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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

SENATE

PRIVATE HEALTH INSURANCE BILL 2006

PRIVATE HEALTH INSURANCE (TRANSITIONAL PROVISIONS AND CONSEQUENTIAL AMENDMENTS) BILL 2006

PRIVATE HEALTH INSURANCE (REINSURANCE TRUST FUND LEVY) AMENDMENT BILL 2006

SUPPLEMENTARY EXPLANATORY MEMORANDUM

Amendments and Requests for Amendments to be Moved on Behalf of the Government

(Circulated by authority of the Minister for Health and Ageing,
the Hon Tony Abbott MP)

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PRIVATE HEALTH INSURANCE (REINSURANCE TRUST FUND LEVY) AMENDMENT BILL 2006

OUTLINE

The proposed government amendments amend the Private Health Insurance Bill 2006, Private Health Insurance (Transitional Provisions and Consequential Amendment) Bill 2006 and the Private Health Insurance (Reinsurance Trust Fund Levy) Amendment Bill 2006.

The Amendments

The Private Health Insurance Bill 2006 (the main Bill) and related Bills were introduced into the Parliament on 7 December 2006. The proposed legislation will support innovation and greater choice in private health care and establishes a clearer and simpler regulatory framework. It reflects the considered and constructive input from the private health sector in an extensive consultation process.

Following comments on the legislation over the summer recess, the Government proposes a range of amendments that improve the clarity and operation of the legislation, correct some technical errors, and add elements to the consequential amendments that could not be included at the time of introduction as they required further consideration within government or consultation with the Ministerial Council on Corporations Law.

Significant groups of amendments include:

- amendments to Parts 3-3 and 3-4 of the main Bill to clarify provisions governing premium discounts and the requirements around standard information statements;
- amending Division 69 to allow the Private Health Insurance (Complying Product) Rules to provide for the continuation of benefits, such as funeral benefits or maternity bonuses, which have been offered as part of health insurance policies;
- amending Division 126 of the main Bill to allow insurers to convert to for-profit status subject to approval by the Private Health Insurance Administration Council (PHIAC);
- amending Division 146 of the main Bill to clarify the operation of the provisions dealing with the restructure, merger and acquisition of health benefits funds;
- amending Division 149 of the main Bill to allow the Private Health Insurance Administration Council, following a report from a terminating manager of a health benefits fund, to apply to the Federal Court for an order that a private health insurer be wound up; and
- amending the Private Health Insurance (Transitional Provisions and Consequential Amendment) Bill to change the date on which the Private Health Insurance Ombudsman will become a statutory agency and to amend the income tax law to provide for income tax offsets complementary to the incentives available under Part 2-2 of the main Bill.

FINANCIAL IMPACT

These amendments will have no financial impact.

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NOTES ON CLAUSES

Amendments to the Private Health Insurance Bill 2006

Item (1) and (2) clarify and make a technical correction to clause 23-10.

Item (3) clarifies clause 26-5.

Items (4) and (5) amend the heading to clause 50-5 and the clause itself to reflect the inclusion of Private Health Insurance (Benefit Requirement) Rules in clause 72-1 as a result of amendments made by Items (19) and (21).

Item (6) amends clause 55-5 to change a reference to paragraph 66-10(2)(a) to a reference to subclause 66-10(2) consequential on the amendment made by Item (13).

Items (7) and (8) add a new subclause 63-1(2) providing that the Private Health Insurance (Complying Product) Rules may exclude certain health insurance business from complying product requirements.

Item (9) adds to clause 63-5 a definition of a ***product subgroup*** as all policies in a product which cover people in the same risk equalisation jurisdiction (within the meaning of clause 146-1) and cover the same insured group. It also provides that an ***insured group*** may be specified in the Private Health Insurance (Complying Product) Rules by reference to the number or kind of people in the group, and any other matter.

The concept of a product subgroup is then used for the purpose of the premium requirement set out in Division 66 and the information obligations in Divisions 93 and 96. This allows greater flexibility in defining categories of people to be covered by policies and simplifies the requirements for standard information statements.

Item (10) amends subclause 66-5(1) to provide that a policy meets the premium requirement if the premium is the amount specified as the most recently approved amount for that product subgroup.

Item (11) amends subclause 66-5(1) to provide that more than one discount can apply to the premium for a policy, and that the total actual discount (apart from a discount due to non-applicability of a State levy) must be less than the maximum specified in the Private Health Insurance (Complying Product) Rules.

Item (12) replaces subclause 66-5(2) dealing with premium discounts with new subclauses (2) and (3) to resolve some uncertainty and technical difficulties in the previous drafting.

The proposed new subclause (2) provides that discounts are allowed:

- if they are for the reasons set out in subclause (3);
- if available for a particular reason, are available for the same reason for every policy in a product;
- if different discounts are available for a particular reason, the same percentage discount is available on the same basis for every policy in a product;
- any other requirements set out in the Rules are met.

Subclause (3) sets out the permissible reasons for a discount, which are the same as in the current subclause (2) with the addition of a discount for persons agreeing to communicate and claim electronically and an ability to add other reasons for discounts under the Rules.

Item (13) replaces subclause 66-10(2) with a new subclause providing that proposed changed premiums must be the same for every policy in the same product subgroup.

Item (14) removes subclause 66-10(5) as it is no longer required following the amendment made by Item (10).

Items (15), (16) and (17) amend clause 69-1 to provide that an insurance policy meets the coverage requirements of the Division if any benefits it offers, other than coverage for particular kinds of treatments, are benefits authorised by the Private Health Insurance (Complying Product) Rules. This amendment is intended to allow the Rules to provide for the continuation of benefits such as funeral benefits or maternity bonuses which have been offered by insurers as part of their policies.

Item (18) adds a new clause 69-10 which includes the definition of **hospital-substitute treatment** currently included in the Dictionary at Schedule 1.

Items (19), (20) and (21) refine the benefit requirement for policies that cover hospital treatment. The items amend clause 72-1 to provide for minimum benefits for complying products and prostheses to be either amounts set out in the Private Health Insurance (Benefit Requirements) Rules and the Private Health Insurance (Prostheses) Rules or amounts worked out by methods specified in the Rules.

Items (22), (25) and (26) are technical corrections amending references in notes to clauses 72, 75 and 78 to a policy holder to references to an insured person.

Item (23) amends clause 72-15 to change the number of days allowed for the payment of an ongoing listing fee under the *Private Health Insurance (Prostheses Application and Listing Fees) Act 2006* from 14 days to 28 days.

Item (24) adds a new clause 72-20 allowing for matters relating to the administration of prostheses application and listing fees to be covered by the Private Health Insurance (Prostheses) Rules.

Item (27) makes a consequential amendment to clause 84-1 following the amendment made by Item (15) providing that policies are not precluded from offering benefits other than for treatment if these are authorised in the Rules.

Items (28) to (46) (excepting Item (42)) amend various provisions in Divisions 93 and 96 to clarify that the standard information requirements apply to product subgroups and that there may thus be more than one standard information statement for a product.

Item (42) amends subclause 93-20(4) to require insurers to notify insured groups of changes in the health benefits fund to which a policy is referable no later than two weeks after the change takes effect. This is intended to allow for a rapid transfer of business between insurers if this is required for fiduciary reasons.

Item (47) amends clause 99-1 to provide that private health insurers can only request a transfer certificate in specified circumstances. This is intended to prevent insurers from embarking on "fishing expeditions" to obtain information on prospective members from competitors.

Item (48) is a technical correction to subclause 121-5(7) amending a reference to policy holders to a reference to persons insured under a product.

Item (49) inserts into subclause 121-5(7) a new criterion that the Minister must have regard to in deciding whether to declare that a facility is a hospital, or to revoke such a declaration. If the Minister is considering revoking such a declaration, this provision requires the Minister to have regard to contraventions of conditions to which the declaration is subject.

Item (50) inserts a new clause 121-7 explicitly providing for conditions on declarations of hospitals under subclause 121-5(6). Under proposed subclauses (1) and (2) declarations generally will be subject to conditions specified in the Private Health Insurance (Health Insurance Business) Rules, and subclause (3) allows the Minister to specify additional conditions to which a particular declaration is subject. Subclause (4) provides that the contravention of a condition imposed on a declaration does not result in the cessation of the declaration.

The following two items amend provisions relating to insurers changing their registration status from not-for-profit to for-profit. The amendments are intended for provide for scrutiny of changes arising from demutualisation to ensure that they do not result in financial benefits to persons other than policy holders and insured persons, and that the distribution of benefits among that group is equitable.

Item (51) amends subclause 126-40(2) to provide that subject to approval by Council, insurers may change their registration status from not-for-profit to for-profit under proposed new clause 126-42.

Item (52) inserts clause 126-42 dealing with conversion to for-profit status.

Subclause (1) provides that a private health insurer may apply to the Council to convert to for-profit status. Under subclause (2), the application must be made in the approved form and include a conversion scheme that meets the additional information requirements set out in the Private Health Insurance (Registration) Rules. Subclause (2) also provides that the application must be given to the Council at least 90 days before the proposed date of effect.

Subclause (3) provides that the Council must approve the application within 30 days if it is satisfied that the conversion scheme does not in substance involve a demutualisation of the insurer. Subclause (6) provides that the Private Health Insurance (Registration) Rules may set out criteria for deciding under subclause (3) if an application to convert to for-profit status does not involve demutualisation.

If an application to convert to for-profit status is not approved through the operation of subclause (3), paragraph (4)(a) requires that the application must be advertised publicly at least 45 days before the proposed date of effect. Paragraph (4)(b) allows the Council to seek further information on the application within 90 days of it being made.

Providing that the insurer has complied with subclause (2) and paragraph (4)(b), the Council must approve the application under subclause (5) if satisfied that the conversion scheme:

- would not result in a financial benefit to a person (including a natural person and a corporate person) who is not a policy holder or not insured through a health benefits fund conducted by the insurer; and
- would not result in an inequitable distribution of financial benefits between policy holders and persons insured through a health benefits fund conducted by the insurer.

Subclause (7) requires the Council to provide written notice to the insurer on the outcome of the application.

Item (53) extends the definition of assets of a health benefits fund in clause 137-1 to include or exclude as appropriate assets that are transferred into or out of the fund as the result of the operation of Division 146.

Items (54) and (55) extend the purposes for which fund assets can be applied under subclause 137-10(2) to include:

- meeting liabilities under business transferred to the fund under Division 146; and
- other purposes specified in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Item (55) will allow the Rules to provide for the payment from a health benefits fund of benefits such as funeral benefits or maternity bonuses which have been offered by insurers as part of their policies.

Item (56) is a technical correction to subclause 137-10(3).

Items (57) and (58) are technical corrections to clause 140-20.

Items (59) and (60) are technical corrections to clause 143-20.

The following eleven items amend provisions in Part 4-4 dealing with the restructure, merger and acquisition of health benefits funds. Comments on these provisions in the Bill as it was introduced indicated that they could be interpreted in different ways and that their effect was not clear.

Items (61) to (68) amend clause 146-1 dealing with insurers conducting internal restructures of health benefits funds to:

- clarify that the effect of a restructure is to make insurance policies relating to policy subgroups become referable to another fund (subclause (1));
- provide that Council must only approve the restructure if satisfied that the net transfer of assets and liabilities to the receiving fund or funds is reasonable having regard to the policy groups to be transferred, and that the distribution between receiving funds is fair, not that the division of particular assets and liabilities between funds is reasonable (subclauses (2) and (2A));
- remove the definitions of transferring fund and receiving fund from subclause (3) as these terms are now defined in subclause (1);
- amend the subjects to be covered by Rules to include working out reasonable estimates and fair distributions under subclause (2) and transferring of assets and liabilities between funds (subclause (4)).

Item (69) substitutes a new clause 146-5 which replaces the concept of insurers transferring funds by making policies referable to different funds with the concept of insurers entering into arrangements to transfer funds. These arrangements include changing the funds to which policies in policy groups are referable (subclause (1)).

Subclause (2) provides that the arrangement must not take effect unless all the insurers involved apply jointly to Council; Council agrees; and the insurers comply with any requirements set out in the Private Health Insurance (Health Benefits Fund Administration) Rules.

Subclauses (3) and (4) provides that Council must only approve the proposed arrangement if it is satisfied:

- that the net effect of the transfer of assets and liabilities to the receiving fund or funds is reasonable having regard to the policy groups to be transferred;
- those assets and liabilities would be fairly distributed between the receiving funds;
- if all policies in a fund were to become referable to another fund or funds, that all assets and liabilities would be transferred out of the fund; and
- that the arrangement will not result in a breach of solvency or capital adequacy standards.

Subclause (5) provides for the Rules to specify a range of matters relating to Council's consideration of the application and the implementation of the arrangement.

Subclause (6) requires a transferee insurer to notify Council within 28 days of the arrangement taking effect.

Subclause (7) provides that if an insurance policy becomes referable to a fund conducted by an insurer other than the insurer that issued the policy, references in the Bill to an insurer that issued a policy are taken to be references to the transferee insurer.

Item (70) inserts a new clause 146-10 which provides that the consent of policy holders to a restructure under clause 146-1 or an arrangement under clause 146-5 is not required unless the constitution of the insurer requires it.

Item (71) inserts a new clause 146-15 clarifying that Division 146 does not override the operation of other relevant laws. For example, the transfer of assets consisting of real property between insurers under an arrangement under clause 146-5 is still subject to State land transfer laws.

Item (72) is a technical correction to clause 149-45.

Items (73), (74) and (75) amend provisions in Division 149 dealing with the termination of health benefits funds. They allow a terminating manager to make a written report to the Council at any time and require such a report as soon as practicable after the termination of the funds. If a terminating manager's report recommends the winding up of an insurer, the Council or the terminating manager may apply to the Federal Court for an order that a private health insurer be wound up. The Federal Court may make such an order if it is satisfied that this would be in the financial interests of the policy holders of the funds.

Item (76) is a technical correction amending a reference in clause 163-10 to a policy holder to a reference to a person insured under a product.

Item (77) is a technical correction replacing a reference to the report in subclause 169-5(2) with a reference to accounts or statements.

Item (78) amends subclause 169-15(1) to change the requirement for a private health insurer to notify a change of chief executive officer before it takes effect to a requirement to notify within 28 days of the change taking effect.

Item (79) adds a note at the end of clause 172-5 pointing out that medical practitioners in dealing with private health insurers may be able to take advantage of collective bargaining provisions in the *Trade Practices Act 1974*.

Item (80) is a technical correction amending a reference in clause 172-10 to policy holders to a reference to persons insured under a product.

Item (81) is a technical correction to clause 200-1.

Item (82) is a technical correction to clause 217-10.

Items (83) and (84) are technical corrections to clause 217-35.

Item (85) inserts a new clause 217-80 which specifies how references in the Bill to the application of provisions of the *Corporations Act 2001* are to be interpreted. It is based on the present section 7 in the *National Health Act 1953*. It broadly provides that:

- the application under the Bill of sections in the Corporations Act includes application of relevant regulations and other instruments made under those sections;
- Rules made under the Bill may for the purposes of the application of the sections override regulations and other instruments made under the Corporations Act;
- Rules made under the Bill may take the place of regulations and other instruments that could be made under the applied sections;
- the definitions and interpretations principles under the Corporations Act have effect on applied sections.

Item (86) is a technical correction to clause 250-1.

Item (87) is a technical correction to clause 261-5.

Item (88) is a technical correction to clause 290-10.

Item (89) adds a new clause 307-30 to allow for matters relating to the payment of levies to be covered by the Private Health Insurance (Levy Administration) Rules.

Items (90) and (91) amend clause 328-5 to add to the list of reviewable decisions a decision to apply conditions on the declaration of a particular facility as a hospital and a decision to refuse an application by an insurer to convert to a for-profit insurer.

Items (92), (95) and (96) amend clauses 333-20 and 333-25 to clarify that a reference in the Act for the Private Health Insurance Rules made by either the Minister or the Council to modify a provision of this or another Act means that the Rules may add, omit or substitute provisions, including the effect or requirements of provisions.

Item (93) amends the table in clause 333-20 setting out the provisions under which Rules may be made to remove the reference to the definition of hospital-substitute treatment in the dictionary following its inclusion in clause 69-10 by Item (18).

Item (94) adds to the table in clause 333-20 setting out the provisions under which Rules may be made a reference to the Private Health Insurance (Benefits Requirements) Rules added by Items (19) and (21).

The following eight amendments amend the Dictionary at Schedule 1 to reflect amendments made by earlier items.

Items (97) and (98) amend the Dictionary to insert definitions relating to the application of provisions of the *Corporations Act 2001* following the addition of clause 217-80 by Item (85).

Item (99) amends the definition of ***assets*** in the dictionary following the amendment to clause 137-1 made by Item (53).

Item (100) amends the definition of ***hospital-substitute treatment*** following the inclusion of the substantive definition in new clause 69-10 under Item (18).

Item (101) inserts a definition of ***net asset position*** of a health benefits fund into the Dictionary to support amendments made to Division 146 by Items (63), (64), and (69).

Item (102) amends the definition of a ***private health insurance policy*** to reflect the amendment made by Item (15) permitting policies to provide benefits, other than coverage for particular kinds of treatments, if these benefits are authorised by the Private Health Insurance (Complying Product) Rules.

Item (103) inserts a definition of ***product subgroup*** into the Dictionary following the amendment to clause 63-5 made by Item (9).

Item (104) removes the definition of ***relevant amount*** from the Dictionary following the amendment to clause 66-10 made by Item (14).

Amendments to the Private Health Insurance (Transitional Provisions and Consequential Amendments) Bill 2006

Items (1) to (3) amend the table of commencement provisions in clause 2 relating to the private health insurance tax offset in Subdivision 61-G of the *Income Tax Assessment Act 1997* to be added under Item (50) and the repealing of redundant references to Subdivision 61-H of the *Income Tax Assessment Act 1997*.

Item (4) amends clause 10 to provide that if the premiums, treatments or benefits of a product are changed, more than 15 days after the commencement time of the new Act, the new product must meet the complying health insurance product requirements under the new Act at the time of the change. This will allow products for which the premiums change in the period from 1 April to 15 April 2007 a further fourteen and a half months to transition to the new regime (unless another relevant change to the product is made during that period).

Items (5) to (39) provide for the postponement of conversion of the Private Health Insurance Ombudsman from a body under the *Commonwealth Authorities and Companies Act 1997* (CAC) to the *Financial Management and Accountability Act 1997* (FMA).

Item (5) amends clause 27 to define the ***Ombudsman conversion time*** as 1 July 2007, or such later day as is set in the Rules.

Item (6) inserts clause 27A which provides for the Ombudsman to convert from a CAC body to a FMA body at the Ombudsman conversion time.

Subclause (1) provides that the sections in the main Act establishing the Ombudsman as a FMA statutory agency do not apply until the Ombudsman conversion time.

Subclause (2) continues the Ombudsman established as a CAC body under the *National Health Act 1953* until the Ombudsman conversion time, and subclause (3) provides for the references in the main Act to the Ombudsman (and the staff of the Ombudsman) are taken to be references to the Ombudsman and the staff under the *National Health Act 1953* from the time the main Act commences until the Ombudsman conversion time.

Items (7) to (39), excepting Items (23), (30), and (34), replace references throughout Part 6 Division 1 of the Bill to the commencement time of the main Act with references to the Ombudsman conversion time.

Item (23) amends clause 35 to provide that things done under the Part of the *National Health Act 1953* establishing the Ombudsman before the commencement time of the main Act have effect after that time as if they were done under the main Act, and that complaints made under the *National Health Act 1953* before the before the commencement time of the main Act may be handled under the main Act.

Items (30) and (34) provide that a person acting as the Private Health Insurance Ombudsman before the Ombudsman conversion time is taken to have been appointed to act under section 253-10 of the main Act at the conversion time.

Item (40) is a technical correction to clause 39.

Item (41) amends Schedule 1 to add an item repealing section 7 of the *National Health Act 1953*. An equivalent to section 7 of the *National Health Act 1953* will be inserted in Division 217 of the Private Health Insurance Bill by Item (85) of the amendments to the main Bill.

Item (42) amends Schedule 2 to add an item amending the definition of ***hospital treatment*** in *A New Tax System (Goods and Services Tax) Act 1999* to provide that hospital treatment is as defined in section 67 of the *National Health Act 1953* as it applied before repeal. This maintains the status quo pending further consideration by the Australian Taxation Office and any necessary consultation with State and Territory Governments.

Item (43) amends an incorrect date reference in item 4 of Schedule 2 amending *A New Tax System (Medicare Levy Surcharge-Fringe Benefits) Act 1999*.

Item (44) amends Schedule 2 to add items 8A and 8B amending the *Australian Securities and Investments Commission Act 2001* and the *Corporations Act 2001* to update the definition of ***health insurance business*** reflecting the replacement of the *National Health Act 1953* with the *Private Health Insurance Act 2007*. These amendments required consultation with the Ministerial Council on Corporations Law before their introduction.

Item (45) amends an incorrect date reference in item 75 of Schedule 2 amending the *Medicare Levy Act 1986*.

The following amendments (Items (46) to (51)) amend Schedule 3 of the Bill to provide for the replacement of Subdivision 61-H of the *Income Tax Assessment Act 1997*, which provides a tax offset complementary to the *Private Health Insurance Incentives Act 1998*, with a new Subdivision 61-G, which provides a tax offset complementary to the Division 26 of the *Private Health Insurance Act 2007*.

Item (46) amends Schedule 3 to replace item 2 with a new item amending subsection 159J(6) of the *Income Tax Assessment Act 1936* to replace the exclusion of payments made under the *Private Health Insurance Incentives Act 1998* from the separate net income of a dependant with a reference to payments made under Division 26 of the *Private Health Insurance Act 2007*.

Item (47) inserts a new item 3 into Schedule 3 amending subsection 170(10AA) of the *Income Tax Assessment Act 1936*. The amendment has the effect of providing that assessments may be amended at any time to give effect to the new Subdivision 61-G of the *Income Tax Assessment Act 1997*.

Item (48) amends Schedule 3 to insert item 7A which amends the list of allowable tax offsets in section 13-1 of the *Income Tax Assessment Act 1997* to replace a reference to Subdivision 61-H with a reference to Subdivision 61-G.

Item (49) amends Schedule 3 to replace item 8 with a new item 8 which replaces the reference in section 52-125 of the *Income Tax Assessment Act 1997* to payments made

under the *Private Health Insurance Incentives Act 1998* with a reference to payments made under Division 26 of the *Private Health Insurance Act 2007*. This exempts such payments from income tax.

Item (50) amends Schedule 3 to insert items 9-9E.

Item 9 repeals Subdivision 61-H of the *Income Tax Assessment Act 1997* and inserts a new Subdivision 61-G. This Subdivision provides a mechanism for claiming a private health insurance tax offset instead of having the premium reduced under Division 23 of the *Private Health Insurance Act 2007* or receiving an incentive payment under Division 26 of that Act.

Item 9A provides that the repeal of Subdivision 61-H of the *Income Tax Assessment Act 1997* and its replacement by Subdivision 61-G effected by the Schedule applies for the 2007-08 and later income years.

Item 9B amends section 67-25 of the *Income Tax Assessment Act 1997* to provide that private health insurance tax offsets under Subdivision 61-G, except those arising under subsection 61-205(2), are subject to the refundable tax offset rules.

Item 9C amends the definition of ***incentive amount*** in the definitions provision (subsection 995-1(1)) of the *Income Tax Assessment Act 1997* to replace the reference to section 61-345 in Subdivision 61-H with a reference to section 61-220 in Subdivision 61-G.

Items 9D and 9E replace references in sections 20-1 and 26-1 of the *Private Health Insurance Act 1997* to Subdivision 61-H of the *Income Tax Assessment Act 1997* with references to Subdivision 61-G.

Item (51) amends Schedule 3 to insert items 17 and 18 amending sections 45-340 and 45-375 of the *Taxation Administration Act 1953* to replace references to Subdivision 61-H of the *Income Tax Assessment Act 1997* with references to Subdivision 61-G. These sections set out methods for working out a taxpayer's adjusted tax and adjusted assessed tax.

Requests for Amendments to the Private Health Insurance (Reinsurance Trust Fund Levy) Amendment Bill 2006

Items (1) and (2) replace references in item 17 of the Schedule to the Bill to determinations of the rate of risk equalisation levy under section 7 of the Act being made by legislative instrument with reference to the determinations being made in writing.

Item (3) adds a new item 18A which amends section 7 of the Act to add a subsection (4) explaining that instruments made under subsection (1) are not legislative instruments.

This is because the Private Health Insurance (Risk Equalisation Policy) Rules to be made under clause 318-30 of the Private Health Insurance Bill 2006 will set out the method for working out the amount to be paid by way of levy. Determinations under section 7 of the *Private Health Insurance (Reinsurance Trust Fund Levy) Act 2003* are thus administrative in character, in that they simply give effect to an outcome determined under the Rules.