grant an interim injunction pending the
28 determination of an application under subsection (1) or (2).
- 29 (5) The court must not require an applicant for an injunction to give an
30 undertaking as to damages as a condition of granting an interim
31 injunction.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (6) The court may discharge or vary an injunction granted under this
2 section.
- 3 (7) The power of the court to grant an injunction restraining a private
4 health insurer from engaging in conduct may be exercised:
- 5 (a) whether or not it appears to the court that the insurer intends
6 to engage again, or to continue to engage, in conduct of that
7 kind; and
- 8 (b) whether or not the insurer has previously engaged in conduct
9 of that kind.
- 10 (8) The power of the court to grant an injunction requiring a private
11 health insurer to do a thing may be exercised:
- 12 (a) whether or not it appears to the court that the insurer intends
13 to refuse or fail again, or to continue to refuse or fail, to do
14 that thing; and
- 15 (b) whether or not the insurer has previously refused or failed to
16 do that thing.

17 **84-15 Remedies for people affected by non-complying policies**

18 On application by the Minister, if the Federal Court is satisfied
19 that:

- 20 (a) a private health insurer has engaged in conduct that
21 contravenes section 63-1 or is an offence against
22 section 84-1; or
- 23 (b) both:
- 24 (i) a private health insurer has refused or failed to do a
25 thing; and
- 26 (ii) that refusal or failure contravenes section 63-1 or is an
27 offence against section 84-1;

28 the court may order the insurer to do either or both of the
29 following:

- 30 (c) take specified action to ensure that an insurance policy
31 becomes a *complying health insurance policy;
- 32 (d) take specified action to ensure that a person insured under an
33 insurance policy is put in the position the person would have

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products
Part 3-3 Requirements for complying health insurance products
Division 84 Enforcement of this Part

Section 84-15

1 been in, had the policy always been a complying health
2 insurance policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 3-4—Obligations relating to complying health**
3 **insurance products**

4 **Division 90—Introduction**

5 **90-1 What this Part is about**

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7
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Private health insurers have obligations to people insured under their complying health insurance products and people seeking to become insured under those products. Private health insurers also have to keep the Department, the Council and the Private Health Insurance Ombudsman informed about their health insurance business.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 93-1

1

2 **Division 93—Giving information to consumers**

3 **93-1 Maintaining up to date standard information statements**

4 (1) A private health insurer must ensure that it maintains at all times an
5 *up to date *standard information statement:

6 (a) for each *complying health insurance product that it makes
7 available; and

8 (b) for each complying health insurance product under which it
9 insures people.

10 (2) The *standard information statement for a *complying health
11 insurance product is *up to date* at a particular time, if, at that time,
12 the information in the statement is accurate.

13 (3) A private health insurer commits an offence if there is no *standard
14 information statement for a *complying health insurance product of
15 the insurer.

16 Penalty: 60 penalty units.

17 (4) A private health insurer commits an offence if:

18 (a) there is a *standard information statement for a *complying
19 health insurance product of the insurer; and

20 (b) the standard information statement is not *up to date.

21 Penalty: 60 penalty units.

22 (5) Strict liability applies to subsections (3) and (4).

23 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

24 **93-5 Meaning of *standard information statement***

25 (1) A *standard information statement* for a *complying health
26 insurance product is a statement about the product that contains the
27 information, and is in the form, set out in the Private Health
28 Insurance (Complying Product) Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) The Private Health Insurance (Complying Product) Rules may set
2 out methods by which *standard information statements are to be
3 made available to people who ask for information about
4 *complying health insurance products.

5 **93-10 Making standard information statements available**

6 A private health insurer must ensure that, if a person asks an
7 *officer, employee or agent of the insurer for information about a
8 *complying health insurance product of the insurer:

- 9 (a) the person is told about the *standard information statement
10 for the product and how to obtain a copy of the statement;
11 and
12 (b) if the person asks for a copy—the person is given an *up to
13 date copy of the statement.

14 **93-15 Giving information to newly insured people**

15 (1) A private health insurer must ensure that, when an *adult first
16 becomes insured under a *complying health insurance policy of the
17 insurer, the adult is given:

- 18 (a) an *up to date copy of the *standard information statement for
19 the *product that the policy is in, by a method (if any) set out
20 in the Private Health Insurance (Complying Product) Rules;
21 and
22 (b) details about what the policy *covers and how benefits
23 provided under it are worked out; and
24 (c) a statement identifying the *health benefits fund to which the
25 policy is referable.

26 (2) If more than one *adult becomes insured under a single *complying
27 health insurance policy of a private health insurer, the insurer is
28 taken to comply with subsection (1) if the insurer complies with
29 that subsection in relation to only one of those adults.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **93-20 Keeping insured people up to date**

2 (1) A private health insurer must ensure that an *adult insured under a
3 *complying health insurance policy issued by the insurer is given
4 the *standard information statement for the *product that the policy
5 is in, at least once every 12 months.

6 (2) A private health insurer must ensure that, if a proposed change to
7 the insurer's *rules:

8 (a) is or might be detrimental to the interests of an insured
9 person; and

10 (b) will require an update to the *standard information statement
11 for a *complying health insurance product of the insurer;

12 an *adult insured under each *complying health insurance policy in
13 the product:

14 (c) is informed about the proposed change a reasonable time
15 before the change takes effect; and

16 (d) is given the updated standard information statement as soon
17 as practicable after the statement is updated.

18 (3) A private health insurer must ensure that, if an *adult who is
19 insured under a *complying health insurance policy of the insurer
20 asks an *officer, employee or agent of the insurer for information
21 about what the policy covers or the benefits the policy provides,
22 the adult is given the information as soon as practicable.

23 (4) A private health insurer must ensure that, if the insurer proposes to
24 change the *health benefits fund to which a *complying health
25 insurance policy of the insurer is *referable, an *adult insured under
26 the policy is, before the change takes effect, given a statement
27 identifying the health benefits fund to which the policy will be
28 referable as a result of the change.

29 Note: The health benefits fund to which a policy is referable may change in
30 accordance with Division 146.

31 (5) If more than one *adult is insured under a single *complying health
32 insurance policy of a private health insurer, the insurer is taken to
33 comply with subsection (1), (2) or (4) if the insurer complies with
34 the subsection in relation to only one of those adults.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **93-25 Giving advance notice of detrimental changes to rules**

2 (1) A private health insurer must ensure an *adult insured under a
3 *complying health insurance policy issued by the insurer is
4 informed about any proposed change to the insurer's *rules (other
5 than a change to which subsection 93-20(2) applies), a reasonable
6 time before the change takes effect, if the proposed change is or
7 might be detrimental to the interests of an insured person.

8 (2) If more than one *adult is insured under a single *complying health
9 insurance policy of a private health insurer, the insurer is taken to
10 comply with subsection (1) if the insurer complies with that
11 subsection in relation to only one of those adults.

12 **93-30 Failure to give information to consumers**

- 13 (1) A private health insurer commits an offence if:
14 (a) the insurer is required under section 93-10, 93-15, 93-20 or
15 93-25 to ensure that a particular thing happens in relation to a
16 particular person; and
17 (b) the thing does not happen in relation to the person.

18 Penalty: 60 penalty units.

19 (2) Strict liability applies to subsection (1).

20 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products

Part 3-4 Obligations relating to complying health insurance products

Division 96 Giving information to the Department, the Council and the Private Health Insurance Ombudsman

Section 96-1

1

2 **Division 96—Giving information to the Department, the**
3 **Council and the Private Health Insurance**
4 **Ombudsman**

5 **96-1 Giving standard information statements on request**

6 A private health insurer must ensure that, if:

- 7 (a) the Secretary of the Department; or
8 (b) the Council; or
9 (c) the Private Health Insurance Ombudsman;

10 requests the private health insurer for the *standard information
11 statement for a *complying health insurance product of the insurer,
12 the insurer gives the person who made the request an *up to date
13 copy of the statement, as soon as practicable after being asked and
14 by the method (if any) specified by the person.

15 **96-5 Giving standard information statements for new products**

16 A private health insurer must ensure that a copy of the *standard
17 information statement for a *complying health insurance product of
18 the insurer is given to:

- 19 (a) the Secretary of the Department; and
20 (b) the Council; and
21 (c) the Private Health Insurance Ombudsman;

22 no later than the first day on which the insurer first begins to make
23 the *product available.

24 **96-10 Giving updated standard information statements**

25 A private health insurer must ensure that, if the *standard
26 information statement for a *complying health insurance product of
27 the insurer is updated, a copy of the updated statement is given to:

- 28 (a) the Secretary of the Department; and
29 (b) the Council; and
30 (c) the Private Health Insurance Ombudsman;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 as soon as practicable after the statement is updated.

2 **96-15 Giving additional information on request**

3 (1) Any of the following:

4 (a) the Secretary of the Department;

5 (b) the Council;

6 (c) the Private Health Insurance Ombudsman;

7 may request a private health insurer for specified information
8 about, or in relation to, a *complying health insurance product or
9 products, or a *complying health insurance policy, of the insurer.

10 (2) The request must:

11 (a) be in writing; and

12 (b) specify the time by which the information requested is to be
13 given.

14 (3) The request may specify the manner and form in which the
15 information requested is to be given.

16 (4) A private health insurer must ensure that the request is complied
17 with, by the time specified in the request or any longer time
18 allowed by the person who made the request.

19 **96-20 Failure to give information to Department, Council or Private**
20 **Health Insurance Ombudsman**

21 (1) A private health insurer commits an offence if:

22 (a) the insurer is required under section 96-1, 96-5, 96-10 or
23 96-15 to ensure that a particular thing is given to a particular
24 person; and

25 (b) the thing is not given to the person.

26 Penalty: 60 penalty units.

27 (2) Strict liability applies to subsection (1).

28 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products

Part 3-4 Obligations relating to complying health insurance products

Division 96 Giving information to the Department, the Council and the Private Health Insurance Ombudsman

Section 96-25

1 **96-25 Giving information required by the Private Health Insurance**
2 **(Complying Product) Rules**

3 The Private Health Insurance (Complying Product) Rules may set
4 out any or all of the following:

- 5 (a) information in relation to *complying health insurance
6 products;
- 7 (b) persons to whom the information is to be given (who may
8 include, but need not be limited to, the Secretary of the
9 Department, the Council or the Private Health Insurance
10 Ombudsman);
- 11 (c) the time within which, or the intervals at which, the
12 information is to be given to a person;
- 13 (d) the manner and form in which the information is to be given
14 to a person.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 99—Transfer certificates**

3 **99-1 Transfer certificates**

4 *Certificate for the insured person*

- 5 (1) A private health insurer (the ***old insurer***) must, if a person ceases
6 to be insured under a *complying private health insurance policy of
7 the insurer and does not become insured under another policy of
8 the insurer, give the person a certificate under this subsection:
9 (a) in the *approved form; and
10 (b) within the period set out in the Private Health Insurance
11 (Complying Product) Rules.

12 *Certificate for the new insurer*

- 13 (2) A private health insurer (the ***new insurer***) must request a certificate
14 from an old insurer if:
15 (a) a person who is or has been insured under a *complying
16 health insurance policy of the old insurer *transfers to a
17 complying health insurance policy of the new insurer; and
18 (b) the person does not give the new insurer the certificate the
19 old insurer gave the person under subsection (1) within 7
20 days of becoming insured by the new insurer.
21 The request must be made:
22 (c) in the *approved form; and
23 (d) within the period set out in the Private Health Insurance
24 (Complying Product) Rules.
- 25 (3) If a certificate is requested by the new insurer (whether or not the
26 request is in the *approved form or made within the period
27 mentioned in paragraph (2)(d)), the old insurer must give the new
28 insurer a certificate:
29 (a) in the approved form; and
30 (b) within the period set out in the Private Health Insurance
31 (Complying Product) Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 Complying health insurance products
Part 3-4 Obligations relating to complying health insurance products
Division 99 Transfer certificates

Section 99-1

1

Offence

2

(4) A private health insurer commits an offence if:

3

(a) the insurer is required to do a thing under subsection (1), (2)
or (3); and

4

5

(b) the insurer does not do the thing.

6

Penalty: 60 penalty units.

7

(5) Strict liability applies to subsection (4).

8

Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 102—Private health insurers to offer cover for**
3 **hospital treatment**

4 **102-1 Private health insurers to offer cover for hospital treatment**

5 At any time when a private health insurer makes available a
6 *complying health insurance product that *covers *general
7 treatment, the insurer must also make available a complying health
8 insurance product that covers *hospital treatment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-1 Introduction

Division 110 Introduction

Section 110-1

1

Chapter 4—Private health insurers

2

3

Part 4-1—Introduction

4

Division 110—Introduction

5

110-1 What this Chapter is about

6

Entities are only permitted to carry on health insurance business if they are registered. Once registered, a number of obligations arise.

7

8

The principal obligation is to have health benefits funds, operated in accordance with the requirements of Part 4-4, for the purpose of health insurance business. (It may, to some degree, also be used for the purpose of health-related businesses.)

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Other obligations include appointment of actuaries, compliance with prudential standards and exclusion of disqualified persons from management.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Part 4-2—Carrying on health insurance business**

3 **Division 115—Introduction**

4 **115-1 What this Part is about**

5

Only entities that are registered under Part 4-3 as health insurers 6 can carry on health insurance business. Other entities can be 7 prevented from carrying on health insurance business.

8 **115-5 The Private Health Insurance (Health Insurance Business)**
9 **Rules**

10 The carrying on of *health insurance business is also dealt with in
11 the Private Health Insurance (Health Insurance Business) Rules.
12 The provisions of this Part indicate when a particular matter is or
13 may be dealt with in these Rules.

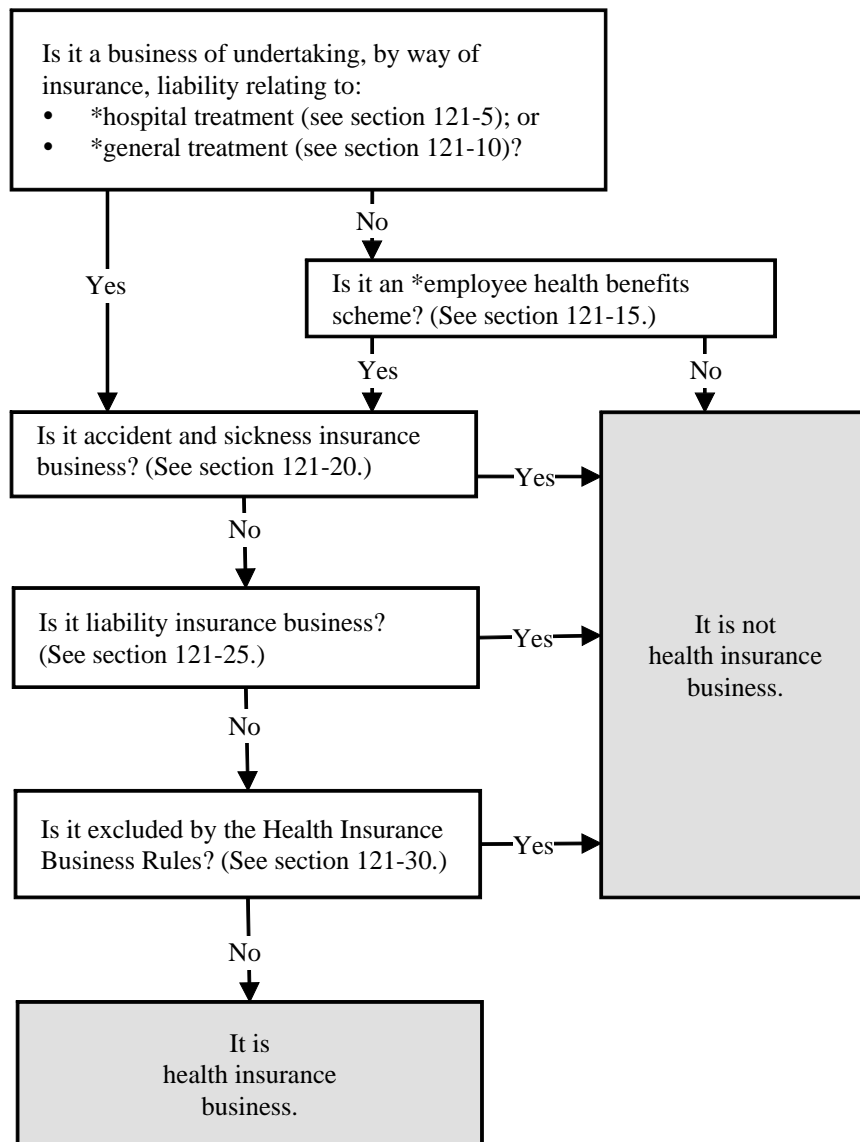
14 Note: The Private Health Insurance (Health Insurance Business) Rules are
15 made by the Minister under section 333-20.

16 **115-10 Whether a business etc. is health insurance business**

17 The following diagram shows how to work out whether a business
18 or arrangement is *health insurance business:
19

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

**Working out whether a business or arrangement
is health insurance business**



1

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 118—Prohibition of carrying on health insurance**
3 **business without registration**

4 **118-1 Carrying on health insurance business without registration**

- 5 (1) A person commits an offence if:
6 (a) the person carries on *health insurance business; and
7 (b) the person is not a private health insurer.

8 Penalty: 40 penalty units.

- 9 (2) A person commits an offence against subsection (1) in respect of
10 each day during which the person contravenes that section,
11 including the day of a conviction for any such offence or any later
12 day.

13 Note: See also subsections 4K(3) and (4) of the *Crimes Act 1914* in relation
14 to multiple contraventions of this provision.

15 **118-5 Injunctions**

- 16 (1) The Federal Court may grant an injunction in such terms as it
17 determines to be appropriate if, on the application of the Minister,
18 the Council or any other person, the court is satisfied that a person
19 has engaged, or is proposing to engage, in conduct that constitutes
20 or would constitute a contravention of section 118-1.
- 21 (2) The Federal Court may grant an interim injunction pending
22 determination of an application under subsection (1).
- 23 (3) The court must not require an applicant for an injunction to give an
24 undertaking as to damages as a condition of granting an interim
25 injunction.
- 26 (4) The court may discharge or vary an injunction granted under
27 subsection (1) or (2).
- 28 (5) The power of the court to grant an injunction restraining a person
29 from engaging in conduct may be exercised:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-2 Carrying on health insurance business

Division 118 Prohibition of carrying on health insurance business without registration

Section 118-5

- 1 (a) whether or not it appears to the court that the person intends
2 to engage again, or to continue to engage, in conduct of that
3 kind; and
4 (b) whether or not the person has previously engaged in conduct
5 of that kind.
- 6 (6) The power of the court to grant an injunction requiring a person to
7 do an act or thing may be exercised:
8 (a) whether or not it appears to the court that the person intends
9 to refuse or fail again, or to continue to refuse or fail, to do
10 that act or thing; and
11 (b) whether or not the person has previously refused or failed to
12 do that act or thing.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 121—What is health insurance business?**

3 **121-1 Meaning of *health insurance business***

- 4 (1) ***Health insurance business*** is:
5 (a) the business of undertaking liability, by way of insurance; or
6 (b) an *employee health benefits scheme;
7 that relates, in a way referred to in subsection (2), to *hospital
8 treatment or *general treatment.

9 Note: The following kinds of insurance business are not health insurance
10 business:

- 11 (a) accident and sickness insurance business (see section 121-20);
12 (b) liability insurance business (see section 121-25);
13 (c) insurance business excluded by the Private Health Insurance
14 (Health Insurance Business) Rules (see section 121-30).

- 15 (2) The liability by way of insurance, or the arrangement to make
16 payments under the *employee health benefits scheme, must relate
17 to:

- 18 (a) loss arising out of a liability to pay fees or charges relating to
19 provision in Australia of such treatment; or
20 (b) provision in Australia of such treatment; or
21 (c) the happening of an occurrence connected with the provision
22 in Australia of such treatment; or
23 (d) the happening of an occurrence in Australia that ordinarily
24 requires the provision of such treatment.

- 25 (3) It does not matter for the purposes of paragraph (2)(d) whether
26 payment of benefits to the insured is dependent upon one or more
27 of the following:

- 28 (a) such treatment or benefit being provided to the insured;
29 (b) the insured requiring such treatment or benefit;
30 (c) fees or charges being payable by the insured in relation to the
31 provision of such treatment or benefit.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **121-5 Meaning of *hospital treatment***

- 2 (1) ***Hospital treatment*** is treatment (including the provision of goods
3 and services) that:
4 (a) is intended to manage a disease, injury or condition; and
5 (b) is provided to a person:
6 (i) by a person who is authorised by a *hospital to provide
7 the treatment; or
8 (ii) under the management or control of such a person; and
9 (c) either:
10 (i) is provided at a hospital; or
11 (ii) is provided, or arranged, with the direct involvement of
12 a hospital.
- 13 (2) Without limiting subsection (1), ***hospital treatment*** includes any
14 other treatment, or treatment included in a class of treatments,
15 specified in the Private Health Insurance (Health Insurance
16 Business) Rules for the purposes of this subsection.
- 17 (3) Without limiting subsection (1) or (2), the reference to treatment in
18 those subsections includes a reference to any of, or any
19 combination of, accommodation, nursing, medical, surgical,
20 podiatric surgical, diagnostic, therapeutic, prosthetic,
21 pharmacological, pathology or other services or goods intended to
22 manage a disease, injury or condition.
- 23 (4) Despite subsections (1) and (2), treatment is not *hospital treatment
24 if it is specified in, or is included in a class of treatments specified
25 in, the Private Health Insurance (Health Insurance Business) Rules
26 for the purposes of this subsection.
- 27 (5) A ***hospital*** is a facility for which a declaration under subsection (6)
28 is in force.
- 29 (6) The Minister may, in writing:
30 (a) declare that a facility is a *hospital; or
31 (b) revoke such a declaration.

32 Note: Refusals to make declarations, and revocations of declarations are
33 reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (7) In deciding whether to declare that a facility is a *hospital, or to
2 revoke such a declaration, the Minister must have regard to:
- 3 (a) the nature of the facility; and
4 (b) the range and scope of the services provided, or proposed to
5 be provided, under the management or control of the facility
6 and at or on behalf of the facility; and
7 (c) whether the necessary approvals by a State or Territory, or by
8 an authority of a State or Territory, have been obtained in
9 relation to the facility; and
10 (d) whether the accreditation requirements of an appropriate
11 accrediting body have been met; and
12 (e) whether undertakings have been made, or have been
13 complied with, relating to providing to private health insurers
14 information, of the kind specified in the Private Health
15 Insurance (Health Insurance Business) Rules, relating to
16 treatment of *policy holders of *health benefits funds; and
17 (f) any other matters specified in the Private Health Insurance
18 (Health Insurance Business) Rules.
- 19 (8) A declaration under subsection (6) that a facility is a *hospital must
20 include either a statement that the hospital is a public hospital or a
21 statement that the hospital is a private hospital.

22 **121-10 Meaning of *general treatment***

- 23 (1) ***General treatment*** is treatment (including the provision of goods
24 and services) that:
- 25 (a) is intended to manage or prevent a disease, injury or
26 condition; and
27 (b) is not *hospital treatment.
- 28 (2) Without limiting subsection (1), ***general treatment*** includes any
29 other treatment, or treatment included in a class of treatments,
30 specified in the Private Health Insurance (Health Insurance
31 Business) Rules for the purposes of this subsection.
- 32 (3) Despite subsections (1) and (2), neither of the following is *general
33 treatment:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 121-15

- 1 (a) the rendering in Australia of a service for which *medicare
2 benefit is payable, unless the Private Health Insurance
3 (Health Insurance Business) Rules provide otherwise;
4 (b) any other treatment, or treatment included in a class of
5 treatments, specified in the Private Health Insurance (Health
6 Insurance Business) Rules for the purposes of this paragraph.

7 **121-15 Extension to *employee health benefits schemes***

- 8 (1) An arrangement is an *employee health benefits scheme* if:
9 (a) the arrangement provides for a person (an *employer*) to
10 arrange payment in respect of the whole or part of the fees
11 and charges that an employee of, or a person providing
12 services to, the employer incurred in relation to *hospital
13 treatment or *general treatment; and
14 (b) one or more of the following applies:
15 (i) the employer is a *constitutional corporation;
16 (ii) the employer is a body corporate incorporated in a
17 Territory;
18 (iii) the employer carries on business in a Territory.
- 19 (2) It does not matter for the purposes of this section whether the
20 arrangement:
21 (a) constitutes a business of undertaking liability by way of
22 insurance; or
23 (b) is a minor or incidental part of the employer's business; or
24 (c) does not require the employee, or person providing services,
25 to pay any contributions; or
26 (d) does not require the employee, or person providing services,
27 to pay contributions that reflect the value of the benefits that
28 the employer is providing under the arrangement; or
29 (e) provides for the employer to make payments in relation to
30 *hospital treatment, or *general treatment, provided to a
31 person other than the employee or person providing services;
32 or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (f) confers on the employer or another person a discretion
2 whether to make payments.
- 3 (3) However, an arrangement:
- 4 (a) is not an *employee health benefits scheme merely because,
5 under the arrangement, the employer will pay, or will
6 reimburse employees, or persons providing services, for
7 payment of, one or both of the following:
- 8 (i) the premiums payable by them for *complying health
9 insurance policies;
- 10 (ii) the difference between benefits payable to them under
11 policies, and amounts that they are liable to pay, for
12 health services provided to them or members of their
13 families; and
- 14 (b) is not an employee health benefits scheme if the Private
15 Health Insurance (Health Insurance Business) Rules provide
16 that:
- 17 (i) it is not an employee health benefits scheme; or
18 (ii) arrangements of a class in which it is included are not
19 employee health benefits schemes; and
- 20 (c) is not an employee health benefits scheme to the extent (if
21 any) that the arrangement constitutes State insurance within
22 the meaning of paragraph 51(xiv) of the Constitution.

23 **121-20 Exception: accident and sickness insurance business**

- 24 (1) Despite section 121-1, *health insurance business does not include
25 the business of undertaking liability, by way of insurance, to pay a
26 lump sum, or to make periodic payments, on the happening of a
27 personal accident, disease or sickness.
- 28 (2) However, this section does not apply to:
- 29 (a) business where liability is undertaken with respect to loss
30 arising out of a liability to pay fees or charges in relation to
31 the provision in Australia of *hospital treatment or *general
32 treatment; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 121-25

- 1 (b) business of a kind specified in the Private Health Insurance
2 (Health Insurance Business) Rules for the purposes of this
3 paragraph.

4 **121-25 Exception: liability insurance business**

5 Despite section 121-1, *health insurance business does not include
6 the business of undertaking liability, by way of insurance, with
7 respect to any loss arising out of a liability to pay compensation or
8 damages, including:

- 9 (a) a liability to pay compensation or damages because of the use
10 of a motor vehicle; or
11 (b) a liability to pay compensation or damages to an employee
12 because of an event occurring in connection with the
13 employee's employment.

14 **121-30 Exception: insurance business excluded by the Private**
15 **Health Insurance (Health Insurance Business) Rules**

16 Despite section 121-1, *health insurance business does not include
17 a business of a kind that the Private Health Insurance (Health
18 Insurance Business) Rules state not to be a health insurance
19 business.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 4-3—Registration**

3 **Division 126—Registration**

4 **126-1 What this Part is about**

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The Private Health Insurance Administration Council has the power, on application, to register as private health insurers bodies that are registered bodies for the purposes of the Corporations Law.

8

126-5 The Private Health Insurance (Registration) Rules

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Registration is also dealt with in the Private Health Insurance (Registration) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

12

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Note: The Private Health Insurance (Registration) Rules are made by the Minister under section 333-20.

14

126-10 Applying for registration

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(1) A body that is:

(a) a company within the meaning of the *Corporations Act 2001*, or a registered body within the meaning of that Act; and

(b) a *constitutional corporation;

may apply to the Council for registration as a private health insurer.

21

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(2) The application:

(a) must be in the *approved form; and

(b) must be accompanied by a copy of the *rules according to which the applicant proposes to conduct the day-to-day operation of its *health insurance business (including any *health-related business that it proposes to conduct through any of its *health benefits funds); and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 126-15

- 1 (c) if the applicant is seeking to be *registered as a for profit
2 insurer—must state that fact; and
3 (d) if the applicant is seeking to be registered as a *restricted
4 access insurer—must state that fact.
- 5 (3) The applicant must also give a copy of its *rules to the Secretary of
6 the Department.

7 **126-15 Requesting further information**

8 The Council may, within 90 days after the application is made,
9 give the applicant written notice requiring the applicant to give the
10 Council such further information relating to the application as is
11 specified in the notice.

12 **126-20 Deciding the application**

- 13 (1) The Council may:
14 (a) grant the application, subject to such terms and conditions as
15 the Council thinks fit; or
16 (b) refuse the application.
- 17 Note: Refusals of applications, and granting of applications subject to terms
18 and conditions, are reviewable under Part 6-9.
- 19 (2) In deciding the application, the Council must consider:
20 (a) whether the applicant will be able to comply with the
21 obligations imposed by or under this Act on private health
22 insurers; and
23 (b) such other matters as the Private Health Insurance
24 (Registration) Rules require the Council to consider.
- 25 (3) In deciding the application, the Council may consider such other
26 matters as it thinks fit, other than matters that the Private Health
27 Insurance (Registration) Rules prohibit the Council from
28 considering.
- 29 (4) The Council must refuse the application if the *rules of the
30 applicant permit *improper discrimination. For the purposes of this

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 subsection, the Council must consult the Secretary of the
2 Department.
- 3 (5) If the Council grants the application:
- 4 (a) the applicant is taken to have been *registered as a private
5 health insurer under this Part with effect from the date
6 specified by the Council in granting the application (which
7 may be a date that occurred before the application was
8 made); and
- 9 (b) if the Council grants the application subject to terms and
10 conditions—the registration is taken to be subject to those
11 terms and conditions from the date on which the applicant is
12 notified of the granting of the application; and
- 13 (c) if the applicant sought to be *registered as a for profit
14 insurer—the registration is taken to be registration of the
15 applicant as a for profit insurer; and
- 16 (d) if the applicant sought to be registered as a *restricted access
17 insurer—subject to subsection (6), the registration is taken to
18 be registration of the applicant as a restricted access insurer.
- 19 (6) The registration cannot be taken to be registration as a *restricted
20 access insurer unless the insurer’s constitution:
- 21 (a) describes the *restricted access group to whom the insurer’s
22 *complying health insurance products are, or will be,
23 available; and
- 24 (b) prohibits the insurer from issuing a complying health
25 insurance product to a person who does not belong to the
26 group; and
- 27 (c) prohibits the insurer from ceasing to insure a person for the
28 reason that the person has ceased to belong to the group.
- 29 (7) A **restricted access group** is a group of people who all belong to a
30 particular group, based on whether they:
- 31 (a) are or were employed in a particular profession, trade,
32 industry or calling; or
- 33 (b) are or were employed by a particular employer or by an
34 employer who belongs to a particular class of employers; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 126-25

- 1 (c) are or were members of a particular profession, professional
2 association or union; or
3 (d) are or were members of the Defence Force or part of the
4 Defence Force; or
5 (e) are or were part of any group described in the Private Health
6 Insurance (Registration) Rules.
7 The partners and *dependent children of people who belong to such
8 a group are also taken to belong to that group.

9 **126-25 Notifying the decision**

- 10 (1) If the Council grants the application, the Council must:
11 (a) notify the applicant in writing of the grant, and of the terms
12 and conditions (if any) to which the grant is subject; and
13 (b) within 7 days after granting the application, notify the
14 Secretary in writing of the grant; and
15 (c) within one month after granting the application, publish in
16 the *Gazette* a notification of the grant setting out:
17 (i) the applicant's name; and
18 (ii) the date of effect of the applicant's registration; and
19 (iii) the terms and conditions (if any) to which the grant is
20 subject.
21 (2) If the Council refuses the application, the Council must:
22 (a) notify the applicant in writing of the refusal; and
23 (b) within 7 days after refusing the application, notify the
24 Secretary in writing of the refusal; and
25 (c) within one month after refusing the application, publish in
26 the *Gazette* a notification of the refusal.

27 **126-30 Council can be taken to refuse application**

- 28 The Council is taken, for the purposes of Part 6-9, to have refused
29 the application if the Council does not notify the applicant of its
30 decision on the application:
31 (a) within 90 days after the application was made; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) within 90 days after a copy of the applicant's *rules was
2 given to the Secretary of the Department; or
3 (c) if the Council had given the applicant a notice under
4 section 126-15 requiring the applicant to give further
5 information relating to the application—within 90 days after
6 the applicant gives that information to the Council;
7 whichever is latest.

8 **126-35 Council to maintain record of registrations etc.**

- 9 (1) The Council must maintain on its website an up to date record that
10 contains:
11 (a) the names of all private health insurers; and
12 (b) in relation to each private health insurer:
13 (i) its address, telephone number and website address; and
14 (ii) the States and Territories in which it operates; and
15 (iii) if the insurer is registered as a *restricted access
16 insurer—the *restricted access group to whom the
17 insurer's *complying health insurance products are, or
18 will be, available.
- 19 (2) The Council must give to a person, in writing, such information
20 from the record as the person requests.

21 **126-40 Changing registration status**

- 22 (1) A private health insurer that:
23 (a) because of paragraph 126-20(5)(c) or subsection (2) of this
24 section, is *registered as a for profit insurer; and
25 (b) notifies the Council, in the *approved form, that it does not
26 wish to be registered as a for profit insurer;
27 is taken, from the day after the day on which the Council receives
28 the notice, not to be registered as a for profit insurer for the
29 purposes of this Act.
- 30 (2) A private health insurer that:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-3 Registration

Division 126 Registration

Section 126-40

- 1 (a) because of subsection (1) or otherwise, is not *registered as a
2 for profit insurer; and
- 3 (b) notifies the Council, in the *approved form, that it wishes to
4 be registered as a for profit insurer;
5 is taken, from the day after the day on which the Council receives
6 the notice, to be registered as a for profit insurer for the purposes of
7 this Act.
- 8 (3) If a private health insurer is taken under this section to be, or not to
9 be, *registered as a for profit insurer, the Council must, as soon as
10 practicable and in writing, notify accordingly:
11 (a) the Secretary of the Department; and
12 (b) the Private Health Insurance Ombudsman; and
13 (c) the Commissioner of Taxation.
- 14 (4) A private health insurer that:
15 (a) because of paragraph 126-20(5)(d) or subsection (5) of this
16 section, is *registered as a *restricted access insurer; and
17 (b) notifies the Council, in the *approved form, that it does not
18 wish to be registered as a restricted access insurer;
19 is taken, from the day after the day on which the Council receives
20 the notice, not to be registered as a restricted access insurer for the
21 purposes of this Act.
- 22 (5) Subject to subsection 126-20(6), a private health insurer that:
23 (a) because of subsection (4) or otherwise, is not *registered as a
24 *restricted access insurer; and
25 (b) notifies the Council, in the *approved form, that it wishes to
26 be registered as a restricted access insurer;
27 is taken, from the day after the day on which the Council receives
28 the notice, to be registered as a restricted access insurer for the
29 purposes of this Act.
- 30 (6) If a private health insurer is taken under this section to be, or not to
31 be, *registered as a *restricted access insurer, the Council must, as
32 soon as practicable and in writing, notify accordingly:
33 (a) the Secretary of the Department; and
34 (b) the Private Health Insurance Ombudsman.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **126-45 Cancellation of registration**

2 (1) The Council must cancel the registration of a private health insurer
3 if:

4 (a) the insurer has not conducted *health insurance business
5 during the preceding 12 months; or

6 (b) the insurer's *health benefits funds have been terminated
7 under Division 149.

8 (2) The Council must:

9 (a) notify the insurer in writing of the cancellation; and

10 (b) within 7 days after the cancellation, notify the Secretary in
11 writing of the cancellation; and

12 (c) within one month after the cancellation, publish in the
13 *Gazette* a notification of the cancellation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2

Part 4-4—Health benefits funds

3

Division 131—Introduction

4

131-1 What this Part is about

5

Private health insurers must have health benefits funds. These funds must be operated in accordance with the requirements of this Part, in particular the requirements relating to solvency and capital adequacy.

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Directors of private health insurers may be personally liable if these requirements are contravened.

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131-5 The Private Health Insurance (Health Benefits Fund) Rules

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*Health benefits funds are also dealt with in the Private Health Insurance (Health Benefits Fund Policy) Rules and the Private Health Insurance (Health Benefits Fund Administration) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

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Note: The Private Health Insurance (Health Benefits Fund Policy) Rules are made by the Minister under section 333-20, and the Private Health Insurance (Health Benefits Fund Administration) Rules are made by the Council under section 333-25.

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131-10 Meaning of *health benefits fund*

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A *health benefits fund* is a fund that:

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(a) is established in the records of a private health insurer; and

24

(b) relates solely to:

25

(i) its *health insurance business, or a particular part of that business; or

26

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (ii) its health insurance business, or a particular part of that
2 business, and some or all of its *health-related
3 businesses, or particular parts of those businesses.

4 **131-15 Meaning of *health-related business***

- 5 (1) ***Health-related business*** is business that is any one or more of the
6 following:
- 7 (a) a business of providing goods or services (or both) in order to
8 manage or prevent diseases, injuries or conditions;
 - 9 (b) a business of undertaking liability, by way of insurance, to
10 indemnify people who are *ineligible for Medicare for costs
11 associated with providing treatment, goods or services that:
 - 12 (i) are provided to those people in Australia; and
 - 13 (ii) are provided to manage or prevent diseases, injuries or
14 conditions;
 - 15 (c) a business of providing a financial service to assist people
16 insured under *complying health insurance products to meet
17 the costs associated with treatment, goods or services that are
18 provided to manage or prevent diseases, injuries or
19 conditions;
 - 20 (d) any other business, or business included in a class of
21 businesses, specified in the Private Health Insurance (Health
22 Benefits Fund Policy) Rules for the purposes of this
23 paragraph.
- 24 (2) Despite subsection (1), neither of the following is ***health-related***
25 ***business***:
- 26 (a) business that is *health insurance business; or
 - 27 (b) any other business, or business included in a class of
28 businesses, specified in the Private Health Insurance (Health
29 Benefits Fund Policy) Rules for the purposes of this
30 paragraph.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 134—The requirement to have health benefits**
3 **funds**

4 **134-1 Private health insurers must have health benefits funds**

5 (1) A private health insurer must at all times have at least one *health
6 benefits fund in respect of:

- 7 (a) its *health insurance business; or
8 (b) its health insurance business and some or all of its
9 *health-related businesses.

10 (2) A private health insurer may have more than one *health benefits
11 fund, but must not have more than one in respect of a particular
12 *risk equalisation jurisdiction.

13 (3) Despite subsection (2), a private health insurer may have more than
14 one *health benefits fund in respect of a particular *risk
15 equalisation jurisdiction if:

- 16 (a) each of those funds; or
17 (b) each of those funds, other than one such fund which was
18 established in connection with a restructure of funds under
19 Division 146;

20 is a fund that existed at the time this Act commenced, and that,
21 immediately before that commencement, was conducted by a
22 registered organization (within the meaning of the *National Health*
23 *Act 1953*).

24 (4) Despite subsection (2), a private health insurer may have more than
25 one *health benefits fund in respect of a particular *risk
26 equalisation jurisdiction in the circumstances specified in the
27 Private Health Insurance (Health Benefits Fund Policy) Rules for
28 the purposes of this subsection.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **134-5 Notifying the Council when health benefits funds are**
2 **established**

- 3 (1) If a private health insurer establishes a *health benefits fund, the
4 insurer must give to the Council written notice of:
5 (a) the establishment of the fund; and
6 (b) the date on which the fund was established; and
7 (c) such other matters as are specified in the Private Health
8 Insurance (Health Benefits Fund Administration) Rules for
9 the purposes of this paragraph.
- 10 (2) The notice must be given in the *approved form.
- 11 (3) This section does not apply if the fund is established under an
12 approval given under Division 146.

13 **134-10 Inclusion of health-related businesses in health benefits funds**

- 14 (1) If a private health insurer has a *health benefits fund in respect of
15 its *health insurance business and some or all of its *health-related
16 businesses, the dominant purpose of the fund must relate to its
17 health insurance business.
- 18 (2) If the Council is satisfied that the insurer is contravening
19 subsection (1):
20 (a) the Council may give to the insurer such directions relating to
21 divesting the fund of *health-related businesses as the
22 Council thinks necessary to ensure the insurer's compliance
23 with subsection (1); and
24 (b) the insurer must comply with those directions.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 137—The operation of health benefits funds**

3 **137-1 Assets of health benefits funds**

- 4 (1) A private health insurer must keep *assets of a *health benefits
5 fund distinct and separate from assets of other health benefits funds
6 and from all other money, assets or investments of the insurer.
- 7 (2) A private health insurer must maintain a separate bank account for
8 each *health benefits fund that it conducts.
- 9 (3) The *assets* of a *health benefits fund at a particular time are the
10 following:
- 11 (a) the balance of money represented by amounts credited to the
12 fund in accordance with section 137-5;
- 13 (b) assets of the insurer obtained as a result of the expenditure or
14 application of money credited to the fund;
- 15 (c) investments held by the insurer as a result of the expenditure
16 or application of money credited to the fund;
- 17 (d) other money, assets or investments of the insurer transferred
18 to the fund, whether under this Act or otherwise.
- 19 (4) Assets or investments obtained by the application of assets (other
20 than money) of a *health benefits fund are themselves *assets* of the
21 fund.
- 22 (5) Despite paragraphs (3)(b) and (c) and subsection (4), *assets or
23 investments obtained by the expenditure of money of, or the
24 application of other assets of, a *health benefits fund are not assets
25 of the fund if:
- 26 (a) the private health insurer conducting the fund is *registered
27 as a for profit insurer; and
- 28 (b) the expenditure or application was not done for the purposes
29 of the fund.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (6) To avoid doubt, nothing in this Act is intended to constitute a
2 private health insurer or its *directors a trustee or trustees of the
3 *assets of the *health benefits funds of the insurer.

4 **137-5 Payments to health benefits funds**

- 5 (1) A private health insurer must credit the following amounts to a
6 *health benefits fund:
7 (a) premiums payable under policies of insurance that are
8 *referable to the fund;
9 (b) amounts paid to the insurer in relation to a liability under
10 Division 152 in relation to the fund;
11 (c) income from the investment of *assets of the fund;
12 (d) money paid to or by the insurer under a judgment of a court
13 relating to any matter concerning the business of the fund or
14 any failure to comply with this Part in relation to the fund;
15 (e) any other money received by the insurer in connection with
16 its conduct of the business of the fund;
17 (f) any other amounts that the Private Health Insurance (Health
18 Benefits Fund Policy) Rules specify.
- 19 (2) This Act does not prevent a private health insurer from *making a
20 capital payment to a *health benefits fund.
- 21 (3) A private health insurer *makes a capital payment* to a *health
22 benefits fund if it credits to the fund an amount that:
23 (a) is not required to be credited to the fund under subsection (1);
24 and
25 (b) either:
26 (i) does not represent any part of the *assets of another
27 health benefits fund; or
28 (ii) is credited to the fund with the Council's written
29 approval.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **137-10 Expenditure and application of health benefits funds**

- 2 (1) A private health insurer must not apply, or deal with, *assets of a
3 *health benefits fund, whether directly or indirectly, except in
4 accordance with this Division.
- 5 (2) The *assets of a *health benefits fund must not be applied:
6 (a) for any purpose other than:
7 (i) meeting liabilities (including *policy liabilities), or
8 expenses, incurred for the purposes of the business of
9 the fund; or
10 (ii) making investments in accordance with section 137-20;
11 or
12 (iii) making a distribution under Division 149; or
13 (b) for a purpose specified in the Private Health Insurance
14 (Health Benefits Fund Policy) Rules for the purposes of this
15 paragraph.
- 16 (3) A private health insurer must not mortgage or charge any of the
17 *assets of a *health benefits fund except:
18 (a) to secure a bank overdraft; or
19 (b) for such other purposes, and subject to such other conditions,
20 as are specified in the Private Health Insurance (Health
21 Benefits Fund Administration) Rules for the purposes of this
22 paragraph.
- 23 (4) A private health insurer must not borrow money for the purposes
24 of the business of a *health benefits fund except in accordance with
25 the Private Health Insurance (Health Benefits Fund
26 Administration) Rules.
- 27 (5) Despite subsection (2), if a private health insurer is *registered as a
28 for profit insurer, the *assets of a *health benefits fund conducted
29 by the insurer may be applied for any purpose, except an
30 application of the assets that is inconsistent with:
31 (a) the *solvency standard; or
32 (b) the *capital adequacy standard; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) a *solvency direction or *capital adequacy direction given to
2 the insurer.
- 3 (6) This section does not apply to the transfer of *assets:
4 (a) from one *health benefits fund to another in accordance with
5 Division 146; or
6 (b) in accordance with a direction under subsection 134-10(2).

7 **137-15 Effect of non-compliance with section 137-10**

8 *General principle*

- 9 (1) A transaction entered into in contravention of section 137-10 is of
10 no effect unless:
11 (a) the Federal Court makes an order under subsection (2); or
12 (b) it is included in a class of transactions specified in the Private
13 Health Insurance (Health Benefits Fund Administration)
14 Rules to be transactions to which this section applies, and the
15 Federal Court has not made an order under subsection (6).

16 *Order declaring the transaction to be effective*

- 17 (2) The Federal Court, on application by a party to the transaction,
18 may make an order declaring that the transaction is effective, and is
19 to be taken always to have been effective, for all purposes.
- 20 (3) The Federal Court must not make an order under subsection (2)
21 unless it is satisfied that the applicant entered into the transaction
22 in good faith and without knowledge of the contravention.
- 23 (4) In deciding whether to make an order under subsection (2), the
24 Federal Court may have regard to any hardship that would be
25 caused to the applicant if the order were not made.
- 26 (5) Subsection (4) is not intended to limit the matters to which the
27 Federal Court may have regard on an application under
28 subsection (2).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 137-20

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Order declaring the transaction to be of no effect

- (6) The Federal Court, on application by the Council, may make an order declaring that a particular transaction that:
 - (a) was entered into in contravention of section 137-10; and
 - (b) is included in a class of transactions of a kind referred to in paragraph (1)(b) of this section;is, and is to be taken always to have been, of no effect for any purpose.
- (7) The Federal Court must not make an order under subsection (6) if it is satisfied that the effect of the order (if made) would be to cause hardship to a person who entered into the transaction in good faith and without knowledge of the contravention.

137-20 Investment of health benefits funds

- (1) A private health insurer may invest *assets of a *health benefits fund in any way that is likely to further the business of the fund.
- (2) However:
 - (a) nothing in this Act authorises a private health insurer to make an investment the insurer would otherwise be prohibited from making; and
 - (b) nothing in this Act authorises a private health insurer to make an investment the insurer would not otherwise have power to make; and
 - (c) a private health insurer must not invest *assets of a *health benefits fund, or keep such assets invested, if the investment, or the retention of the investment, as the case requires, is prohibited by the Private Health Insurance (Health Benefits Fund Administration) Rules.
- (3) A transaction is not ineffective merely because it involves a contravention of paragraph (2)(c).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **137-25 Restriction on restructure, merger, acquisition or**
2 **termination of health benefits funds**

- 3 (1) A private health insurer must not change the *health benefits fund
4 to which a policy of insurance is *referable unless the change is
5 made in accordance with Division 146.
- 6 (2) A private health insurer must not terminate a *health benefits fund
7 except in accordance with Division 149.
- 8 (3) This section does not prevent a liquidator doing anything
9 authorised or required by or under this Act or any other law of the
10 Commonwealth or of a State or Territory.

11 **137-30 Operation of health-related businesses through health**
12 **benefits funds**

13 If a private health insurer has a *health benefits fund in respect of
14 its *health insurance business and some or all of its *health-related
15 businesses, the insurer must comply with any requirements
16 specified in the Private Health Insurance (Health Benefits Fund
17 Policy) Rules relating to how the health-related businesses are to
18 be conducted.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 140—The solvency standard for health benefits**
3 **funds**

4 **140-1 Purpose of Division**

5 The purpose of this Division is to establish, and require private
6 health insurers to comply with, standards of solvency in order to
7 ensure that the *health benefits funds conducted by private health
8 insurers remain solvent.

9 **140-5 Council to establish solvency standard**

- 10 (1) The Private Health Insurance (Health Benefits Fund
11 Administration) Rules may establish a solvency standard for the
12 purposes of this Division.
- 13 (2) The *solvency standard may be expressed:
14 (a) to set different standards of solvency:
15 (i) for *health benefits funds conducted by different private
16 health insurers; or
17 (ii) for different classes of health benefits funds; or
18 (b) to apply to a health benefits fund only in circumstances
19 specified in the standard.

20 **140-10 Purpose of solvency standard**

21 The purpose of the *solvency standard is to ensure, as far as
22 practicable, that at any time the financial position of a *health
23 benefits fund conducted by a private health insurer is such that the
24 insurer will be able, out of the fund's *assets, to meet all liabilities
25 that are referable to the fund as those liabilities become due.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **140-15 Compliance with solvency standard**

2 *Private health insurers to comply with solvency standard*

- 3 (1) Subject to subsection (2), every private health insurer must comply
4 with the *solvency standard as it applies in respect of that insurer.

5 *Declarations that solvency standard does not apply*

- 6 (2) The Council may declare, by notice in writing, that the *solvency
7 standard does not apply to a particular private health insurer. The
8 declaration may be expressed to be limited to particular specified
9 circumstances, or to a particular specified period, or both.

10 Note: Refusals to make declarations are reviewable under Part 6-9.

11 *Conditions applying to declarations*

- 12 (3) The Council may:
13 (a) in a declaration under subsection (2); or
14 (b) by a separate notice in writing;
15 impose conditions to be complied with by any private health
16 insurer that is to get the benefit of the declaration.

17 Note: Decisions to impose conditions are reviewable under Part 6-9.

- 18 (4) If a private health insurer fails to comply with a condition referred
19 to in subsection (3), the declaration is taken to cease to apply to the
20 insurer.

21 *Revoking or varying declarations and conditions*

- 22 (5) If the Council is satisfied that a declaration under subsection (2), or
23 a condition referred to in subsection (3), is no longer required or
24 should be varied, the Council must, by notice in writing, revoke or
25 vary the declaration or condition accordingly.
- 26 (6) If a private health insurer requests the Council, in writing, to
27 revoke or vary a declaration under subsection (2), or a condition
28 referred to in subsection (3), the Council must, within 28 days after
29 receiving the request:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-4 Health benefits funds

Division 140 The solvency standard for health benefits funds

Section 140-20

- 1 (a) if the Council is satisfied that the declaration or condition is
2 no longer necessary or should be varied—revoke or vary the
3 declaration or condition; or
4 (b) in any other case—refuse to revoke or vary the declaration or
5 condition.

6 Note: Refusals to revoke or vary declarations or conditions are reviewable
7 under Part 6-9.

- 8 (7) If the Council does not, within the 28 days referred to in
9 subsection (6), either revoke or vary or refuse to revoke or vary the
10 declaration or condition concerned, the Council is to be taken, for
11 the purposes of this Act, to have refused to revoke or vary the
12 declaration or condition at the end of that period.

13 Note: Decisions that the Council is taken under this subsection to have made
14 are reviewable under Part 6-9.

- 15 (8) The Council must give to the private health insurer written notice
16 of a decision made under subsection (6) and, if the Council refuses
17 to revoke or vary the declaration or condition concerned, provide a
18 statement of reasons for so refusing.

19 *Declarations etc. are not legislative instruments*

- 20 (9) A notice under subsection (2), (3), (5) or (8) is not a legislative
21 instrument.

22 *References to declarations etc.*

- 23 (10) A reference in this section to a declaration or condition includes a
24 reference to a declaration or condition as varied.

25 **140-20 Solvency directions**

26 *Council may give solvency directions*

- 27 (1) The Council may give written directions (*solvency directions*) to a
28 private health insurer if, having regard to:
29 (a) the nature and value of the *assets of a *health benefits fund
30 conducted by the insurer; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) the nature and extent of the liabilities that are referable to the
2 business of the fund; or
3 (c) any other matters that the Council considers relevant;
4 the Council is satisfied that there are reasonable grounds for
5 believing that the insurer might not be able to meet, out of the
6 assets of the fund, all liabilities referable to the business of the fund
7 as they become due.
- 8 (2) *Solvency directions are directions that, in the Council's opinion,
9 are reasonably necessary to ensure, as far as practicable, that a
10 private health insurer will be able to meet the liabilities of a *health
11 benefits fund conducted by the insurer out of the *assets of the fund
12 as they become due.
- 13 (3) The Council may give a *solvency direction to a private health
14 insurer even if, when the direction is given:
15 (a) the insurer meets the requirements of the *solvency standard
16 applicable to that organisation in respect of the fund; and
17 (b) there are reasonable grounds to believe that the insurer will
18 meet that standard at all times while the direction is in force.

19 *Compliance with solvency directions*

- 20 (4) A private health insurer must comply with a *solvency direction
21 given to it under subsection (1).

22 *Duration of solvency directions*

- 23 (5) Subject to subsections (7) and (8), a *solvency direction remains in
24 force for a period specified in the direction, not exceeding 3 years,
25 commencing on the day when the direction is given.
- 26 (6) Subsection (5) does not prevent the Council from issuing a further
27 *solvency direction in the same terms to take effect immediately
28 after the expiry of a previous direction.

29 *Revoking or varying solvency directions*

- 30 (7) If the Council is satisfied that a particular *solvency direction is no
31 longer required or should be varied, the Council must, by written

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-4 Health benefits funds

Division 140 The solvency standard for health benefits funds

Section 140-20

- 1 notice given to the private health insurer, revoke or vary the
2 direction accordingly.
- 3 (8) If a private health insurer to which a *solvency direction has been
4 given requests the Council, in writing, to revoke or vary the
5 direction, the Council must, within 28 days after receiving the
6 request:
- 7 (a) if the Council is satisfied that the direction is no longer
8 necessary or should be varied—revoke or vary the direction;
9 or
10 (b) in any other case—refuse to revoke or vary the direction.
- 11 Note: Refusals to revoke or vary solvency directions are reviewable under
12 Part 6-9.
- 13 (9) If the Council does not, within the 28 days referred to in
14 subsection (8), either revoke or vary or refuse to revoke or vary the
15 *solvency direction concerned, the Council is to be taken, for the
16 purposes of this Act, to have refused to revoke or vary the direction
17 at the end of that period.
- 18 Note: Decisions that the Council is taken under this subsection to have made
19 are reviewable under Part 6-9.
- 20 (10) The Council must give to the private health insurer written notice
21 of a decision made under subsection (8) and, if the Council refuses
22 to revoke or vary the *solvency direction concerned, provide a
23 statement of reasons for refusing.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 143—The capital adequacy standard for health**
3 **benefits funds**

4 **143-1 Purpose of Division**

5 The purpose of this Division is to establish, and require private
6 health insurers to comply with, a standard in order to maintain the
7 capital adequacy of the *health benefits funds they conduct.

8 **143-5 Council to establish capital adequacy standard**

- 9 (1) The Private Health Insurance (Health Benefits Fund
10 Administration) Rules may establish a capital adequacy standard
11 for the purposes of this Division.
- 12 (2) The *capital adequacy standard may be expressed:
13 (a) to set different standards of capital adequacy:
14 (i) for *health benefits funds conducted by different private
15 health insurers; or
16 (ii) for different classes of health benefits funds; or
17 (b) to apply to a health benefits fund only in circumstances
18 specified in the standard.

19 **143-10 Purpose of capital adequacy standard**

- 20 The purpose of the *capital adequacy standard is to ensure, as far as
21 practicable, that there are sufficient *assets in a *health benefits
22 fund conducted by a private health insurer to provide adequate
23 capital for the conduct of the fund:
24 (a) in accordance with this Act; and
25 (b) in the interests of the *policy holders of the fund.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **143-15 Compliance with capital adequacy standard**

2 *Private health insurers to comply with capital adequacy standard*

- 3 (1) Subject to subsection (2), every private health insurer must comply
4 with the *capital adequacy standard as it applies in respect of that
5 insurer.

6 *Declarations that capital adequacy standard does not apply*

- 7 (2) The Council may declare, by notice in writing, that the *capital
8 adequacy standard does not apply to a particular private health
9 insurer. The declaration may be expressed to be limited to
10 particular specified circumstances, or to a particular specified
11 period, or both.

12 Note: Refusals to make declarations are reviewable under Part 6-9.

13 *Conditions applying to declarations*

- 14 (3) The Council may:
15 (a) in a declaration under subsection (2); or
16 (b) by a separate notice in writing;
17 impose conditions to be complied with by any private health
18 insurer that is to get the benefit of the declaration.

19 Note: Decisions to impose conditions are reviewable under Part 6-9.

- 20 (4) If a private health insurer fails to comply with a condition referred
21 to in subsection (3), the declaration is taken to cease to apply to the
22 insurer.

23 *Revoking or varying declarations and conditions*

- 24 (5) If the Council is satisfied that a declaration under subsection (2), or
25 a condition referred to in subsection (3), is no longer required or
26 should be varied, the Council must, by notice in writing, revoke or
27 vary the declaration or condition accordingly.

- 28 (6) If a private health insurer requests the Council, in writing, to
29 revoke or vary a declaration under subsection (2), or a condition

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 referred to in subsection (3), the Council must, within 28 days after
2 receiving the request:

3 (a) if the Council is satisfied that the declaration or condition is
4 no longer necessary or should be varied—revoke or vary the
5 declaration or condition; or

6 (b) in any other case—refuse to revoke or vary the declaration or
7 condition.

8 Note: Refusals to revoke or vary declarations or conditions are reviewable
9 under Part 6-9.

10 (7) If the Council does not, within the 28 days referred to in
11 subsection (6), either revoke or vary or refuse to revoke or vary the
12 declaration or condition concerned, the Council is to be taken, for
13 the purposes of this Act, to have refused to revoke or vary the
14 declaration or condition at the end of that period.

15 Note: Decisions that the Council is taken under this subsection to have made
16 are reviewable under Part 6-9.

17 (8) The Council must give to the private health insurer written notice
18 of a decision made under subsection (6) and, if the Council refuses
19 to revoke or vary the declaration or condition concerned, provide a
20 statement of reasons for so refusing.

21 *Declarations etc. are not legislative instruments*

22 (9) A notice under subsection (2), (3), (5) or (8) is not a legislative
23 instrument.

24 *References to declarations etc.*

25 (10) A reference in this section to a declaration or condition includes a
26 reference to a declaration or condition as varied.

27 **143-20 Capital adequacy directions**

28 *Council may give capital adequacy directions*

29 (1) The Council may give written directions (*capital adequacy*
30 *directions*) to a private health insurer if, having regard to:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-4 Health benefits funds

Division 143 The capital adequacy standard for health benefits funds

Section 143-20

- 1 (a) the nature and value of the *assets of a *health benefits fund
2 conducted by the insurer; or
3 (b) the nature and extent of the liabilities that are referable to the
4 business of the fund; or
5 (c) any other matters that the Council considers relevant;
6 the Council is satisfied that there are reasonable grounds for
7 believing that the assets of the fund will not provide adequate
8 capital for the conduct of the business of the fund in accordance
9 with this Act and in the interests of the *policy holders of the fund.

10 (2) *Capital adequacy directions are directions that, in the Council's
11 opinion, are reasonably necessary to ensure, as far as practicable,
12 that *assets of a *health benefits fund conducted by a private health
13 insurer will provide adequate capital for the purposes described in
14 subsection (1).

- 15 (3) The Council may give a *capital adequacy direction to a private
16 health insurer even if, when the direction is given:
17 (a) the insurer meets the requirements of the *capital adequacy
18 standard applicable to that organisation in respect of the fund;
19 and
20 (b) there are reasonable grounds to believe that the insurer will
21 meet that standard at all times while the direction is in force.

22 *Compliance with capital adequacy directions*

- 23 (4) A private health insurer must comply with a *capital adequacy
24 direction given to it under subsection (1).

25 *Duration of capital adequacy directions*

- 26 (5) Subject to subsections (7) and (8), a *capital adequacy direction
27 remains in force for a period specified in the direction, not
28 exceeding 3 years, commencing on the day when the direction is
29 given.

- 30 (6) Subsection (5) does not prevent the Council from issuing a further
31 *capital adequacy direction in the same terms to take effect
32 immediately after the expiry of a previous direction.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 *Revoking or varying capital adequacy directions*

- 2 (7) If the Council is satisfied that a particular *capital adequacy
3 direction is no longer required or should be varied, the Council
4 must, by written notice given to the private health insurer, revoke
5 or vary the direction accordingly.
- 6 (8) If a private health insurer to which a *capital adequacy direction
7 has been given requests the Council, in writing, to revoke or vary
8 the direction, the Council must, within 28 days after receiving the
9 request:
- 10 (a) if the Council is satisfied that the direction is no longer
11 necessary or should be varied—revoke or vary the direction;
12 or
13 (b) in any other case—refuse to revoke or vary the direction.
- 14 Note: Refusals to revoke or vary capital adequacy directions are reviewable
15 under Part 6-9.
- 16 (9) If the Council does not, within the 28 days referred to in
17 subsection (8), either revoke or vary or refuse to revoke or vary the
18 *capital adequacy direction concerned, the Council is to be taken,
19 for the purposes of this Act, to have refused to revoke or vary the
20 direction at the end of that period.
- 21 Note: Decisions that the Council is taken under this subsection to have made
22 are reviewable under Part 6-9.
- 23 (10) The Council must give to the private health insurer written notice
24 of a decision made under subsection (8) and, if the Council refuses
25 to revoke or vary the *capital adequacy direction concerned,
26 provide a statement of reasons for so refusing.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Division 146—Restructure, merger and acquisition of health benefits funds

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146-1 Restructure of health benefits funds

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(1) A private health insurer may restructure its *health benefits funds by making all of the insurance policies that are *referable to a health benefits fund of the insurer, and that belong to a *policy group of that fund, become referable to another health benefits fund or funds of the insurer (whether existing or proposed) if:

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(a) the insurer applies to the Council, in the *approved form, for approval of the restructure; and

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(b) the Council approves the restructure in writing; and

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(c) the insurer complies with any requirements that the Private Health Insurance (Health Benefits Fund Administration) Rules impose on the insurer in relation to the restructure.

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(2) Subject to subsection (3), the Council must approve the restructure if it is satisfied that:

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(a) the proposed division of *assets and liabilities between the funds is reasonable; and

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(b) the restructure will not result in any breach of the *solvency standard or the *capital adequacy standard.

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(3) The Council must not approve the application if:

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(a) it considers that the restructure will result in unfairness to the *policy holders of a *health benefits fund of the insurer as that fund exists immediately before the restructure (a ***transferring fund***), when those policy holders are viewed as a group; or

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(b) it considers that the restructure will result in unfairness to the persons who would be policy holders of a health benefits fund of the insurer as that fund would exist immediately after the restructure (a ***receiving fund***), when those persons are viewed as a group; or

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(c) the insurer is being wound up when the application is made.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 Note: Refusals to approve restructures are reviewable under Part 6-9.

- 2 (4) The Private Health Insurance (Health Benefits Fund
3 Administration) Rules may provide for the following:
4 (a) criteria for approving or refusing to approve applications
5 under subsection (1);
6 (b) requirements to notify interested persons of the outcomes of
7 such applications;
8 (c) matters connected with how restructures take place, including
9 the following:
10 (i) insurance policies becoming *referable to a receiving
11 fund or funds;
12 (ii) *policy liabilities and other liabilities becoming
13 referable to a receiving fund or funds;
14 (iii) *assets of a transferring fund becoming assets of a
15 receiving fund or funds;
16 (iv) the timing of restructures;
17 (v) if a receiving fund is a proposed new *health benefits
18 fund—the establishment of that fund;
19 (d) requirements for private health insurers to give the Council
20 information following restructures.

- 21 (5) A **policy group**, of a *health benefits fund, is all of the insurance
22 policies:
23 (a) that are *referable to the fund; and
24 (b) the addresses of the *holders of which, as known to the
25 private health insurer conducting the fund, are located in the
26 same *risk equalisation jurisdiction.

27 The Private Health Insurance (Health Benefits Fund
28 Administration) Rules may provide for how to work out the policy
29 group for a policy that has 2 or more holders whose addresses are
30 not all located in the same risk equalisation jurisdiction.

- 31 (6) An area is a **risk equalisation jurisdiction** if the Private Health
32 Insurance (Health Benefits Fund Administration) Rules so provide.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **146-5 Merger and acquisition of health benefits funds**

- 2 (1) Two or more private health insurers may:
- 3 (a) transfer to a *health benefits fund or funds of one of the
- 4 insurers (the *transferee insurer*) the health benefits fund or
- 5 funds of the other insurer; or
- 6 (b) transfer to a health benefits fund or funds of one of the
- 7 insurers (the *transferee insurer*) the health benefits fund or
- 8 funds of the other insurers;
- 9 by making the insurance policies that are *referable to a health
- 10 benefits fund or funds of the other insurer, or other insurers,
- 11 become referable to the health benefits fund or funds of the
- 12 transferee insurer.
- 13 (2) However, the transfer must not take place without the Council's
- 14 written approval if one or more of the following apply:
- 15 (a) the transfer involves the establishment of a new *health
- 16 benefits fund or funds;
- 17 (b) a *solvency direction is in force in relation to the other
- 18 insurer, or one or more of the other insurers;
- 19 (c) a *capital adequacy direction is in force in relation to the
- 20 other insurer, or one or more of the other insurers.
- 21 (3) The Council must approve the transfer if, and only if:
- 22 (a) the insurers referred to in subsection (1) apply jointly to the
- 23 Council, in the *approved form, for approval of the transfer;
- 24 and
- 25 (b) if paragraph (2)(a) applies—the Council is satisfied that the
- 26 allocation of *assets and liabilities to the new *health benefits
- 27 fund or funds is reasonable; and
- 28 (c) if paragraph (2)(b) or (c) applies—the Council is satisfied
- 29 that the transferee insurer will be able to take action that will
- 30 allow the direction, or directions, to be revoked.

31 Note: Refusals to approve transfers are reviewable under Part 6-9.

- 32 (4) The Private Health Insurance (Health Benefits Fund
- 33 Administration) Rules may provide for the following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (a) criteria for approving or refusing to approve applications
2 under subsection (3);
3 (b) requirements to notify interested persons of the outcomes of
4 such applications;
5 (c) matters connected with how restructures take place, including
6 the following:
7 (i) insurance policies becoming *referable to a *health
8 benefits fund or funds of the transferee insurer;
9 (ii) *policy liabilities and other liabilities becoming
10 referable to such a fund or funds;
11 (iii) *assets of a transferring fund becoming assets of such a
12 fund or funds;
13 (iv) the timing of restructures;
14 (v) if any such fund is a proposed new health benefits
15 fund—the establishment of that fund;
16 (d) requirements for private health insurers to give the Council
17 information following transfers.
- 18 (5) The transferee insurer must, within 28 days after the transfer takes
19 place, notify the Council of the transfer. The notice must comply
20 with any requirements specified in the Private Health Insurance
21 (Health Benefits Fund Administration) Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 149—Termination of health benefits funds**

3 **Subdivision 149-A—Approving the termination of health**
4 **benefits funds**

5 **149-1 Applying for termination**

6 A private health insurer may apply to the Council, in the *approved
7 form, for approval of the termination of each of its *health benefits
8 funds.

9 **149-5 Requesting further information**

10 The Council may, within 28 days after the application is made,
11 give the applicant written notice requiring the applicant to give the
12 Council such further information relating to the application as is
13 specified in the notice.

14 **149-10 Deciding the application**

- 15 (1) The Council must approve the termination if it is satisfied that:
16 (a) the insurer is not in the process of being wound up; and
17 (b) each of its *health benefits funds meets the *solvency
18 standard; and
19 (c) in relation to each of the funds, termination of the fund will
20 not result in unfairness to the *policy holders of the fund,
21 when those policy holders are viewed as a group;
22 and is satisfied as to such other matters are specified in the Private
23 Health Insurance (Health Benefits Fund Policy) Rules.
- 24 (2) If the Council grants the application, the Council:
25 (a) may appoint a person other than the applicant as the
26 *terminating manager of the funds; and
27 (b) must notify the insurer in writing:
28 (i) that it approves the termination; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (ii) if paragraph (a) applies—of the appointment of the
2 terminating manager.

3 (3) If the Council refuses the application, the Council must notify the
4 insurer in writing of the refusal.

5 Note: Refusals to approve terminations are reviewable under Part 6-9.

6 **149-15 Council can be taken to refuse application**

7 The Council is taken, for the purposes of Part 6-9, to have refused
8 the application if the Council does not notify the applicant of its
9 decision on the application:

- 10 (a) within 90 days after the application was made; or
11 (b) if the Council had given the applicant a notice under
12 section 149-5 requiring the applicant to give further
13 information relating to the application—within 90 days after
14 the applicant gives that information to the Council;
15 whichever is later.

16 **Subdivision 149-B—Conducting the termination of health**
17 **benefits funds**

18 **149-20 Conduct of funds during termination process**

- 19 (1) A private health insurer must not, after being notified under
20 subsection 149-10(2) that termination of its *health benefits funds
21 has been approved:
- 22 (a) enter into an insurance policy that is *referable to any of its
23 funds with a person who is not already a *holder of such a
24 policy; or
25 (b) if the insurer is *registered as a for profit insurer—apply the
26 *assets of any of the funds except in accordance with
27 subsection 137-10(2) (unless this paragraph has ceased to
28 apply to the insurer because of section 149-45); or
29 (c) if the insurer is not registered as a for profit insurer—become
30 registered as a for profit insurer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 149-25

- 1 (2) The insurer must, within 60 days after being notified under
2 subsection 149-10(2) that termination of its *health benefits funds
3 has been approved:
- 4 (a) give a written notice, stating the day (the *termination day*)
5 from which it will not renew insurance policies that are
6 *referable to any of its funds, to:
- 7 (i) each *policy holder of any of its funds; and
8 (ii) the Council; and
- 9 (b) notify the termination day in a national newspaper, or in a
10 newspaper circulating in each jurisdiction where the insurer
11 has its registered office or carries on business.
- 12 The termination day must not be earlier than 90 days after the
13 insurer finishes giving notices under this subsection.
- 14 (3) The insurer must not, on or after the *termination day, renew any
15 insurance policies that are *referable to any of those funds.
- 16 (4) The insurer must accept any valid claim for benefits under an
17 insurance policy that is or was *referable to any of those funds if
18 the claim is made before the end of the period of 12 months
19 following the expiry of the last policy that was referable to any of
20 those funds.

21 **149-25 Insurers etc. to give reports to Council**

- 22 If the Council has approved the termination of the *health benefits
23 funds of a private health insurer:
- 24 (a) the insurer; or
25 (b) if a *terminating manager of the funds has been appointed—
26 the terminating manager;
- 27 must, within 28 days after the end of the *termination day, make a
28 written report to the Council setting out details of the *assets and
29 liabilities of each of the funds as at that day.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **149-30 Terminating managers displace management of funds**

2 If a *terminating manager of the *health benefits funds of a private
3 health insurer has been appointed, then, for so long as the
4 appointment is in force and until the termination is completed:

5 (a) the management of the fund vests in the terminating
6 manager; and

7 (b) any *officer of the *responsible insurer for the fund who was
8 vested with the management of the fund immediately before
9 the appointment is, by force of this section, divested of that
10 management.

11 **Subdivision 149-C—Ending the termination of health benefits**
12 **funds**

13 **149-35 Power to end termination**

14 (1) At any time during the termination of the *health benefits funds of
15 a private health insurer, the Federal Court may, on application,
16 make an order ending the termination on a day specified in the
17 order.

18 (2) An application may be made by:

19 (a) the Council; or

20 (b) the *terminating manager.

21 (3) On such an application, the Federal Court may, before making an
22 order, direct the *terminating manager to give a report with respect
23 to a relevant fact or matter.

24 (4) If the Federal Court has made an order ending the termination, the
25 Court may give such directions as it thinks fit for the resumption of
26 the management and control of the *health benefits funds of the
27 private health insurer by its *officers.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **Subdivision 149-D—Completing the termination of health**
2 **benefits funds**

3 **149-40 Completion of the termination process**

4 The termination of the *health benefits funds of a private health
5 insurer is completed if:

- 6 (a) the period of 12 months referred to in subsection 149-20(4)
7 has come to an end; and
8 (b) so far as possible having regard to the extent of the *assets of
9 the funds:
10 (i) the liabilities of the funds to the *policy holders of the
11 funds have been discharged; and
12 (ii) any amounts of *collapsed insurer levy that the Council
13 has paid, for the purposes of any of the funds, to the
14 insurer or to the person appointed to administer the
15 termination of the funds have been repaid to the
16 Council; and
17 (iii) any other liabilities of the funds have been discharged.

18 **149-45 Distribution of remaining assets after completion of the**
19 **termination process**

20 If the termination of the funds is completed and, on the completion,
21 there are *assets of those funds, then:

- 22 (a) if the insurer is *registered as a for profit insurer—paragraph
23 149-20(1)(b) ceases to apply to the insurer; or
24 (b) if the insurer is not registered as a for profit insurer—the
25 insurer is liable to pay to the Council an amount equal to the
26 amount of those assets.

27 **149-50 Liability of officers of insurers for loss to terminated funds**

- 28 (1) If:
29 (a) a private health insurer contravenes this Act in relation to a
30 *health benefits fund that it conducts; and
31 (b) the contravention results in a loss to the fund; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) the termination of the fund is completed;
2 the persons who were *officers of the insurer when the
3 contravention occurred are jointly and severally liable to pay to the
4 Council, for payment to the *Risk Equalisation Trust Fund, an
5 amount equal to the amount of the loss.
- 6 (2) A person is not liable under subsection (1) if the person proves that
7 he or she used due diligence to prevent the occurrence of such a
8 contravention.
- 9 (3) On application by the Council, the Federal Court may order any
10 person liable under subsection (1) to pay to the Council, for
11 payment to the *Risk Equalisation Trust Fund, the whole or any
12 part of the loss.

13 **149-55 Report of terminating manager**

- 14 (1) As soon as practicable after the termination of the *health benefits
15 funds of a private health insurer is completed, the *terminating
16 manager must make a written report to the Council on the
17 termination of the funds.
- 18 (2) If, in the *terminating manager's opinion, the private health insurer
19 is not carrying on any business after the termination of the funds,
20 the report may include a recommendation that an application be
21 made under section 149-60 for the winding up of the insurer.

22 **149-60 Applying for winding up**

- 23 (1) If:
- 24 (a) the termination of the *health benefits funds of a private
25 health insurer is completed; and
- 26 (b) the *terminating manager's report under section 149-55
27 includes a recommendation that an application be made
28 under this section for the winding up of the insurer; and
- 29 (c) the insurer is not carrying on any business after the
30 termination of the funds;
- 31 the Council, or the terminating manager, may apply to the Federal
32 Court for an order that a private health insurer be wound up.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers

Part 4-4 Health benefits funds

Division 149 Termination of health benefits funds

Section 149-60

- 1 (2) However, the *terminating manager must not apply unless directed
2 by the Council to apply.
- 3 (3) The winding up of the insurer is to be conducted in accordance
4 with the *Corporations Act 2001*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 152—Duties and liabilities of directors etc.**

3 **152-1 Duty and liability of directors in relation to health benefits**
4 **funds**

- 5 (1) A *director of a private health insurer has a duty to the *policy
6 holders of a *health benefits fund conducted by the insurer.
- 7 (2) The *director's duty is a duty to take reasonable care, and use due
8 diligence to see, that in the investment, administration and
9 management of the *assets of the fund, the insurer complies with
10 this Part.
- 11 (3) The *director is not guilty of a breach of the duty imposed by
12 subsection (1) if the director has taken reasonable steps to ensure
13 that systems are in place to ensure that the insurer complies with
14 this Part.
- 15 (4) If:
- 16 (a) in respect of any act or omission of a private health insurer, a
17 *director of the insurer is guilty of a breach of the duty
18 imposed by subsection (1); and
- 19 (b) the act or omission of the insurer results in a loss to a *health
20 benefits fund conducted by the insurer;
21 the director is liable to pay the insurer an amount equal to the
22 amount of the loss.
- 23 (5) If 2 or more persons are liable under subsection (4) in relation to
24 the same act or omission, their liability is joint and several.
- 25 (6) An action to recover an amount for which a *director is liable
26 under subsection (4) may be brought:
- 27 (a) by the insurer; or
28 (b) with the written approval of the Council, by a *policy holder
29 of the *health benefits fund involved.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 152-5

- 1 (7) An approval under subsection (6) may be given subject to
2 conditions relating to the persons, or the number of persons, who
3 may join in the action as plaintiffs.
- 4 (8) Nothing in this section affects duties imposed on a *director under
5 the *Corporations Act 2001*.

6 **152-5 Notices to remedy contraventions**

- 7 (1) If a private health insurer has contravened this Part, the Council
8 may give the insurer a written notice requiring the insurer, within a
9 specified period, to take such action as is specified in the notice to
10 remedy the contravention.
- 11 (2) The period specified in the notice must be a period ending not
12 earlier than one month after the giving of the notice.
- 13 (3) The action to be specified in the notice is such action as the
14 Council thinks appropriate and reasonable to overcome the effects
15 of the contravention.
- 16 (4) At any time before the end of the period specified in the notice, the
17 Council may extend the period by such further period as the
18 Council thinks fit.
- 19 (5) The insurer must comply with the notice.

20 **152-10 Liability of directors in relation to non-compliance with**
21 **notices**

- 22 (1) If:
23 (a) the Council has given a notice to a private health insurer
24 under section 152-5 in respect of a contravention of this Part;
25 and
26 (b) the contravention has resulted in a loss to a *health benefits
27 fund; and
28 (c) the insurer has failed to comply with the notice within the
29 period specified in it or within that period as extended under
30 subsection 152-5(4);

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 the persons who were the *directors of the insurer when the
2 contravention occurred are jointly and severally liable to pay the
3 insurer an amount equal to the amount of the loss.
- 4 (2) A person is not liable under subsection (1) if the person proves that
5 he or she used due diligence to ensure that the insurer complied
6 with the notice.
- 7 (3) An action to recover an amount for which a person is liable under
8 subsection (1) may be brought:
9 (a) by the insurer; or
10 (b) with the written approval of the Council, by a *policy holder
11 of the *health benefits fund involved.
- 12 (4) An approval under subsection (3) may be given subject to
13 conditions relating to the persons, or the number of persons, who
14 may join in the action as plaintiffs.

15 **152-15 Council may sue in the name of private health insurers**

16 If the Council thinks that it is in the interests of the *policy holders
17 of a *health benefits fund to do so, the Council may bring an action
18 against a person in the name, and for the benefit, of a private health
19 insurer for the recovery of an amount that the insurer is entitled to
20 recover under this Division.

21 **152-20 Directors cannot be liable twice for the same act etc.**

22 A person cannot be made liable both under section 152-1 and
23 under section 152-10 in respect of the same act or omission of a
24 private health insurer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Part 4-5—Other obligations of private health insurers

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Division 157—Introduction

5

157-1 What this Part is about

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In addition to the obligations about health benefits funds, private health insurers have several other obligations relating to the conduct of their businesses. These include the following:

9

(a) having appointed actuaries;

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(b) complying with prudential standards;

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(c) exclusion of disqualified persons from management;

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(d) reporting and notification obligations.

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157-5 The Private Health Insurance (Insurer Obligations) Rules

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Obligations of private health insurers are also dealt with in the Private Health Insurance (Insurer Obligations) Rules and the Private Health Insurance (Data Provision) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

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Note: The Private Health Insurance (Insurer Obligations) Rules are made by the Council under section 333-25. The Private Health Insurance (Data Provision) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 160—Appointed actuaries**

3 **160-1 Appointment**

- 4 (1) Subject to subsection (2), a private health insurer must have an
5 actuary appointed by the insurer.
- 6 (2) Within 6 weeks after a person ceases to be the *appointed actuary
7 of a private health insurer, the insurer must appoint another person
8 to be the insurer's actuary.
- 9 (3) A person must not hold an appointment as actuary of a private
10 health insurer unless the person is eligible for such an appointment.
- 11 (4) A private health insurer may, in writing, ask the Council to
12 approve the appointment of a specified person as the insurer's
13 actuary.
- 14 (5) The Council may, in writing, approve the appointment of a person
15 as actuary of a private health insurer if the Council is satisfied that
16 the person has actuarial qualifications and experience that fit him
17 or her to perform the functions of the insurer's *appointed actuary.
- 18 Note: Refusals to give approval are reviewable under Part 6-9.
- 19 (6) An appointment of a person as actuary of a private health insurer
20 cannot take effect while there is in force an appointment of another
21 person as the insurer's actuary.

22 **160-5 Eligibility for appointment**

- 23 (1) A person is eligible for appointment as a private health insurer's
24 actuary if the person meets the eligibility requirements specified in
25 the Private Health Insurance (Insurer Obligations) Rules.
- 26 (2) However, a person who, apart from this subsection, would be
27 eligible for appointment as a private health insurer's actuary is not
28 so eligible if there is in force a declaration by the Council in
29 accordance with the Private Health Insurance (Insurer Obligations)
30 Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **160-10 Notification of appointment etc.**

2 A private health insurer must give the Council written notice in
3 accordance with the Private Health Insurance (Insurer Obligations)
4 Rules if:

- 5 (a) the insurer appoints a person under section 160-1; or
6 (b) a person ceases to be the *appointed actuary of the insurer.

7 **160-15 Cessation of appointment**

8 A person ceases to hold an appointment as the actuary of a private
9 health insurer in the circumstances set out in the Private Health
10 Insurance (Insurer Obligations) Rules.

11 **160-20 Compliance with the Private Health Insurance (Insurer
12 Obligations) Rules**

13 The *appointed actuary of a private health insurer, in the
14 performance of his or her duties and the exercise of his or her
15 powers, must comply with the Private Health Insurance (Insurer
16 Obligations) Rules.

17 **160-25 Powers of appointed actuary**

- 18 (1) The *appointed actuary of a private health insurer is entitled to
19 have access to any information or document in the possession, or
20 under the control, of the insurer if the access is reasonably
21 necessary for the proper performance of the actuary's functions
22 and duties.
- 23 (2) The *appointed actuary of a private health insurer may require any
24 *officer or employee of the insurer to answer questions or produce
25 documents for the purpose of enabling the actuary to have the
26 access to information and documents provided for by
27 subsection (1).
- 28 (3) A private health insurer commits an offence if the insurer refuses
29 or fails to allow access to information or a document under
30 subsection (1).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 Penalty: 30 penalty units.

2 (4) An *officer or employee of a private health insurer commits an
3 offence if he or she refuses or fails to comply with a requirement
4 under subsection (2).

5 Penalty: 30 penalty units.

6 (5) The *appointed actuary of a private health insurer is entitled to
7 attend a meeting of the *directors of the insurer and to speak on any
8 matter being considered at the meeting:

9 (a) that relates to, or may affect:

10 (i) the solvency of a *health benefits fund conducted by the
11 insurer; or

12 (ii) the adequacy of the capital of a health benefits fund
13 conducted by the insurer; or

14 (b) that relates to advice given by the actuary to the directors; or

15 (c) that concerns a matter in relation to which the actuary will be
16 required to give advice.

17 (6) The *appointed actuary of a private health insurer is entitled to
18 attend:

19 (a) any annual general meeting of members of the insurer; and

20 (b) any other meeting of members of the insurer at which:

21 (i) the insurer's annual accounts or financial statements are
22 to be considered; or

23 (ii) any matter in connection with which the actuary is or
24 has been subject to a duty under this Act is to be
25 considered.

26 **160-30 Actuary's obligations to report**

27 (1) The *appointed actuary of a private health insurer must draw to the
28 attention of the insurer, or of the *directors or an *officer of the
29 insurer, any matter that comes to the attention of the actuary and
30 that the actuary thinks requires action to be taken by the company
31 or its directors to avoid a contravention of this Act.

32 (2) If the *appointed actuary of a private health insurer thinks:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers
Part 4-5 Other obligations of private health insurers
Division 160 Appointed actuaries

Section 160-30

- 1 (a) that there are reasonable grounds for believing that the
2 insurer or a *director of the insurer may have contravened
3 this Act or any other law; and
4 (b) that the contravention is of such a nature that it may affect
5 significantly the interests of *policy holders of any *health
6 benefits funds conducted by the insurer;
7 the actuary must inform the Council in writing of his or her opinion
8 and of the information on which it is based.
- 9 (3) If:
- 10 (a) the *appointed actuary of a private health insurer has drawn
11 to the attention of the insurer, or of the *directors or an
12 *officer of the insurer, a matter that the actuary thinks
13 requires action to be taken by the insurer or its directors to
14 avoid a contravention of this Act; and
15 (b) the actuary is satisfied that there has been reasonable time for
16 the taking of the action but the action has not been taken;
17 the actuary must inform the Council in writing of the matter.
- 18 (4) If the *appointed actuary of a private health insurer thinks that:
- 19 (a) the *directors of the insurer have failed to take such action as
20 is reasonably necessary to enable the actuary to exercise his
21 or her right under subsection 160-25(5) or (6); or
22 (b) an *officer or employee of the insurer has engaged in conduct
23 calculated to prevent the actuary exercising his or her right
24 under subsection 160-25(5) or (6);
25 the actuary may inform the Council of his or her opinion and of the
26 information on which it is based.
- 27 (5) If:
- 28 (a) a person becomes subject to an obligation under
29 subsection (2) or (3) to inform the Council of anything; and
30 (b) before the person informs the Council, the person ceases to
31 be the *appointed actuary of the private health insurer
32 concerned;
33 the person remains subject to the obligation as if he or she were
34 still the appointed actuary of the insurer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **160-35 Qualified privilege of appointed actuary**

2 (1) A person who is, or has been, the *appointed actuary of a private
3 health insurer has qualified privilege in respect of any statement,
4 whether written or oral, made by him or her for the purpose of the
5 performance of his or her functions as appointed actuary of the
6 insurer.

7 (2) In particular (and without limiting subsection (1)), a person who is
8 or has been the *appointed actuary of a private health insurer has
9 qualified privilege in respect of:

10 (a) any statement, written or oral, made by him or her under, or
11 for the purposes of, a provision of this Act; and

12 (b) the answer to any question he or she is required by the
13 insurer to answer.

14 (3) The privilege conferred by this section is in addition to any
15 privilege conferred on a person by any other law.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Division 163—Prudential standards

3

163-1 Private Health Insurance (Insurer Obligations) Rules to establish prudential standards

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(1) The Private Health Insurance (Insurer Obligations) Rules may establish prudential standards relating to *prudential matters for private health insurers.

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(2) *Prudential matters* are matters relating to:

9

(a) the conduct by private health insurers of any of their affairs in such a way as:

10

11

(i) to keep themselves in a sound financial position; or

12

(ii) not to cause or promote instability in the Australian private health insurance system; or

13

14

(b) the conduct by private health insurers of any of their affairs with integrity, prudence and professional skill;

15

16

but does not include matters relating to the solvency or capital adequacy of *health benefits funds.

17

18

(3) A *prudential standard may impose different requirements to be complied with:

19

20

(a) by different classes of private health insurers; or

21

(b) in different situations; or

22

(c) in respect of different activities.

23

(4) A *prudential standard may provide for the Council to exercise powers and discretions under the standard, including but not limited to discretions to approve, impose, adjust or exclude specific prudential requirements in relation to a particular private health insurer or a particular class of private health insurers.

24

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(5) A *prudential standard takes effect on the day on which it is established in the Private Health Insurance (Insurer Obligations) Rules, or on such later day as is specified in the Private Health Insurance (Insurer Obligations) Rules.

29

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31

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **163-5 Compliance with prudential standards**

2 Every private health insurer must comply with the *prudential
3 standards as they apply in respect of that insurer.

4 **163-10 Notice of breaches of prudential standards etc.**

- 5 (1) A private health insurer commits an offence if:
6 (a) it becomes aware of:
7 (i) a breach by it of a *prudential standard; or
8 (ii) any other matter or occurrence that materially affects its
9 financial position; and
10 (b) it fails to notify the Council, as soon as practicable, in writing
11 of the breach or of the other matter or occurrence.

12 Penalty: 200 penalty units.

- 13 (2) If an individual:
14 (a) commits an offence against subsection (1) because of Part 2.4
15 of the *Criminal Code* (extensions of criminal responsibility);
16 or
17 (b) commits an offence under Part 2.4 of the *Criminal Code* in
18 relation to an offence against subsection (1);
19 he or she is punishable, on conviction, by a fine not exceeding 40
20 penalty units.
- 21 (3) A notification given to the Council of a matter referred to in
22 paragraph (1)(a) must not include *personal information relating to
23 a *policy holder of a *health benefits fund conducted by the insurer,
24 unless the information relates to *prudential matters relating to the
25 insurer.

26 **163-15 Directions to comply with standards**

- 27 (1) If the Council is satisfied that a private health insurer:
28 (a) has breached a *prudential standard; or
29 (b) is likely to breach a prudential standard in a way that is likely
30 to give rise to a prudential risk;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 163-20

1 the Council may (in writing) direct the insurer to comply with all
2 or a part of the standard, or to take specified action, within a
3 specified time.

4 Note: Decisions to give directions are reviewable under Part 6-9.

5 (2) The insurer must comply with the direction despite anything in its
6 constitution or in any contract or arrangement to which it is a party.

7 (3) The Council may revoke a direction that the Council considers is
8 no longer necessary or appropriate by giving written notice to the
9 insurer.

10 Note: Refusals to revoke directions are reviewable under Part 6-9.

11 **163-20 Failure to comply with directions**

12 (1) A private health insurer commits an offence if the insurer
13 contravenes a direction given to it under section 163-15.

14 Penalty: 300 penalty units.

15 (2) If an individual:

16 (a) commits an offence against subsection (1) because of Part 2.4
17 of the *Criminal Code* (extensions of criminal responsibility);
18 or

19 (b) commits an offence under Part 2.4 of the *Criminal Code* in
20 relation to an offence against subsection (1);

21 he or she is punishable, on conviction, by a fine not exceeding 60
22 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 166—Disqualified persons**

3 **166-1 Private health insurers not to allow disqualified persons to act**
4 **as directors**

5 (1) A private health insurer commits an offence if the insurer allows a
6 *disqualified person to be or to act as a *director or *senior
7 manager of the insurer.

8 Penalty: 250 penalty units.

9 (2) Subsection (1) does not apply if the insurer:

10 (a) contacted the Council within a reasonable period before
11 allowing the person to be to or act as a *director or *senior
12 manager, as the case may be; and

13 (b) was advised by the Council that the person was not a
14 *disqualified person.

15 Note: A defendant bears an evidential burden in relation to the matters in
16 this subsection. See subsection 13.3(3) of the *Criminal Code*.

17 **166-5 Disqualified persons must not act for private health insurers**

18 A *disqualified person commits an offence if he or she is, or acts
19 as, a *director or *senior manager of a private health insurer.

20 Penalty: 120 penalty units or imprisonment for 2 years, or both.

21 **166-10 Effect of non-compliance**

22 A failure to comply with section 166-1 or 166-5 does not affect the
23 validity of an appointment or transaction.

24 **166-15 Who is a *disqualified person*?**

25 (1) A person is a *disqualified person* if, at any time:

26 (a) the person has been convicted of an offence against or arising
27 out of:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 166-20

- 1 (i) this Act; or
2 (ii) the *Corporations Act 2001*, the Corporations Law that
3 was previously in force, or any law of a foreign country
4 that corresponds to that Act or to that Corporations
5 Law; or
6 (b) the person has been convicted of an offence against or arising
7 out of a law in force in Australia, or the law of a foreign
8 country, if the offence concerns dishonest conduct or conduct
9 relating to a financial sector company (within the meaning of
10 the *Financial Sector (Shareholdings) Act 1998*); or
11 (c) the person has been or becomes bankrupt; or
12 (d) the person has applied to take the benefit of a law for the
13 relief of bankrupt or insolvent debtors; or
14 (e) the person has compounded with his or her creditors; or
15 (f) the Council has disqualified the person under section 166-20.

16 Note: The Council may determine that a person is not a disqualified person
17 (see section 166-25).

- 18 (2) A reference in subsection (1) to a person who has been convicted
19 of an offence includes a reference to a person in respect of whom
20 an order has been made relating to the offence under:
21 (a) section 19B of the *Crimes Act 1914*; or
22 (b) a corresponding provision of a law of a State, a Territory or a
23 foreign country.
24 (3) Nothing in this section affects the operation of Part VIIC of the
25 *Crimes Act 1914* (which includes provisions that, in certain
26 circumstances, relieve persons from the requirement to disclose
27 spent convictions and require persons aware of such convictions to
28 disregard them).

29 **166-20 Council may disqualify persons**

- 30 (1) The Council may disqualify a person if it is satisfied that the
31 person is not a fit and proper person to be or to act as a *director or
32 *senior manager of a private health insurer.

33 Note: Disqualifications are reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) A disqualification takes effect on the day on which it is made.
- 2 (3) The Council may revoke a disqualification on application by the
3 *disqualified person or on its own initiative. A revocation takes
4 effect on the day on which it is made.
- 5 Note: Refusals to revoke disqualifications are reviewable under Part 6-9.
- 6 (4) The Council must give the person written notice of a
7 disqualification, revocation of a disqualification or a refusal to
8 revoke a disqualification.
- 9 (5) As soon as practicable after a notice is given to a person under
10 subsection (4), the Council must cause particulars of the
11 disqualification, revocation or refusal to which the notice relates:
12 (a) if the person is, or is acting as, a *director or *senior manager
13 of a private health insurer—to be given to the insurer; and
14 (b) to be published in the *Gazette*.

15 **166-25 Council may determine that persons are not disqualified**

- 16 (1) Despite section 166-15, the Council may determine (in writing)
17 that a person is not a *disqualified person. The Council may do so
18 on its own initiative or on the application of the person.
- 19 (2) However, the Council must not make the determination unless it is
20 satisfied that the person is highly unlikely to be a prudential risk to
21 any private health insurer.
- 22 (3) If a person applies for a determination under this section, the
23 Council must:
24 (a) either make, or refuse to make, the determination; and
25 (b) in the case of a refusal, give the person written notice of the
26 refusal.
- 27 Note: Refusals to make determinations are reviewable under Part 6-9.
- 28 (4) The Council may do any of the following:
29 (a) when making a determination under subsection (1), specify in
30 the determination conditions to which the determination is to
31 be subject;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4 Private health insurers
Part 4-5 Other obligations of private health insurers
Division 166 Disqualified persons

Section 166-25

- 1 (b) at any later time while a determination under subsection (1)
2 is in force, make a further determination specifying
3 conditions or additional conditions to which the
4 determination under subsection (1) is to be subject;
5 (c) at any time make a determination varying or revoking
6 conditions that have been specified under paragraph (a) or
7 (b).

8 Note: Decisions to specify, or to vary, conditions are reviewable under
9 Part 6-9.

10 (5) A determination takes effect on the day on which it is made.

11 (6) The Council must, as soon as practicable after a determination is
12 made, give written notice of the making of the determination, and a
13 copy of the determination, to the person concerned and to any
14 affected private health insurer.

15 (7) A notice of a refusal to make a determination, or a notice of the
16 making of a determination that specifies or varies conditions, must
17 state the reasons for the refusal or for the specifying or variation of
18 the conditions, as the case may be.

19 (8) The Council may revoke a determination under this section by
20 giving written notice to the person concerned and must give a copy
21 of the notice to any affected private health insurer.

22 Note: Revocations of determinations are reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 169—Reporting and notification requirements**

3 **169-1 Copies of reports to policy holders**

4 A private health insurer that makes any report to all or any of the
5 *policy holders of a *health benefits fund conducted by the insurer
6 must, if the Private Health Insurance (Insurer Obligations) Rules so
7 require, give a copy of the report to the Council:

- 8 (a) within one month after making the report; or
9 (b) within such further time as the Council allows.

10 **169-5 Information to be given to the Council annually**

11 (1) A private health insurer must, within 3 months after the end of
12 each financial year, or within such further time as the Council
13 allows, give to the Council:

14 (a) such financial accounts and statements in respect of that year
15 as the Council requires to be given for use in preparing the
16 report referred to in section 264-15; and

17 (b) such other statements in respect of that year as are required
18 by the Private Health Insurance (Insurer Obligations) Rules.

19 (2) The report must be certified on behalf of the insurer, in accordance
20 with the Private Health Insurance (Insurer Obligations) Rules, to be
21 true and correct.

22 (3) A private health insurer commits an offence if the insurer fails to
23 comply with this section.

24 Penalty: 30 penalty units.

25 (4) Strict liability applies to subsection (3).

26 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **169-10 Private health insurers to notify any changes to rules**

- 2 (1) A private health insurer that proposes to change its *rules (other
3 than a change to which section 66-10 applies) must notify the
4 Secretary of the Department of the proposed change:
5 (a) in the *approved form; and
6 (b) before the day on which the insurer proposes the change to
7 take effect.

8 Note: See section 93-25 for a private health insurer's obligation to notify
9 insured persons of changes to its rules.

- 10 (2) The Minister may, in writing, direct the insurer not to make the
11 change if the Minister is satisfied that the change might or would
12 result in a breach of the Act.

13 Note: Directions are reviewable under Part 6-9.

- 14 (3) The Minister must give the Secretary and the Council a copy of a
15 direction under subsection (2).

16 **169-15 Private health insurers to notify Department and Council**
17 **about current chief executive officer**

- 18 (1) An applicant for registration under Division 126 must, before
19 starting to operate its *health insurance business, notify the name
20 and contact details of its *chief executive officer to the Secretary of
21 the Department, and to the Council, in the *approved form.
- 22 (2) A private health insurer must ensure that, if the name or contact
23 details of its *chief executive officer change, the change is notified,
24 before the change takes effect, to the Secretary of the Department,
25 and to the Council, in the *approved form.
- 26 (3) A private health insurer commits an offence if:
27 (a) the insurer is required under subsection (2) to ensure that a
28 particular thing happens; and
29 (b) the thing does not happen.

30 Penalty: 60 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (4) Strict liability applies to subsection (3).

2 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 172—Miscellaneous**

3 **172-1 Private health insurers to comply with Council’s requirements**

4 A private health insurer must comply, within a reasonable time,
5 with such requirements as the Council, in the performance of its
6 functions, imposes on the insurer.

7 **172-5 Agreements with medical practitioners**

8 If a private health insurer enters into an agreement with a *medical
9 practitioner for the provision of treatment to persons insured by the
10 insurer, the agreement must not limit the medical practitioner’s
11 professional freedom, within the scope of accepted clinical
12 practice, to identify and provide appropriate treatments.

13 **172-10 Private health insurers to give information to Secretary**

14 (1) The Private Health Insurance (Data Provision) Rules may specify
15 kinds of information, relating to treatment of *policy holders of
16 *health benefits funds, that private health insurers are to give to the
17 Secretary of the Department.

18 (2) A private health insurer must, in accordance with the Private
19 Health Insurance (Data Provision) Rules, give to the Secretary of
20 the Department any information of that kind that the insurer
21 receives from a *hospital.

22 **172-15 Restrictions on payment of pecuniary penalties etc.**

23 A private health insurer must not:

- 24 (a) use its money, or permit the use of its money, for:
- 25 (i) the payment of a pecuniary penalty imposed on a
26 *director or *officer of the insurer because of an offence
27 under this Act; or
- 28 (ii) the payment of an amount that a director or officer of
29 the insurer, or a person who has been such a director or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 officer, is liable to pay under Division 149, 152, 203 or
2 293; or
3 (b) reimburse:
4 (i) a director or officer of the insurer in respect of a
5 pecuniary penalty imposed on the director or officer
6 because of an offence under this Act; or
7 (ii) a director or officer of the insurer, or a person who has
8 been such a director or officer, in respect of a liability
9 imposed on the director under Division 149, 152, 203 or
10 293.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Chapter 5—Enforcement**

3 **Part 5-1—Introduction**

4 **Division 180—Introduction**

5 **180-1 What this Chapter is about**

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Private health insurers who do not comply with this Act may have action taken against them under this Chapter. Both the Minister and the Council have powers under this Chapter.

9
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Note: The methods set out in this Chapter are not the only enforcement methods available (see for example Division 84).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 5-2—General enforcement methods**

3 **Division 185—What this Part is about**

4 **185-1 Introduction**

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This Part gives the Minister and the Council powers that enable them to find out whether a private health insurer is complying with its enforceable obligations or (in the case of the Council) its Council-supervised obligations, and to encourage or compel an insurer to comply with those obligations.

10

The Minister can:

11

(a) set performance indicators for insurers;

12

(b) seek explanations from insurers;

13

(c) investigate insurers;

14

(d) obtain enforceable undertakings from insurers;

15

(e) direct insurers to do particular things;

16

(f) seek remedies in the Federal Court;

17

(g) revoke an insurer's entitlement to offer tax rebates as premium reductions.

18

19

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21

The Council can also do these things (except those mentioned in paragraphs (a) and (g)), as well as take action under Part 5-3 in relation to an insurer's health benefits fund.

22 **185-5 Meaning of *enforceable obligation***

23

All of the following provisions are *enforceable obligations*:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 185-10

- 1 (a) a provision of this Act;
2 (b) a provision of any Private Health Insurance Rules made
3 under section 333-20 or 333-25;
4 (c) a provision of the regulations;
5 (d) a direction given to a private health insurer under this Act;
6 (e) if the insurer is a *restricted access insurer—a provision
7 included in the insurer’s constitution in order to comply with
8 subsection 126-20(6).

9 **185-10 Meaning of *Council-supervised obligation***

- 10 All of the following *enforceable obligations are
11 ***Council-supervised obligations***, to the extent to which they relate
12 to risk equalisation, *health benefits funds or Division 163
13 (*prudential standards):
14 (a) a provision of this Act;
15 (b) a provision of any Private Health Insurance Rules made
16 under section 333-20 or 333-25;
17 (c) a provision of the regulations;
18 (d) a direction given to a private health insurer under this Act.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 188—Performance indicators**

3 **188-1 Performance indicators**

- 4 (1) The Private Health Insurance (Complying Product) Rules may set
5 out performance indicators to be used by the Minister in
6 monitoring private health insurers' compliance with the principle
7 of community rating in section 55-5 and the community rating
8 requirements in Division 66.
- 9 (2) The performance indicators are to be framed:
- 10 (a) to assist the Minister in detecting breaches of the principle of
11 community rating in section 55-5 or the community rating
12 requirements in Division 66; and
- 13 (b) to alert the Minister to any practices of a private health
14 insurer in relation to community rating that may require
15 investigation; and
- 16 (c) to alert the Minister to any practices of one or more private
17 health insurers in relation to community rating that may be
18 contrary to government health policy and may require a
19 regulatory response.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Division 191—Explanation of private health insurer's operations

3

4

191-1 Minister or Council may seek an explanation from a private health insurer

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6

(1) If:

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(a) the Minister believes that, having regard to information available to the Minister or to any performance indicators under the Private Health Insurance (Complying Product) Rules, a private health insurer may have contravened an *enforceable obligation; or

8

9

10

11

12

(b) the Council believes that, having regard to information available to the Council, a private health insurer may have contravened a *Council-supervised obligation;

13

14

15

the Minister (if paragraph (a) applies) or the Council (if paragraph (b) applies) may write to the private health insurer:

16

17

(c) explaining the writer's concerns; and

18

(d) asking the insurer to explain its operations in relation to those concerns; and

19

20

(e) specifying the period within which the writer requires the insurer's response.

21

22

(2) The private health insurer must respond within the specified period, or any longer period that the writer, in writing before the end of the specified period, allows.

23

24

25

(3) If the writer refuses a request by the private health insurer for a longer period to respond, the writer must state the writer's reasons for refusing.

26

27

28

Note: Refusals of requests for longer periods to respond are reviewable under Part 6-9.

29

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **191-5 Writer must respond to insurer's explanation**

2 The writer under subsection 191-1(1) must, after receiving an
3 explanation from a private health insurer in response, inform the
4 insurer in writing:

- 5 (a) whether the writer is or is not satisfied with the explanation;
6 and
7 (b) if the writer is not satisfied with the explanation—what steps
8 the writer intends to take.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Division 194—Investigation of private health insurer's operations

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194-1 Minister or Council may investigate a private health insurer

5

(1) The Minister may, at any time and for any reason, begin an investigation of the operations of a private health insurer by doing either or both of the following:

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7

8

(a) giving a notice under any one or more sections of this Division;

9

10

(b) authorising a person under section 194-25.

11

(2) The Council may, at any time, if for any reason it considers that a private health insurer might have contravened a *Council-supervised obligation or it otherwise has concerns about the insurer's compliance with a Council-supervised obligation, begin an investigation of the operations of a private health insurer by doing either or both of the following:

12

13

14

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16

17

(a) giving a notice under any one or more sections of this Division;

18

19

(b) authorising a person under section 194-25.

20

194-5 Notice to give information

21

(1) The Minister, or, if subsection 194-1(2) applies, the Council, may give a written notice to a person who is or who has been an *officer, employee or agent of:

22

23

24

(a) a private health insurer; or

25

26

(b) an entity that was a private health insurer at any time in the year ending on the day on which the notice is given;

27

requiring the person to give the notice-giver or the person specified in the notice, within the period specified in the notice, information about the area of the insurer's operations specified in the notice.

28

29

30

(2) The notice-giver may require the person to give the information orally or in writing.

31

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (3) The notice-giver may require the person to give the information on
2 oath or affirmation. For that purpose, the notice-giver or the person
3 specified in the notice may administer an oath or affirmation.
- 4 (4) The person is not excused from giving information on the ground
5 that giving the information might tend to incriminate the person or
6 make the person liable to a penalty. However, the information, or
7 anything obtained as a direct or indirect consequence of the
8 information, is not admissible in evidence against the person in any
9 proceedings, other than proceedings for an offence against
10 section 137.1 or 137.2 of the *Criminal Code*.

11 **194-10 Notice to produce documents**

- 12 (1) The Minister, or, if subsection 194-1(2) applies, the Council, may
13 give a written notice to a person who is or who has been an
14 *officer, employee or agent of:
15 (a) a private health insurer; or
16 (b) an entity that was a private health insurer at any time in the
17 year ending on the day on which the notice is given;
18 requiring the person to produce, at the time and place specified in
19 the notice, records, books, accounts and other documents of the
20 insurer that are in the person's custody or under the person's
21 control and that relate to the area of the insurer's operations
22 specified in the notice.
- 23 (2) The person is not excused from producing a document on the
24 ground that the production of the document might tend to
25 incriminate the person or make the person liable to a penalty.
26 However, the production of the document, or anything obtained as
27 a direct or indirect consequence of the production, is not
28 admissible in evidence against the person in any proceedings, other
29 than proceedings for an offence against section 137.1 or 137.2 of
30 the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **194-15 Notice to give evidence**

- 2 (1) The Minister, or, if subsection 194-1(2) applies, the Council, may
3 give a written notice to a person who is or who has been an
4 *officer, employee or agent of:
5 (a) a private health insurer; or
6 (b) an entity that was a private health insurer at any time in the
7 year ending on the day on which the notice is given;
8 requiring the person to attend, at the time and place specified in the
9 notice, before the notice-giver or the person specified in the notice
10 and give evidence relating to an area of the insurer's operations
11 specified in the notice.
- 12 (2) The notice-giver may require the person to give the evidence orally
13 or in writing.
- 14 (3) The notice-giver may require the person to give the evidence on
15 oath or affirmation. For that purpose, the notice-giver or the person
16 specified in the notice may administer an oath or affirmation.
- 17 (4) The person is not excused from answering a question on the
18 ground that the answer to the question might tend to incriminate
19 the person or make the person liable to a penalty. However, the
20 answer, or anything obtained as a direct or indirect consequence of
21 the answer, is not admissible in evidence against the person in any
22 proceedings, other than proceedings for an offence against
23 section 137.1 or 137.2 of the *Criminal Code*.

24 **194-20 Offences in relation to investigation notices**

- 25 (1) A person must not fail to comply with a requirement contained in a
26 notice given to the person:
27 (a) under section 194-5 (notice to give information); or
28 (b) under section 194-10 (notice to produce documents); or
29 (c) under section 194-15 (notice to give evidence).

30 Penalty: 10 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) A person must not fail to be sworn or to make an affirmation when
2 required to do so:
3 (a) under section 194-5 (notice to give information); or
4 (b) under section 194-15 (notice to give evidence).

5 Penalty: 10 penalty units.

- 6 (3) An offence under subsection (1) or (2) is an offence of strict
7 liability.

8 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

9 **194-25 Authorisation to examine books and records etc.**

- 10 (1) The Minister, or, if subsection 194-1(2) applies, the Council, may,
11 in writing, authorise a person to examine and report on the records,
12 books, accounts and other documents of:
13 (a) a private health insurer; or
14 (b) an entity that was a private health insurer at any time in the
15 year ending on the day on which the authorisation is given.
- 16 (2) A person authorised under subsection (1) must, at all reasonable
17 times, have full and free access to any *premises at which the
18 records, books, accounts and other documents are kept and may
19 take extracts from, or copies of, the records, books, accounts and
20 other documents.

21 **194-30 Minister may consult Council**

- 22 If, in the course of an investigation conducted by the Minister, the
23 Minister believes that there are issues concerning a
24 *Council-supervised obligation, the Minister may:
25 (a) consult the Council on that matter; and
26 (b) if the Minister considers it appropriate—request the Council
27 to take over any part of the investigation that relates to those
28 issues.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **194-35 Minister or Council must notify outcome of investigation**

2 After completing an investigation under this Division of a private
3 health insurer or former private health insurer, the Minister or the
4 Council (whichever was the investigator) must inform the insurer
5 in writing:

- 6 (a) whether the investigator is or is not satisfied with the
7 performance of the insurer; and
8 (b) if the investigator is not satisfied with the performance of the
9 insurer—what steps the investigator intends to take.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 197—Enforceable undertakings**

3 **197-1 Minister or Council may accept written undertakings given by**
4 **a private health insurer**

- 5 (1) The Minister may accept a written undertaking, given by a private
6 health insurer at the Minister's request, if the Minister considers
7 that compliance with the undertaking will:
8 (a) be likely to improve the performance of the insurer; or
9 (b) if the Minister is satisfied that the insurer has contravened an
10 *enforceable obligation—be likely to ensure that the insurer
11 will cease to be in contravention of the enforceable
12 obligation.
- 13 (2) The Council may accept a written undertaking, given by a private
14 health insurer at the Council's request, if the Council considers that
15 compliance with the undertaking will be likely to improve the
16 insurer's operations in relation to its *Council-supervised
17 obligations.
- 18 (3) The private health insurer may withdraw or vary the undertaking at
19 any time with the consent of the acceptor of the undertaking.

20 **197-5 Enforcement of undertakings**

- 21 (1) If the acceptor of an undertaking under this Division considers that
22 a private health insurer that gave an undertaking under this
23 Division has contravened any of its terms, the acceptor may apply
24 to the Federal Court for an order under subsection (2).
- 25 (2) If the Federal Court is satisfied that the private health insurer has
26 contravened a term of the undertaking, the court may make one or
27 more of the following orders:
28 (a) an order directing the insurer to comply with the terms of the
29 undertaking;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement
Part 5-2 General enforcement methods
Division 197 Enforceable undertakings

Section 197-5

- 1 (b) if there is a contravention of an *enforceable obligation—any
2 other order of a kind set out in Division 203 that the court
3 considers appropriate.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 200—Ministerial and Council directions**

3 **200-1 Minister or Council may give directions**

4

(1) If, at any time and for any reason:

5

(a) the Minister considers that it will assist in the prevention of
*improper discrimination to do so; or

6

7

(b) the Council considers that it will assist in the prevention of
contraventions of *Council-supervised obligations to do so;

8

9

the Minister (if paragraph (a) applies) or Council (if paragraph (b)
applies) may give a direction to the insurer requiring it:

10

11

(c) to modify its day-to-day operations in a particular respect; or

12

(d) to modify its *rules in a particular respect; or

13

14

(e) if the insurer is a *restricted access insurer and the Minister
gives the direction—to modify the provisions included in its
constitution in order to comply with subsection 126-20(6) in
a particular respect.

15

16

17

Note: A decision to give a direction is reviewable under Part 6-9.

18

(2) If, at any time and for any reason:

19

(a) the Minister considers that there appears to be a
contravention of an *enforceable obligation involving
*improper discrimination by the private health insurer; or

20

21

22

(b) the Council considers that there appears to be a contravention
of a *Council-supervised obligation;

23

24

the Minister (if paragraph (a) applies) or Council (if paragraph (b)
applies) may give a direction to the insurer:

25

26

(c) requiring it to modify its day-to-day operations; or

27

(d) requiring it to modify its *rules; or

28

29

(e) if the insurer is a *restricted access insurer and the Minister
gives the direction—requiring it to modify the provisions
included in its constitution in order to comply with
subsection 126-20(6);

30

31

so as to address that contravention.

32

33

Note: A decision to give a direction is reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 200-5

- 1 (3) A direction mentioned in subsection (1) or (2) may, if the person
2 who gives the direction considers it proper to do so, include
3 requirements with respect to the reconsideration by the private
4 health insurer of an application or claim made to the insurer and
5 dealt with by it before the direction takes effect.
- 6 (4) A private health insurer must, in reconsidering an application or
7 claim in accordance with subsection (3), deal with the application
8 or claim as if the direction had been in force at the time when the
9 application or claim was first considered.
- 10 (5) A direction given under this section must be published:
11 (a) if given by the Minister—on the Department’s website; and
12 (b) if given by the Council—on the Council’s website;
13 not later than 5 working days after the direction is given.

14 **200-5 Direction requirements**

- 15 A direction given under this Division to a private health insurer:
16 (a) must be in writing; and
17 (b) must be signed by the person giving the direction; and
18 (c) may be served on the insurer by serving a copy on the
19 insurer’s *chief executive officer.

20 Note: Private health insurers must keep the Department and Council
21 informed about who the current chief executive officer is (see
22 section 169-15).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 203—Remedies in the Federal Court**

3 **203-1 Minister or Council may apply to the Federal Court**

4 (1) If the Minister is satisfied that a private health insurer has
5 contravened an *enforceable obligation, the Minister may apply to
6 the Federal Court for:

- 7 (a) a *declaration of contravention; and
8 (b) any one or more of the following orders:
9 (i) a pecuniary penalty order under section 203-10;
10 (ii) a compensation order under section 203-15;
11 (iii) an adverse publicity order under section 203-20;
12 (iv) any other order that the Minister considers to be
13 appropriate to redress the contravention.

14 (2) If the Council is satisfied that a private health insurer has
15 contravened a *Council-supervised obligation, the Council may
16 apply to the Federal Court for:

- 17 (a) a *declaration of contravention; and
18 (b) either or both of the following orders:
19 (i) a pecuniary penalty order under section 203-10;
20 (ii) any order that the Council considers to be appropriate to
21 redress the contravention, other than an order under
22 section 203-15 or 203-20.

23 **203-5 Declarations of contravention**

24 (1) If the Federal Court is satisfied that a private health insurer has
25 contravened an *enforceable obligation, it must make a declaration
26 of contravention.

- 27 (2) The declaration must specify:
28 (a) the *enforceable obligation that was contravened; and
29 (b) the private health insurer that contravened the provision; and
30 (c) the conduct that constituted the contravention; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 203-10

- 1 (d) if the court is satisfied that an *officer of the private health
2 insurer failed to take reasonable steps to prevent the insurer
3 contravening the enforceable obligation—the officer.
- 4 (3) A *declaration of contravention is conclusive evidence of the
5 matters mentioned in subsection (2).

6 **203-10 Pecuniary penalty order**

- 7 (1) If the Federal Court has made a *declaration of contravention
8 (whether on application by the Minister or the Council) that
9 specifies an *officer of a private health insurer (see paragraph
10 203-5(2)(d)), the court may order the officer to pay the
11 Commonwealth a pecuniary penalty of up to 1,000 penalty units.
- 12 (2) The court must not make an order under subsection (1) if it is
13 satisfied that a court has ordered the *officer to pay damages in the
14 nature of punitive damages in respect of:
15 (a) the contravention of the *enforceable obligation; or
16 (b) the officer's failure to take reasonable steps to prevent the
17 insurer contravening the enforceable obligation.
- 18 (3) The penalty is a civil debt payable to the Commonwealth. The
19 Commonwealth may enforce the order as if it were an order made
20 in civil proceedings against the *officer to recover a debt due by
21 the officer. The debt arising from the order is taken to be a
22 judgment debt.

23 **203-15 Compensation order**

- 24 (1) If the Federal Court has made a *declaration of contravention on
25 application by the Minister, the court may order the private health
26 insurer specified in the declaration to compensate an individual for
27 any injury or loss suffered by the individual as a result of the
28 contravention.
- 29 (2) The order must specify the amount of compensation.
- 30 (3) The order may be enforced as if it were a judgment of the court.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **203-20 Adverse publicity order**

2 (1) If the Federal Court has made a *declaration of contravention on
3 application by the Minister, the court may make an order requiring
4 the private health insurer specified in the declaration to do either or
5 both of the following:

6 (a) disclose in a way, and to the person or persons, specified in
7 the order, the information specified in the notice to correct or
8 counter the effect of the contravention;

9 (b) publish, in the way specified in the order, an advertisement to
10 correct or counter the effect of the contravention in the terms
11 specified in, or determined in accordance with, the order.

12 (2) The order may be enforced as if it were a judgment of the court.

13 **203-25 Other order**

14 (1) If the Federal Court has made a *declaration of contravention
15 (whether on application by the Minister or the Council), the court
16 may make any order that the applicant applies for.

17 (2) The order may be enforced as if it were a judgment of the court.

18 **203-30 Time limit for declarations and orders**

19 Proceedings under this Division may be started no later than 6
20 years after the contravention.

21 **203-35 Civil evidence and procedure rules for declarations and**
22 **orders**

23 The Federal Court must apply the rules of evidence and procedure
24 for civil matters in proceedings under this Division.

25 Note: The standard of proof in civil proceedings is the balance of
26 probabilities (see section 140 of the *Evidence Act 1995*).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **203-40 Civil proceedings after criminal proceedings**

2 The Federal Court must not make a pecuniary penalty order against
3 an *officer of a private health insurer under section 203-10 if the
4 officer has been convicted of an offence constituted by conduct
5 that is substantially the same as the conduct to which the court had
6 regard in satisfying itself that the officer failed to take reasonable
7 steps to prevent the insurer contravening the *enforceable
8 obligation.

9 **203-45 Criminal proceedings during civil proceedings**

- 10 (1) Proceedings for a pecuniary penalty order against an *officer of a
11 private health insurer are stayed if:
- 12 (a) criminal proceedings are started or have already been started
13 against the officer for an offence; and
 - 14 (b) the offence is constituted by conduct that is substantially the
15 same as the conduct to which the court had regard in
16 satisfying itself that the officer failed to take reasonable steps
17 to prevent the insurer contravening the *enforceable
18 obligation.
- 19 (2) The proceedings for the order may be resumed if the *officer is not
20 convicted of the offence. Otherwise, the proceedings for the order
21 are dismissed.

22 **203-50 Criminal proceedings after civil proceedings**

23 Criminal proceedings may be started against a person for conduct
24 that is substantially the same as conduct constituting a
25 contravention of an *enforceable obligation regardless of whether:

- 26 (a) a *declaration of contravention has been made that specifies
27 the person; or
- 28 (b) an order has been made against the person under this
29 Division.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **203-55 Evidence given in proceedings for penalty not admissible in**
2 **criminal proceedings**

3 Evidence of information given or evidence of production of
4 documents by an *officer of a private health insurer is not
5 admissible in criminal proceedings against the officer if:

- 6 (a) the officer previously gave the evidence or produced the
7 documents in proceedings for a pecuniary penalty order
8 against the officer under section 203-10 (whether or not the
9 order was made); and
10 (b) the conduct alleged to constitute the offence is substantially
11 the same as the conduct to which the court had regard in
12 satisfying itself that the officer failed to take reasonable steps
13 to prevent the insurer contravening the *enforceable
14 obligation.

15 However, this does not apply to a criminal proceeding in respect of
16 the falsity of the evidence given by the officer in the proceedings
17 for the pecuniary penalty order.

18 **203-60 Minister or Council may require person to assist**

- 19 (1) The Minister may, in writing, require a person to give all
20 reasonable assistance in connection with:
21 (a) an application by the Minister:
22 (i) for a *declaration of contravention in relation to a
23 private health insurer; or
24 (ii) for a declaration of contravention that specifies an
25 *officer of a private health insurer; or
26 (iii) for a pecuniary penalty order under section 203-10 in
27 relation to an officer of a private health insurer; or
28 (b) criminal proceedings against a private health insurer, or an
29 officer of a private health insurer, for an offence against this
30 Act.

31 The person must comply with the request.

32 Penalty: 5 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 203-60

- 1 (2) The Council may, in writing, require a person to give all
2 reasonable assistance in connection with an application by the
3 Council:
4 (a) for a *declaration of contravention in relation to a private
5 health insurer; or
6 (b) for a declaration of contravention that specifies an * officer of
7 a private health insurer; or
8 (c) for a pecuniary penalty order under section 203-10 in relation
9 to an officer of a private health insurer.
10 The person must comply with the request.
11 Penalty: 5 penalty units.
- 12 (3) The Minister or Council must not require the person to assist in
13 connection with an application for a declaration or order unless:
14 (a) it appears to the Minister or Council that someone other than
15 the person required to assist may have contravened an
16 *enforceable obligation; and
17 (b) the Minister or Council suspects or believes that the person
18 required to assist can give information relevant to the
19 application.
- 20 (4) The Minister must not require the person to assist in connection
21 with criminal proceedings unless:
22 (a) it appears to the Minister that the person required to assist is
23 unlikely to be a defendant in the proceedings; and
24 (b) the person required to assist is an employee or agent
25 (including a banker or auditor) of the private health insurer
26 concerned.
- 27 (5) The Minister or Council may require the person to assist regardless
28 of whether:
29 (a) an application for the declaration or order has actually been
30 made; or
31 (b) criminal proceedings for the offence have actually begun.
- 32 (6) The person cannot be required to assist if the person is or has been
33 a lawyer for:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (a) in an application for a declaration or order—the person
2 suspected of the contravention; or
3 (b) in criminal proceedings—a defendant or likely defendant in
4 the proceedings.
- 5 (7) The Federal Court may order the person to comply with the
6 requirement in a specified way. Only the Minister and the Council
7 may apply to the court for an order under this subsection.

8 **203-65 Relief from liability for contravening an enforceable**
9 **obligation**

- 10 (1) If, in proceedings brought against a person under this Division, it
11 appears to the Federal Court that:
12 (a) the person has, or may have:
13 (i) contravened an *enforceable obligation; or
14 (ii) if the person is an *officer of a private health insurer—
15 failed to take reasonable steps to prevent the insurer
16 from contravening an enforceable obligation; but
17 (b) the person has acted honestly and, having regard to all the
18 circumstances of the case, the person ought fairly to be
19 excused for the contravention;
20 the court may relieve the person either wholly or partly from a
21 liability to which the person would otherwise be subject, or that
22 might otherwise be imposed on the person, because of the
23 contravention.
- 24 (2) A person who thinks that proceedings will or may be begun against
25 the person under this Division may apply to the Federal Court for
26 relief.
- 27 (3) On an application under subsection (2), the court may grant relief
28 under subsection (1) as if the proceedings had been begun in the
29 court.
- 30 (4) For the purposes of subsection (1) as applying for the purposes of a
31 case tried by a judge with a jury:
32 (a) a reference in that subsection to the court is a reference to the
33 judge; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-2 General enforcement methods

Division 203 Remedies in the Federal Court

Section 203-70

1 (b) the relief that may be granted includes withdrawing the case
2 in whole or in part from the jury and directing judgment to be
3 entered for the defendant on such terms as to costs as the
4 judge thinks appropriate.

5 **203-70 Powers of Federal Court**

6 A provision of this Act conferring a power on the Federal Court
7 does not affect any other power of the court conferred by this Act
8 or otherwise.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 206—Revoking entitlement to offer rebate as a**
3 **premium reduction**

4 **206-1 Revocation of status of participating insurer**

- 5 (1) If a *participating insurer:
6 (a) has repeatedly failed to comply with subsection 26-1(5)
7 (receipt for payment of premiums); or
8 (b) has failed to comply with a condition specified in the Private
9 Health Insurance (Incentives) Rules as a condition of
10 participation in the *premiums reduction scheme; or
11 (c) refuses or fails to comply with:
12 (i) a direction given by the Minister under section 200-1; or
13 (ii) the principle of community rating in section 55-5;
14 the Minister may, by notice given to the insurer, revoke the
15 insurer's status as a participating insurer.
- 16 (2) Upon the giving of the notice, the insurer ceases to be a
17 *participating insurer.
- 18 Note: Decisions to revoke an insurer's status as a participating insurer are
19 reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Part 5-3—Enforcement of health benefits fund requirements

3

4

Division 211—Introduction

5

211-1 What this Part is about

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9

In order to protect the interests of the policy holders, and to ensure that health benefits funds are operated in accordance with Part 4-4, specific powers and processes are required in addition to the general powers and processes in Part 5-2.

10

11

12

13

Inspectors may be appointed to investigate the affairs of private health insurers, and external managers may be appointed to manage health benefits funds. These processes may lead to terminating managers of funds being appointed.

14

211-5 Purpose of this Part

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The purpose of this Part is:

16

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19

- (a) to provide for the supervision of the business, affairs and property of *health benefits funds, so as to ensure that the business and affairs are carried on, and the property is managed:

20

21

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23

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- (i) in the interests of the *policy holders of the funds; and
(ii) in accordance with Part 4-4; and

25

26

27

28

- (b) to provide for the *external management of health benefits funds in a way consistent with the interests of those policy holders; and
(c) to provide, as a consequence either of that supervision or external management, for the orderly termination of health benefits funds in a way that is consistent with the interests of those policy holders.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **211-10 The Private Health Insurance (Health Benefits Fund**
2 **Enforcement) Rules**

3 Enforcement of the requirements for *health benefits funds is also
4 dealt with in the Private Health Insurance (Health Benefits Fund
5 Enforcement) Rules. The provisions of this Part indicate when a
6 particular matter is or may be dealt with in these Rules.

7 Note: The Private Health Insurance (Health Benefits Fund Enforcement)
8 Rules are made by the Minister under section 333-20.

9 **211-15 Limitation on external management and termination of**
10 **health benefits funds**

- 11 (1) Despite the provisions of any other law of the Commonwealth or
12 of any law of a State or Territory, a *health benefits fund can only
13 be placed under *external management, or dealt with as a fund
14 under external management, in accordance with Division 217.
- 15 (2) Despite the provisions of any other law of the Commonwealth or
16 any other law of a State or Territory, a *health benefits fund can
17 only be terminated in accordance with Division 149.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 214—Investigations into affairs of private health**
3 **insurers**

4 **214-1 Investigation of private health insurers by inspectors**

- 5 (1) The Council may, in writing, appoint an *inspector to investigate
6 the affairs of a private health insurer if the Council has reason to
7 suspect that:
8 (a) the affairs of the insurer are being, or are about to be, carried
9 on in a way that is not in the interests of the *policy holders
10 of a *health benefits fund conducted by the insurer; or
11 (b) the insurer has contravened a provision of Part 4-4.
- 12 (2) The instrument of appointment must specify:
13 (a) the matter referred to in paragraph (1)(a) or (b) that the
14 Council suspects; and
15 (b) the ground on which the Council suspects the matter; and
16 (c) the matters into which the investigation is to be made, being
17 the whole or some part of the affairs of the insurer.
- 18 (3) An *inspector so appointed may be a person engaged or appointed
19 under the *Public Service Act 1999* or by an authority of the
20 Commonwealth.

21 **214-5 Powers of inspectors**

- 22 (1) An *inspector may, by notice in writing given to a person whom
23 the inspector believes to have some knowledge of the affairs of the
24 private health insurer that the inspector is investigating, require that
25 person:
26 (a) to produce to the inspector all or any of the records relating
27 to the affairs of the insurer that are in the custody, or under
28 the control, of that person; or
29 (b) to give to the inspector all reasonable assistance within the
30 person's power in connection with the investigation; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) to appear before the inspector for examination concerning
2 matters that are relevant to the investigation and are within
3 the knowledge of the person;
4 within the period (that must not be less than 14 days) specified in
5 the notice.
- 6 (2) If records are produced to an *inspector under subsection (1), the
7 inspector may:
8 (a) take possession of them for such period as the inspector
9 thinks necessary for the purposes of the investigation; and
10 (b) make copies of, and take extracts from, them.
- 11 (3) An *inspector is not entitled to refuse to permit a person to inspect
12 records that are in the possession of the inspector under
13 subsection (2) if the person would be entitled to inspect those
14 records if the inspector had not taken possession of them.
- 15 (4) A person who complies with a requirement of an *inspector under
16 subsection (1) does not incur any liability to any other person
17 merely because of that compliance.

18 **214-10 Person may be represented by lawyer**

- 19 A lawyer acting for a person being examined by an *inspector:
20 (a) may attend the examination; and
21 (b) may, to the extent that the inspector allows:
22 (i) address the inspector; and
23 (ii) examine the person;
24 in relation to matters in respect of which the inspector has
25 questioned the person.

26 **214-15 Compliance with requirements of inspectors**

- 27 (1) A person is guilty of an offence if the person refuses or fails to
28 comply with a requirement of an *inspector under section 214-5
29 that is applicable to the person.
- 30 Penalty: 30 penalty units or imprisonment for 6 months, or both.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 214 Investigations into affairs of private health insurers

Section 214-20

- 1 (2) However, the person is only required to comply with the
2 requirement to the extent that the person is capable of doing so.
- 3 Note: The defendant bears an evidential burden in relation to the matter in
4 subsection (2). See subsection 13.3(3) of the *Criminal Code*.
- 5 (3) A person being examined by an *inspector is not excused from
6 answering a question put to the person by the inspector on the
7 ground that the answer might tend to incriminate the person.
- 8 (4) However, if the person informs the *inspector before answering the
9 question that the answer might tend to incriminate the person,
10 neither the question nor the answer is admissible in evidence
11 against the person in criminal proceedings (other than proceedings
12 in relation to an offence under subsection (1)).

13 **214-20 Access to premises**

- 14 (1) An *inspector who:
15 (a) is empowered to investigate the whole or a part of the affairs
16 of a private health insurer; and
17 (b) enters any *premises under subsection (3) or in accordance
18 with a warrant granted under subsection (5);
19 may exercise the functions of an inspector under this section in
20 relation to the insurer.
- 21 (2) The functions of an *inspector under this section in relation to the
22 insurer are to exercise *search powers in relation to any records
23 that relate, or that the inspector believes, on reasonable grounds, to
24 relate, to the affairs of the insurer.
- 25 (3) An *inspector may, with the consent of the *occupier of any
26 *premises, enter the premises for the purpose of exercising the
27 functions of an inspector under this section in relation to the
28 private health insurer whose affairs the inspector is empowered to
29 investigate.
- 30 (4) An *inspector who has reason to believe that there are on any
31 *premises records relating to the affairs of the private health insurer
32 whose affairs the inspector is empowered to investigate may apply

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 to a Magistrate for a warrant authorising the inspector to enter the
2 premises for the purpose of exercising the functions of an inspector
3 under this section in relation to the insurer.

- 4 (5) The Magistrate may grant a warrant if satisfied by information on
5 oath or affirmation:
6 (a) that there is reasonable ground for believing that there are on
7 the *premises to which the application relates any records
8 relating to the affairs of the insurer concerned; and
9 (b) that the issue of a warrant is reasonably required for the
10 purposes of this Act.

11 The warrant may be in the form set out in the Private Health
12 Insurance (Health Benefits Fund Enforcement) Rules.

- 13 (6) The warrant authorises the *inspector, with such assistance as the
14 inspector thinks necessary, to enter the *premises, using such force
15 as is necessary and reasonable in the circumstances:
16 (a) during such hours of the day or night as the warrant specifies;
17 or
18 (b) if the warrant so specifies, at any time;
19 for the purpose of exercising the functions of an inspector under
20 this section in relation to the insurer concerned.

- 21 (7) A person is guilty of an offence if the person obstructs or hinders
22 an *inspector exercising the functions of an inspector under this
23 section.

24 Penalty: 30 penalty units or imprisonment for 6 months, or both.

- 25 (8) Subsection (7) does not apply if the person has a reasonable
26 excuse.

27 Note: The defendant bears an evidential burden in relation to the matter in
28 subsection (8). See subsection 13.3(3) of the *Criminal Code*.

29 **214-25 Reports of inspectors**

- 30 (1) An *inspector:
31 (a) must, on the completion or termination of an investigation of
32 the whole or a part of the affairs of a private health insurer,

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 214 Investigations into affairs of private health insurers

Section 214-25

- 1 report in writing to the Council on the result of the
2 investigation; and
- 3 (b) if so directed in writing by the Council, must make such
4 written reports during the investigation as are specified in the
5 direction; and
- 6 (c) may make one or more other written reports to the Council
7 during the investigation.
- 8 (2) The report made on the completion of the investigation must
9 include the *inspector's recommendations with respect to:
- 10 (a) the question whether the insurer should be permitted to
11 continue to conduct a particular *health benefits fund; and
- 12 (b) the question whether the insurer's affairs should be
13 reorganised to enable it better to conduct the fund and, if so,
14 the way in which they should be reorganised; and
- 15 (c) such other matters affecting the insurer, or the interests of the
16 *policy holders of the fund, as the inspector thinks fit.
- 17 (3) If the matters investigated included:
- 18 (a) the question whether the insurer is, or is about to become,
19 unable to meet its liabilities relating to a *health benefits
20 fund; or
- 21 (b) the question whether the insurer's affairs are being, or are
22 about to be, carried on in a way that is not in the interests of
23 the *policy holders of the fund;
- 24 the report made on the completion of the investigation must
25 include a statement of the *inspector's opinion in relation to that
26 question and the facts on which that opinion is based.
- 27 (4) An *inspector must not include in a report under this section:
- 28 (a) a recommendation relating to the institution of criminal
29 proceedings; or
- 30 (b) a statement to the effect that, in the inspector's opinion, a
31 specified person has committed a criminal offence.
- 32 (5) However, if an *inspector is of the opinion that criminal
33 proceedings ought to be instituted or that a person has committed a

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 criminal offence, the inspector must state that opinion in writing
2 given to the Council.

3 **214-30 Dissemination of reports**

4 (1) The Council must give a copy of a report made to the Council
5 under paragraph 214-25(1)(a) to the private health insurer to which
6 the report relates.

7 (2) However, subsection (1) does not apply if the Council thinks that,
8 having regard to proceedings that have been or might be instituted,
9 a copy of the report should not be given to the insurer.

10 (3) If the Council has given a copy of the report to the insurer under
11 subsection (1), the Council may, if it thinks it is in the public
12 interest to do so, cause the whole or a part of the report to be
13 published.

14 (4) A court before which proceedings under this Act are brought
15 against a private health insurer or other person in respect of matters
16 dealt with in a report under section 214-25 may order that a copy
17 of the report be given to that insurer or other person.

18 **214-35 Liability for publishing reports etc.**

19 (1) An action or proceeding, civil or criminal, does not lie against a
20 person for publishing in good faith a copy of, or a fair extract from
21 or of, a publication made under subsection 214-30(3).

22 (2) An action or proceeding, civil or criminal, does not lie against an
23 *inspector:
24 (a) in respect of the publication to the Council of a report under
25 section 214-25; or
26 (b) in respect of the inspector's opinion given to the Council in
27 accordance with subsection 214-25(5);
28 if the inspector has acted in good faith.

29 (3) For the purposes of this section, a publication or other action is
30 taken to be made in good faith if the person by whom it is made is

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 214 Investigations into affairs of private health insurers

Section 214-40

1 not actuated by ill will to a person affected by the publication or
2 other action, or by any other improper motive.

3 **214-40 Delegation by inspectors**

4 (1) An *inspector may, by writing signed by the inspector, delegate
5 any of the inspector's powers under this Act to a person engaged or
6 appointed under the *Public Service Act 1999* or by an authority of
7 the Commonwealth.

8 (2) A delegate who proposes to exercise his or her delegated powers
9 must, at the request of any person who may be affected by the
10 proposed exercise, produce for the inspection of that person the
11 instrument of delegation or a copy of that instrument.

12 Note: See also sections 34AA, 34AB and 34A of the *Acts Interpretation Act*
13 *1901* relating to delegations.

14 **214-45 Records not to be concealed etc.**

15 (1) A person is guilty of an offence if:
16 (a) the person engages in conduct; and
17 (b) the conduct results in the concealment, destruction,
18 mutilation or alteration of records relating to the affairs of a
19 private health insurer; and
20 (c) those affairs are being investigated under this Act.

21 Penalty: 30 penalty units or imprisonment for 6 months, or both.

22 (2) Subsection (1) does not apply if the person did not act with intent
23 to defeat the purposes of this Act and did not act with intent to
24 delay or obstruct the carrying out of the investigation under this
25 Act.

26 Note: The defendant bears an evidential burden in relation to the matters in
27 subsection (2). See subsection 13.3(3) of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 217—External management of health benefits**
3 **funds**

4 **Subdivision 217-A—Preliminary**

5 **217-1 Purpose of Division**

6 The purpose of this Division is to permit the business, affairs and
7 property of a *health benefits fund under *external management to
8 be managed in a way:

- 9 (a) that maximises the chance that the *policy holders of the fund
10 continue to be *covered for health insurance either by that
11 fund or by another fund to which the business of that fund is
12 transferred; or
13 (b) if it is not possible for that coverage to be maintained—that,
14 to the extent possible, safeguards the financial interests of
15 those policy holders if the fund is terminated.

16 **217-5 The basis of the law relating to external management**

- 17 (1) The *external management of a *health benefits fund is regulated:
18 (a) by the provisions of this Division; and
19 (b) by the provisions of Divisions 6, 7, 8, 10, 11, 13 and 16 of
20 Part 5.3A of Chapter 5 of the *Corporations Act 2001* and of
21 Division 7A of Part 5.6 of that Chapter, all applying, so far as
22 they are capable of so doing, subject to such modifications as
23 are set out in:
24 (i) this Act; or
25 (ii) the Private Health Insurance (Health Benefits Fund
26 Enforcement) Rules.
- 27 (2) Subject to this section, any provisions of a law of the
28 Commonwealth, or a State or Territory, that, but for this section,
29 would relate to the *external management of such a fund cease, by
30 force of this section, to apply in relation to the fund.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 217 External management of health benefits funds

Section 217-10

- 1 (3) In the application of the provisions of the *Corporations Act 2001*
2 referred to in subsection (1) in relation to the *external
3 management of a *health benefits fund, those provisions apply as
4 if:
5 (a) a reference to the company were a reference to the fund; and
6 (b) a reference to the administrator were a reference to the
7 *external manager of the fund appointed under this Act; and
8 (c) a reference to the Court were a reference to the Federal
9 Court.
- 10 (4) The Private Health Insurance (Health Benefits Fund Enforcement)
11 Rules may provide for different modifications according to the
12 nature of the *health benefits fund that is to be, or that is being,
13 administered.

14 **Subdivision 217-B—Appointment of external managers**

15 **217-10 Council may appoint external managers**

- 16 (1) The Council may, in writing, appoint a person as the *external
17 manager of a *health benefits fund if the requirements of
18 subsections 217-15(1) and (2) are satisfied.
- 19 (2) However, the person:
20 (a) must be registered, or taken to be registered, as an official
21 liquidator under the *Corporations Act 2001*; and
22 (b) must not be a person who is:
23 (i) the *policy holder of the fund; or
24 (ii) an auditor of the fund; or
25 (iii) a chargee of property of the fund; or
26 (iv) an officer of a body corporate that is a chargee of
27 property of the fund; or
28 (v) a person who is otherwise related to the fund.
- 29 (3) The appointment takes effect from the date specified in the
30 instrument of appointment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **217-15 Grounds of appointment of external managers**

- 2 (1) The Council must not appoint an *external manager to a *health
3 benefits fund unless the Council believes that the appointment of
4 an external manager to the fund is, in the circumstances, in the
5 interests of the *policy holders of the fund.
- 6 (2) The Council must not appoint an *external manager to a *health
7 benefits fund unless:
- 8 (a) the Council is satisfied, on reasonable grounds, that the
9 private health insurer conducting the fund has contravened
10 section 140-15 (compliance with the *solvency standard) in
11 its conduct of the fund; or
- 12 (b) the Council is satisfied, on reasonable grounds, that the
13 insurer has, in its conduct of the fund, contravened a
14 *solvency direction, a *capital adequacy direction or
15 *prudential direction that the Council has given to the insurer;
16 or
- 17 (c) a request for *external management of the fund is made to the
18 Council by a resolution of the board of *directors of the
19 insurer; or
- 20 (d) a ground specified in the Private Health Insurance (Health
21 Benefits Fund Enforcement) Rules made for the purposes of
22 this paragraph applies in respect of the fund.
- 23 (3) In forming the requisite state of mind for the purpose of
24 subsection (1), or of any Private Health Insurance (Health Benefits
25 Fund Enforcement) Rules made for the purposes of
26 paragraph(2)(d) that require a particular state of mind, the Council
27 may have regard:
- 28 (a) to any information in its own records; and
29 (b) to any report or return made to it, including any report
30 received from an *inspector under section 214-25.

31 **217-20 External managers to displace management of funds**

32 If a person is appointed as *external manager of a *health benefits
33 fund, then, for so long as the fund is under *external management:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 217 External management of health benefits funds

Section 217-25

- 1 (a) the management of the fund vests in the external manager;
2 and
3 (b) any *officer of the *responsible insurer for the fund who was
4 vested with the management of the fund immediately before
5 the appointment of the external manager is, by force of this
6 section, divested of that management.

7 **Subdivision 217-C—Duties and powers of external managers**

8 **217-25 Duties of external managers**

- 9 (1) The main duties of the *external manager of a *health benefits fund
10 are:
11 (a) to examine the business, affairs and property of the fund; and
12 (b) to ascertain the *assets and liabilities of the fund; and
13 (c) if the business of the fund has been mixed with other
14 business of the private health insurer concerned—to
15 apportion the assets and liabilities as between the fund and
16 that other business; and
17 (d) to form an opinion as to which course of action maximises
18 the chance that the *policy holders of the fund continue to be
19 *covered for health insurance either by that fund or by
20 another fund to which the business of that fund is transferred;
21 and
22 (e) to make a final written report to the Council, in accordance
23 with Subdivision 217-E, recommending that course of action.
24 (2) In the day-to-day administration of a *health benefits fund, it is the
25 duty of the *external manager to administer the fund as efficiently
26 and economically as possible.

27 **217-30 Additional powers of external managers**

- 28 (1) In the application of the provisions of Division 8 of Part 5.3A of
29 Chapter 5 of the *Corporations Act 2001*, for the purpose of:
30 (a) conferring further powers on the *external manager of a
31 *health benefits fund; and
32 (b) where appropriate, qualifying the exercise of those powers;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 the provisions of that Division are taken not to include
2 section 442A or subsection 442D(1).

3 (2) For the purposes of section 442F of the *Corporations Act 2001* as
4 so applying, sections 128 and 129 of that Act are also taken to
5 apply, subject to such modifications as are specified in the Private
6 Health Insurance (Health Benefits Fund Enforcement) Rules.

7 **217-35 Protection of property during external management**

8 (1) In the application of the provisions of Division 6 of Part 5.3A of
9 Chapter 5 of the *Corporations Act 2001* in relation to the
10 protection, during the *external management of a *health benefits
11 fund, of the property of the fund, the provisions of that Division are
12 taken not to include section 440A.

13 (2) In determining, for the purposes of section 440D of the
14 *Corporations Act 2001* as so applying, whether the administrator
15 should consent to, or the court should give leave for, a person's
16 beginning or continuing legal proceedings, the administrator or the
17 court must have regard to whether:

- 18 (a) the proceedings do, or do not, relate to any property of the
19 fund under *external management; and
20 (b) the proceedings would, or would not, be materially
21 detrimental to the interests of the *policy holders of the fund.

22 **217-40 Rights of chargee, owner or lessor of property of fund under**
23 **external management**

24 (1) In the application of the provisions of Division 7 of Part 5.3A of
25 Chapter 5 of the *Corporations Act 2001* in relation to the property
26 of a *health benefits fund under *external management:

- 27 (a) the provisions of that Division are taken not to include
28 section 441A; and
29 (b) subsection 441D(1) is taken not to include the words
30 following paragraph 441D(1)(b).

31 (2) Nothing in that Division as so applying prevents:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 217 External management of health benefits funds

Section 217-45

- 1 (a) the *external manager of a *health benefits fund giving
2 written consent; or
3 (b) the court giving leave;
4 for the enforcement of a charge, subject to any condition specified
5 by the external manager or by the court, as the case requires, if the
6 external manager or the court is satisfied:
7 (c) that the charge does not relate to the property of the fund
8 under *external management; and
9 (d) that the enforcement of the charge will not be materially
10 detrimental to the interests of the *policy holders of the fund.

11 **Subdivision 217-D—Procedure relating to voluntary deeds of**
12 **arrangement**

13 **217-45 Matters that may be included in the Private Health**
14 **Insurance (Health Benefits Fund Enforcement) Rules**

- 15 (1) The Private Health Insurance (Health Benefits Fund Enforcement)
16 Rules may provide for all or any of the following:
17 (a) the convening by *external managers of *health benefits
18 funds of meetings of creditors of those funds, and the *policy
19 holders of the funds, to consider the possibility of the
20 *responsible insurers for those funds executing *voluntary
21 deeds of arrangement;
22 (b) the procedure for convening such meetings (including the
23 giving of notices);
24 (c) the conduct of such meetings;
25 (d) the matters that may be decided at such meetings;
26 (e) the circumstances in which the external managers must
27 include in their reports to the Council under section 217-50,
28 recommendations arising out of decisions taken at such
29 meetings;
30 (f) the kinds of such recommendations that may be included in
31 those reports;
32 (g) the actions that the Council may take if such
33 recommendations are included in those reports.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) This section does not limit the matters that may be included in the
2 Private Health Insurance (Health Benefits Fund Enforcement)
3 Rules for the purposes of any other provision of this Part.

4 **Subdivision 217-E—External managers’ reports to Council**

5 **217-50 External managers to give reports to Council**

- 6 (1) As soon as practicable after being appointed as *external manager
7 of a *health benefits fund, and in any case within the period under
8 subsection (2), the external manager must:
9 (a) conclude the examination of the business, affairs and
10 property of the fund; and
11 (b) make a final written report to the Council.
- 12 (2) The period is:
13 (a) the 3 months after being appointed as *external manager; or
14 (b) such longer period as the Council notifies to the external
15 manager.
- 16 (3) The *external manager must, in the report to the Council:
17 (a) recommend a course of action that, in the external manager’s
18 opinion, maximises, in the circumstances, the chance that the
19 *policy holders of the fund continue to be *covered for health
20 insurance either by that fund or by another fund to which the
21 business of that fund is transferred; and
22 (b) set out the reasons for that recommendation.
- 23 (4) Without limiting subsection (3), the *external manager may
24 recommend:
25 (a) subject to the Federal Court’s making an order or orders in
26 relation to the matter, that the *responsible insurer for the
27 fund implement a scheme of arrangement concerning the
28 business of the fund; or
29 (b) subject to the Federal Court’s making an order or orders in
30 relation to the matter, that a *terminating manager of the
31 *health benefits funds of the responsible insurer be appointed;
32 or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 217 External management of health benefits funds

Section 217-55

- 1 (c) that the *external management cease and that the business of
2 the fund be resumed by the responsible insurer for the fund.
- 3 (5) However, if the Private Health Insurance (Health Benefits Fund
4 Enforcement) Rules so provide, the *external manager must
5 recommend that the Council approve the execution of a *voluntary
6 deed of arrangement.
- 7 (6) Without limiting the matters that may be dealt with in a scheme of
8 arrangement referred to in paragraph (4)(a), such a scheme may
9 provide for:
- 10 (a) the continuance, on terms or conditions set out in the scheme,
11 of the business of the fund; or
- 12 (b) the transfer of the fund, on terms set out in the scheme, to a
13 private health insurer other than the *responsible insurer for
14 the fund; or
- 15 (c) the execution of a deed in the same terms as a proposed
16 *voluntary deed of arrangement rejected at a meeting of a
17 kind referred to in section 217-45.

18 **217-55 Dealing with reports given to the Council**

- 19 (1) In deciding whether or not to approve a course of action
20 recommended under subsection 217-50(3), the Council may:
- 21 (a) request the *external manager to provide further information
22 on any matter; and
- 23 (b) engage any person to assist it in evaluating assessments
24 made, or projections relied on, by the external manager in
25 relation to matters dealt with in the report.
- 26 The Council must have regard to the external manager's report,
27 and to any additional information provided by the external
28 manager or by any person engaged to assist the Council, in
29 reaching its decision.
- 30 (2) If the Council is satisfied that a course of action recommended by
31 the *external manager under subsection 217-50(3) will, in the
32 circumstances, be in the interests of the *policy holders of the fund,

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 the Council must, by written notice, inform the external manager to
2 that effect and either:
- 3 (a) if the course of action is of a kind specified in paragraph
4 217-50(4)(a)—direct the external manager to apply under
5 subsection 217-60(1) to give effect to the course of action; or
6 (b) if the course of action is termination of the funds of the
7 private health insurer in question—direct the external
8 manager to apply under subsection 220-1(1) for the
9 appointment of a *terminating manager of the funds.
- 10 (3) If the Council is not satisfied as mentioned in subsection (2), the
11 Council may take a different course of action that the Council is
12 satisfied will, in the circumstances, be in the interests of *policy
13 holders of the fund.
- 14 (4) The courses of action that the Council may take under
15 subsection (3) include:
- 16 (a) the Council applying to the Federal Court for an order or
17 orders in relation to the *responsible insurer for the fund
18 implementing a scheme of arrangement concerning the
19 business of the fund; and
20 (b) the Council applying to the Federal Court for an order or
21 orders for the appointment of a *terminating manager of the
22 *health benefits funds of the responsible insurer.

23 **217-60 Court orders in respect of schemes of arrangement**

- 24 (1) If, under paragraph 217-55(2)(a), the Council directs the *external
25 manager to apply under this subsection to give effect to a course of
26 action of a kind specified in paragraph 217-50(4)(a), the external
27 manager must apply to the Federal Court for an order or orders to
28 give effect to the course of action.

29 Note: For what is to happen if the course of action is to be termination of a
30 fund, see subsection 220-1(1).

- 31 (2) On an application under subsection (1) of this section, or under
32 paragraph 217-55(4)(a), for such an order or orders:
- 33 (a) the Council and any other person interested are entitled to be
34 heard; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5 Enforcement

Part 5-3 Enforcement of health benefits fund requirements

Division 217 External management of health benefits funds

Section 217-65

- 1 (b) the Federal Court may make such order or orders in respect
2 of the course of action the subject of the application as it
3 considers to be, in all the circumstances, in the interests of
4 the *policy holders of the *health benefits fund concerned.
- 5 (3) An order under this section:
6 (a) is binding on all persons; and
7 (b) takes effect despite anything in the constitution or other
8 *rules of the *responsible insurer for the fund concerned.
- 9 (4) To avoid doubt, an order of the Federal Court is not required:
10 (a) in order to give effect to a *voluntary deed of arrangement—
11 if the Council approves the execution of the deed; or
12 (b) in order to effect a termination of an *external management.

13 **Subdivision 217-F—Miscellaneous**

14 **217-65 When an external management begins and ends**

- 15 (1) The *external management of a *health benefits fund begins when
16 an *external manager is appointed under section 217-10 to
17 administer the fund.
- 18 (2) The *external management of a *health benefits fund ends when:
19 (a) the Council terminates the appointment of the *external
20 manager and does not appoint a replacement external
21 manager; or
22 (b) a *voluntary deed of arrangement relating to the fund is
23 executed; or
24 (c) the Council notifies the external manager, under subsection
25 217-55(2), that it has accepted the external manager's
26 recommendation, made under subsection 217-50(4), that the
27 external management cease; or
28 (d) the Federal Court makes an order or orders under
29 section 217-60 for a course of action approved by the
30 Council and incorporated in a scheme of arrangement; or
31 (e) a *terminating manager of the fund is appointed.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **217-70 Effect of things done during external management of health**
2 **benefits funds**

3 A payment made, transaction entered into, or other act or thing
4 done, in good faith, by, or with the consent of, the *external
5 manager of a *health benefits fund:

- 6 (a) is valid and effectual for the purposes of this Act and for the
7 purposes of the *Corporations Act 2001* as it applies in
8 relation to the fund; and
9 (b) is not liable to be set aside in a termination of the fund.

10 **217-75 Disclaimer of onerous property**

11 (1) In the application of the provisions of Division 7A of Part 5.6 of
12 Chapter 5 of the *Corporations Act 2001* for the purpose of
13 determining the power of an *external manager of a *health
14 benefits fund to disclaim property of the fund, those provisions
15 have effect as if:

- 16 (a) the external manager were the liquidator of the company that
17 the fund is taken to constitute; and
18 (b) the references in subsections 568B(3) and 568E(5) of that
19 Act to the company's creditors were references to the *policy
20 holders of the fund.

21 (2) A disclaimer by an *external manager of a *health benefits fund has
22 the same effect, and the external manager is under the same
23 obligations, for the purposes of this Act, as if the disclaimer had
24 been made under Division 7A of Part 5.6 of Chapter 5 of the
25 *Corporations Act 2001*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 220—Ordering the termination of health benefits**
3 **funds**

4 **220-1 Applications by external managers to the Federal Court**

- 5 (1) If, under paragraph 217-55(2)(b), the Council directs the *external
6 manager to apply under this subsection for the appointment of a
7 *terminating manager of the *health benefits funds of a private
8 health insurer, the external manager must apply to the Federal
9 Court for an order or orders to give effect to such an appointment.
- 10 (2) The Council and any other person likely to be affected by the
11 termination of the funds are entitled to be heard on the application.

12 **220-5 Orders made on applications for appointments of terminating**
13 **managers**

- 14 (1) On an application under subsection 220-1(1), or under paragraph
15 217-55(4)(b), the Federal Court may make an order for the
16 appointment of a *terminating manager of the *health benefits
17 funds of a private health insurer, and any related orders.
- 18 (2) However, the Federal Court must not do so unless it considers the
19 orders to be, in the circumstances, in the interests of the *policy
20 holders of the funds.

21 **220-10 Binding nature of Court orders**

- 22 Any orders made by the Federal Court under section 220-5:
23 (a) are binding on all persons; and
24 (b) take effect despite anything in the constitution or *rules of the
25 *responsible insurer of the funds concerned.

26 **220-15 Notice of appointments**

27 If the Federal Court orders the appointment of a *terminating
28 manager of the *health benefits funds of a private health insurer,

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 the Council must notify the insurer in writing of the person
2 appointed as the terminating manager.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Chapter 6—Administration

2

3

Part 6-1—Introduction

4

Division 230—Introduction

5

230-1 What this Chapter is about

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This Chapter:

7

(a) provides for the Private Health Insurance Ombudsman to deal with complaints and conduct investigations;

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(b) provides for the powers, functions and duties of the Private Health Insurance Administration Council;

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(c) deals with some general administrative matters relating to the incentives schemes in Part 2-2;

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14

(d) deals with some general aspects of external and terminating managers (relevant to Divisions 149 and 217);

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(e) deals with administration and collection of private health insurance levies;

18

19

(f) provides for the Private Health Insurance Risk Equalisation Trust Fund;

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21

(g) protects information obtained for the purposes of this Act and sets out the circumstances in which such information may be used;

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23

24

(h) provides for review by the Administrative Appeals Tribunal of certain decisions made under this Act;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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(i) provides for miscellaneous other matters such as delegations, the approval of forms and the making of Private Health Insurance Rules and regulations.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Part 6-2—Private Health Insurance Ombudsman

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Division 235—Introduction

4

235-1 Principal object of this Part

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The principal object of this Part is to establish the office of, and set out the powers and functions of, the Private Health Insurance Ombudsman so that he or she may protect the interests of people who are covered by private health insurance by:

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- (a) assisting people who have made complaints relating to private health insurance to resolve those complaints; and
- (b) investigating the practices and procedures of private health insurers, *private health insurance brokers and *health care providers; and
- (c) mediating between private health insurers and health care providers; and
- (d) disseminating information about private health insurance and the rights and obligations of privately insured people.

18

235-5 Private Health Insurance (Ombudsman) Rules

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Matters relevant to this Part are also dealt with in the Private Health Insurance (Ombudsman) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

23

24

Note: The Private Health Insurance (Ombudsman) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Division 238—Establishment and functions

3

238-1 Establishment of office of Private Health Insurance Ombudsman

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For the purposes of this Act, there is to be a Private Health
Insurance Ombudsman.

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Note: See Division 253 for matters relating to the office of Private Health
Insurance Ombudsman.

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238-5 Functions of Private Health Insurance Ombudsman

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The Private Health Insurance Ombudsman has the following
functions:

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(a) dealing with complaints under Division 241;

13

(b) conducting investigations under Division 244;

14

(c) publishing (in written form and on the Private Health
Insurance Ombudsman's website) a report, called the State of
the Health Funds Report, as soon as practicable after the end
of each financial year providing comparative information on
the performance and service delivery of all private health
insurers during that financial year;

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(d) collecting and publishing (in written form and on the
Internet) information about the *complying health insurance
products available to people, in order to assist people to
understand the entitlements and benefits available under
those products;

21

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(e) publishing, in aggregate form, information (not *personal
information) about complaints under Division 241;

26

27

(f) reporting and making recommendations to the Minister under
sections 241-60 and 244-15;

28

29

(g) reporting to the Minister or to the Department about the
practices of particular private health insurers or *private
health insurance brokers;

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32

(h) reporting (as part of reports mentioned in paragraph (g)) to
the Minister or to the Department about the practices of

33

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 238-5

- 1 particular *health care providers, to the extent to which those
2 practices relate to:
- 3 (i) the application of *private health insurance
4 arrangements or classes of private health insurance
5 arrangements to services or goods provided, or to goods
6 manufactured or supplied, by the health care providers;
7 or
- 8 (ii) private health insurance arrangements or classes of
9 private health insurance arrangements to which those
10 kinds of health care providers may be party;
- 11 (i) making recommendations to the Minister or the Department
12 about regulatory practices or industry practices relating to
13 private health insurers or private health insurance brokers;
- 14 (j) making recommendations (as part of recommendations
15 mentioned in paragraph (i)) to the Minister or to the
16 Department about regulatory practices or industry practices
17 relating to health care providers, to the extent to which those
18 practices relate to:
- 19 (i) the application of private health insurance arrangements
20 or classes of private health insurance arrangements to
21 services or goods provided, or to goods manufactured or
22 supplied, by the health care providers; or
- 23 (ii) private health insurance arrangements or classes of
24 private health insurance arrangements to which those
25 kinds of health care providers may be party;
- 26 (k) promoting a knowledge and understanding of the Private
27 Health Insurance Ombudsman's functions;
- 28 (l) any other functions that are incidental to the performance of
29 any of the preceding functions.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 241—Complaints**

3 **Subdivision 241-A—Relevant complaints**

4 **241-1 Who may make a complaint**

- 5 (1) A complaint may be made to the Private Health Insurance
6 Ombudsman by any of the following:
- 7 (a) a person who is, or was at the time of the incident to which
8 the complaint relates, insured or seeking to be insured under
9 a *private health insurance policy;
 - 10 (b) a private health insurer;
 - 11 (c) a *health care provider;
 - 12 (d) a *private health insurance broker.
- 13 (2) A complaint may be made by a person on behalf of a person
14 mentioned in subsection (1).

15 **241-5 Persons against whom complaints may be made**

- 16 A complaint may be made to the Private Health Insurance
17 Ombudsman against any of the following:
- 18 (a) a private health insurer;
 - 19 (b) a *health care provider;
 - 20 (c) a *private health insurance broker.

21 **241-10 Grounds for complaint**

- 22 (1) The complaint may be about:
- 23 (a) any matter arising out of or connected with a *private health
24 insurance arrangement; or
 - 25 (b) any matter arising out of or connected with Chapter 2.
- 26 (2) A complaint against a *health care provider must, in addition to
27 being about a matter in subsection (1), also:
- 28 (a) be about either or both of the following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 241-15

- 1 (i) the application of a *private health insurance
2 arrangement to goods or a service provided, or goods
3 manufactured or supplied, by the health care provider;
4 (ii) a private health insurance arrangement to which the
5 health care provider is, or was at the time of the incident
6 to which the complaint relates, a party; and
7 (b) satisfy at least one of the following:
8 (i) the complaint must also be made against a private health
9 insurer;
10 (ii) the complainant must be a private health insurer or a
11 person insured under a *private health insurance policy;
12 (iii) if the complainant is another health care provider or a
13 *private health insurance broker—a private health
14 insurer or a person insured under a private health
15 insurance policy must also be a complainant in relation
16 to the complaint.
- 17 (3) The Private Health Insurance (Ombudsman) Rules may specify
18 matters about which complaints cannot be made.

19 **Subdivision 241-B—Dealing with complaints**

20 **241-15 Initial receipt of complaint**

- 21 On receiving a complaint, the Private Health Insurance
22 Ombudsman may:
23 (a) inform the subject of the complaint of the nature of the
24 complaint; and
25 (b) request information from the subject under Division 250.

26 **241-20 Ways of dealing with complaints**

- 27 (1) The Private Health Insurance Ombudsman may deal with a
28 complaint by:
29 (a) conducting mediation under Division 247; or
30 (b) referring the complaint to the subject of the complaint under
31 Subdivision 241-C; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) if section 241-45 applies—investigating the complaint under
2 Subdivision 241-D.
- 3 (2) The Private Health Insurance Ombudsman must not take any
4 action mentioned in subsection (1) unless the complainant agrees
5 to the action being taken.
- 6 (3) The Private Health Insurance Ombudsman must not take, or
7 continue to take, any action mentioned in paragraph (1)(a) or (c) if
8 the complainant withdraws the complaint.
- 9 (4) The Private Health Insurance Ombudsman must not take any
10 action mentioned in subsection (1) if the complaint is about a
11 matter specified in the Private Health Insurance (Ombudsman)
12 Rules for the purposes of subsection 241-10(3).

13 **241-25 Referral to the Australian Competition and Consumer**
14 **Commission**

- 15 (1) If, in the Private Health Insurance Ombudsman's opinion, a
16 complaint raises a matter that could be dealt with more effectively
17 or conveniently by the Australian Competition and Consumer
18 Commission, the Private Health Insurance Ombudsman must,
19 subject to subsections (2) and (3), refer the matter to the Australian
20 Competition and Consumer Commission.
- 21 (2) The Private Health Insurance Ombudsman must not refer the
22 matter to the Australian Competition and Consumer Commission
23 unless the complainant agrees to the referral.
- 24 (3) The Private Health Insurance Ombudsman must not refer the
25 matter to the Australian Competition and Consumer Commission if
26 the complainant withdraws the complaint.
- 27 (4) If the Private Health Insurance Ombudsman refers the matter to the
28 Australian Competition and Consumer Commission, the Private
29 Health Insurance Ombudsman must:
- 30 (a) tell the complainant of the matter's referral; and
31 (b) give the Australian Competition and Consumer Commission
32 any information or documents that relate to the complaint and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 241-30

- 1 that are in the Private Health Insurance Ombudsman's
2 possession or under his or her control.
- 3 (5) The Australian Competition and Consumer Commission may
4 investigate the matter. If it does, it must, within 30 days after the
5 referral, report to the Private Health Insurance Ombudsman on:
6 (a) the conduct of the investigation; and
7 (b) any findings that it has made as a result of the investigation.
- 8 (6) If the Australian Competition and Consumer Commission decides
9 not to investigate the matter, it must, within 30 days after the
10 referral, give the Private Health Insurance Ombudsman a written
11 notice informing the Private Health Insurance Ombudsman of its
12 decision and of the reasons for its decision.

13 **241-30 Referral to other bodies**

- 14 (1) If, in the Private Health Insurance Ombudsman's opinion, a
15 complaint raises a matter that could be dealt with more effectively
16 or conveniently by another body, the Private Health Insurance
17 Ombudsman must, subject to this section, refer the matter to that
18 body.
- 19 (2) The Private Health Insurance Ombudsman must not refer the
20 matter to the other body unless the complainant agrees to the
21 referral.
- 22 (3) The Private Health Insurance Ombudsman must not refer the
23 matter to the other body if the complainant withdraws the
24 complaint.

25 **241-35 Deciding not to deal with a complaint**

- 26 (1) The Private Health Insurance Ombudsman may decide not to deal,
27 or not to continue to deal, with a complaint in accordance with this
28 section. If the Private Health Insurance Ombudsman so decides, he
29 or she must:
30 (a) tell the complainant of the decision and the reasons for the
31 decision; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) if requested by the complainant—give the complainant
2 written notice of the decision and the reasons for the
3 decision.
- 4 (2) The Private Health Insurance Ombudsman may decide not to take
5 any action in relation to a complaint if the incident to which the
6 complaint relates occurred more than 12 months before the
7 complaint is made.
- 8 (3) The Private Health Insurance Ombudsman may decide not to deal
9 with a complaint if he or she is satisfied that the complainant has
10 not taken reasonable steps to negotiate a settlement of the
11 complaint with the subject of the complaint.
- 12 (4) The Private Health Insurance Ombudsman may decide not to deal,
13 or not to continue to deal, with a complaint if the complainant does
14 not agree to a matter relating to the complaint being referred to
15 another body under section 241-30.
- 16 (5) The Private Health Insurance Ombudsman may decide not to deal,
17 or not to continue to deal, with a complaint, if he or she believes
18 that:
- 19 (a) the subject of the complaint has dealt, or is dealing,
20 adequately with the complaint, or has not yet had an adequate
21 opportunity to do so; or
- 22 (b) the Private Health Insurance Ombudsman has dealt
23 adequately with the complaint; or
- 24 (c) the complainant is capable of assisting the Private Health
25 Insurance Ombudsman in dealing with the complaint but
26 does not do so on request; or
- 27 (d) the complainant does not have a sufficient interest in the
28 subject matter of the complaint; or
- 29 (e) the matter is trivial; or
- 30 (f) the complaint is frivolous or vexatious or was not made in
31 good faith; or
- 32 (g) the complaint is mainly about commercial negotiations and,
33 having regard to the object of this Part, it is not appropriate to
34 deal, or to continue to deal, with the complaint; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 241-40

- 1 (h) the complaint is mainly about clinical matters and, having
2 regard to the object of this Part, it is not appropriate to deal,
3 or continue to deal, with the complaint; or
4 (i) the complainant has exercised, or exercises, a right to have
5 the matter to which the complaint relates reviewed by a court
6 or tribunal constituted by or under a law of the
7 Commonwealth or of a State or Territory; or
8 (j) both:
9 (i) the complainant has, or had, a right to have the matter to
10 which the complaint relates reviewed by a court or by a
11 tribunal constituted by or under a law of the
12 Commonwealth or of a State or Territory, but has not
13 exercised that right; and
14 (ii) it is, or would have been, reasonable for the
15 complainant to exercise that right.

16 **Subdivision 241-C—Referral to subjects of complaints**

17 **241-40 Referral to the subject of the complaint**

- 18 (1) The Private Health Insurance Ombudsman may, at any time and
19 whether or not mediation has been conducted under Division 247,
20 refer a complaint to the subject of the complaint and request the
21 subject:
22 (a) to investigate the complaint; and
23 (b) to report to the Private Health Insurance Ombudsman on the
24 outcome of the investigation and any action that the subject
25 proposes to take as a result, before the end of the period
26 specified in the request.
- 27 Note: The Private Health Insurance Ombudsman must have the
28 complainant's agreement to act under this section (see subsection
29 241-20(2)).
- 30 (2) The subject may, before the end of the period specified in the
31 request, ask the Private Health Insurance Ombudsman to extend
32 that period.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (3) If the Private Health Insurance Ombudsman refuses the request, the
2 Private Health Insurance Ombudsman must give his or her reasons
3 for refusing.

4 Note: A refusal to extend the period is reviewable under Part 6-9.

5 **Subdivision 241-D—Investigation of complaints**

6 **241-45 Investigation of complaint**

7 The Private Health Insurance Ombudsman may investigate a
8 complaint if:

- 9 (a) the complaint is not resolved to the complainant's
10 satisfaction by mediation under Division 247; or
11 (b) the Private Health Insurance Ombudsman is not satisfied
12 with the outcome of a referral under Subdivision 241-C.

13 Note: The Private Health Insurance Ombudsman must have the
14 complainant's agreement to act under this section and cannot continue
15 if the complaint is withdrawn (see subsections 241-20(2) and (3)).

16 **241-50 Minister may direct Private Health Insurance Ombudsman**
17 **to investigate, or to continue to investigate, a complaint**

- 18 (1) If the Private Health Insurance Ombudsman decides under
19 section 241-35 not to investigate, or not to continue to investigate,
20 a complaint made by a person, the person may apply, in writing, to
21 the Minister for a direction by the Minister to the Private Health
22 Insurance Ombudsman to investigate, or to continue to investigate,
23 the complaint.
- 24 (2) If the Minister directs the Private Health Insurance Ombudsman to
25 do so, the Private Health Insurance Ombudsman must:
26 (a) investigate, or continue to investigate, the complaint; and
27 (b) report to the Minister under section 241-60 on the findings of
28 his or her investigation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **Subdivision 241-E—Recommendations and reports**

2 **241-55 Recommendations as a result of referral or investigation**

- 3 (1) The Private Health Insurance Ombudsman may make
4 recommendations under this section after:
5 (a) receiving a report from the subject of a complaint after
6 referral under Subdivision 241-C; or
7 (b) investigating a complaint under Subdivision 241-D.
- 8 (2) The Private Health Insurance Ombudsman may recommend any or
9 all of the following:
10 (a) to a private health insurer, that the insurer take a specific
11 course of action in relation to the complaint or make changes
12 to its *rules, or both;
13 (b) to a private health insurer, that the insurer request a *health
14 care provider or *private health insurance broker to take a
15 specific course of action in relation to the complaint;
16 (c) to a health care provider or private health insurance broker,
17 that the provider or broker take a specific course of action in
18 relation to the complaint.
- 19 (3) The Private Health Insurance Ombudsman may request the person
20 to whom the recommendation was made, or an *officer of that
21 person, to report to the Private Health Insurance Ombudsman,
22 before action is taken to give effect to the recommendation, on the
23 action proposed to be taken. The request must specify the period
24 within which the report is to be given.
- 25 (4) A person commits an offence if:
26 (a) a request is made of the person under subsection (3); and
27 (c) the person does not comply with the request.

28 Penalty: 30 penalty units.

- 29 (5) Strict liability applies to subsection (4).

30 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **241-60 Report to Minister on outcome of investigation under**
2 **Subdivision 241-D**

- 3 (1) The Private Health Insurance Ombudsman may report and make
4 recommendations under this section after completing an
5 investigation of a complaint against a particular subject under
6 Subdivision 241-D.
- 7 (2) The Private Health Insurance Ombudsman may report to the
8 Minister on the outcome of the investigation (including any
9 recommendations made to the subject of the complaint and any
10 responses to those recommendations).
- 11 (3) The Private Health Insurance Ombudsman may recommend to the
12 Minister either or both of the following:
13 (a) general changes in regulatory practice or industry practices
14 relating to the kind of subject of complaint;
15 (b) possible means of dealing with specific problems arising in
16 relation to the particular subject of the complaint.
- 17 (4) The Private Health Insurance Ombudsman may make
18 recommendations under paragraph (3)(b) concerning *health care
19 providers or a particular health care provider only to the extent to
20 which the recommendations relate to:
21 (a) the application of a *private health insurance arrangement or
22 a class of private health insurance arrangements to services or
23 goods provided, or goods manufactured or supplied, by that
24 kind of health care provider; or
25 (b) a private health insurance arrangement or a class of private
26 health insurance arrangements to which that kind of health
27 care provider may be party.
- 28 (5) Before reporting to the Minister under this section, the Private
29 Health Insurance Ombudsman must:
30 (a) inform the subject of the complaint that the Private Health
31 Insurance Ombudsman proposes to make the report and of
32 the nature of any criticism of the subject's conduct that will
33 appear in the report; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 241-65

- 1 (b) invite the subject to comment on such criticism, before the
2 end of the period specified in the invitation.
3 The Private Health Insurance Ombudsman must include in the
4 report any comments made by the subject.

5 **Subdivision 241-F—Miscellaneous**

6 **241-65 Complainant to be kept informed**

- 7 (1) The Private Health Insurance Ombudsman must keep the
8 complainant informed about the Private Health Insurance
9 Ombudsman's handling of the complaint.
- 10 (2) The Private Health Insurance Ombudsman must inform the
11 complainant in writing of:
- 12 (a) any action taken by a private health insurer, a *health care
13 provider or *private health insurance broker as a result of the
14 Private Health Insurance Ombudsman's handling of the
15 complaint; and
- 16 (b) any recommendations made by the Private Health Insurance
17 Ombudsman under section 241-55;
18 and the reasons for the action or recommendation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 244—Investigations**

3 **Subdivision 244-A—Investigations**

4 **244-1 Initiating investigations**

- 5 (1) The Private Health Insurance Ombudsman may, on his or her own
6 initiative, investigate the practices and procedures of a private
7 health insurer or a *private health insurance broker.
- 8 (2) The Private Health Insurance Ombudsman may, on his or her own
9 initiative, investigate the practices and procedures of a *health care
10 provider together with an investigation of a private health insurer
11 under subsection (1), if:
- 12 (a) the investigation relates to a matter arising out of or
13 connected with a *private health insurance arrangement; and
 - 14 (b) the practices and procedures relate to either or both of the
15 following:
 - 16 (i) the application of a private health insurance
17 arrangement to services or goods provided, or to goods
18 manufactured or supplied, by the health care provider;
 - 19 (ii) a private health insurance arrangement to which the
20 health care provider is, or was in the period to be
21 investigated, a party; and
 - 22 (c) the Private Health Insurance Ombudsman considers, having
23 regard to the object of this Part, that investigation of the
24 health care provider together with the private health insurer is
25 necessary or appropriate in order to consider the matter
26 effectively.

27 Note: An investigation may include mediation (see section 247-1).

28 **244-5 Investigations at Minister's request**

- 29 (1) The Minister may request the Private Health Insurance
30 Ombudsman to investigate the practices and procedures of a
31 private health insurer or a *private health insurance broker.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 244-10

- 1 (2) The Minister may request the Private Health Insurance
2 Ombudsman to investigate the practices and procedures of a
3 *health care provider together with an investigation of a private
4 health insurer under subsection (1), if:
- 5 (a) the investigation relates to a matter arising out of or
6 connected with a *private health insurance arrangement; and
7 (b) the practices and procedures relate to either or both of the
8 following:
- 9 (i) the application of a private health insurance
10 arrangement to services or goods provided, or to goods
11 manufactured or supplied, by the health care provider;
12 (ii) a private health insurance arrangement to which the
13 health care provider is, or was in the period to be
14 investigated, a party; and
- 15 (c) the Minister considers, having regard to the object of this
16 Part, that investigation of the health care provider together
17 with the private health insurer is necessary or appropriate in
18 order to consider the matter effectively.
- 19 (3) If the Minister makes a request under this section, the Private
20 Health Insurance Ombudsman must conduct an investigation.
- 21 Note: An investigation may include mediation (see section 247-1).

22 **Subdivision 244-B—Recommendations and reports**

23 **244-10 Recommendations as a result of investigation**

- 24 (1) The Private Health Insurance Ombudsman may make
25 recommendations under this section after conducting an
26 investigation under this Division.
- 27 (2) The Private Health Insurance Ombudsman may recommend either
28 or both of the following:
- 29 (a) to a private health insurer, that the insurer take a specific
30 course of action or make changes to its *rules, or both;
- 31 (b) to a *health care provider or *private health insurance broker,
32 that the provider or broker take a specific course of action.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (3) The Private Health Insurance Ombudsman may request the person
2 to whom the recommendation was made, or an *officer of that
3 person, to report to the Private Health Insurance Ombudsman,
4 before action is taken to give effect to the recommendation, on the
5 action proposed to be taken. The request must specify the period
6 within which the report is to be given.

7 (4) A person commits an offence if:
8 (a) a request is made of the person under subsection (3); and
9 (b) the person does not comply with the request.

10 Penalty: 30 penalty units.

11 (5) Strict liability applies to subsection (4).

12 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

13 **244-15 Report to Minister on outcome of investigations under this**
14 **Division**

15 (1) The Private Health Insurance Ombudsman may, after completing
16 an investigation under section 244-1, and must after completing an
17 investigation under section 244-5:

18 (a) report to the Minister on the outcome of the investigation and
19 any mediation conducted as part of the investigation
20 (including any recommendations made to the subject of the
21 investigation); and

22 (b) make recommendations to the Minister:

23 (i) concerning general changes in regulatory practice or
24 industry practices relating to that kind of subject of
25 investigation; or

26 (ii) concerning possible means of dealing with specific
27 problems arising in relation to the particular subject of
28 the investigation.

29 (2) The Private Health Insurance Ombudsman may make
30 recommendations under paragraph (1)(b) concerning *health care
31 providers or a particular health care provider only to the extent to
32 which the recommendations relate to:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 244-20

- 1 (a) the application of a *private health insurance arrangement or
2 a class of private health insurance arrangements to services or
3 goods provided, or to goods manufactured or supplied, by
4 that kind of health care provider; or
5 (b) a private health insurance arrangement or a class of private
6 health insurance arrangements to which that kind of health
7 care provider may be party.
- 8 (3) Before reporting to the Minister under this section, the Private
9 Health Insurance Ombudsman must:
- 10 (a) inform the subject of the investigation that the Private Health
11 Insurance Ombudsman proposes to make the report and of
12 the nature of any criticism of the conduct of the subject that
13 will appear in the report; and
14 (b) invite the subject to comment on such criticism, before the
15 end of the period specified in the invitation.
- 16 The Private Health Insurance Ombudsman must include in the
17 report any comments made by the subject.

18 **244-20 Consultation with Australian Competition and Consumer**
19 **Commission**

20 If the Private Health Insurance Ombudsman considers, as a result
21 of an investigation under this Division, that there might have been
22 conduct in the nature of a restrictive trade practice for the purposes
23 of the *Trade Practices Act 1974*, the Private Health Insurance
24 Ombudsman must consult with the Australian Competition and
25 Consumer Commission and have regard to the advice of the
26 Australian Competition and Consumer Commission on the matter
27 before reporting on it under section 244-15.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 247—Mediation**

3 **247-1 Conducting mediation**

- 4 (1) The Private Health Insurance Ombudsman may, at any time, try to
5 settle a complaint made under Division 241 by mediating between
6 the complainant and the subject of the complaint.
- 7 (2) The Private Health Insurance Ombudsman may, if he or she
8 considers it appropriate and consistent with the object of this Part,
9 try to resolve a matter being investigated under Division 244 by
10 mediating between a private health insurer and a *health care
11 provider.
- 12 (3) A party's participation in the mediation may be:
13 (a) voluntary; or
14 (b) required by a direction given to the party by the Private
15 Health Insurance Ombudsman under section 247-5.

16 Note: If mediating a complaint, the Private Health Insurance Ombudsman
17 must have the complainant's agreement to act under this section and
18 cannot continue if the complaint is withdrawn (see subsections
19 241-20(2) and (3)).

20 **247-5 Participation in mediation may be compulsory**

- 21 (1) The Private Health Insurance Ombudsman may direct:
22 (a) the subject of a complaint made under Division 241; or
23 (b) a private health insurer that is the subject of an investigation
24 under Division 244; or
25 (c) a *health care provider that is the subject of an investigation
26 under Division 244;
27 to participate in mediation under section 247-1.
- 28 (2) The Private Health Insurance (Ombudsman) Rules may set out
29 matters to which the Private Health Insurance Ombudsman is to
30 have regard when deciding whether or not to give a direction under
31 subsection (1).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 247-10

- 1 (3) The direction must:
2 (a) be in writing; and
3 (b) name either or both of the following:
4 (i) the subject of the complaint or investigation;
5 (ii) an *officer, or officers, of that subject; and
6 (c) be given to those named in it; and
7 (d) specify the time of the mediation, which must not be earlier
8 than 14 days after the day on which the direction is given;
9 and
10 (e) specify the place of the mediation.

11 Note: Subsection 33(3) of the *Acts Interpretation Act 1901* has the effect that
12 the direction may be varied or revoked.

- 13 (4) A person commits an offence if:
14 (a) the person is named in a direction under subsection (1); and
15 (b) the other party to the mediation attends, or was willing to
16 attend, the mediation; and
17 (c) the person, or, if the person is a *medical practitioner who
18 has appointed a representative in relation to the mediation
19 under section 247-10, the person's representative, fails to
20 participate in part or all of the mediation.

21 Penalty: 30 penalty units.

22 **247-10 Medical practitioners may appoint representatives**

- 23 (1) If the Private Health Insurance Ombudsman directs a *medical
24 practitioner under subsection 247-5(1) to participate in mediation,
25 the medical practitioner may appoint an individual to participate in
26 the mediation on the practitioner's behalf.
- 27 (2) The appointment must be:
28 (a) in writing; and
29 (b) signed by the *medical practitioner; and
30 (c) made before the mediation starts.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **247-15 Conduct of compulsory mediation**

- 2 (1) If the Private Health Insurance Ombudsman directs a party to
3 participate in mediation, the mediation may be conducted by:
4 (a) the Private Health Insurance Ombudsman; or
5 (b) a person appointed by the Private Health Insurance
6 Ombudsman under section 247-25.
- 7 (2) Mediation in which a party is directed to participate ceases:
8 (a) if the parties agree to settle the matter; or
9 (b) if the Private Health Insurance Ombudsman concludes that
10 the matter cannot be settled by mediation.
- 11 (3) The Private Health Insurance (Ombudsman) Rules may set out
12 matters to which the Private Health Insurance Ombudsman is to
13 have regard before concluding that a matter cannot be settled by
14 mediation.
- 15 (4) A person appointed by the Private Health Insurance Ombudsman
16 under section 247-25 to conduct mediation must, as soon as
17 practicable after the mediation is conducted or should have been
18 conducted, report to the Private Health Insurance Ombudsman
19 about:
20 (a) whether the mediation was conducted; and
21 (b) if the mediation failed—the reasons for the failure; and
22 (c) if the parties agreed to settle the complaint—the terms of the
23 settlement, including any action to be taken.

24 **247-20 Admissibility of things said in mediation**

- 25 (1) Evidence of anything said, or any admission made, during
26 participation in mediation under section 247-1 is not admissible:
27 (a) in any court (whether exercising federal jurisdiction or not);
28 or
29 (b) in any proceedings before a person authorised by a law of the
30 Commonwealth or of a State or Territory, or by the consent
31 of the parties, to hear evidence.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 247-25

- 1 (2) This section applies whether or not a party is directed to participate
2 in the mediation.

3 **247-25 Appointment of mediators**

- 4 (1) The Private Health Insurance Ombudsman may appoint a person to
5 conduct mediation in which a person is or will be directed to
6 participate under section 247-5.
- 7 (2) The Private Health Insurance (Ombudsman) Rules may set out
8 matters to which the Private Health Insurance Ombudsman is to
9 have regard when appointing a person under this section.
- 10 (3) The person is appointed for the period specified by the Private
11 Health Insurance Ombudsman in the instrument of appointment.
- 12 (4) Subject to Division 323 (disclosure of information), the person is
13 not personally liable to an action or other proceeding for damages
14 in relation to anything done or omitted to be done, reasonably and
15 in good faith, in or in relation to the conduct of the mediation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 250—Information-gathering**

3 **250-1 Information-gathering**

4 *Information-gathering for Division 241 complaints*

- 5 (1) The Private Health Insurance Ombudsman may, for the purposes
6 of:
- 7 (a) deciding if, and how, to deal with a complaint made under
8 Division 241; or
 - 9 (b) mediating a complaint made under Division 241; or
 - 10 (c) investigating a complaint made under Division 241; or
 - 11 (d) evaluating action proposed by the subject of a complaint after
12 referral of the complaint to the subject under
13 Subdivision 241-C;
- 14 request the subject of the complaint, or an *officer of the subject, to
15 give the Private Health Insurance Ombudsman the *records of the
16 subject (relating to the complaint) that are specified in the request,
17 before the end of the period specified in the request.

18 *Information-gathering for Division 244 investigations*

- 19 (2) The Private Health Insurance Ombudsman may, for the purposes of
20 an investigation under Division 244 (including mediating as part of
21 the investigation under Division 247), request the subject of the
22 investigation, or an *officer of the subject:
- 23 (a) to give the Private Health Insurance Ombudsman the
24 information (relating to the practices and procedures being
25 investigated) that is specified in the request; or
 - 26 (b) to give the Private Health Insurance Ombudsman the *records
27 of the subject (relating to the practices and procedures being
28 investigated) that are specified in the request;
- 29 before the end of the period specified in the request.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 250-1

- 1 *General provisions about information-gathering*
- 2 (3) The Private Health Insurance Ombudsman may make one or more
- 3 requests under subsection (1) or (2) in relation to a complaint or
- 4 investigation, at any time while the Private Health Insurance
- 5 Ombudsman is dealing with the complaint or investigation.
- 6 (4) A person to whom a request is made under subsection (1) or (2)
- 7 may, before the end of the period specified in the request, ask the
- 8 Private Health Insurance Ombudsman to extend the period
- 9 specified in the request.
- 10 (5) If the Private Health Insurance Ombudsman refuses to extend the
- 11 period, the Private Health Insurance Ombudsman must give his or
- 12 her reasons for refusing.
- 13 Note: A refusal to extend the period is reviewable under Part 6-9.
- 14 (6) A person is not excused from giving information or producing a
- 15 *record when required to do so under subsection (1) on the ground
- 16 that the giving of the information, or the production of the record,
- 17 might tend to incriminate the person or make the person liable to a
- 18 penalty. However, the giving of the information, or the production
- 19 of the record, or anything obtained as a direct or indirect
- 20 consequence of the giving or production, is not admissible in
- 21 evidence against the person in any proceedings, other than
- 22 proceedings for an offence against section 137.1 or 137.2 of the
- 23 *Criminal Code*.
- 24 (7) A person commits an offence if:
- 25 (a) a request is made to the person under subsection (1) or (2);
- 26 and
- 27 (b) the person fails to comply with the request by the end of the
- 28 period specified in the request or, if that period has been
- 29 extended, by the end of the extended period.
- 30 Penalty: 30 penalty units.
- 31 (8) Strict liability applies to subsection (7).
- 32 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **250-5 Limits on information-gathering**

- 2 (1) A request made to the subject of a complaint, or an *officer of the
3 subject of a complaint, under subsection 250-1(1) must not request
4 *records that relate to the subject's dealings with the complainant
5 unless the complainant consents to the records being given.
- 6 (2) A request made to a private health insurer, or an *officer of a
7 private health insurer, under subsection 250-1(2) must not request
8 information or *records that relate to a particular individual who is
9 or was insured, or is or was seeking to be insured, under a *private
10 health insurance policy of the insurer, unless the individual
11 consents to the records or information being given.
- 12 (3) A request made to a *health care provider, or an *officer of a health
13 care provider, under subsection 250-1(2) must not request
14 information or *records that relate to a particular individual who is
15 or was a patient of the health care provider, unless the individual
16 consents to the information or records being given.
- 17 (4) A request made to a *private health insurance broker, or an *officer
18 of a private health insurance broker, under subsection 250-1(2)
19 must not request information or *records that relate to a particular
20 individual who is or was a client of the broker unless the individual
21 consents to the information or records being given.

22 **250-10 Disclosure of personal information**

- 23 (1) This section applies if a person gives a *record, information or a
24 document to the Private Health Insurance Ombudsman, reasonably
25 believing that this would assist the Private Health Insurance
26 Ombudsman in:
- 27 (a) mediating a complaint under Division 247 or otherwise
28 dealing with it under Subdivision 241-B or 241-D; or
29 (b) referring a complaint under section 241-25 or 241-30; or
30 (c) making a decision under section 241-35 not to deal, or not to
31 continue to deal, with a complaint; or
32 (d) investigating a matter under section 244-1 or 244-5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration
Part 6-2 Private Health Insurance Ombudsman
Division 250 Information-gathering

Section 250-10

- 1 (2) For the purposes of:
- 2 (a) the *Privacy Act 1988*; and
- 3 (b) any provision of a law of a State or Territory that provides
- 4 that *personal information contained in a *record, information
- 5 or document may be disclosed if the disclosure is authorised
- 6 by law;
- 7 the giving of the record, information or document to the Private
- 8 Health Insurance Ombudsman is taken to be authorised by law.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 253—Provisions relating to the Private Health**
3 **Insurance Ombudsman**

4 **253-1 Appointment of the Private Health Insurance Ombudsman**

- 5 (1) The Private Health Insurance Ombudsman is to be appointed by
6 the Minister, by written instrument, in accordance with any Private
7 Health Insurance (Ombudsman) Rules.
- 8 (2) The Private Health Insurance Ombudsman may be appointed on a
9 full-time or a part-time basis.
- 10 (3) The Private Health Insurance Ombudsman holds office on the
11 terms and conditions (if any) in relation to matters not covered by
12 this Act that are determined by the Minister.

13 **253-5 Validity of appointments**

14 The appointment of a person as Private Health Insurance
15 Ombudsman is not invalid merely because there was a defect or
16 irregularity in connection with the appointment.

17 **253-10 Acting appointments**

- 18 (1) The Minister may appoint a person to act as the Private Health
19 Insurance Ombudsman:
20 (a) during a vacancy in the office of Private Health Insurance
21 Ombudsman (whether or not an appointment has previously
22 been made to the office); or
23 (b) during any period, or during all periods, when the Private
24 Health Insurance Ombudsman is absent from duty or from
25 Australia or is, for any other reason, unable to perform the
26 duties of the office.
- 27 (2) Anything done by or in relation to a person purporting to act under
28 an appointment under this section is not invalid merely because:
29 (a) the occasion for the appointment had not arisen; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 253-15

- 1 (b) there was a defect or irregularity in connection with the
2 appointment; or
3 (c) the appointment had ceased to have effect; or
4 (d) the occasion to act had not arisen or had ceased.

5 **253-15 Remuneration and allowances**

- 6 (1) The Private Health Insurance Ombudsman is to be paid the
7 remuneration that is determined by the Remuneration Tribunal. If
8 no determination of that remuneration by the Tribunal is in
9 operation, the Private Health Insurance Ombudsman is to be paid
10 the remuneration that is specified in the Private Health Insurance
11 (Ombudsman) Rules.
- 12 (2) The Private Health Insurance Ombudsman is to be paid such
13 allowances as are set out in the Private Health Insurance
14 (Ombudsman) Rules.
- 15 (3) This section has effect subject to the *Remuneration Tribunal Act*
16 *1973*.

17 **253-20 Outside employment**

- 18 (1) A person who holds the office of Private Health Insurance
19 Ombudsman on a full-time basis must not engage in any paid
20 employment outside the duties of that office without the Minister's
21 written approval.
- 22 (2) A person who holds the office of Private Health Insurance
23 Ombudsman on a part-time basis must not engage in any paid
24 employment that, in the Minister's opinion, conflicts with the
25 proper performance of the Private Health Insurance Ombudsman's
26 functions.

27 **253-25 Leave of absence**

- 28 (1) If the Private Health Insurance Ombudsman holds office on a
29 full-time basis, he or she has such recreation leave entitlements as
30 are determined by the Remuneration Tribunal.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) The Minister may grant the Private Health Insurance Ombudsman
2 leave of absence, other than recreational leave, on such terms and
3 conditions as to remuneration or otherwise as the Minister
4 determines in writing.

5 **253-30 Resignation**

6 The Private Health Insurance Ombudsman may resign his or her
7 appointment by giving the Minister a written resignation.

8 **253-35 Termination of appointment**

- 9 (1) The Minister may terminate the Private Health Insurance
10 Ombudsman's appointment for misbehaviour or physical or mental
11 incapacity.
- 12 (2) The Minister must terminate the Private Health Insurance
13 Ombudsman's appointment if the Private Health Insurance
14 Ombudsman:
- 15 (a) becomes bankrupt, applies to take the benefit of any law for
16 the relief of bankrupt or insolvent debtors, compounds with
17 creditors or makes an assignment of remuneration for their
18 benefit; or
- 19 (b) is appointed on a full-time basis and is absent from duty,
20 except on leave of absence, for 14 consecutive days or for 28
21 days in any 12 months; or
- 22 (c) is appointed on a full-time basis and engages, except with the
23 Minister's approval, in paid employment outside the duties of
24 his or her office; or
- 25 (d) is appointed on a part-time basis and engages in paid
26 employment that, in the Minister's opinion, conflicts with the
27 proper performance of his or her duties; or
- 28 (e) fails, without reasonable excuse, to comply with
29 section 253-40.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **253-40 Disclosure of interest by Private Health Insurance**
2 **Ombudsman**

3 If the Private Health Insurance Ombudsman has a material
4 personal interest in a matter that the Private Health Insurance
5 Ombudsman is considering or about to consider, the Private Health
6 Insurance Ombudsman must give written notice of the interest to
7 the Minister.

8 **253-45 Statutory agency etc. for purposes of Public Service Act**

9 (1) The staff required to assist the Private Health Insurance
10 Ombudsman are to be persons engaged under the *Public Service*
11 Act 1999.

12 (2) For the purposes of the *Public Service Act 1999*:

- 13 (a) the Private Health Insurance Ombudsman and the APS
14 employees assisting him or her together constitute a Statutory
15 Agency; and
16 (b) the Private Health Insurance Ombudsman is the Head of that
17 Statutory Agency.

18 **253-50 Annual report**

19 (1) The Private Health Insurance Ombudsman must, as soon as
20 practicable after the end of each financial year, prepare and give to
21 the Minister, for presentation to the Parliament, a report on the
22 operations during that year of the office of the Private Health
23 Insurance Ombudsman.

24 Note: See also section 34C of the *Acts Interpretation Act 1901*, which
25 contains extra rules about annual reports.

26 (2) The Private Health Insurance Ombudsman must include in the
27 report:

- 28 (a) the number and nature of complaints received under
29 section 241-1; and
30 (b) the outcomes of any actions taken, recommendations made or
31 investigations conducted in relation to such complaints; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) the outcomes in relation to complaints referred to another
2 body under section 241-30; and
3 (d) investigations (if any) conducted by the Private Health
4 Insurance Ombudsman under section 244-1; and
5 (e) requests (if any) by the Minister under section 244-5 that the
6 Private Health Insurance Ombudsman conduct an
7 investigation; and
8 (f) the outcomes of investigations conducted under
9 sections 244-1 and 244-5.

10 **253-55 Delegation**

11 The Private Health Insurance Ombudsman may, by writing,
12 delegate to a member of staff referred to in section 253-45 all or
13 any of the Private Health Insurance Ombudsman's powers and
14 functions under this Act.

15 **253-60 Private Health Insurance Ombudsman and staff not**
16 **personally liable**

17 Subject to Division 323 (disclosure of information), neither the
18 Private Health Insurance Ombudsman nor a member of staff
19 referred to in section 253-45 is personally liable to an action or
20 other proceeding for damages in relation to anything done or
21 omitted to be done reasonably and in good faith:

- 22 (a) in the performance or purported performance of any function
23 of the Private Health Insurance Ombudsman; or
24 (b) in the exercise or purported exercise of any power of the
25 Private Health Insurance Ombudsman.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 256-1

1

2 **Division 256—Miscellaneous**

3 **256-1 Protection from civil actions**

4 Civil proceedings do not lie against a person in respect of loss,
5 damage or injury of any kind suffered by another person because a
6 statement was made, or information or a document given, in good
7 faith to the Private Health Insurance Ombudsman in connection
8 with:

- 9 (a) the making of a complaint under Division 241; or
10 (b) the Private Health Insurance Ombudsman's handling of such
11 a complaint; or
12 (c) an investigation under Division 244.

13 **256-5 Victimisation**

14 A person commits an offence if:

- 15 (a) the person subjects, or threatens to subject, another person to
16 detriment; and
17 (b) the person does so because the other person has made, or
18 proposes to make, a complaint under this Part.

19 Penalty: Imprisonment for 6 months.

20 **256-10 Giving information about the Private Health Insurance**
21 **Ombudsman**

- 22 (1) The Private Health Insurance Ombudsman may direct private
23 health insurers:
24 (a) to give *adults insured under the insurers' *products the
25 information specified in the direction, in the manner specified
26 in the direction; or
27 (b) to publish the information specified in the direction, in the
28 manner specified in the direction.
29 (2) A direction must only specify information that relates to the
30 functions of the Private Health Insurance Ombudsman.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (3) If more than one *adult is insured under a single *complying health
2 insurance policy of a private health insurer, the insurer is taken to
3 comply with a direction if the insurer complies with the direction
4 in relation to only one of those adults.

5 (4) A private health insurer commits an offence if:
6 (a) the Private Health Insurance Ombudsman gives private
7 health insurers a direction under subsection (1); and
8 (b) the insurer does not comply with the direction.

9 Penalty: 60 penalty units.

10 (5) Strict liability applies to subsection (4).

11 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Part 6-3—Private Health Insurance Administration Council

3

4

Division 261—Introduction

5

261-1 What this Part is about

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7

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9

The Private Health Insurance Administration Council continues in existence with functions and powers relating largely to the regulation of private health insurers through the administration of Chapter 4 and Part 5-3.

10

261-5 The Private Health Insurance (Council) Rules

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14

*External management and *terminating management of *health benefits funds is also dealt with in the Private Health Insurance (Council) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

15

16

Note: The Private Health Insurance (Council) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 264—Continuation, purposes, functions and**
3 **powers**

4 **264-1 Continuation of the Council**

5 (1) The Private Health Insurance Administration Council established
6 under section 82B of the *National Health Act 1953* continues in
7 existence by force of this section, under and subject to the
8 provisions of this Act.

9 (2) The Council:

10 (a) is a body corporate with perpetual succession; and

11 (b) must have a common seal; and

12 (c) may acquire, hold and dispose of real and personal property;
13 and

14 (d) may sue and be sued in its corporate name.

15 Note: The *Commonwealth Authorities and Companies Act 1997* applies
16 to the Council (subject to section 267-20). That Act deals with
17 matters relating to Commonwealth authorities, including reporting
18 and accountability, banking and investment, and conduct of
19 officers.

20 (3) The common seal of the Council must be kept in such custody as
21 the Council directs and must not be used except as authorised by
22 the Council.

23 (4) All courts, judges and persons acting judicially must:

24 (a) take judicial notice of the imprint of the common seal of the
25 Council appearing on a document; and

26 (b) presume that the document was duly sealed.

27 **264-5 Objectives of the Council**

28 In performing its functions and exercising its powers, the Council
29 must take all reasonable steps to achieve an appropriate balance
30 between the following objectives:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 264-10

- 1 (a) fostering an efficient and competitive health insurance
2 industry;
3 (b) protecting the interests of consumers;
4 (c) ensuring the prudential safety of individual private health
5 insurers.

6 **264-10 Functions of the Council**

7 *General*

- 8 (1) The functions of the Council are:
9 (a) to administer the *Risk Equalisation Trust Fund; and
10 (b) to administer the registration of private health insurers under
11 Part 4-3; and
12 (c) the information collection function under subsection (2); and
13 (d) the compliance functions under subsection (3); and
14 (e) the enforcement functions under subsection (4); and
15 (f) the public information functions under subsection (5); and
16 (g) the agency cooperation functions under subsection (6); and
17 (h) to advise the Minister about the financial operations and
18 affairs of private health insurers; and
19 (i) functions incidental to any other functions of the Council;
20 and
21 (j) any other functions conferred on the Council by this, or any
22 other, Act.

23 *Information collection function*

- 24 (2) The information collection function of the Council is to obtain
25 from each private health insurer regular reports about the insurer's
26 operations, including reports supported by actuarial certification.

27 *Compliance functions*

- 28 (3) The compliance functions of the Council are:
29 (a) to establish a *solvency standard and a *capital adequacy
30 standard to be complied with by private health insurers, and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 to give *solvency directions and *capital adequacy directions
2 to private health insurers; and

3 Note: The solvency standard and the capital adequacy standard are
4 established by the Private Health Insurance (Health Benefits
5 Administration) Rules.

6 (b) to exercise powers and discretions under the *prudential
7 standards, and to give directions to private health insurers
8 relating to compliance with the prudential standards; and

9 Note: The prudential standards are established by the Private Health
10 Insurance (Insurer Obligations) Rules.

11 (c) to consider, in accordance with Division 160, whether
12 persons should, or should not, be *appointed actuaries; and

13 (d) to consider, in accordance with Division 166, whether
14 persons should, or should not, be *disqualified persons; and

15 (e) to examine, from time to time, the financial affairs of private
16 health insurers, by the inspection and analysis of the records,
17 books and accounts of the insurers and any other relevant
18 information; and

19 (f) to review, by carrying out independent actuarial assessment,
20 the value of the assets and liabilities of each *health benefits
21 fund; and

22 (g) if it is necessary, for the purpose of making a proper
23 examination of the financial affairs of a private health
24 insurer, for the Council to incur unusually high costs—to
25 impose an appropriate fee on the private health insurer
26 concerned.

27 *Enforcement functions*

28 (4) The enforcement functions of the Council are:

29 (a) to take action under Part 5-2 to monitor compliance with, and
30 to encourage or compel compliance with,
31 *Council-supervised obligations; and

32 (b) to appoint, under section 214-1, *inspectors for the purpose
33 of investigating the affairs of private health insurers under
34 Division 214, and to exercise other related powers and
35 functions of the Council under that Division; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-3 Private Health Insurance Administration Council

Division 264 Continuation, purposes, functions and powers

Section 264-15

- 1 (c) to appoint, under Subdivision 217-B, persons as *external
2 managers of *health benefits funds, and to exercise other
3 related powers and functions of the Council under
4 Division 217 and 220.

5 *Public information functions*

- 6 (5) The public information functions of the Council are:
7 (a) to make statistics, and other financial information, relating to
8 a private health insurer or private health insurers, publicly
9 available in accordance with the Private Health Insurance
10 (Council) Rules; and
11 (b) to collect and disseminate information about private health
12 insurance, for the purpose of enabling people to make
13 informed choices about private health insurance.

14 *Agency cooperation functions*

- 15 (6) The agency cooperation functions of the Council are:
16 (a) to cooperate with other regulatory agencies on matters
17 affecting private health insurers and the private health
18 insurance industry generally; and
19 (b) to provide the Private Health Insurance Ombudsman, from
20 time to time, with information in the Council's possession
21 that the Council considers likely to be of use in production of
22 the State of the Health Funds Reports referred to in paragraph
23 238-5(c).

24 **264-15 Report on private health insurers**

- 25 (1) The Council must, as soon as practicable after 30 September in
26 each year, give the Minister a report, for presentation to the
27 Parliament, on the operations of private health insurers during the
28 financial year ending on 30 June in that year.

29 Note: See also section 34C of the *Acts Interpretation Act 1901*, which
30 contains extra rules about annual reports.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) The report must include, in respect of each *health benefits fund
2 conducted by a private health insurer during the year to which the
3 report relates, the following information:
4 (a) premiums payable to the fund;
5 (b) other amounts payable to the fund;
6 (c) fund benefits payable out of the fund;
7 (d) management expenses;
8 (e) other amounts payable out of the fund;
9 (f) the balance of the fund as at the end of that year;
10 (g) details of how the reserves of the fund have been invested;
11 (h) such other information as the Minister requires to be
12 included.

13 Note: An annual report on the Council's operations must also be prepared
14 under section 9 of the *Commonwealth Authorities and Companies Act*
15 *1997*.

16 **264-20 Powers**

17 The Council has power to do all things necessary or convenient to
18 be done for, or in connection with the performance of its functions.

19 **264-25 Directions by Minister**

- 20 (1) The Minister may, by legislative instrument, give directions with
21 respect to the performance of the Council's functions or the
22 exercise of its powers.
23 (2) The Council must comply with any such direction.
24 (3) Before giving a direction under subsection (1), the Minister must
25 consult the Council about the proposed direction.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 267—Constitution and administration**

3 **267-1 Constitution of the Council**

- 4 (1) The Council consists of the following members:
- 5 (a) a Commissioner of Private Health Insurance Administration;
- 6 (b) at least 2, and not more than 4, other members.
- 7 (2) The performance of the functions, or the exercise of the powers, of
- 8 the Council is not affected only because there is a vacancy or
- 9 vacancies in the membership of the Council.

10 **267-5 Appointment of members**

- 11 (1) The *members are to be appointed in writing by the Minister.
- 12 (2) One of the *members may be appointed in writing by the Minister
- 13 to be the Deputy Commissioner.
- 14 (3) Appointments must be made in accordance with the requirements
- 15 (if any) specified in the Private Health Insurance (Council) Rules.
- 16 (4) The *Commissioner is to be appointed on a full-time basis or on a
- 17 part-time basis.
- 18 (5) A *member, other than the *Commissioner, is to be appointed on a
- 19 part-time basis.
- 20 (6) If a *member is appointed as *Deputy Commissioner, that
- 21 appointment is on a part-time basis.
- 22 (7) A person cannot be appointed as a *member if that person is a
- 23 *director, *officer or employee of a body regulated by the Council.

24 **267-10 Meetings of the Council**

- 25 (1) Subject to subsection (2), the *Commissioner must convene a
- 26 meeting of the Council when:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (a) the Commissioner thinks it necessary for the efficient
2 performance of the Council's functions; or
3 (b) directed to do so by written notice of the Minister; or
4 (c) requested in writing to do so by at least 2 *members.
- 5 (2) The *Commissioner must convene a meeting at least once every 6
6 months.
- 7 (3) The *Commissioner must determine the time and place at which a
8 meeting is to be held.
- 9 (4) A majority of the *members constitutes a quorum.
- 10 (5) The *Commissioner must preside at all meetings.
- 11 (6) A question arising at a meeting is decided by a majority of the
12 votes of the *members present and voting. The *Commissioner has
13 a deliberative vote and, if necessary, also has a casting vote.
- 14 (7) Subject to this section, the *Commissioner must determine the
15 procedure of the meeting.

16 **267-15 Delegation by the Council**

17 The Council may, by writing under its common seal, delegate to:

- 18 (a) the *Chief Executive Officer; or
19 (b) another member of staff of the Council;
20 all or any of the functions and powers of the Council, other than
21 functions and powers under the *Commonwealth Authorities and*
22 *Companies Act 1997*.

23 **267-20 Modification of the *Commonwealth Authorities and***
24 ***Companies Act 1997***

25 Section 14 of the *Commonwealth Authorities and Companies Act*
26 *1997* does not apply in relation to the Council.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 270—Members**

3 **270-1 Terms and conditions etc.**

4 The Private Health Insurance (Council) Rules may, subject to this
5 Part, specify:

- 6 (a) the terms and conditions of appointment of the
7 *Commissioner, of the other *members, and of a member as
8 *Deputy Commissioner; and
9 (b) their periods of appointment.

10 **270-5 Validity of appointments**

11 The appointment of a person as *Commissioner or as another
12 *member is not invalid because of a defect or irregularity in
13 connection with the person's appointment.

14 **270-10 Acting Commissioner**

- 15 (1) The Minister may appoint a person to act as *Commissioner:
16 (a) during a vacancy in the office of Commissioner (whether or
17 not an appointment has been previously made to the office);
18 or
19 (b) during any period, or during all periods, when, the
20 Commissioner is absent from duty or from Australia or is, for
21 any other reason, unable to perform the duties of the office;
22 but a person appointed to act during a vacancy must not continue to
23 act for more than 12 months.
- 24 (2) Anything done by or in relation to a person purporting to act as
25 *Commissioner is not invalid because:
26 (a) the occasion for the appointment had not arisen; or
27 (b) there was a defect or irregularity in connection with the
28 appointment; or
29 (c) the appointment had ceased to have effect; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (d) the occasion for the person to act as Commissioner had not
2 arisen or had ceased.

3 **270-15 Deputy Commissioner to act as Commissioner in certain**
4 **circumstances**

- 5 (1) The *Deputy Commissioner is to act as *Commissioner:
6 (a) during a vacancy in the office of Commissioner (whether or
7 not an appointment has been made to the office) if no-one has
8 been appointed to act as Commissioner; or
9 (b) during any period, or during all periods, when the
10 Commissioner, and any person appointed to act as
11 Commissioner, are absent from duty or from Australia or are,
12 for any other reason, unable to perform the duties of the
13 Commissioner.
- 14 (2) The *Deputy Commissioner must not act as *Commissioner during
15 a vacancy in the office of Commissioner for more than 12 months.
- 16 (3) Anything done by or in relation to a person purporting to act as
17 *Commissioner under this section is not invalid because the
18 occasion for the person to act as Commissioner had not arisen or
19 had ceased.

20 **270-20 Powers and duties of persons acting as Commissioner**

- 21 (1) Subject to any direction by the *Commissioner, an acting
22 Commissioner, or the *Deputy Commissioner when acting as
23 Commissioner, has all the powers and functions of the
24 Commissioner under this Act.
- 25 (2) A power or function of the *Commissioner under this Act or any
26 other Act, when exercised or performed by an acting
27 Commissioner, or by the *Deputy Commissioner when acting as
28 Commissioner, is to be taken, for the purposes of this Act or any
29 other Act, to have been exercised or performed by the
30 Commissioner.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 270-25

- 1 (3) The exercise of a power or the performance of a function of the
2 *Commissioner under this Act or any other Act by an acting
3 Commissioner, or by the *Deputy Commissioner when acting as
4 Commissioner, does not prevent the exercise of the power or the
5 performance of the function by the Commissioner.
- 6 (4) If, under this Act or any other Act:
- 7 (a) the exercise of a power or the performance of a function by
8 the *Commissioner; or
- 9 (b) the operation of a provision of this Act or that other Act;
10 is dependent on the opinion, belief or state of mind of the
11 Commissioner in relation to a matter:
- 12 (c) that power or function may be exercised or performed by an
13 acting Commissioner, or by the *Deputy Commissioner when
14 acting as Commissioner; and
- 15 (d) that provision may operate;
16 on the opinion, belief or state of mind in relation to that matter of
17 the acting Commissioner, or of the Deputy Commissioner when so
18 acting.

19 **270-25 Remuneration and allowances of members**

- 20 (1) A *member is to be paid the remuneration that is determined by the
21 Remuneration Tribunal. If no determination of that remuneration
22 by the Tribunal is in operation, the member is to be paid the
23 remuneration that is specified in the Private Health Insurance
24 (Council) Rules.
- 25 (2) A *member is to be paid such allowances as are set out in the
26 Private Health Insurance (Council) Rules.
- 27 (3) This section has effect subject to the *Remuneration Tribunal Act*
28 *1973*.

29 **270-30 Leave of absence**

- 30 (1) A full-time *Commissioner has such recreation leave entitlements
31 as are determined by the Remuneration Tribunal.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) The Minister may grant a full-time *Commissioner leave of
2 absence, other than recreation leave, on such terms and conditions
3 as to remuneration or otherwise as are specified in the Private
4 Health Insurance (Council) Rules.
- 5 (3) The *Commissioner may grant another *member leave to be absent
6 from a meeting or meetings of the Council.

7 **270-35 Resignation**

- 8 A *member may resign by writing signed and given to the
9 Minister.

10 **270-40 Termination of appointment**

- 11 (1) The Minister may terminate the appointment of a *member for
12 misbehaviour or physical or mental incapacity.
- 13 (2) The Minister must terminate the appointment of *a member if:
14 (a) the member becomes bankrupt, applies to take the benefit of
15 a law for the relief of bankrupt or insolvent debtors,
16 compounds with his or her creditors or makes an assignment
17 of his or her remuneration for their benefit; or
18 (b) the member is absent, except with the leave of the
19 *Commissioner, from 3 consecutive meetings of the Council;
20 or
21 (c) the member is appointed as the Commissioner on a full-time
22 basis and engages, except with the Minister's approval, in
23 paid employment outside the duties of his or her office; or
24 (d) the member is appointed on a part-time basis and engages in
25 paid employment that, in the Minister's opinion, conflicts
26 with the proper performance of his or her duties; or
27 (e) the member fails, without reasonable excuse, to comply with
28 section 270-45.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **270-45 Disclosure of interests**

- 2 (1) A *member who has a direct or indirect pecuniary interest in a
3 matter being considered or about to be considered by the Council
4 must disclose the nature of the interest to a meeting of the Council.
- 5 (2) The disclosure must be made as soon as possible after the relevant
6 facts have come to the *member's knowledge.
- 7 (3) The disclosure must be recorded in the minutes of the meeting of
8 the Council.
- 9 (4) The *member:
- 10 (a) must not be present during any deliberation by the Council
11 on the matter; and
- 12 (b) must not take part in any decision on the Council with respect
13 to the matter.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 273—Chief Executive Officer and staff**

3 **273-1 Chief Executive Officer**

- 4 (1) There is to be a *Chief Executive Officer of the Council who is to
5 be appointed by the Council.
- 6 (2) The Council may:
- 7 (a) determine the terms and conditions of service of the *Chief
8 Executive Officer in respect of matters not provided for by
9 this Part; and
- 10 (b) at any time terminate such an appointment.
- 11 (3) The *Chief Executive Officer holds office on a full-time basis.
- 12 (4) The *Chief Executive Officer holds office for the period, and
13 subject to the terms and conditions, specified in the instrument of
14 appointment.
- 15 (5) The appointment of a person as *Chief Executive Officer is not
16 invalid because of a defect or irregularity in connection with the
17 person's appointment.

18 **273-5 Duties of Chief Executive Officer**

- 19 (1) To the extent determined by the Council, the *Chief Executive
20 Officer is to manage the affairs of the Council.
- 21 (2) The *Chief Executive Officer must, in managing the affairs of the
22 Council, act in accordance with the policy of, and with any
23 directions given by, the Council.

24 **273-10 Conflict of interests**

- 25 (1) The *Chief Executive Officer must not be present at a meeting of
26 the Council when the Council is making a decision in relation to
27 the office of Chief Executive Officer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 273-15

- 1 (2) If the *Chief Executive Officer has a direct or indirect pecuniary
2 interest in a matter related to his or her duties as Chief Executive
3 Officer, he or she must disclose the nature of the interest to the
4 *Commissioner as soon as possible after the relevant facts have
5 come to his or her knowledge.

6 **273-15 Staff and consultants**

- 7 (1) The Council may employ such staff as the Council thinks
8 necessary to employ to assist the Council in the performance of its
9 functions and the exercise of its powers.
- 10 (2) The *Commissioner may arrange with an Agency Head (within the
11 meaning of the *Public Service Act 1999*) for the services of
12 *officers or employees in the Agency to be made available to the
13 Council.
- 14 (3) The Council may engage, under agreements in writing, persons
15 having suitable qualifications and experience to perform services
16 as consultants to the Council.
- 17 (4) The terms and conditions of staff employed, or consultants
18 engaged, by the Council are such as are determined by the Council
19 from time to time.

20 **273-20 Remuneration and allowances of Chief Executive Officer**

- 21 (1) The *Chief Executive Officer is to be paid the remuneration that is
22 determined by the Remuneration Tribunal. If no determination of
23 that remuneration by the Tribunal is in operation, the Chief
24 Executive Officer is to be paid the remuneration that is specified in
25 the Private Health Insurance (Council) Rules.
- 26 (2) The *Chief Executive Officer is to be paid such allowances as are
27 set out in the Private Health Insurance (Council) Rules.
- 28 (3) This section has effect subject to the *Remuneration Tribunal Act*
29 *1973*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **273-25 Leave of absence of Chief Executive Officer**

- 2 (1) The *Chief Executive Officer has such recreation leave
3 entitlements as are determined by the Remuneration Tribunal.
- 4 (2) The Council may grant the *Chief Executive Officer leave of
5 absence, other than recreation leave, on such terms and conditions
6 as to remuneration or otherwise as are specified in the Private
7 Health Insurance (Council) Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2

Part 6-4—Administration of premiums reduction and incentive payments schemes

3

4

Division 276—Introduction

5

276-1 What this Part is about

6

Part 2-2 provides for a premiums reduction scheme and an incentives payment scheme. This Part provides:

7

8

(a) for private health insurers to be reimbursed for premiums that were reduced under the premiums reduction scheme in Division 23; and

9

10

11

(b) for the Medicare Australia CEO to supervise that reimbursement and related matters; and

12

13

(c) for recovery of amounts paid in error; and

14

(d) for various other related administrative matters in relation to the schemes.

15

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 279—Provisions applying only to premiums**
3 **reduction scheme**

4 **Subdivision 279-A—Reimbursement of private health insurers**
5 **for premiums reduced under scheme**

6 **279-1 Participating insurers may claim reimbursement**

7 A private health insurer may claim reimbursement from the
8 Medicare Australia CEO in accordance with section 279-10 for
9 each month during which it is a *participating insurer.

10 **279-5 Participating insurers**

- 11 (1) A private health insurer may apply to the Minister, in the
12 *approved form, to become a *participating insurer for the purposes
13 of this Part.
- 14 (2) If the Minister approves the application, the private health insurer
15 becomes a *participating insurer.
- 16 (3) The Minister must approve the application, unless:
17 (a) the insurer's status as a *participating insurer has previously
18 been revoked under subsection 206-1(1); and
19 (b) the Minister is satisfied that the insurer is continuing, or will
20 continue, to fail to comply with a provision or condition
21 mentioned in that subsection.
- 22 Note: Rejections of applications are reviewable under Part 6-9.
- 23 (4) The Minister must notify the applicant, within 28 days after the
24 date of the decision, whether the application has been approved or
25 rejected.
- 26 (5) If the application is rejected, the Minister must include his or her
27 reasons for rejecting the application in the notice.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **279-10 Requirements for claims**

- 2 (1) A claim by a private health insurer in respect of a month must be
3 made to the Medicare Australia CEO, in the *approved form, on or
4 before the seventh day of the following month.
- 5 (2) If the Medicare Australia CEO decides the claim is correct, the
6 Medicare Australia CEO must pay the insurer, in accordance with
7 section 279-15, the amount payable under that section in respect of
8 the month to which the claim relates.

9 **279-15 Amounts payable to the private health insurer**

- 10 (1) Subject to subsection (2), the amount payable to the private health
11 insurer in respect of the month is the sum of the amounts by which
12 premiums in respect of that month under the *complying private
13 health insurance policies issued by the private health insurer were
14 reduced because of the operation of Division 23.
- 15 (2) The amount must be paid to the private health insurer within the
16 period of 15 days starting on the first day of the following month.
- 17 (3) The amount must be paid in the way determined, in writing, by the
18 Medicare Australia CEO.

19 **279-20 Notifying private health insurers if amount is not payable**

- 20 (1) If the Medicare Australia CEO considers that a claim is incorrect,
21 the Medicare Australia CEO may either refuse the claim or pay
22 only such part of the claim as he or she is satisfied is correct.
- 23 (2) The Medicare Australia CEO must notify a private health insurer if
24 the Medicare Australia CEO makes a decision mentioned in
25 subsection (1).
- 26 (3) A notice under subsection (2) must include reasons for the
27 decision.
- 28 (4) The Medicare Australia CEO is taken, for the purposes of this Part,
29 to have decided that a claim is correct if the Medicare Australia
30 CEO does not give notice of his or her decision that the claim is

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 incorrect on or before the day under subsection 279-15(2) on or
2 before which, if the claim were correct, it would have been
3 required to have been paid.

4 **279-25 Additional payment if insurer claims less than entitlement**

- 5 (1) This section applies to a private health insurer in respect of a
6 month if:
- 7 (a) the private health insurer is a *participating insurer in respect
8 of the month; and
 - 9 (b) the private health insurer made a claim in respect of the
10 month under section 279-1; and
 - 11 (c) the amount claimed by the private health insurer was less
12 than the sum of the amounts by which premiums in respect of
13 the month under the *complying health insurance policies
14 issued by the private health insurer were reduced because of
15 the operation of this Division.
- 16 (2) The private health insurer may apply to the Medicare Australia
17 CEO for payment of an amount (the *additional amount*) not
18 exceeding the difference between:
- 19 (a) the sum of the amounts by which premiums in respect of the
20 month under the *complying health insurance policies issued
21 by the private health insurer were reduced because of the
22 operation of this Division; and
 - 23 (b) the amount already paid to the private health insurer under
24 section 279-1 in respect of the month.
- 25 (3) An application under subsection (2) may relate to more than one
26 month.

27 **279-30 Additional payment if insurer makes a late claim**

- 28 (1) This section applies to a private health insurer in respect of a
29 month if:
- 30 (a) the private health insurer did not make a claim in respect of
31 the month on or before the seventh day of the following
32 month; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 279 Provisions applying only to premiums reduction scheme

Section 279-35

- 1 (b) premiums in respect of the month under the *complying
2 health insurance policies issued by the private health insurer
3 were reduced because of the operation of this Division.
- 4 (2) The private health insurer may apply to the Medicare Australia
5 CEO for payment of an amount (the *additional amount*) not
6 exceeding the sum of the amounts by which premiums in respect of
7 the month under the *complying health insurance policies issued by
8 the private health insurer were reduced because of the operation of
9 Division 23.
- 10 (3) An application under subsection (2) may relate to more than one
11 month.

12 **279-35 Content and timing of application**

- 13 (1) An application by a private health insurer under section 279-25 or
14 279-30 for payment of an additional amount must be in the
15 *approved form.
- 16 (2) The application must be made:
17 (a) if the application relates to only one month—within 3 years
18 of the end of that month; or
19 (b) if the application relates to more than one month—within 3
20 years of the end of the first of those months.

21 **279-40 Decision on application**

- 22 (1) If a private health insurer makes an application under
23 section 279-25 or 279-30 for payment of an additional amount, the
24 Medicare Australia CEO must pay the additional amount sought if
25 the Medicare Australia CEO is satisfied:
26 (a) that the additional amount sought is correct; and
27 (b) that it would be reasonable to grant the application.
- 28 (2) The Medicare Australia CEO may refuse the application, or decide
29 to pay only part of the additional amount sought, if the Medicare
30 Australia CEO is satisfied:
31 (a) that the additional amount sought is incorrect; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) that it would not be reasonable to grant the application.
- 2 (3) The Medicare Australia CEO must notify the private health insurer
3 of the Medicare Australia CEO's decision on the application.
- 4 (4) A notice under subsection (3) must include reasons for the
5 decision.
- 6 (5) The Medicare Australia CEO is taken, for the purposes of this Part,
7 to have decided that:
- 8 (a) the additional amount sought is correct; and
9 (b) that it would be reasonable to grant the application;
10 if the Medicare Australia CEO does not give notice of his or her
11 decision that the additional amount sought is incorrect, or that it
12 would not be reasonable to grant the application, within the period
13 of 3 months after the application was received by the Medicare
14 Australia CEO.
- 15 (6) If the Medicare Australia CEO is taken to have made a decision
16 under subsection (5) in respect of a private health insurer, the
17 Medicare Australia CEO is taken to have given notice of that
18 decision to the private health insurer.

19 **279-45 Reconsideration of decisions**

- 20 (1) A private health insurer that has been given a notice under
21 subsection 279-20(2) or 279-40(3) may request the Medicare
22 Australia CEO to reconsider the decision.
- 23 (2) The request must:
- 24 (a) set out the reasons for the request; and
25 (b) be made within the period of 28 days after the day on which
26 the Medicare Australia CEO gave the notice.
- 27 (3) As soon as practicable after receiving the request, the Medicare
28 Australia CEO must reconsider the decision and:
- 29 (a) affirm it; or
30 (b) vary it; or
31 (c) revoke it and make a fresh decision.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 279 Provisions applying only to premiums reduction scheme

Section 279-50

- 1 Note: Decisions on reconsideration are reviewable under Part 6-9.
- 2 (4) If the Medicare Australia CEO varies the decision or revokes the
3 decision and makes a fresh decision, the decision as varied, or the
4 fresh decision, as the case may be, has effect according to its terms
5 and is taken always to have had that effect from the time when the
6 original decision was made.
- 7 (5) The Medicare Australia CEO must notify the private health insurer
8 stating the Medicare Australia CEO's decision on the
9 reconsideration together with a statement of his or her reasons for
10 the decision.
- 11 (6) The Medicare Australia CEO is taken, for the purposes of this Part,
12 to have revoked the decision if the Medicare Australia CEO does
13 not notify the private health insurer of his or her decision on the
14 reconsideration within 28 days after receiving the request.

15 **Subdivision 279-B—Powers of Medicare Australia CEO in**
16 **relation to participating insurers**

17 **279-50 Audits by Medicare Australia CEO**

- 18 (1) The Medicare Australia CEO may, at any time, audit the accounts
19 and records of a private health insurer that is, or has been, a
20 *participating insurer.
- 21 (2) An audit under subsection (1) must relate only to the accounts and
22 records of the private health insurer to the extent that they deal
23 with:
- 24 (a) participation by persons in the *premiums reduction scheme;
25 or
- 26 (b) reductions of premium payable under *complying private
27 health insurance policies under the premiums reduction
28 scheme; or
- 29 (c) receipt of money from the Medicare Australia CEO under
30 this Division.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (3) The Medicare Australia CEO must not carry out an audit unless he
2 or she has given notice to the private health insurer concerned
3 stating that an audit is to be carried out.
- 4 (4) The private health insurer must ensure that the Medicare Australia
5 CEO has full and free access to all accounts, records, documents
6 and papers of the private health insurer that are relevant to the
7 audit.
- 8 (5) The person carrying out the audit may make copies of, or take
9 extracts from, such accounts, records, documents or papers for use
10 in the audit.
- 11 (6) Without limiting the powers of the Medicare Australia CEO under
12 this section, the Medicare Australia CEO may, by notice given to a
13 private health insurer, require the insurer to give to the Medicare
14 Australia CEO, within a period specified in the notice beginning at
15 the end of a financial year, a certificate in writing by a registered
16 company auditor as to the correctness of the accounts and records
17 of the insurer for that year to the extent that those accounts and
18 records deal with matters mentioned in paragraphs (2)(a), (b) and
19 (c).

20 **279-55 Medicare Australia CEO may require production of**
21 **applications**

- 22 (1) The Medicare Australia CEO may, by notice given to a private
23 health insurer, require the private health insurer:
24 (a) to produce to the Medicare Australia CEO, within the period
25 and in the manner specified in the notice, applications
26 retained under section 23-45; or
27 (b) to make copies of any such applications and give them to the
28 Medicare Australia CEO within the period and in the manner
29 specified in the notice.
- 30 (2) A period specified under subsection (1) must not be less than one
31 month.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 279 Provisions applying only to premiums reduction scheme

Section 279-55

- 1 (3) A private health insurer is entitled to be paid by the Medicare
2 Australia CEO reasonable compensation for complying with
3 paragraph (1)(b).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 282—Provisions applying to premiums reduction**
3 **scheme and incentive payments scheme**

4 **Subdivision 282-A—When and how payments can be recovered**

5 **282-1 Recovery of payments**

6 (1) The following amounts are recoverable as debts due to the
7 Commonwealth:

- 8 (a) a payment made to a person under Subdivision 26-B to which
9 the person was not entitled;
- 10 (b) a payment made to a person under Subdivision 26-B in
11 respect of a premium that was afterwards refunded;
- 12 (c) a payment made to a person under Subdivision 26-B in
13 respect of a claim that has been withdrawn under
14 section 26-15;
- 15 (d) so much of a payment made under section 279-15 or 279-40
16 as relates to a *complying health insurance policy that covers
17 a person who was:
- 18 (i) a *participant in the premiums reduction scheme for the
19 financial year concerned in respect of the policy; and
- 20 (ii) not eligible to participate in that scheme in respect of
21 that policy;
- 22 (e) so much of a payment made under section 279-15 or 279-40
23 as relates to a premium for which a reduction was not
24 allowable under section 23-1;
- 25 (f) 150% of so much of a payment made under section 279-15 or
26 279-40 as:
- 27 (i) is not reflected in reductions in premiums payable under
28 complying private health insurance policies issued by
29 the private health insurer concerned; or
- 30 (ii) relates to a person whose application under subsection
31 23-15(1) has not been retained by the private health
32 insurer as required by section 23-45; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 282 Provisions applying to premiums reduction scheme and incentive payments scheme

Section 282-5

- 1 (iii) relates to a person whose application under subsection
2 23-15(1) has been so retained, but has not been
3 produced to the Medicare Australia CEO by the private
4 health insurer in accordance with a requirement made
5 by the Medicare Australia CEO under section 279-55;
- 6 (g) so much of a payment purportedly made under
7 section 279-15 or 279-40 as was not payable under that
8 section;
- 9 (h) interest payable under subsection 282-5(2).
- 10 (2) The amounts are recoverable from:
- 11 (a) if paragraph (1)(a), (b) or (c) applies—the person referred to
12 in that paragraph or that person’s estate; or
- 13 (b) if paragraph (1)(d), (e), (f) or (g) applies—the private health
14 insurer to which the payment concerned was made; or
- 15 (c) if paragraph (1)(h) applies:
- 16 (i) if the payment was made to a private health insurer—
17 that insurer; or
- 18 (ii) if the payment was made to an individual—the
19 individual or his or her estate.
- 20 (3) An amount recoverable under subsection (1) is recoverable
21 whether or not any person has been convicted of an offence
22 relating to the payment.

282-5 Interest on amounts recoverable

- 24 (1) If the Medicare Australia CEO has served, on an individual from
25 whom an amount is recoverable or the legal personal representative
26 of such an individual, or on a private health insurer from which an
27 amount is recoverable, under subsection 282-1(1) a notice claiming
28 an amount as a debt due to the Commonwealth and:
- 29 (a) an arrangement for the repayment of the amount has been
30 entered into between the Medicare Australia CEO and the
31 individual or the individual’s legal personal representative, or
32 the private health insurer, as the case may be, within the
33 period referred to in subsection (3), and there has been a

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 default in payment of an amount required to be paid under
2 the arrangement; or
- 3 (b) at the end of the period such an arrangement has not been
4 entered into and all or part of the amount remains unpaid;
5 then, from and including the day after the end of the period,
6 interest becomes payable on so much of the amount as from time to
7 time remains unpaid.
- 8 (2) Interest is payable:
- 9 (a) at the rate of 15% per annum; or
- 10 (b) if a lower rate is specified in the Private Health Insurance
11 (Incentives) Rules for the purposes of this paragraph—that
12 rate.
- 13 (3) The period for entering into an arrangement under paragraph (1)(a)
14 is the period of 3 months following the service of the notice under
15 subsection (1), or such longer period as the Medicare Australia
16 CEO allows.
- 17 (4) Despite subsection (1), in any proceedings instituted by the
18 Commonwealth for the recovery of an amount due under paragraph
19 282-1(1)(h), the court may order that the interest payable under
20 that paragraph is, and is taken to have been, so payable from and
21 including a day later than the day referred to in subsection (1).

22 **282-10 Medicare Australia CEO may set off debts against amounts**
23 **payable**

- 24 (1) Despite any other provision of Part 2-2 or this Part, if:
- 25 (a) except for this section, an amount would be payable by the
26 Medicare Australia CEO to a person or his or her estate, or to
27 a private health insurer, under Part 2-2 or this Part; and
- 28 (b) an amount is recoverable under section 282-1 by the
29 Commonwealth from the person or his or her estate, or from
30 the insurer, as the case may be;
- 31 the Medicare Australia CEO may set off the whole or a part of the
32 amount referred to in paragraph (b) against the amount referred to
33 in paragraph (a).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 282 Provisions applying to premiums reduction scheme and incentive payments scheme

Section 282-15

- 1 (2) If the Medicare Australia CEO decides to make such a set-off in
2 respect of a person or his or her estate, the Medicare Australia
3 CEO must serve on the person or his or her legal personal
4 representative or the legal personal representative of his or her
5 estate a notice of the decision.
- 6 (3) If the Medicare Australia CEO makes such a set-off:
- 7 (a) the Medicare Australia CEO is liable to pay to the person or
8 his or her estate, or to the insurer, only the amount remaining
9 after the set-off; and
- 10 (b) the amount referred to in paragraph (1)(b) is reduced by the
11 amount set off.

12 **282-15 Reconsideration of certain decisions under this Division**

- 13 (1) A person (the *applicant*) may apply to the Medicare Australia CEO
14 for the Medicare Australia CEO to reconsider the following
15 decisions:
- 16 (a) a decision that an amount is recoverable as a debt due to the
17 Commonwealth under:
- 18 (i) paragraph 282-1(1)(a) or (b); or
19 (ii) paragraph 282-1(1)(h) in respect of a payment made to
20 an individual; or
- 21 (b) a decision under subsection 282-10(1) to set off a debt
22 against an amount otherwise payable to a person (other than a
23 private health insurer) or his or her estate.
- 24 (2) The application must:
- 25 (a) be in writing; and
26 (b) set out the reasons for the application.
- 27 (3) The application must be made within:
- 28 (a) 28 days after the day on which the applicant is notified of the
29 decision; or
30 (b) if, either before or after the end of that period of 28 days, the
31 Medicare Australia CEO extends the period within which the
32 application may be made—the extended period for making
33 the application.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (4) Upon receiving such an application, the Medicare Australia CEO
2 must:
- 3 (a) reconsider the decision; and
4 (b) either affirm or revoke the decision.
- 5 Note: Decisions affirming an original decision of the Medicare Australia
6 CEO are reviewable under Part 6-9.
- 7 (5) If the Medicare Australia CEO revokes the decision, the revocation
8 is taken to be a decision:
- 9 (a) in the case of a decision mentioned in paragraph (1)(a)—to
10 waive the debt; or
11 (b) in the case of a decision mentioned in paragraph (1)(b)—not
12 to set off a debt against an otherwise payable amount.
- 13 (6) The Medicare Australia CEO must give the applicant a notice
14 stating his or her decision on the reconsideration together with a
15 statement of his or her reasons for the decision.
- 16 (7) The Medicare Australia CEO must make his or her decision on the
17 reconsideration within 28 days after the day on which he or she
18 received the application for the reconsideration.
- 19 (8) The Medicare Australia CEO is taken, for the purposes of this
20 Subdivision, to have made a decision confirming the original
21 decision if the Medicare Australia CEO has not told the applicant
22 of his or her decision on the reconsideration before the end of the
23 period of 28 days.

24 **Subdivision 282-B—Miscellaneous**

25 **282-20 Notification requirements—private health insurers**

- 26 (1) The Medicare Australia CEO may, by notice given to a private
27 health insurer, require the insurer, within the period specified in the
28 notice, to provide information specified in the notice about a
29 person who:
- 30 (a) is covered at any time during a financial year specified in the
31 notice by a *complying health insurance policy issued by the
32 insurer; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-4 Administration of premiums reduction and incentive payments schemes

Division 282 Provisions applying to premiums reduction scheme and incentive payments scheme

Section 282-25

- 1 (b) paid premiums under such a policy.
- 2 (2) The information must be given in the *approved form.
- 3 (3) A private health insurer commits an offence if:
- 4 (a) the insurer is required by a notice under subsection (1) to
- 5 provide information within a specified period about a person
- 6 or matter; and
- 7 (b) the insurer fails to comply with the requirement.
- 8 Penalty: 20 penalty units.
- 9 Note: The obligation to provide information in response to a notice under
- 10 subsection (1) is a continuing obligation and a private health insurer
- 11 commits an offence for each day, after the period specified in the
- 12 notice, until the information is provided (see section 4K of the *Crimes*
- 13 *Act 1914*).
- 14 (4) Strict liability applies to subsection (3).
- 15 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

282-25 Use etc. of information relating to another person

- 17 A person commits an offence if:
- 18 (a) the person uses, makes a record of, or discloses or
- 19 communicates to any person, any information that relates to
- 20 the affairs of another person and was acquired under or for
- 21 the purposes of Part 2-2 or this Part; and
- 22 (b) the use, making of the record, disclosure or communication
- 23 was not carried out in the performance of a function or
- 24 obligation, or the exercise of a power, under Part 2-2 or this
- 25 Part.
- 26 Penalty: Imprisonment for 1 year.

282-30 Information to be provided to the Commissioner of Taxation

- 28 (1) The Medicare Australia CEO must, within 120 days after the end
- 29 of each financial year, give to the Commissioner of Taxation the
- 30 information that the Commissioner of Taxation, by legislative
- 31 instrument, determines.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) A determination under subsection (1) must not require the
2 Medicare Australia CEO to give:
3 (a) the *tax file number of any person; or
4 (b) information about the physical, psychological or emotional
5 health of any person.

6 **282-35 Delegation**

7 The Medicare Australia CEO may, by writing, delegate all or any
8 of his or her powers under Part 2-2 or this Part to an employee of
9 Medicare Australia.

10 Note: The Minister may also delegate his or her powers under Part 2-2 or
11 this Part (see section 333-5).

12 **282-40 Appropriation**

13 The Consolidated Revenue Fund is appropriated for the purpose of
14 making payments under Part 2-2 and this Part.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 287-1

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**Part 6-5—External managers and terminating
managers**

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Division 287—Introduction

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287-1 What this Part is about

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External management of health benefits funds takes place under Division 217, and terminating management of health benefits funds takes place under Division 149. This Part provides for several matters relating to external management and terminating management under those Divisions.

11

287-5 The Private Health Insurance (Management) Rules

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*External management and *terminating management of *health benefits funds is also dealt with in the Private Health Insurance (Management) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

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Note: The Private Health Insurance (Management) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Division 290—Powers of managers**

3 **290-1 Powers of managers**

4 (1) While a *health benefits fund is under *external management or
5 *terminating management, the *manager has power, in the interests
6 of the *policy holders of the fund:

- 7 (a) to control the business, affairs and property of the fund; and
8 (b) to carry on the business of the fund, and to manage the affairs
9 and property of the fund; and
10 (c) to terminate or dispose of all or any part of the business, and
11 to dispose of all or any part of the property, of the fund; and
12 (d) to execute a document, bring or defend proceedings, or do
13 any other thing, in the name of the *responsible insurer for the
14 fund, for the purposes of the business of the fund; and
15 (e) to appoint a solicitor to assist him or her in his or her duties;
16 and
17 (f) to appoint an agent to do any business that the manager is
18 unable to do, or that it is unreasonable to expect the manager
19 to do, in person; and
20 (g) to perform any other function and exercise any other power
21 that the insurer or any of its *officers could perform or
22 exercise in relation to the conduct of the fund if the fund
23 were not under external management or terminating
24 management.

25 (2) The rights of the insurer, and any of its *officers, to exercise any of
26 those powers in relation to the fund is suspended while the fund is
27 under *external management or *terminating management.

28 **290-5 Officers etc. not to perform functions etc. while fund is under**
29 **management**

- 30 (1) A person commits an offence if:
31 (a) a *health benefits fund is under *external management or
32 *terminating management; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-5 External managers and terminating managers

Division 290 Powers of managers

Section 290-10

- 1 (b) the person performs or exercises in relation to the fund, or
2 purports to perform or exercise in relation to the fund, a
3 function or power of:
4 (i) an *officer of the *responsible insurer for the fund; or
5 (ii) a receiver, or receiver and manager, of any of the *assets
6 of the fund; and
7 (c) the person is not the *manager of the fund; and
8 (d) it is a function or power of the manager; and
9 (e) the person does so without the manager's written approval.

10 Penalty: 30 penalty units or imprisonment for 6 months, or both.

- 11 (2) Subsection (1) does not imply that an *officer of the insurer is
12 removed from his or her office.
13 (3) Section 149-30 or 217-20 does not limit the scope of
14 subsection (1).
15 (4) To avoid doubt, a person is not an *officer of a private health
16 insurer merely because he or she is an employee of the insurer.

17 **290-10 Managers act as agents of private health insurers**

- 18 (1) When exercising a power as *manager of a *health benefits fund,
19 the manager is taken to be acting as the agent of the *responsible
20 insurer for the fund.
21 (2) To avoid doubt, subsection (1) does not confer on the *responsible
22 insurer for the fund to direct the *manager in the exercise of his or
23 her powers.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 293—Information concerning, and records and**
3 **property of, health benefits funds**

4 **293-1 Directors etc. to help managers**

- 5 (1) As soon as practicable after the *external management or
6 *terminating management of a *health benefits fund begins, each
7 *director of the *responsible insurer for the fund must:
8 (a) deliver to the *manager all records in the director's
9 possession that relate to the business of the fund, other than
10 records that the director is entitled to retain as against the
11 manager and the insurer; and
12 (b) if the director knows of the locality of other records relating
13 to the business of the fund—tell the manager of that locality.
- 14 (2) Within 7 days after the *external management or *terminating
15 management of the fund begins, or such longer period as the
16 *manager allows, the *directors and other *officers of the
17 *responsible insurer for the fund must give to the manager a
18 statement about the business, property, affairs and financial
19 circumstances of the fund.
- 20 (3) The statement must comply with any requirements of the *manager
21 as to its form and contents.
- 22 (4) A *director or other *officer of the *responsible insurer for the fund
23 must:
24 (a) attend on the *manager at such times; and
25 (b) give the manager such information about the business,
26 property, affairs and financial circumstances of the fund;
27 as the manager reasonably requires.
- 28 (5) A person who fails to comply with the requirements of
29 subsection (1), (2), (3) or (4) commits an offence.

30 Penalty: 30 penalty units or imprisonment for 6 months, or both.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-5 External managers and terminating managers

Division 293 Information concerning, and records and property of, health benefits funds

Section 293-5

1

293-5 Managers' rights to certain records

2

(1) A person is not entitled, as against the *manager of a *health benefits fund:

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(a) to retain possession of records of the *responsible insurer for the fund; or

5

6

(b) to claim or enforce a lien on such records;

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but such a lien is not otherwise prejudiced.

8

(2) Paragraph (1)(a) does not apply in relation to records of which a secured creditor of the *responsible insurer for the fund is entitled to possession otherwise than because of a lien. However, the *manager is entitled to inspect, and make copies of, such records at any reasonable time.

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(3) The *manager of a *health benefits fund may give to a person written notice requiring the person to deliver to the manager, as specified in the notice, records so specified that are in the person's possession.

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(4) A notice under subsection (3) must specify a period of at least 3 days as the period within which the notice must be complied with.

18

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(5) A person commits an offence if:

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(a) the person receives a notice under subsection (3) from the *manager of a *health benefits fund; and

(b) the person does not comply with the notice.

23

Penalty: 30 penalty units or imprisonment for 6 months, or both.

24

(6) Subsection (5) does not apply if the person is entitled to retain possession of the records, as against the *manager and also as against the *responsible insurer for the fund.

25

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Note: The defendant bears an evidential burden in relation to the matter in subsection (6). See subsection 13.3(3) of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

293-10 Only manager can deal with property of fund under management

- 1
2
3 (1) A transaction or dealing affecting the property of a *health benefits
4 fund under *external management or *terminating management,
5 that is entered into by the *responsible insurer for the fund or by a
6 person purportedly on behalf of the fund or the responsible insurer,
7 is void unless:
- 8 (a) the transaction or dealing has been entered into by the
9 *manager of the fund; or
 - 10 (b) the manager consented to the transaction or dealing before it
11 was entered into; or
 - 12 (c) the transaction or dealing was entered into by order of the
13 Federal Court or of the Supreme Court of a State or Territory.
- 14 (2) Subsection (1) does not apply to a payment that an *ADI makes,
15 out of an account kept with the ADI by the *responsible insurer for
16 the fund, that is made:
- 17 (a) in good faith and in the ordinary course of the ADI's banking
18 business; and
 - 19 (b) after the *external management or *terminating management
20 began but on or before the day on which:
 - 21 (i) the *manager gives to the ADI written notice of the
22 appointment that began the external management or
23 terminating management; or
 - 24 (ii) the manager notifies the appointment in a national
25 newspaper, or in a newspaper circulating in each
26 jurisdiction where the responsible insurer has its
27 registered office or carries on business;
- 28 whichever happens first.
- 29 (3) Subsection (1) has effect subject to any order that the Federal
30 Court makes after the purported transaction or dealing.
- 31 (4) A person commits an offence if:
32 (a) the person is:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-5 External managers and terminating managers

Division 293 Information concerning, and records and property of, health benefits funds

Section 293-15

- 1 (i) an *officer of the *responsible insurer for a *health
2 benefits fund under *external management or
3 *terminating management; or
4 (ii) a receiver, or receiver and manager, of any of the *assets
5 of the fund; and
6 (b) the person:
7 (i) purported to enter into a transaction or dealing on behalf
8 of the responsible insurer; or
9 (ii) was in any way, by act or omission, directly or
10 indirectly concerned in, or party to, a transaction or
11 dealing; and
12 (c) the transaction or dealing is, because of the operation of
13 subsection (1), void, or would be void apart from
14 subsection (3).

15 Penalty: 30 penalty units or imprisonment for 6 months, or both.

16 **293-15 Order for compensation where officer involved in void**
17 **transaction**

- 18 (1) If:
19 (a) a court finds a person guilty of an offence against subsection
20 293-10(4) (including such an offence that is taken to have
21 been committed because of section 5 of the *Crimes Act*
22 *1914*); and
23 (b) the court is satisfied that the *health benefits fund under
24 *external management or *terminating management to which
25 the offence relates has suffered loss or damage because of the
26 act or omission constituting the offence;
27 the court may (whether or not it imposes a penalty) order the
28 person to pay compensation of such amount as the order specifies
29 to the *responsible insurer for the fund.
30 (2) An order under subsection (1) may be enforced as if it were a
31 judgment of the court.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 293-15

- 1 (3) If, in proceedings against a person under subsection 293-10(4), it
2 appears to the court that the person is, or might be, liable to pay
3 compensation under subsection (1), but that:
4 (a) the person has acted honestly; and
5 (b) having regard to all the circumstances of the case, the person
6 ought fairly to be excused from paying compensation;
7 the court may relieve the person either wholly or partly from a
8 liability to pay compensation under subsection (2) to which the
9 person would otherwise be subject, or that might otherwise be
10 imposed on the person.
- 11 (4) If a person thinks that proceedings under subsection 293-10(4)
12 will, or might be, begun against him or her, he or she may apply to
13 the Federal Court for relief.
- 14 (5) On an application under subsection (4), the Federal Court may
15 grant relief under subsection (3) as if proceedings under subsection
16 293-10(4) had been begun in the Federal Court.
- 17 (6) For the purposes of subsection (3) as it applies for the purposes of
18 a case tried by a judge with a jury:
19 (a) a reference in that subsection to the court is a reference to the
20 judge; and
21 (b) the relief that may be granted includes withdrawing the case
22 in whole or in part from the jury and directing judgment to be
23 entered for the defendant on such terms as to costs as the
24 judge thinks appropriate.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 296-1

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Division 296—Provisions incidental to appointment of managers

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296-1 Remuneration of managers

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(1) The Council may, in writing, determine:

6

(a) the remuneration and allowances that an *external manager or *terminating manager is to receive; and

7

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(b) who is to pay that remuneration and those allowances, if they are not to be paid as mentioned in subsection (2).

9

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(2) Unless the Council determines otherwise, the remuneration and allowances are to be paid out of the *assets of the *health benefits fund under *external management or *terminating management.

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296-5 Council may give directions to managers

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(1) The Council may give a *manager written directions concerning the exercise of the powers that are vested in the manager.

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(2) The directions given to the *manager will ordinarily be of a general nature but may, where appropriate, take into account specific circumstances relevant to the particular *health benefits fund under *external management or *terminating management.

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(3) The Council may also give directions to the *manager concerning the provision to the Council, from time to time, of interim reports relating to the business of the *health benefits fund under *external management or *terminating management.

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(4) The *manager must comply with any directions given to him or her under this section.

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296-10 Termination of appointments of managers

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(1) The Council may, at any time, by written notice given to a *manager, terminate the appointment of the manager with effect from the date specified in the instrument of termination.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) If the Council terminates the appointment of an *external manager,
2 it may appoint another external manager (the *replacement external*
3 *manager*) to carry on the *external management.
- 4 (3) If the Council terminates the appointment of an *external manager
5 of a *health benefits fund but does not appoint a replacement
6 external manager, then, with effect from the termination:
7 (a) the external manager whose appointment has been terminated
8 is divested of the power:
9 (i) to control the business, affairs and property of the fund;
10 and
11 (ii) to carry on the business, and to manage the affairs and
12 property, of the fund;
13 and those powers vest once again in the *officers of the
14 *responsible insurer for the fund; and
15 (b) all of the other powers of the external manager in relation to
16 the fund cease.
- 17 (4) If the Council terminates the appointment of a *terminating
18 manager, it must appoint another terminating manager to carry on
19 the *terminating management, unless:
20 (a) the Federal Court has ordered under section 149-35 an end to
21 the termination of the *health benefits funds in question; or
22 (b) the termination of those funds has been *completed, and the
23 terminating manager has reported to the Council under
24 section 149-55.

25 **296-15 Acts of managers valid etc.**

- 26 (1) The acts of the *manager of a *health benefits fund are valid
27 despite any defects that may afterwards be discovered in his or her
28 appointment.
- 29 (2) Despite any defect or irregularity affecting the validity of the
30 appointment of *manager of a *health benefits fund:
31 (a) a conveyance, assignment, transfer, mortgage or charge of
32 *assets of the fund; or
33 (b) a payment of money of the fund; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-5 External managers and terminating managers

Division 296 Provisions incidental to appointment of managers

Section 296-20

1 (c) any other disposition of assets of the fund;
2 is valid in favour of any person taking such assets in good faith and
3 for value and without actual knowledge of the defect or
4 irregularity.

5 (3) Despite any defect or irregularity affecting the validity of the
6 appointment of *manager of a *health benefits fund, a person
7 making or permitting:

8 (a) a payment of money of the fund; or

9 (b) any other disposition of *assets of the fund;

10 is to be protected and indemnified in so doing despite any defect or
11 irregularity affecting the validity of the appointment of the
12 manager that is not then known to that person.

13 **296-20 Indemnity**

14 The *manager of a *health benefits fund is not subject to any
15 action, claim or demand by, or liable to, any person in respect of
16 anything done or omitted to be done in good faith in, or in
17 connection with, the exercise of the powers conferred on the
18 manager by this Act.

19 **296-25 Qualified privilege**

20 The *manager of a *health benefits fund has qualified privilege in
21 respect of a statement that he or she makes, whether orally or in
22 writing, in the course of his or her duties as manager.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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2 **Division 299—Miscellaneous**

3 **299-1 Time for doing act does not run while act prevented by this**
4 **Division**

5 If:

6 (a) for any purpose (for example, the purposes of a law,
7 agreement or instrument) an act must or may be done within
8 a particular period or before a particular time; and

9 (b) Division 149 or Part 5-3 or this Part prevents the act from
10 being done within that period or before that time;

11 the period is extended, or the time is deferred, because of this
12 section, according to how long Division 149 or Part 5-3 or this Part
13 prevented the act from being done.

14 **299-5 Continued application of other provisions of Act**

15 (1) The appointment of a person as the *external manager of a *health
16 benefits fund does not affect the continued operation of provisions
17 of this Act other than the provisions of Division 217:

18 (a) in relation to the fund; or

19 (b) in relation to the rights and obligations of persons in relation
20 to the *responsible insurer for the fund.

21 (2) The appointment of a person as the *terminating manager of a
22 *health benefits fund does not affect the continued operation of
23 provisions of this Act other than the provisions of Division 149 or
24 220:

25 (a) in relation to the fund; or

26 (b) in relation to the rights and obligations of persons in relation
27 to the *responsible insurer for the fund.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 299-10

1 **299-10 Modifications of this Act in relation to health benefits funds**
2 **under management**

- 3 (1) The Private Health Insurance (Management) Rules may set out
4 modifications of this Act (including omissions, additions and
5 substitutions) relating to how Chapter 3 applies in relation to
6 *health benefits funds for which:
7 (a) *external managers have been appointed under Division 217;
8 or
9 (b) *terminating managers have been appointed under
10 Division 149 or 220.
- 11 (2) The Private Health Insurance (Management) Rules may provide for
12 different such modifications according to the nature of the *health
13 benefits funds concerned.
- 14 (3) The modifications cannot:
15 (a) modify a provision of this Act that creates an offence; or
16 (b) include new provisions that create offences.
- 17 (4) This Act has effect subject to the modifications.

18 **299-15 Order of Court to be binding on all persons**

19 An order of the Court made under Division 149, Part 5-3 or this
20 Part, relating to any matter, is binding on all persons and has effect
21 despite anything in the constitution or *rules of a private health
22 insurer to which the order may relate.

23 **299-20 Jurisdiction of Federal Court**

24 The Federal Court has jurisdiction to hear and determine
25 applications under Division 149, Part 5-3 or this Part and to make
26 any necessary orders in respect of those applications.

27 **299-25 Private Health Insurance (Management) Rules dealing with**
28 **various matters**

29 The Private Health Insurance (Management) Rules may:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (a) make provision for, or in relation to, any of the following
2 matters in relation to meetings required or permitted to be
3 held by Division 217, or by provisions of the Private Health
4 Insurance (Health Benefits Fund Enforcement) Rules made
5 for the purposes of that Division:
6 (i) the convening, conduct of, and procedure at, a meeting;
7 (ii) voting at a meeting (including proxy voting);
8 (iii) the number of persons that constitutes a quorum at a
9 meeting;
10 (iv) the sending of notices to persons entitled to attend a
11 meeting;
12 (v) the lodging of copies of notices of, or resolutions passed
13 at, a meeting; and
14 (b) make provision relating to the form and contents of any
15 document or instrument required or permitted to be given to
16 the Council, or to an *external manager or *terminating
17 manager of a *health benefits fund, by a provision of
18 Division 217 or 149.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Part 6-6—Private health insurance levies

3

Division 304—Introduction

4

304-1 What this Part is about

5

Each private health insurance levy is imposed under a levy Act.
This Part deals with collection of the levies and other matters
relating to their administration.

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304-5 Private Health Insurance (Levy Administration) Rules

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The collection of *private health insurance levies and other matters
relating to administration of the levies are also dealt with in the
Private Health Insurance (Levy Administration) Rules. The
provisions of this Part indicate when a particular matter is or may
be dealt with in these Rules.

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Note: The Private Health Insurance (Levy Administration) Rules are made
by the Minister under section 333-20.

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304-10 Meaning of *private health insurance levy*

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Each of the following levies is a *private health insurance levy*:

18

(a) levy imposed under the *Private Health Insurance (Collapsed
Insurer Levy) Act 2003 (collapsed insurer levy)*;

19

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(b) levy imposed under the *Private Health Insurance
(Complaints Levy) Act 1995 (complaints levy)*;

21

22

(c) levy imposed under the *Private Health Insurance (Council
Administration Levy) Act 2003 (Council administration
levy)*;

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(d) levy imposed under the *Private Health Insurance (Risk
Equalisation Levy) Act 2003 (risk equalisation levy)*.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 307—Collection and recovery of private health**
3 **insurance levies**

4 **307-1 When private health insurance levy must be paid**

- 5 (1) A *private health insurance levy that is imposed on a particular day
6 (the *imposition day*) becomes due and payable on the day specified
7 as the payment day for that imposition day in:
8 (a) a determination made by the Minister, by legislative
9 instrument, if the levy is:
10 (i) *collapsed insurer levy; or
11 (ii) *Council administration levy imposed on a
12 supplementary Council administration levy day (within
13 the meaning of the *Private Health Insurance (Council*
14 *Administration Levy) Act 2003*; or
15 (iii) *complaints levy imposed on a supplementary
16 complaints levy administration day (within the meaning
17 of the *Private Health Insurance (Complaints Levy) Act*
18 *1995*; or
19 (iv) *risk equalisation levy imposed on a supplementary risk
20 equalisation levy day (within the meaning of the *Private*
21 *Health Insurance (Risk Equalisation Levy) Act 2003*;
22 and
23 (b) otherwise—the Private Health Insurance (Levy
24 Administration) Rules.
- 25 (2) The Minister must obtain, and take into account, advice from the
26 Council in relation to the day that is to be specified as the payment
27 day in a determination made under subparagraph (1)(a)(i), (ii) or
28 (iv).
- 29 (3) Advice given to the Minister under subsection (2) in relation to a
30 determination under subparagraph (1)(a)(i) must be laid before
31 each House of the Parliament with the determination to which it
32 relates.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 307-5

1 **307-5 Late payment penalty**

2 (1) If a *private health insurance levy remains wholly or partly unpaid
3 by a private health insurer after it becomes due and payable, the
4 insurer is liable to pay a late payment penalty under this section.

5 (2) The *late payment penalty is calculated:

6 (a) at the rate specified in the Private Health Insurance (Levy
7 Administration) Rules (which must not be higher than 15%);
8 and

9 (b) on the unpaid amount of the levy; and

10 (c) for the period:

11 (i) starting when the levy becomes due and payable; and

12 (ii) ending when the levy, and the penalty payable under
13 this section, have been paid in full.

14 **307-10 Payment of levy and late payment penalty**

15 (1) The following must be paid to the Commonwealth:

16 (a) a *complaints levy;

17 (b) a *late payment penalty in respect of a complaints levy.

18 (2) An amount of a kind specified in column 2 of the table must be
19 paid to the Council. The amount is paid to the Council for the
20 purpose specified in column 3 of the table:
21

Amounts payable to Council for certain purposes

Item	An amount of this kind ...	is payable to the Council for the purpose of ...
1	*collapsed insurer levy that is due and payable	helping a private health insurer that is unable to meet its liabilities to its contributors to meet those liabilities.
2	*late payment penalty in respect of *collapsed insurer levy	helping a private health insurer that is unable to meet its liabilities to its contributors to meet those liabilities.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Amounts payable to Council for certain purposes

Item	An amount of this kind ...	is payable to the Council for the purpose of ...
3	*Council administration levy that is due and payable	meeting the general administrative costs of the Council.
4	*late payment penalty in respect of *Council administration levy	meeting the general administrative costs of the Council.
5	*risk equalisation levy that is due and payable	the *Risk Equalisation Trust Fund
6	*late payment penalty in respect of *risk equalisation levy	the *Risk Equalisation Trust Fund

1 (3) The Consolidated Revenue Fund is appropriated for the purposes
 2 of subsection (2).

3 **307-15 Recovery of levy and late payment penalty**

4 (1) A *private health insurance levy that is due and payable is a debt
 5 due to the Commonwealth.

6 (2) A *late payment penalty is a debt due to the Commonwealth.

7 (3) An amount referred to in subsection (1) or (2) may be recovered as
 8 a debt by action in a court of competent jurisdiction by:

9 (a) the Commonwealth, in respect of a debt payable to the
 10 Commonwealth under subsection 307-10(1); or

11 (b) the Council, in respect of a debt payable to the Council under
 12 subsection 307-10(2).

13 **307-20 Waiver of late payment penalty for levies other than**
 14 **collapsed insurer levy**

15 (1) The Minister may waive the whole or part of an amount of *late
 16 payment penalty in respect of an unpaid amount of *complaints

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 307-25

1 levy, if the Minister considers that there are good reasons for doing
2 so.

- 3 (2) The Council may waive the whole or part of an amount of *late
4 payment penalty in respect of an unpaid amount of:
5 (a) a *Council administration levy; or
6 (b) a *risk equalisation levy;
7 if the Council considers that there are good reasons for doing so.

8 **307-25 Waiver of collapsed insurer levy and late payment penalty**
9 **for that levy**

- 10 (1) If an amount of *collapsed insurer levy or *late payment penalty in
11 respect of an amount of collapsed insurer levy (a ***collapsed insurer***
12 ***levy amount***) is payable by a private health insurer, the insurer may
13 apply for a waiver under this section.
- 14 (2) The application must be in writing and in the *approved form.
- 15 (3) The Minister may waive the whole or a part of the collapsed
16 insurer levy amount if satisfied that the payment of the amount by
17 the insurer would have a significantly adverse effect on the
18 insurer's ability to comply with:
19 (a) the *solvency standard or a *solvency direction; or
20 (b) the *capital adequacy standard or a *capital adequacy
21 direction.
- 22 Note: Decisions under subsection (3) are reviewable under Part 6-9.
- 23 (4) Before making a decision under subsection (3), the Minister must
24 obtain, and take into account, advice from the Council as to
25 whether to waive the collapsed insurer levy amount.
- 26 (5) The Minister must notify the insurer of the Minister's decision
27 under subsection (3).
- 28 (6) The notification must be:
29 (a) in writing; and
30 (b) given to the insurer within 28 days after the day on which the
31 decision under subsection (3) is made.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1
2 **Division 310—Returns, requesting information and**
3 **keeping records**

4 **310-1 Returns must be lodged with Council and Department**

- 5 (1) A private health insurer must lodge a return for each *census day
6 for the following levies:
7 (a) *collapsed insurer levy;
8 (b) *complaints levy;
9 (c) *Council administration levy.
- 10 (2) A *census day* for a levy means the day specified as the census day
11 for that levy under the Act imposing the levy.
- 12 (3) The return must:
13 (a) be in the *approved form; and
14 (b) be lodged with:
15 (i) if the return relates to *complaints levy—the Secretary
16 of the Department; and
17 (ii) otherwise—the Council; and
18 (c) be lodged within 28 days after the *census day for the levy to
19 which it relates.
- 20 (4) A private health insurer commits an offence if the insurer fails to
21 lodge the return.
- 22 Penalty: 60 penalty units.
- 23 (5) Strict liability applies to subsection (4).
24 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

25 **310-5 Insurer must keep records**

- 26 (1) A private health insurer must keep all records that are relevant to
27 either or both of following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration

Part 6-6 Private health insurance levies

Division 310 Returns, requesting information and keeping records

Section 310-10

- 1 (a) whether the insurer is liable to pay a *private health insurance
2 levy;
3 (b) the amount of the private health insurance levy that the
4 insurer is liable to pay.
- 5 (2) The records must be kept in:
6 (a) an electronic form; or
7 (b) if the Council approves another form—that form.
- 8 (3) The records must be retained for a period of 7 years (or a shorter
9 period allowed by the Private Health Insurance (Levy
10 Administration) Rules) starting on the later of:
11 (a) the day on which the records were created; or
12 (b) 1 July 2004.
- 13 (4) A private health insurer commits an offence if the insurer fails to:
14 (a) keep the records; or
15 (b) keep the records in the form required by or under
16 subsection (2); or
17 (c) retain the records for the period required by or under
18 subsection (3).
- 19 Penalty: 60 penalty units.
- 20 (5) Strict liability applies to subsection (4).
21 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.
- 22 (6) Nothing in this section is to be taken to have required an insurer to
23 do an act or thing before the day on which this Act commences.

24 **310-10 Council may request information from insurer**

- 25 (1) The Council may, if it believes on reasonable grounds that a
26 private health insurer is capable of giving information that is
27 relevant to:
28 (a) whether the insurer is liable to pay a *private health insurance
29 levy (other than *complaints levy); or
30 (b) the amount of the private health insurance levy (other than
31 complaints levy) that the insurer is liable to pay;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 request the insurer to give the Council the information or records
2 that are specified in the request, before the end of the period
3 specified in the request.
- 4 (2) The Secretary of the Department may, if he or she believes on
5 reasonable grounds that a private health insurer is capable of giving
6 information that is relevant to:
7 (a) whether the insurer is liable to pay *complaints levy; or
8 (b) the amount of complaints levy that the insurer is liable to
9 pay;
10 request the insurer to give him or her the information or records
11 that are specified in the request, before the end of the period
12 specified in the request.
- 13 (3) A request under subsection (1) or (2):
14 (a) must be served on the *chief executive officer of the insurer;
15 and
16 (b) may require the information to be verified by statutory
17 declaration; and
18 (c) must specify the manner in which the information must be
19 given; and
20 (d) must contain a statement to the effect that a failure to comply
21 with the request is an offence.
- 22 (4) A private health insurer commits an offence if the insurer fails to
23 comply with a request under subsection (1) or (2).
- 24 Penalty: 60 penalty units.
- 25 (5) Strict liability applies to subsection (4).
- 26 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Division 313—Power to enter premises and search for documents

3

4

313-1 Authorised officer may enter premises with consent

5

(1) A person who is a member of staff of the Council or authorised in writing by the Minister for this purpose (both of these kinds of persons are *authorised officers*) may enter any *premises for the purpose of exercising *search powers in relation to *levy-related documents if:

6

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10

(c) the *occupier of the premises consents to the entry; and

11

(d) the officer shows the occupier his or her identity card.

12

(2) A *levy-related document* is a document (including a copy of a document) that contains information relevant to:

13

14

(a) whether a private health insurer is liable to pay a *private health insurance levy; or

15

16

(b) the amount of the private health insurance levy that the insurer is liable to pay.

17

18

(3) Before obtaining the consent of the *occupier, the *authorised officer must inform the occupier that he or she may refuse consent.

19

20

(4) An entry by an *authorised officer with the consent of the *occupier is not lawful if the consent of the occupier is not voluntary.

21

22

23

(5) The *authorised officer must leave the *premises if the *occupier asks the officer to do so.

24

25

313-5 Authorised officer may enter premises under warrant

26

(1) If an *authorised officer has reason to believe that there are *levy-related documents on particular *premises, the officer may apply to a magistrate for a warrant authorising the officer to enter the premises for the purpose of exercising *search powers in relation to the documents.

27

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (2) If the magistrate is satisfied by information on oath or affirmation
2 that there are reasonable grounds for believing that there are
3 *levy-related documents on the *premises, the magistrate may issue
4 a warrant.
- 5 (3) The warrant must:
- 6 (a) authorise one or more *authorised officers to enter the
7 *premises for the purpose of exercising *search powers in
8 relation to *levy-related documents; and
- 9 (b) state whether the entry is authorised at any time of the day or
10 night or during specified hours of the day or night; and
- 11 (c) authorise the officers to use such assistance and force as is
12 necessary and reasonable to enter the premises for the
13 purpose of exercising search powers in relation to
14 levy-related documents.
- 15 (4) The *authorised officers do not have to be named in the warrant.

16 **313-10 Announcement before entry**

- 17 An *authorised officer executing a warrant under section 313-5 in
18 respect of *premises must, before entering the premises under the
19 warrant:
- 20 (a) announce that he or she is authorised to enter the premises;
21 and
- 22 (b) before using assistance and force under the warrant to enter
23 the premises—give any person on the premises an
24 opportunity to allow the authorised officer to enter the
25 premises without the use of assistance and force.

26 **313-15 Executing a warrant to enter premises**

27 *Circumstances in which this section applies*

- 28 (1) This section applies if:
- 29 (a) a warrant under section 313-5 is being executed by an
30 *authorised officer in respect of *premises; and
- 31 (b) the *occupier of the premises is present.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 313-20

1 *Obligations of authorised officer executing a warrant*

- 2 (2) The *authorised officer must:
- 3 (a) make a copy of the warrant available to the *occupier; and
- 4 (b) show the occupier the officer's identity card; and
- 5 (c) inform the occupier of the occupier's rights and
- 6 responsibilities under subsections (3) to (6).

7 *Persons entitled to observe execution of warrant*

- 8 (3) The *occupier, or a person nominated by the occupier who is
- 9 readily available, is entitled to observe the execution of the
- 10 warrant.
- 11 (4) The right to observe the execution of the warrant ceases if the
- 12 *occupier or the nominated person impedes that execution.
- 13 (5) Subsection (3) does not prevent the execution of the warrant in 2 or
- 14 more areas of the *premises at the same time.

15 *Occupier to provide reasonable facilities and assistance*

- 16 (6) An *occupier commits an offence if the occupier fails to provide
- 17 the *authorised officer and any person assisting that officer with all
- 18 reasonable facilities and assistance for the effective exercise of
- 19 their powers under the warrant.

20 Penalty: 60 penalty units.

21 **313-20 Identity cards**

- 22 (1) For the purposes of this Division, the Council must issue an
- 23 identity card to an *authorised officer in the *approved form. It
- 24 must contain a recent photograph of the authorised officer.
- 25 (2) A person commits an offence if:
- 26 (a) the person has been issued with an identity card; and
- 27 (b) the person ceases to be an *authorised officer; and
- 28 (c) the person does not, as soon as it is practicable after so
- 29 ceasing, return the identity card to the Council.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 Penalty: 1 penalty unit.
- 2 (3) Strict liability applies to subsection (2).
- 3 Note: For *strict liability*, see section 6.1 of the *Criminal Code*.
- 4 (4) An *authorised officer must carry the identity card at all times
- 5 when exercising powers or performing functions under this
- 6 Division as an authorised officer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Part 6-7—Private Health Insurance Risk Equalisation Trust Fund

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Division 318—Private Health Insurance Risk Equalisation Trust Fund

5

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318-1 Private Health Insurance Risk Equalisation Trust Fund

7

The Health Benefits Reinsurance Trust Fund established under section 73BC of the *National Health Act 1953* is continued in existence as the Private Health Insurance Risk Equalisation Trust Fund (the *Risk Equalisation Trust Fund*).

8

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318-5 Amounts to be paid into the Risk Equalisation Trust Fund

12

(1) The following amounts are to be paid into the *Risk Equalisation Trust Fund:

13

14

(a) amounts appropriated by the Parliament for the purposes of the Fund;

15

16

(b) amounts received from the States or Territories for payment to the Fund;

17

18

(c) amounts of *risk equalisation levy received from private health insurers;

19

20

(d) amounts of *late payment penalty received from private health insurers in respect of unpaid amounts of risk equalisation levy;

21

22

23

(e) amounts received by the Council under paragraph 149-45(b) or because of section 149-50;

24

25

(f) the proceeds from any investments made using Fund money.

26

(2) The Consolidated Revenue Fund is appropriated for the purposes of paragraphs (1)(b), (c), (d) and (e) to the extent that section 81 of the Constitution applies to the amounts mentioned in those paragraphs.

27

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **318-10 Operation of the Risk Equalisation Trust Fund**

- 2 (1) The Private Health Insurance (Risk Equalisation Policy) Rules may
3 set out requirements relating to how the *Risk Equalisation Trust
4 Fund is to operate.
- 5 (2) Without limiting the matters that may be dealt with in those Rules,
6 the Rules must specify:
- 7 (a) the method for working out the amount to be paid out of the
8 Fund to a private health insurer; and
- 9 (b) the method for working out the amount to be paid into the
10 Fund by private health insurers as *risk equalisation levy.
- 11 (3) If the Minister changes the Private Health Insurance (Risk
12 Equalisation Policy) Rules, the Minister must notify the Council
13 that the Minister has done so, as soon as practicable.

14 **318-15 Administration of the Risk Equalisation Trust Fund**

- 15 The Private Health Insurance (Risk Equalisation Administration)
16 Rules may set out requirements relating to the administration of the
17 *Risk Equalisation Trust Fund and the *risk equalisation levy,
18 including:
- 19 (a) the kinds of records to be kept by insurers who are required
20 to pay risk equalisation levy; and
- 21 (b) the form in which those records are to be kept.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

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Part 6-8—Disclosure of information

3

Division 323—Disclosure of information

4

323-1 Prohibition on disclosure of information

5

(1) A person commits an offence if:

6

(a) the person has, or has at any time had, a duty, function or power under this Act; and

7

8

(b) the person discloses information to another person; and

9

(c) the information is *protected information; and

10

(d) the disclosure is not an *authorised disclosure.

11

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

12

(2) Information is *protected information* if the information:

13

(a) either:

14

(i) is obtained by a person in the course of performing duties or functions, or exercising powers, under this Act; or

15

16

17

(ii) was information to which subparagraph (i) applied and is obtained by a person by way of an *authorised disclosure under section 323-10, 323-15 or 323-20; and

18

19

20

(b) relates to a person other than the person who obtained it.

21

(3) A disclosure of information is an *authorised disclosure* if the disclosure is one that the person may make under section 323-5, 323-10, 323-15, 323-20, 323-25, 323-30 or 323-35.

22

23

24

323-5 Authorised disclosure: official duties

25

For the purposes of subsection 323-1(3), a person may disclose information if the disclosure is made:

26

27

(a) in the course of performing a duty or function, or exercising a power, under this Act; or

28

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) for the purpose of enabling a person to perform functions
2 under the *Medicare Australia Act 1973*.

3 **323-10 Authorised disclosure: sharing information about insurers**
4 **among agencies**

- 5 (1) For the purposes of subsection 323-1(3), a person to whom
6 subsection (2) applies may disclose information to another such
7 person if:
8 (a) the information relates to any or all of the following:
9 (i) a private health insurer;
10 (ii) an applicant to become a private health insurer;
11 (iii) a person carrying on *health insurance business;
12 (iv) a *director or *officer of a person mentioned in
13 subparagraph (i), (ii) or (iii); and
14 (b) the information is not information of a kind specified in the
15 Private Health Insurance (Information Disclosure) Rules as
16 information that must not be disclosed under this section; and
17 (c) the disclosure is made in accordance with any requirements
18 in the Private Health Insurance (Information Disclosure)
19 Rules.
- 20 (2) This subsection applies to the following persons:
21 (a) the Minister;
22 (b) the Secretary of the Department;
23 (c) an APS employee in, or a person holding or performing the
24 duties of an office in, the Department;
25 (d) a member of the Council;
26 (e) a person employed, or a consultant engaged, by the Council;
27 (f) the Private Health Insurance Ombudsman;
28 (g) an APS employee in, or a person holding or performing the
29 duties of an office in, the Statutory Agency of the Private
30 Health Insurance Ombudsman;
31 (h) the Medicare Australia CEO;
32 (i) an APS employee in, or a person holding or performing the
33 duties of an office in, Medicare Australia.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **323-15 Authorised disclosure: sharing information about insurers**
2 **other than among agencies**

- 3 (1) For the purposes of subsection 323-1(3), a person may disclose
4 information to another person if:
- 5 (a) the information relates to any or all of the following:
 - 6 (i) a private health insurer;
 - 7 (ii) an applicant to become a private health insurer;
 - 8 (iii) a person carrying on *health insurance business;
 - 9 (iv) a *director or *officer of a person mentioned in
10 subparagraph (i), (ii) or (iii); and
 - 11 (b) the information is not information of a kind specified in the
12 Private Health Insurance (Information Disclosure) Rules as
13 information that must not be disclosed under this section; and
 - 14 (c) the disclosure is made in accordance with any requirements
15 in the Private Health Insurance (Information Disclosure)
16 Rules; and
 - 17 (d) the disclosure is, or is a kind of disclosure, certified by the
18 Minister by written instrument to be in the public interest;
19 and
 - 20 (e) if there are any conditions specified in the certificate—the
21 conditions are met.
- 22 (2) The Minister may specify conditions in a certificate under
23 paragraph (1)(d) relating to the application of the certificate.
- 24 (3) A certificate under paragraph (1)(d) is not a legislative instrument.

25 **323-20 Authorised disclosure: public interest**

- 26 (1) For the purposes of subsection 323-1(3), a person may disclose
27 information to another person if:
- 28 (a) the information does not relate to any of the following:
 - 29 (i) a private health insurer;
 - 30 (ii) an applicant to become a private health insurer;
 - 31 (iii) a person carrying on *health insurance business;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (iv) a *director or *officer of a person mentioned in
2 subparagraph (i), (ii) or (iii); and
3 (b) the information is not information of a kind specified in the
4 Private Health Insurance (Information Disclosure) Rules as
5 information that must not be disclosed under this section; and
6 (c) the disclosure is made in accordance with any requirements
7 in the Private Health Insurance (Information Disclosure)
8 Rules; and
9 (d) the disclosure is, or is a kind of disclosure, certified by the
10 Minister by written instrument to be in the public interest;
11 and
12 (e) if there are any conditions specified in the certificate—the
13 conditions are met.
- 14 (2) The Minister may specify conditions in a certificate under
15 paragraph (1)(d) relating to the application of the certificate.
- 16 (3) A certificate under paragraph (1)(d) is not a legislative instrument.

17 **323-25 Authorised disclosure: by the Secretary or Council if**
18 **authorised by affected person**

19 For the purposes of subsection 323-1(3), the Secretary or the
20 Council may disclose information to a person who is expressly or
21 impliedly authorised by the person to whom the information relates
22 to obtain it.

23 **323-30 Authorised disclosure: court proceedings**

24 For the purposes of subsection 323-1(3), a person who has, or has
25 at any time had, a duty, function or power under this Act may
26 disclose to a court information that relates to another person for the
27 purposes of an action or proceeding before the court to which that
28 other person is a party.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **323-35 Authorised disclosure: Council's public information and**
2 **agency cooperation functions**

3 For the purposes of subsection 323-1(3), the Council may disclose
4 information to the extent necessary to perform the Council's public
5 information functions under subsection 264-10(5) and agency
6 cooperation functions under subsection 264-10(6).

7 **323-40 Offence: disclosure of information obtained by certain**
8 **authorised disclosures**

9 A person commits an offence if:

- 10 (a) the person obtains information; and
11 (b) the person does so by way of an *authorised disclosure under
12 section 323-10, 323-15 or 323-20; and
13 (c) the person discloses the information; and
14 (d) the disclosure by the person is not an authorised disclosure.

15 Penalty: Imprisonment for 2 years or 120 penalty units, or both.

16 **323-45 Offence: soliciting disclosure of information**

17 A person commits an offence if:

- 18 (a) the person solicits the disclosure of information from another
19 person; and
20 (b) the information is *protected information; and
21 (c) the person knows, or ought reasonably to know, that the
22 information is protected information; and
23 (d) the disclosure would not be an *authorised disclosure.

24 Penalty: Imprisonment for 2 years or 120 penalty units, or both.

25 **323-50 Offence: use etc. of unauthorised information**

26 A person commits an offence if:

- 27 (a) information is disclosed to the person; and
28 (b) the information is *protected information; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (c) the disclosure to the person is not an *authorised disclosure;
2 and
3 (d) the person knows, or ought reasonably to know, that the
4 disclosure to the person is not an authorised disclosure; and
5 (e) any of the following apply:
6 (i) the person solicited the disclosure of the information;
7 (ii) the person discloses the information;
8 (iii) the person uses the information.

9 Penalty: Imprisonment for 2 years or 120 penalty units, or both.

10 **323-55 Offence: offering to supply protected information**

11 A person commits an offence if:

- 12 (a) the person:
13 (i) offers; or
14 (ii) holds himself or herself out as being able;
15 to supply (whether or not to a particular person) information
16 about another person; and
17 (b) the person knows that the information is *protected
18 information; and
19 (c) the supply would not be an *authorised disclosure.

20 Penalty: Imprisonment for 2 years or 120 penalty units, or both.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 328-1

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Part 6-9—Review of decisions

Division 328—Review of decisions

328-1 What this Part is about

Several kinds of decisions made under this Act by the Medicare CEO, the Council, the Minister and the Private Health Insurance Ombudsman are reviewable by the Administrative Appeals Tribunal.

328-5 AAT review of decisions

An application may be made to the Administrative Appeals Tribunal for the review of any of the following decisions:

Reviewable decisions		
Item	Decision	Provision under which decision is made
1	To reject an application for registration of a person in respect of a health insurance policy	section 23-20
2	To revoke a person's registration in respect of a health insurance policy	section 23-35
3	To affirm an original decision of the Medicare Australia CEO rejecting a claim to be paid an amount under Division 26	section 26-25
4	To refuse to make a declaration, or to revoke a declaration, that a facility is a *hospital	subsection 121-5(6)
5	To refuse an application for registration as a private health insurer	subsection 126-20(1)
6	To grant an application, subject to terms and conditions, for registration as a private health insurer	subsection 126-20(1)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions		
Item	Decision	Provision under which decision is made
7	To refuse to make a declaration that the *solvency standard does not apply to a particular private health insurer	subsection 140-15(2)
8	To impose conditions on a declaration that the *solvency standard does not apply to a particular private health insurer	subsection 140-15(3)
9	To refuse to revoke or vary a declaration that the *solvency standard does not apply to a particular private health insurer	subsection 140-15(6) or (7)
10	To refuse to revoke or vary conditions imposed on a declaration that the *solvency standard does not apply to a particular private health insurer	subsection 140-15(6) or (7)
11	To refuse to revoke or vary a *solvency direction	subsection 140-20(8) or (9)
12	To refuse to make a declaration that the *capital adequacy standard does not apply to a particular private health insurer	subsection 143-15(2)
13	To impose conditions on a declaration that the *capital adequacy standard does not apply to a particular private health insurer	subsection 143-15(3)
14	To refuse to revoke or vary a declaration that the *capital adequacy standard does not apply to a particular private health insurer	subsection 143-15(6) or (7)
15	To refuse to revoke or vary conditions imposed on a declaration that the *capital adequacy standard does not apply to a particular private health insurer	subsection 143-15(6) or (7)
16	To refuse to revoke or vary a *capital adequacy direction	subsection 143-20(8) or (9)
17	To refuse to approve a restructure of the *health benefits funds of a private health insurer	subsection 146-1(3)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration
Part 6-9 Review of decisions
Division 328 Review of decisions

Section 328-5

Reviewable decisions		
Item	Decision	Provision under which decision is made
18	To refuse to approve a transfer of the *health benefits funds of one or more private health insurers	subsection 146-5(3)
19	To refuse to approve a restructure of the *health benefits funds of a private health insurer	section 149-10
20	To refuse to approve the appointment of a person as a private health insurer's actuary	subsection 160-1(5)
21	To declare under the Private Health Insurance (Insurer Obligations) Rules that a person is not eligible for appointment as a private health insurer's actuary	subsection 160-5(2)
22	To give a *prudential direction to a private health insurer	subsection 163-15(1)
23	To refuse to revoke a *prudential direction	subsection 163-15(3)
24	To disqualify a person from being or acting as a *director or *senior manager of a private health insurer	subsection 166-20(1)
25	To refuse to revoke a disqualification of a *disqualified person	subsection 166-20(3)
26	To refuse to determine that a person is not a *disqualified person	subsection 166-25(3)
27	To specify conditions in a determination that a person is not a *disqualified person	subsection 166-25(4)
28	To specify additional conditions to which determination that a person is not a *disqualified person is to be subject	subsection 166-25(4)
29	To vary conditions to which determination that a person is not a *disqualified person is to be subject	subsection 166-25(4)
30	To revoke a determination that a person is not a *disqualified person	subsection 166-25(8)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions		
Item	Decision	Provision under which decision is made
31	To direct a private health insurer not to make a change that it proposes to make to its *rules	subsection 169-10(2)
32	To refuse a request for a longer period for a private health insurer to respond to a request for an explanation	subsection 191-1(3)
33	To refuse to consent to a private health insurer withdrawing or varying an undertaking	subsection 197-1(3)
34	To give a direction to a private health insurer	section 200-1
35	To revoke a private health insurer's status as a *participating insurer	section 206-1
36	To refuse to extend a period to report to the Private Health Insurance Ombudsman	subsection 241-40(3)
37	To refuse to extend a period to give a record or information to the Private Health Insurance Ombudsman	subsection 250-1(5)
38	To reject an application to become a *participating insurer	section 279-5
39	On reconsideration of a decision notifying a private health insurer in relation to a claim for payment under Division 279	section 279-45
40	To affirm an original decision by the Medicare Australia CEO that an amount is recoverable as a debt under paragraph 282-1(1)(a) or (b)	section 282-15
41	To affirm an original decision by the Medicare Australia CEO that an amount is recoverable as a debt under paragraph 282-1(1)(h) in respect of a payment made to an individual	section 282-15

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6 Administration
Part 6-9 Review of decisions
Division 328 Review of decisions

Section 328-5

Reviewable decisions

Item	Decision	Provision under which decision is made
42	To affirm an original decision by the Medicare Australia CEO to set off a debt against an amount otherwise payable to a person or his or her estate	section 282-15
43	Not to waive, or to waive only a part of, an amount of *late payment penalty (other than late payment penalty in respect of an amount of *collapsed insurer levy)	section 307-20
44	Not to waive, or to waive only a part of, an amount of *collapsed insurer levy or *late payment penalty in respect of an amount of collapsed insurer levy	section 307-25

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1

2 **Part 6-10—Miscellaneous**

3 **Division 333—Miscellaneous**

4 **333-1 Delegation by Minister**

- 5 (1) The Minister may, by writing, delegate all or any of his or her
6 functions or powers under this Act (other than section 66-10) to:
7 (a) the Secretary of the Department; or
8 (b) an SES employee, or acting SES employee, in the
9 Department; or
10 (c) the Council.
- 11 (2) Without limiting subsection (1), the Minister may, by writing,
12 delegate all or any of his or her functions or powers under Part 2-2
13 or Part 6-4 to:
14 (a) the Medicare Australia CEO; or
15 (b) an employee of Medicare Australia; or
16 (c) an APS employee in the Department.
- 17 (3) In performing a function or exercising a power under a delegation,
18 the delegate must comply with any directions of the Minister.

19 **333-5 Delegation by Secretary**

- 20 (1) The Secretary of the Department may, by writing, delegate all or
21 any of his or her functions or powers under this Act to an APS
22 employee in the Department.
- 23 (2) In performing a function or exercising a power under a delegation,
24 the delegate must comply with any directions of the Secretary.

25 **333-10 Approved forms**

- 26 (1) A statement, notice, application or other document is in the
27 *approved form* if:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 333-10

- 1 (a) it is in the form approved in writing by the person specified
2 in the table as the approver of that form; and
3 (b) it contains a declaration signed by a person or persons as the
4 form requires (see section 333-15); and
5 (c) it contains the information that the form requires, and any
6 further information, statement or document required by the
7 approver, whether in the form or otherwise; and
8 (d) it is given in the manner (if any) required by the approver.
9

Person who approves forms

Item	This person ...	is the approver of these forms ...
1	the Secretary of the Department	forms for which there is no other approver specified in this table.
2	the Medicare Australia CEO	forms under Part 2-2.
3	the Council	(a) forms under Chapter 4, except a form under section 169-10; (b) a form under subsection 310-1(1), except a form that relates to *complaints levy; (c) a form under subsection 313-20(1).

10

- 11 (2) Despite subsection (1), a document that satisfies paragraphs (1)(a),
12 (b) and (d) but not paragraph (1)(c) is also in the *approved form if
13 it contains the information required by the approver. The approver
14 must specify the requirement in writing.
- 15 (3) The approver may combine in the same *approved form more than
16 one notice, statement, application or other document.
- 17 (4) The approver may approve a different *approved form for different
18 kinds of private health insurers.
- 19 (5) The Medicare Australia CEO must not approve a form that requires
20 a person to provide:
21 (a) the *tax file number of any person; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (b) information about the physical, psychological or emotional
2 health of any person.

3 **333-15 Signing approved forms**

4 A person who is required to do something in an *approved form
5 must, if the form requires it, sign a declaration, or (if allowed by
6 the form) have a declaration signed on the person's behalf.

7 **333-20 Private Health Insurance Rules made by the Minister**

8 The Minister may, by legislative instrument, make Private Health
9 Insurance Rules, specified in the second column of the table,
10 providing for matters:

- 11 (a) required or permitted by the corresponding Chapter, Part or
12 section specified in the third column of the table to be
13 provided; or
14 (b) necessary or convenient to be provided in order to carry out
15 or give effect to that Chapter, Part or section.
16

Private Health Insurance Rules made by Minister

Item	Private Health Insurance Rules	Chapter/Part/section
1	Private Health Insurance (Incentives) Rules	Part 2-2, section 206-1, Part 6-4
2	Private Health Insurance (Lifetime Health Cover) Rules	Part 2-3
3	Private Health Insurance (Complying Product) Rules	Chapter 3, section 188-1 and definition of <i>hospital-substitute treatment</i> in the Dictionary in Schedule 1
4	Private Health Insurance (Prostheses) Rules	Part 3-3
5	Private Health Insurance (Accreditation) Rules	section 81-1
6	Private Health Insurance (Health Insurance Business) Rules	Part 4-2

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 333-25

Private Health Insurance Rules made by Minister

Item	Private Health Insurance Rules	Chapter/Part/section
7	Private Health Insurance (Registration) Rules	Part 4-3
8	Private Health Insurance (Health Benefits Fund Policy) Rules	Part 4-4
9	Private Health Insurance (Data Provision) Rules	Part 4-5
10	Private Health Insurance (Health Benefits Fund Enforcement) Rules	Part 5-3
11	Private Health Insurance (Ombudsman) Rules	Part 6-2
12	Private Health Insurance (Council) Rules	Part 6-3
13	Private Health Insurance (Management) Rules	Part 6-5
14	Private Health Insurance (Levy Administration) Rules	Part 6-6
15	Private Health Insurance (Risk Equalisation Policy) Rules	Part 6-7
16	Private Health Insurance (Information Disclosure) Rules	Part 6-8

1

2 **333-25 Private Health Insurance Rules made by the Council**

- 3 (1) The Council may, by legislative instrument, make Private Health
4 Insurance Rules, specified in the second column of the table,
5 providing for matters:
6 (a) required or permitted by the corresponding Chapter, Part or
7 section specified in the third column of the table to be
8 provided; or
9 (b) necessary or convenient to be provided in order to carry out
10 or give effect to that Chapter, Part or section.

11

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Private Health Insurance Rules made by Council

Item	Private Health Insurance Rules	Chapter/Part/section
1	Private Health Insurance (Health Benefits Fund Administration) Rules	Part 4-4
2	Private Health Insurance (Insurer Obligations) Rules	Part 4-5
3	Private Health Insurance (Risk Equalisation Administration) Rules	Part 6-7

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6

- (2) To the extent that Private Health Insurance Rules made under this section deal with a matter that is dealt with in Private Health Insurance Rules made under section 333-20, they must do so in a way that is not inconsistent with the Rules made under section 333-20.

7

333-30 Regulations

8

9

10

11

- The Governor-General may make regulations prescribing matters:
- (a) required or permitted by this Act to be prescribed; or
 - (b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **Schedule 1—Dictionary**

2 Note: See section 1-10.
3
4

5 **1 Dictionary**

6 In this Act:

7 **ADI** (authorised deposit-taking institution) means a corporation
8 that is an ADI for the purposes of the *Banking Act 1959*.

9 **adult** means a person who is not a *dependent child.

10 **applicable benefits arrangement** means an applicable benefits
11 arrangement within the meaning of the *National Health Act 1953*
12 as in force before 1 April 2007.

13 **appointed actuary**, of a private health insurer, means the person
14 holding an appointment by the insurer under section 160-1.

15 **approved form** is a form that meets the requirements in
16 section 333-10.

17 **assets**, of a *health benefits fund, is defined in subsections 137-1(3)
18 and (4).

19 **authorised disclosure** is defined in subsection 323-1(3).

20 **authorised officer** is defined in subsection 313-1(1).

21 **base rate** is defined in subsection 34-1(2).

22 **capital adequacy direction** means a direction given under
23 section 143-20, and includes such a direction as varied under that
24 section.

25 **capital adequacy standard** means a standard established under
26 section 143-5.

27 **census day**, for a levy, is defined in subsection 310-1(2).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 **Chief Executive Officer** means the Chief Executive Officer of the
2 Council referred to in section 273-1.

3 **chief executive officer**, of a private health insurer, is the person
4 who is primarily and directly responsible to the *directors of the
5 insurer for the general and overall management of the insurer.

6 **collapsed insurer levy** is defined in paragraph 304-10(a).

7 **Commissioner** means the Commissioner of Private Health
8 Insurance Administration referred to in paragraph 267-1(1)(a).

9 **complaints levy** is defined in paragraph 304-10(b).

10 **complying health insurance policy** is defined in section 63-10.

11 **complying health insurance product** is defined in section 63-5.

12 **constitutional corporation** means a corporation to which
13 paragraph 51(xx) of the Constitution applies.

14 **Council** means the Private Health Insurance Administration
15 Council continued in existence under Part 6-3.

16 **Council administration levy** is defined in paragraph 304-10(c).

17 **Council-supervised obligation** is defined in section 185-10.

18 **cover** has a meaning affected by section 69-5.

19 **declaration of contravention** means a declaration under
20 section 203-5.

21 **dependent child** means a person:

- 22 (a) who is:
 - 23 (i) aged under 18; or
 - 24 (ii) a dependent child under the *rules of the private health
 - 25 insurer that insures the person; and
- 26 (b) who is not aged 25 or over; and
- 27 (c) who does not have a partner.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

- 1 **Deputy Commissioner** means the *member (if any) appointed
2 under subsection 267-5(2) to be the Deputy Commissioner.
- 3 **director** has the same meaning as in the *Corporations Act 2001*.
- 4 **disqualified person** is defined in section 166-15.
- 5 **employee health benefits scheme** is defined in section 121-15.
- 6 **enforceable obligation** is defined in section 185-5.
- 7 **external management** means management under Division 217 and
8 Part 6-5.
- 9 **external manager**, in relation to a *health benefits fund, means a
10 person appointed under section 217-10 as the external manager of
11 the fund.
- 12 **Federal Court** means the Federal Court of Australia.
- 13 **fringe benefit** means:
14 (a) a fringe benefit as defined by subsection 136(1) of the *Fringe*
15 *Benefits Tax Assessment Act 1986*; and
16 (b) a benefit that would be a fringe benefit (as defined by
17 subsection 136(1) of that Act) if paragraphs (d) and (e) of the
18 definition of **employer** in that subsection of that Act were
19 omitted.
- 20 **general treatment** is defined in section 121-10.
- 21 **gold card** is defined in subsection 34-15(3).
- 22 **health benefits fund** is defined in section 131-10.
- 23 **health care provider** means:
24 (a) a person who provides goods or services as, or as part of,
25 *hospital treatment or *general treatment; or
26 (b) a person who manufactures or supplies goods provided as, or
27 as part of, hospital treatment or general treatment.
- 28 **health insurance business** is defined in Division 121.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 **health-related business** is defined in section 131-15.
- 2 **holder**, of an insurance policy, means a person who is insured
3 under the policy and who is not a *dependent child.
- 4 **hospital** is defined in subsection 121-5(5).
- 5 **hospital cover** is defined in section 34-15.
- 6 **hospital-substitute treatment** means *general treatment that:
7 (a) substitutes for an episode of *hospital treatment; and
8 (b) is any of, or any combination of, nursing, medical, surgical,
9 podiatric surgical, diagnostic, therapeutic, prosthetic,
10 pharmacological, pathology or other services or goods
11 intended to manage a disease, injury or condition; and
12 (c) is not specified in the Private Health Insurance (Complying
13 Product) Rules as a treatment that is excluded from this
14 definition.
- 15 **hospital treatment** is defined in section 121-5.
- 16 **improper discrimination**:
- 17 (a) in relation to an insurer who is not a *restricted access
18 insurer—has the meaning given by subsection 55-5(2); and
19 (b) in relation to a restricted access insurer—has the meaning
20 given by subsection 55-5(2) as affected by subsection
21 55-5(3).
- 22 **incentive amount** is defined in section 23-5.
- 23 **incentive payments scheme** means the scheme provided for by
24 Division 26.
- 25 **ineligible for Medicare**, in relation to a person, means not an
26 eligible person within the meaning of the *Health Insurance Act*
27 1973.
- 28 **inspector** means a person appointed as an inspector under
29 section 214-1, and (except in section 214-40) includes a person
30 exercising powers under a delegation under section 214-40.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

- 1 **insurance** is defined in section 5-1.
- 2 **late payment penalty** means a late payment penalty incurred under
3 section 307-5 in respect of a *private health insurance levy.
- 4 **levy-related document** is defined in subsection 313-1(3).
- 5 **lifetime health cover base day** is defined in section 34-25.
- 6 **makes a capital payment** is defined in subsection 137-5(3).
- 7 **manager**, in relation to a *health benefits fund, means an *external
8 manager or *terminating manager of the fund.
- 9 **medical practitioner** means a medical practitioner within the
10 meaning of the *Health Insurance Act 1973*.
- 11 **Medicare Australia CEO** means the Chief Executive Officer of
12 Medicare Australia.
- 13 **medicare benefit** means a medicare benefit under Part II of the
14 *Health Insurance Act 1973*.
- 15 **medicare eligibility day** is defined in subsection 34-25(3).
- 16 **member** means a member of the Council and includes the
17 *Commissioner.
- 18 **new arrival** is defined in subsection 34-25(2).
- 19 **occupier**, of *premises, includes:
20 (a) the person in charge or control, or apparently in charge or
21 control, of the premises; or
22 (b) a person who represents, or apparently represents, that
23 person.
- 24 **officer**, of a private health insurer, means:
25 (a) a *director of the insurer; or
26 (b) a *chief executive officer of the insurer; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 (c) a person who makes, or participates in making, decisions that
 2 affect the whole, or a substantial part, of the business of the
 3 insurer.

4 **officer**, of a subject of a complaint under Division 241 or an
 5 investigation under Division 244, means:

- 6 (a) if the subject is an individual—the individual; or
 7 (b) if the subject is a private health insurer—a person who is an
 8 *officer of the insurer; or
 9 (c) if the subject is a company within the meaning of the
 10 *Corporations Act 2001*—a *director of the company; or
 11 (d) if the subject is an incorporated association—a member of
 12 the management committee of the association; or
 13 (e) if the subject is an unincorporated entity—a member of the
 14 governing body of the entity; or
 15 (f) if the subject is a partnership—a partner in the partnership.

16 **old Schedule 2** is defined in subsection 34-10(5).

17 **overseas** has a meaning affected by section 34-30.

18 **participant**, in relation to the *premiums reduction scheme, means:

- 19 (a) a person who is registered as a participant in the scheme
 20 under subsection 23-15(3); or
 21 (b) a person who has applied to be registered as a participant in
 22 the scheme under subsection 23-15(1) and whose application
 23 has not been refused.

24 **participating insurer** means:

- 25 (a) a private health insurer approved by the Minister under
 26 subsection 279-5(2); or
 27 (b) a private health insurer that has applied under subsection
 28 279-5(1) to be approved and whose application has not been
 29 rejected.

30 **permitted days without hospital cover** is defined in section 34-20.

31 **personal information** means information or an opinion (including
 32 information or an opinion forming part of a database), whether true

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

1 or not, and whether recorded in a material form or not, about an
2 individual whose identity is apparent, or can reasonably be
3 ascertained, from the information or opinion.

4 **policy group**, of a *health benefits fund, is defined in subsection
5 146-1(5).

6 **policy holder**, of a *health benefits fund, means a *holder of a
7 policy that is *referable to the fund.

8 **policy liability** of a private health insurer means:

- 9 (a) a liability that has arisen under an insurance policy; or
10 (b) a liability that, subject to the terms and conditions of an
11 insurance policy, will arise on the happening of an event, or
12 at a time, specified in the policy.

13 **pre-existing condition** is defined in section 75-15.

14 **premises** includes the following:

- 15 (a) a structure, building, vehicle or vessel;
16 (b) a place (whether enclosed or built on);
17 (c) a part of a thing referred to in paragraph (a) or (b).

18 **premiums reduction scheme** means the scheme provided for by
19 Division 23.

20 **private health insurance arrangement** includes any of the
21 following:

- 22 (a) a *private health insurance policy or a *product;
23 (b) an agreement or arrangement between a private health insurer
24 and a *health care provider;
25 (c) an agreement or arrangement between a private health insurer
26 and another person (other than a health care provider) that
27 relates to insurance in relation to *hospital treatment or
28 *general treatment;
29 (d) an agreement or arrangement between two or more health
30 care providers that relates to insurance in relation to hospital
31 treatment or general treatment;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

- 1 (e) Private Health Insurance (Complying Product) Rules made
- 2 for the purposes of item 1 or 5 of the table in subsection
- 3 72-1(2);
- 4 (f) Private Health Insurance (Prostheses) Rules made for the
- 5 purposes of item 4 of the table in subsection 72-1(2);
- 6 (g) an arrangement between a private health insurer and a
- 7 *private health insurance broker;
- 8 (h) an arrangement between a private health insurance broker
- 9 and a person seeking to become insured under a private
- 10 health insurance policy.

11 **private health insurance broker** means a person:

- 12 (a) who deals (otherwise than by carrying on *health insurance
- 13 business) in insurance policies that *cover *hospital treatment
- 14 or *general treatment or both; and
- 15 (b) who acts on behalf of persons seeking to become insured
- 16 under those policies.

17 **private health insurance levy** is defined in section 304-10.

18 **Private Health Insurance Ombudsman** means the Private Health

19 Insurance Ombudsman appointed for the purposes of Part 6-2.

20 **private health insurance policy** means an insurance policy that

21 *covers *hospital treatment or *general treatment or both (whether

22 or not it also covers any other treatment).

23 **private health insurer** means a person registered under Part 4-3.

24 **product** is defined in subsection 63-5(2).

25 **protected information** is defined in subsection 323-1(2).

26 **prudential direction** means a direction given under section 163-15.

27 **prudential matters** is defined in subsection 163-1(2).

28 **prudential standard** means a standard established under subsection

29 163-1(1).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

1 **records**, of a subject of a complaint under Division 241 or an
2 investigation under Division 244, includes any of the following
3 that are in the possession, or under the control, of the subject:
4 (a) the constitution and *rules of the subject, if the subject is a
5 private health insurer;
6 (b) the internal training manuals and related documents of the
7 subject;
8 (c) any documents relevant to a *private health insurance
9 arrangement to which the subject is a party or that applies to
10 the subject;
11 (d) to the extent that the complaint or investigation relates to the
12 subject's dealings with a particular person—the subject's
13 records relating to its dealings with that particular person
14 including correspondence, internal memoranda, emails, and
15 recordings of taped conversations;
16 whenever those records came into existence.

17 **referable**: an insurance policy is referable to a *health benefits fund
18 if:

- 19 (a) the fund is identified under paragraph 93-15(c) as the fund to
20 which the policy is referable (and the policy has not been
21 made referable to another *health benefits fund under
22 Division 146); or
23 (b) the policy has been made referable to the fund under
24 Division 146.

25 **registered as a for profit insurer** means a private health insurer
26 that is registered under Part 4-3 as a for profit insurer.

27 **relevant amount** is defined in subsection 66-10(5).

28 **responsible insurer** means:

- 29 (a) for a *health benefits fund that is under *external
30 management—the private health insurer that was conducting
31 the fund prior to the appointment of the *external manager of
32 the fund; or
33 (b) for a health benefits fund that is under *terminating
34 management—the private health insurer that was conducting

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

1 the fund prior to the appointment of the *terminating manager
2 of the fund.

3 **restricted access group** is defined in subsection 126-20(7).

4 **restricted access insurer** means a private health insurer that is
5 registered under Part 4-3 as a restricted access insurer.

6 **risk equalisation jurisdiction** is defined in subsection 146-1(6).

7 **risk equalisation levy** is defined in paragraph 304-10(d).

8 **Risk Equalisation Trust Fund** means the Private Health Insurance
9 Risk Equalisation Trust Fund continued in existence under
10 Part 6-7.

11 **rules**, of a private health insurer, means the body of rules
12 established by the insurer that relate to the day-to-day operation of
13 the insurer's *health insurance business and (if any) *health-related
14 business.

15 **schedule fee** means the Schedule fee within the meaning of Part II
16 of the *Health Insurance Act 1973*.

17 **search powers** means powers to search for, inspect, take extracts
18 from, and make copies of, documents.

19 **senior manager** of a private health insurer means a person who has
20 or exercises any of the senior management responsibilities (within
21 the meaning of the *prudential standards) for the insurer.

22 **solvency direction** means a direction given under section 140-20,
23 and includes such a direction as varied under that section.

24 **solvency standard** means a standard established under
25 section 140-5.

26 **standard information statement** is defined in section 93-5.

27 **tax file number** means a tax file number as defined in
28 section 202A of the *Income Tax Assessment Act 1936*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

1 **terminating management** means management under Division 149
2 and Part 6-5.

3 **terminating manager**, in relation to the *health benefits funds of a
4 private health insurer, means a person appointed under paragraph
5 149-10(2)(a) or Division 220 as the terminating manager of the
6 funds.

7 **termination day**, in relation to the *health benefits funds of a
8 private health insurer, is defined in subsection 149-20(2).

9 **transfer**, in relation to a person, is defined in section 75-10.

10 **up to date**, in relation to a *standard information statement, is
11 defined in subsection 93-1(2).

12 **voluntary deed of arrangement** means:

- 13 (a) a deed of arrangement agreed on at a meeting of a kind
14 referred to in section 217-45; or
15 (b) such a deed as varied in accordance with the Health Benefits
16 Fund Enforcement Rules.

17 **waiting period** is defined in section 75-5.
18

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.
