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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

PRIVATE HEALTH INSURANCE BILL 2006

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

PRIVATE HEALTH INSURANCE (PROSTHESES APPLICATION AND LISTING FEES) BILL 2006

PRIVATE HEALTH INSURANCE (COLLAPSED ORGANIZATION LEVY) AMENDMENT BILL 2006

PRIVATE HEALTH INSURANCE COMPLAINTS LEVY AMENDMENT BILL 2006

PRIVATE HEALTH INSURANCE (COUNCIL ADMINISTRATION LEVY) AMENDMENT BILL 2006

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

EXPLANATORY MEMORANDUM

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

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INTRODUCTION

This package of Bills will provide a legislative framework for important reforms to private health insurance announced by the Government on 26 April 2006 to enhance choice, certainty and the value of private health care. The changes, which will come into effect on 1 April next year, will support improved information and services for consumers and greater competition in the insurance sector. They will also bring much clearer and simpler regulation for health insurers and service providers.

This package is the most significant change to health insurance legislation in more than a decade. It will allow the private health sector to develop innovative products that reflect contemporary clinical practice, and support greater choice in private health care for consumers.

The legislation complements other initiatives implemented in recent years and reaffirms the Government's long-standing commitment to choice in health care. These initiatives include: the 30% Rebate; the increased rebate for older Australians; Lifetime Health Cover; and the No Gap and Known Gap arrangements. These measures have helped ensure a viable and sustainable private health sector, while also improving the capacity of the public hospital system to deliver services to the Australian community.

This package of Bills does not detract in any way from people's entitlements under Medicare, and will not result in a two-tier health care system. The Government continues to be strongly committed to Medicare.

Specifically, the Bills are intended to:

- clarify and simplify the legislative regime for private health insurance so that organisations can offer private health insurance products with the minimum

compliance requirements necessary to achieve the Government's policy objectives and protect the interests of consumers;

- allow private health insurance to provide and include in risk equalisation arrangements benefits for outpatient and out-of-hospital services, including chronic care management for conditions such as diabetes and asthma, and disease prevention programs;
- require insurers to provide standard product information to help people compare policies and to understand their entitlements;
- eliminate Lifetime Health Cover penalties for fund members who have retained their hospital cover for more than ten years continuously;
- provide for the transition from the current regulatory regime;
- repeal redundant parts of the *National Health Act 1953* and amend a range of other Acts to reflect the new regime;
- impose application and listing fees on the sponsors of prostheses; and
- amend the Acts imposing levies on private health insurers.

OUTLINE

PRIVATE HEALTH INSURANCE BILL 2006

This Bill sets out a comprehensive regulatory regime for the private health insurance sector, replacing the current regime which is mainly set out in the *National Health Act 1953*, the *Health Insurance Act 1973* and the *Private Health Insurance Incentives Act 1998*.

Chapter 1 of the Bill deals with preliminary matters, including how terms are defined, the structure of the Bill, and Constitutional issues.

Chapter 2 of the Bill provides incentives for people to purchase insurance, including rebates on the cost of premiums and penalties for people purchasing insurance after their 31st birthday.

Chapter 3 of the Bill sets out the rules with which health insurance products must comply to meet the requirements of the Bill. These include adherence to the principle of community rating as well as premium, benefit, waiting period, portability, quality assurance, and information provision requirements.

Chapter 4 imposes obligations on private health insurers. It defines health insurance business and creates an offence to carry on such business without being registered under the Bill, establishes a registration regime, provides for insurers to carry on their business through health benefits funds subject to prudential supervision, and requires insurers to meet other prudential and administrative obligations. It also sets out rules for the restructuring or termination of health benefits funds.

Chapter 5 provides for enforcement of the Bill. It empowers the Minister and the Private Health Insurance Administration Council ("the Council") to take a range of actions to encourage or compel insurers to comply with the Bill. It also empowers the Council to appoint an inspector to examine the affairs of a health benefits fund, and appoint an external manager to carry on the business of the fund in certain circumstances.

Chapter 6 contains a range of provisions of an administrative nature, including establishment of the Private Health Insurance Ombudsman and the Council, setting out the powers of external and terminating managers, safeguarding information acquired in administering the Bill, and the approval of forms under the Bill and the making of subordinate legislation known as Private Health Insurance ([subject matter]) Rules as legislative instruments.

Schedule 1 is a Dictionary which either defines terms used in the Bill or references the sections in the Bill where they are defined.

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

This Bill (the Transitional and Consequential Bill) provides for the transition from the current regulatory regime to the new Private Health Insurance Bill. It also provides for the repeal of redundant Parts of the *National Health Act 1953* and *Health Insurance Act 1973* and makes amendments to a range of other Acts, mainly to reflect changes in the definitions of insurers and the products they offer.

PRIVATE HEALTH INSURANCE (PROSTHESES APPLICATION AND LISTING FEES) BILL 2006

This Bill imposes application and listing fees on the sponsors of prostheses.

PRIVATE HEALTH INSURANCE (COLLAPSED ORGANIZATION LEVY) AMENDMENT BILL 2006

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These four Bills (the Levy Amendment Bills) amend the Acts imposing various levies on private health insurers to update definitions resulting from the replacement of the *National Health Act 1953* by the proposed Private Health Insurance Act.

FINANCIAL IMPACT

There will be no financial impact from this package of legislation.

REGULATION IMPACT STATEMENT: PRIVATE HEALTH INSURANCE – OPTIONS TO REINFORCE THE LEGITIMACY OF PRIVATE HEALTH CARE

BACKGROUND

1. Private health insurance supports individuals' private financing of hospital care and ancillary services such as dental and optical services. It sits alongside Medicare and free public hospital treatment that is available to all Australians. Private health insurance helps consumers to finance and to have choice in their health care. It also improves the capacity of the public health system to provide health care to the Australian community.

2. In recent years, the Government has introduced several initiatives to improve the attractiveness of and participation in private health insurance for consumers. These include:

- introducing the 30 % Private Health Insurance Rebate;
- increasing the rate of the Private Health Insurance Rebate for older Australians;
- initiating Lifetime Health Cover (LHC);
- introducing the No Gap/Known Gap scheme;
- introducing the Medicare Levy Surcharge;
- protecting consumers' health interests entitlements through broadening the powers of the Private Health Insurance Ombudsman (PHIO); and
- encouraging efficiencies in service delivery through the Hospital Outreach Program.

3. Under these measures:

- those who purchase private health insurance have 30 per cent of their premium subsidised by the Australian Government, with rebates of up to 40 per cent for older Australians;
- Australians are encouraged to take out private health insurance when they are younger (as under the Lifetime Health Cover arrangements a loading is added to the cost of a premium where a person takes out cover from the age of 32);
- patients will not have out-of-pocket expenses, or will be better informed about prospective out-of-pocket expenses under the No Gap/Known Gap schemes;
- consumers can be assisted more by the PHIO when there are disputes about benefits payable for services; and
- more patients will be able to benefit from hospital services delivered in their own homes.

4. While these initiatives have increased PHI participation from 30 per cent to 43 per cent (2001-02 to 2004-05 PHIAC A Report), the participation rate has been stagnant for the last few years. To address concerns about the participation rate, the value and attractiveness of the PHI product and to explore opportunities to invigorate PHI, the Government conducted reviews of the PHI industry throughout 2005 to:

- examine the impact on private health insurance premiums, coverage and costs of a range of measures to make health insurance more attractive;
- identify any required changes to reinsurance flowing from these measures;
- review the impact on premiums of default benefit arrangements; and
- identify further options for reviewing and updating the PHI legislation to provide a more efficient regulatory framework.

PROBLEM

5. Current PHI arrangements inhibit health insurers from developing flexible health care products that better meet consumers' needs and expectations.

6. The Australian Government considers choice in health care as intrinsically valuable and has developed policies to encourage Australians to take out PHI and to support them when they do. However, analysts such as Standard and Poors consider that, under the current policy settings, there is little scope for growth in the Australian private health insurance market. Standard and Poors have forecast a slow and inevitable decline in the local market over the next five years.

7. Research also shows that consumers want a wider range of services covered by private health insurance, particularly services that support people to maintain good health or prevent hospitalisation. These views came through strongly in consumer surveys undertaken on behalf of the Department of Health and Ageing and in broader studies of consumer behaviour.

8. It has also been a long held view across the private health insurance industry and the Department of Health and Ageing that the current private health insurance legislation is unwieldy, out of date, and difficult to interpret and consequently leading to inefficiencies for industry and consumers.

9. Arguably, the Government needs to reset parts of the regulatory framework so that it can:

- continue to meet its policy objectives;
- encourage the private health sector to deliver health services more efficiently;
- assist Australians to participate further in private health insurance;
- enhance the value of private health insurance for the Australian community; and
- improve the long term sustainability of the industry.

10. In order to help private health insurance meet the requirements of consumers the following issues need to be addressed:

- improved product design and value of the PHI product;
- enhanced consumer protection under PHI;
- the financing arrangements that underpin PHI; and
- updating the PHI framework so that it supports efficient regulation.

Objective

11. The objective of Government action in changing the regulation of Private Health Insurance is to:

- give Australians greater choice in health care;
- ensure a sustainable and balanced health system by supporting a viable private health sector that complements the public health system; and
- make private health insurance more competitive and attractive to consumers.

12. There are three key components to achieving these objectives:
Component 1: improving private health insurance products;
Component 2: enhancing private health insurance choices; and
Component 3: ensuring there is appropriate regulation of private health.

13. The options to achieve these objectives will be analysed with reference to directly affected parties, including:

- private health insurers;
- patients/consumers;
- health service providers;
- the Australian Government; and
- taxpayers.

14. The private health industry was unable to supply detailed costs. Instead, educated assumptions have been made to consider the financial impact of compliance.

15. The Office of Small Business' model for costing compliance was also considered.

COMPONENT 1 – IMPROVED PRIVATE HEALTH INSURANCE PRODUCTS – PROPOSED ACTIONS/OPTIONS

Option 1A – status quo
16. Under this option, the current regulatory and financing arrangements would remain. No changes would be made to: the structure of hospital and ancillary benefits tables; reinsurance arrangements; the requirements to provide consumers with product information; or the legislative framework by which private health insurance is regulated.

Option 1B – broadening the private hospital insurance product
17. Under this option, the range of services that can be covered by private health insurance would be broadened to include services that form part of an episode of hospital care or substitute for or prevent hospitalisation. In this way, insurers would be able to pay benefits for some medical services that can safely and effectively be provided outside of hospital. This would potentially include services such as domestic nursing assistance, allied health services, dialysis and chemotherapy, which would give insurers more flexibility in working with service providers to design products that better suit consumer needs and expectations.

18. The legislation would not list all the services that could be included in a broader health product. However, some exclusions would apply, such as general practice services and the costs of accommodation in an aged care facility. Services that substitute for or prevent hospitalisation would be eligible for reinsurance subject to meeting criteria set out in subordinate legislation. Broadened hospital products would be subject to the community rating arrangements and would continue to attract the rebate on premiums.

Option 1C – removal of Lifetime Health Cover loadings for members with ten years continuous membership
19. The current Lifetime Health Cover arrangements are designed to encourage Australians to take out private health insurance whilst they are relatively young – by the time a person turns 31 years of age. If people take up private health insurance for the first time when or after they turn 32 loadings are added to the premiums they pay. The older a person is when

he or she purchases private health insurance, the greater the percentage of loading applies to the premium to be paid.

20. Under this proposal any loadings which applied to a person's premium as a result of the Lifetime Health Cover arrangements would be removed if the person maintained private health insurance continuously for ten years. This would be a "reward" for continuous cover, as the cost of a person's premium would drop, and an incentive to maintain cover now that the cost was lower.

Option 1D – introducing safety and quality standards for all private health providers
21. Under this option insurers would need to ensure that all service providers meet safety and quality standards. There is no impact on any of the parties under this option as many service providers already conform to a system of accreditation or attain suitable qualifications. A cost-benefit analysis will therefore not be needed.

Impact Analysis
22.

- Under option 1A – maintaining the status quo - there would be no opportunities or incentives for insurers or providers to finance or develop more comprehensive products which could cover more efficient alternatives to hospital services. Additionally, the Government would have to continue administering complex and, in some contexts, unwieldy legislation. The cost of compliance for insurers would remain at 1% of benefits paid (currently $81.28 million) and the cost of private health insurance rebates to the taxpayer would remain at approximately $2.8 billion. No benefits would accrue to any party to offset current costs, resulting in no net benefit for any party under this option.

- The impact under option 1B – broadening the private hospital insurance product - would be the complete opposite of option 1A for private health insurers, service providers and consumers. The Government would need to change current legislation with the costs of compliance and the rebates remaining the same. The benefits of more flexible products and services would provide a net benefit to all the parties of improved private health insurance products covering contemporary health services.

- The impact of option 1C - removing Lifetime Health Cover loadings for members with ten years continuous membership - on private health insurers will be ensuring all service providers meet safety and quality standards (although many already do). Consumers will need to be aware of safety and quality standards for providers and the Government will need to change legislation. The net benefit of this option is that consumers will benefit from the improved private health insurance product.

- The impact of option 1D – see paragraph 21.

23. The cost benefit analysis of Options 1A, 1B, and 1C is at Appendix A.

Consultations
24. Formal consultations have taken place in relation to all of the options canvassed above. These consultations have included representatives from both individual private health insurers and their industry representatives (AHIA and HIRMAA), private hospitals and their industry representatives (APHA and CHA), the AMA, the PHIAC, the PHIO, CHF and central agencies. All of the industry representatives have expressed strong support for the

types of improvements proposed under these options. Consumer representatives were also supportive, though wary of options which might increase costs for consumers.

25. Further details on the organisations involved in the consultation process can be found at Appendices B and C.

Conclusion
26. All of the industry representatives have expressed strong support for the types of improvements proposed under these options. Consumer representatives were also supportive, though wary of options which might increase costs for consumers.

27. Options 1B to 1D taken as a package will provide improvements to private health insurance products and so are recommended. Options 1A will not. Ultimately, Option 1A may inhibit the expansion of the private health sector and dampen the community's participation in private health insurance.

Implementation
28. Legislative or other regulatory changes would be introduced during 2006 and early 2007 to implement the options and give insurers time to adapt their business practices. The Government will continue to consult the private health industry generally as it develops the details of the options, including identifying the preferred process for accrediting services.

COMPONENT 2 – ENHANCED PRIVATE HEALTH INSURANCE CHOICES – PROPOSED ACTIONS/OPTIONS

Option 2A – status quo
29. Under this option there would be no change to the current arrangements for providing information to consumers about products. The focus of current regulation is on having service providers provide a level of informed financial consent, for example, private hospitals are required to have a private hospital patient charter. However, current regulation is not effective at helping consumers compare the relative merits of products very easily.

Option 2B – providing standard product information
30. There are a myriad of private health insurance products available to consumers. Finding a neat, easy way for consumers to compare all health insurance products and understand their entitlements has been a perennial problem.

31. Under this option Government would specify in legislation the information that private health insurers have to provide to consumers about every product they offer in the market. The proposed standard pieces of information would cover the cost of premiums, waiting periods, exclusions, gaps and excesses.

Option 2C – private health insurance consumer website
32. This website will allow consumers better product comparison. The website would include the standard product information (see Option 2B above) - information that is currently provided on the Rules Application Processing System and further information to be developed following consultation with the private health insurance industry and market testing. The PHIO would be responsible for the maintenance of the website.

Impact analysis

33.

- Under option 2A neither insurers nor service providers would need to change their current information arrangements. Consumers would continue to have difficulties comparing products easily and the Government would continue to receive correspondence from aggrieved members of the public about deficiencies in their private health insurance product. The costs of the current arrangements are principally in the difficulties for insurers and consumers as neither are satisfied by them. This option presents no benefits to any party.

- Under option 2B insurers will need to adapt their current marketing arrangements and service providers will need to be clear about service pricing with insurers so that gap information can be published. The Government will need to change legislation but consumers will be able to compare products more easily. The overall net benefit of this option is improved information for consumers.

- Under option 2C insurers will be required to provide up-to-date information to the Private Health Insurance Ombudsman. Service providers may need to do the same. The Government will need to change legislation but consumers will be able to compare products more easily. The overall net benefit of this option is that consumers will be better informed.

34. The cost- benefit analysis of Options 2A, 2B and 2C is at Appendix A.

Consultation

35. Formal consultations have taken place in relation to option 2B and 2C. These consultations have included representatives from individual private health insurers and their industry representatives (AHIA and HIRMAA), private hospitals and their industry representatives (APHA and CHA), the AMA, the PHIAC, the PHIO, CHF and central agencies. All of the industry representatives and consumer representatives have expressed strong support for options and 2B and 2C which offer better information to consumers about private health insurance products.

36. Further details on the organisations involved in the consultation process can be found at Appendices B and C.

Conclusion

37. Option 2A (the status quo) will not resolve existing problems for consumers to get clear, unambiguous information about the relative merits of the many different private health insurance products on the market. Option 2B (providing standard product information) will provide a mechanism to standardise the presentation of key pieces of information about products. This will be a useful tool for consumers whilst not placing an additional financial burden on insurers, other than their regular cost for advertising their products and providing written or web-based information to potential customers. Option 2C (PHI consumers website) will provide comprehensive private health information for consumers and will enable an easy comparison of the many PHI products. Consequently, Options 2B and 2C are recommended and Option 2A is not.

Implementation
38. Legislative changes would be made during 2006 and early 2007 to provide for standardised product information. The standard information will be available to consumers from 2007–08.

39. The website would be operational from 2007–08.

COMPONENT 3 – ENSURING THERE IS APPROPRIATE REGULATION OF PRIVATE HEALTH - PROPOSED ACTION / OPTIONS

40. Components 1 and 2 focus on improving private health insurance products and enhancing consumers' private health insurance choices. Component 3 considers the new and necessary financial and regulatory changes which are needed to support the Government's private health insurance policies.

41. There are two core elements to this component on appropriate regulation of private health:

- inter-insurer financing – i.e. risk equalisation; and
- reframing the current regulatory regime.

42. Within these two broad themes there are several options.

Risk equalisation

Option 3A – Status quo
43. Under this option the current reinsurance arrangements would remain. The limits of this option continue to affect products offered by insurers.

Option 3B – PHI industry model of risk equalisation
44. This option was proposed by the Australian Health Insurance Association (AHIA) and is based on the current reinsurance arrangements with the following changes:

- Benefit equalisation will be explicitly separated from so called "true reinsurance" or protection against catastrophic claims. High cost claims would be dealt with in a compulsory high cost pooling arrangement;
- Each quarter, the portion of hospital benefits paid into and from the renamed "Benefit Equalisation Pools" will be calculated on a sliding scale that starts with 15% of benefits paid for 55 year-olds up to 82% of benefits for the 95+;
- Allows for ancillary benefits paid for appropriate out-of-hospital services, according to criteria to be agreed with PHIAC to be included in the benefits pooled for the elderly; and
- Accommodate single parent policies as one single equivalent unit.

Option 3C – demographic risk based capitation model
45. Under this option, risk equalisation would involve risk sharing arrangements based on applying industry average age/sex utilisation rates and costs to the demographic profile of individual funds. This model would see funds with a younger, healthier membership provide reinsurance support to funds with an older sicker membership. However, the support is based on the risk that a particular fund will incur larger than average payments. This risk is

calculated by comparing the demographic composition of each fund's membership to the average of all funds.

46. This risk based model would differ from the current reinsurance system by enabling financial transfers between funds on the basis of their membership risk profiles but does not cross subsidise the actual benefits paid. Therefore, funds that are more efficient in the provision of health services are able to retain cost savings. The proposed model rewards funds that are more efficient and will encourage all funds to have better claims management, contractual arrangements and/or preventative programs.

Impact Analysis

47.

- Under option 3A the impact on insurers would be that they continue to suffer the limitations of current administratively complex arrangements. At present, these result in $164 million moving between funds from the reinsurance pool. These arrangements would continue to affect what services providers were able to offer, although community rating arrangements would remain. There would be no impact on Government and no change to service providers' or consumers' current costs. Overall there are no net benefits to the status quo.

- Under option 3B, which is the industry preferred approach, insurers would benefit from an improved pooling of risk and access to a high cost claims pool. The cost of this option would be $154 million. There should be no direct impact on service providers. The impact on Government would be administratively simpler arrangements. Consumers would have broadened hospital products covered. Little cost is expected to these parties with the benefit of continuing support for community rating.

- Under option 3C, the impact on insurers would also be improved pooling of risk funds. However, industry does not support this model. The costs would be $189 million moving into the reinsurance pool, with marginal effects on cash-flows and some larger funds contributing to the pool where currently they are drawing out of it. The impact and costs of this option on Government, service providers and consumers are the same as option 3B. The Government considers that this is the best strategic option for the long term.

48. The cost-benefit analysis of Options 3A, 3B and 3C is at Appendix A.

Consultations

49. Formal consultations have taken place with private health insurers in relation to options 3A, 3B and 3C. The insurers reached agreement during consultations during 2005. The insurers have expressed opposition to option 3C being implemented immediately whereas all funds have expressed support for option 3B being the shorter term solution.

50. Further details on the organisations involved in the consultation process can be found at Appendices B and C.

Conclusion
51. Formal consultations have taken place with private health insurers in relation to options 3A, 3B and 3C. The insurers reached agreement during consultations during 2005. The insurers have expressed opposition to option 3C being implemented immediately whereas all funds have expressed support for option 3B being the shorter- term solution.

52. The private health insurers view the current risk equalisation system as inflexible but do not support demographic risk equalisation in option 3C. Option 3B will bring a measure of improvement to reinsurance and so it is recommended for the immediate term. The Government will continue to consult with industry about the potential for option 3C to be implemented in the longer-term. Option 3B is the recommended option.

Implementation
53. It is anticipated that the new risk equalisation arrangements will be introduced in 2006-07. The risk equalisation arrangements would be reviewed in 2010.

Appropriate regulation

Option 3D – status quo
54. There would be no change to the current regulatory regime under this option.

Option 3E – clarify and simplify the existing legislative framework
55. Currently, the regulatory regime for private health insurance is expressed in nine primary Acts, nine sets of regulations, several schedules to Acts and numerous determinations. Under this option this existing regulation (with the exception of the taxing provisions) would be consolidated into one primary Act, which will set out the requirements for the conduct of private health insurance business, one primary set of regulations and a systematic, uniform approach to developing and expressing subordinate legislation.

56. The proposed new legislation would:

- maintain the Government's current policy thrust for private health insurance but recast the now higgledy-piggledy order of provisions into five broad themes covering insurance products, consumer protection, information, prudential supervision; and compliance;
- co-locate and consolidate provisions which address aspects of the same element of private health insurance business (e.g. provisions relating to loyalty bonuses are to be found in four different places within the current primary and secondary legislation);
- remove any redundant provisions, for example removing provisions which do not clearly express current policy (this is an issue for provisions concerning portability - when consumers may wish to change funds but purchase a similar level of benefits) or provisions which are no longer operative; and
- update the penalties in the offence provisions to reflect contemporary tariffs.

57. The proposed new legislation would shift the regulatory focus from principally imposing conditions of registration on private health insurers to achieve a range of outcomes to one where the outcomes the Government wants to achieve would be stated directly in the legislation.

58. Under this option:

- at least a dozen provisions could be deleted as they are either redundant or inoperative;
- over 50 provisions would be relocated to improve the collocation of like provisions;
- newly collocated provisions would be examined further with a view to expressing regulatory requirements more efficiently.

Option 3F – clarify and simplify the existing legislative framework plus incorporating recommended options

59. Under this option all of the amendments proposed under option 3E would be undertaken along with new regulation required to support the recommended options. This proposal reframes the legislation so that it focuses on insurance products not health insurance fund activities. It would incorporate new provisions to allow:

- PHI rebates to attach to complying health insurance products;
- the expansion of the scope of hospital table coverage and the ability of hospital tables to pay for out-of-hospital treatment;
- greater transparency and prudential oversight of health benefits funds (which are required under the existing legislative arrangements) through a framework for their establishment, operation, merger and termination;
- improved risk equalisation arrangements to include different pooling of benefits arrangements;
- consumers to make a better comparison of products by stipulating specific, uniform types of information that private health insurers need to provide about their products, and the form in which it is to be given; and
- the safety and quality of services provided or supported by all providers in the private health industry to be interrogated.

Consultations

60. Consultation with key industry participants, the AMA, AHIA, APHA, PHIAC and central agencies has taken place in relation to simplifying the legislation framework. The industry supports Options 3E and 3F as they would lead to a more efficient industry.

61. Further details on the organisations involved in the consultation process can be found at Appendices B and C.

Impact Analysis

62. These options explore ways of clarifying and simplifying the existing legislative framework.

- Under option 3D the current regulatory arrangements would remain in place. The impact on insurers would be that the regulatory burden and current compliance costs would remain and new entrants may be deterred from entering the market. Whilst there would not be an impact on service providers, the costs of compliance would still be factored into consumers' premiums. Departmental resources would still be diverted to discuss legislative interpretations with insurers. There would not be any net benefits in this option.

- Under option 3E the existing legislative framework would be clarified and simplified. The impact on insurers would be reduced compliance costs, possibly less than 1% of benefits paid, as the legislation became easier to understand. However, service providers

would still not be able to develop efficient alternatives to hospital services as these would not attract a private health insurance benefit. The impact on consumers may be downward pressure on the price of premiums if compliance costs are reduced. The impact on Government will be more transparent policy but there would be costs in redrafting the legislation. The net benefit would be potentially reduced costs and a more efficient regulatory framework.

- Under option 3F the existing regulatory framework would be clarified and simplified and new measures recommended in component 1 would be included. The impact on insurers and service providers would be that they could develop more innovative products and services in a more efficient regulatory framework. Consumers would have access to these products and be able to get more information about them. Government policy would be more transparent. Whilst there would be costs to Government to redraft the legislation, the net benefit would be improved business opportunities and a more efficient regulatory framework.

63. The cost-benefit analysis for Options 3D, 3E and 3F is at Appendix A.

Conclusion

64. Maintaining the status quo would mean that the current complexity and inefficiency in the legislation is maintained. Option 3E addresses the complexity of the current legislative arrangements. Option 3F is recommended as it will ensure that consumers are well informed, allowing innovative product design and increased market efficiency.

Implementation

65. Legislation to give effect to these measures would be introduced in 2006 by the Minister for Health and Ageing. An exposure draft of this legislation is proposed to be provided to stakeholders for comment.

66. PHIAC will continue to prudentially oversee the PHI industry.

COST-BENEFIT ANALYSIS OF OPTIONS TO REINFORCE THE LEGITIMACY OF PRIVATE HEALTH INSURANCE

Component 1: improving private health insurance products

Cost-benefit analysis of Option 1A – Status Quo (Existing arrangements remaining)

This table represents the reference model for comparison options 1B and 1C

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers would not be able to offer a comprehensive product	The cost of regulation compliance is currently $81.28 million. This represents 1% of benefits paid		No change to current arrangements
Service providers	Providers are not able to develop efficient alternatives to hospital services as these services do not attract a PHI benefit	Nil		No change to current arrangements
Patients and consumers	Consumers are limited by PHI for some out of hospital services, notably oncology services	Gaps in cover for some services that are part of an episode of hospital care or which substitute for or prevent hospitalisation will remain		No change to current arrangements
Govt/ taxpayers	Burden of regulation would continue unchanged	Cost of 30% Rebate is approximately $2.8 billion, which is paid for hospital and ancillary cover		No change to current arrangements
			Option 1A net benefit	**No net benefit**

Cost-benefit analysis of option 1B – Broadened hospital product

Options 1B and 1C are measured against the Reference model above. Modelling of the costs and benefits of the following options under Component 1 was undertaken by the Department of Health and Ageing. The following table represents the best available information along with qualitative information.

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers are able to offer a more comprehensive product While the demand for services is expected to increase this would be offset by reduced costs due to the substitution to lower cost out of hospital services	The cost of regulation compliance is currently $81.28 million (1% of benefits paid)	Insurers support this measure	Insurers are able to provide products that cater to consumers' needs
Service providers	Providers are able to develop efficient alternatives to hospital services as these services attract a PHI benefit	Nil	Service providers support this measure	Service providers are better able to reflect current health practices and not be restricted by funding and regulatory restrictions
Patients and consumers	Consumers can choose to be covered for services that are part of an episode of care or which substitute for or prevent hospitalisation	Negligible impact on premiums	Consumers have more choice	Consumers are able to purchase products that cater to their needs
Govt/ taxpayers	Legislation would need to be amended	Would have negligible effect on the Rebates		
			Net benefit	**Improved PHI products that reflect the contemporary delivery of health services**

Cost-benefit analysis of option 1C – Removing Lifetime Health Cover loadings

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers would need to administer the changes to premiums for which the loading could be removed	The total cost of regulation compliance is currently $81.28 million (1% of benefits paid)	Consumers have more reason to retain their insurance	Insurers retain members who benefit from the 10 year loyalty arrangement
Service providers	Negligible impact	Nil	Nil	Nil
Patients and consumers	Consumers with premium loadings will pay less for their premiums in the future relative to prices that they were charged in the past	More than 300,000 people pay loadings. Up to 60,000 consumers each year (after year 10 -11 of membership) will benefit.	Consumers perceive the current arrangements as an unfair penalty. They will now see a relief mechanism	Consumers will benefit from the 10 year loyalty arrangement. Insurers will retain members
Govt/ taxpayers	Supports Govt's policy of supporting PHI and encourages participation. Legislation will need to be amended	Cost of the 30% Rebate is approximately $2.8 billion		
			Net benefit	**Retention of consumers**

Component 2: Enhanced private health insurance choices

Cost-benefit analysis of Option 2A – Status Quo (Existing information arrangements remaining)

This table represents the reference model for comparison for options 2B and 2C

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers do not need to change their existing information arrangements	Insurers also view the *Key features Guide* and other information requirements as not helpful for consumers and costly to produce		No change to current arrangements
Service providers	Service providers do not need to change their current information arrangements	Nil		No change to current arrangements
Patients and consumers	Consumers will not be able to compare products easily. The *Key Features Guide* is too complex	Difficult for consumers to see the value of the product they purchase		No change to current arrangements
Govt/ taxpayers	Govt agencies will continue to receive correspondence from aggrieved members of the public who have become aware of deficiencies in their PHI product	Nil		No change to current arrangements
			Net benefit	**No net benefit**

Cost-benefit analysis of Option 2B – Providing Standard Product Information

The following options under Component 2 are measured against the Reference model above

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers will have to adapt their marketing information	Negligible as insurers change products in the normal course of business and would have to change promotional material		
Service providers	Service providers will have to be clear about service pricing with insurers so that gap information can be published	Nil		
Patients and consumers	Consumers will be able to compare numerous products across funds more easily	Nil	Consumers will be able to understand which product offers the best choice for them. Consumer representatives support this option	
Govt/ taxpayers	Govt would specify in legislation the information that insurers must provide to consumers	Nil		
			Net benefit	**Improved information for consumers**

Cost-benefit analysis of Option 2C – Private Health Insurance Consumers Website

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers will be required to provide up to date information and data to the PHIO	Minimal impact as there would be a small increase in the PHIO levy to be shared proportionally across 40 funds	More information on products will lead to increased competition between insurers	
Service providers	Service providers may provide information to the PHIO	Nil		
Patients and consumers	Consumers will be able to compare numerous products across funds more easily	Negligible impact on premiums	Consumers will be able to make better purchasing decisions. Consumer representatives support this option.	
Govt/ taxpayers	Govt would specify in legislation the information that insurers must provide to the PHIO	Estimated at $1.4 million in development and start up costs in the first year		
			Net benefit	**Consumers will be better informed**

Component 3: appropriate regulation

Cost-benefit analysis of Option 3A – Status Quo (Existing reinsurance arrangements remaining in place)

This table represents the reference model for comparison for options 3B and 3C

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Limitations of the model continue to affect products offered by insurers. This model is administratively complex	$164 million moves between funds from the reinsurance pool. There is an average effect of zero but it can affect funds' cash flows		No change to current arrangements
Service providers	This arrangement continues to affect products offered by service providers	Nil		No change to current arrangements
Patients and consumers	The community rating principle continues to apply	Nil	.	No change to current arrangements
Govt/ taxpayers	No change to current arrangements	Nil		No change to current arrangements
			Net benefit	**No net benefit**

Cost-benefit analysis of Option 3B – PHI industry risk equalisation model

Options 3B and 3Care measured against the Reference model (3A) above. Modelling of the costs and benefits of the following options under Component 1 was undertaken by the Department of Health and Ageing. The following table represents the best available information along with qualitative information.

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	This model has improved pooling of risks and includes a new arrangement for high cost claims	$154 million would move from funds to risk equalisation pools. Average effect would be zero, but effects on cash flow may be slightly less	Insurers support this model, which includes a new arrangement for high cost claims	Industry supports moving to this model
Service providers	Should not have a direct impact on service providers	Nil		
Patients and consumers	Will accommodate broadened hospital products	No significant increase in premiums as reinsurance is a zero sum operation	This model supports the community rating principle	
Govt/ taxpayers	Administratively simpler	Negligible effect on the 30% Rebate		
			Net benefit	**Industry supports this model**

Cost-benefit analysis of Option 3C – Demographic risk equalisation model

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	This model has improved pooling of risks of funds Industry does not support this model	$189 million would move from funds to risk equalisation pools. The average effect would be zero. There will be a marginal negative effect on cash flows. Some of the larger funds would be contributing to the risk equalisation pools whereas before they were drawing from them	This option encourages funds to find efficiencies in product development, claims managements and contractual arrangements	
Service providers	Should not have a direct impact on service providers	Nil		
Patients and consumers	Will accommodate broadened hospital products There would be no direct impact on patients	No significant increase in premiums as reinsurance is a zero sum operation	Consumers may benefit from a reduction in premiums	
Govt/ taxpayers	Administratively simpler	Negligible effect on the 30% Rebate		
			Net benefit	**Best option for the long term**

Cost-benefit analysis of Option 3D – Status Quo (Existing regulatory arrangements remaining in place)

This table represents the reference model for comparison for options 3E and 3F

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	The burden of regulation would continue unchanged. New entrants to the market may be deterred	1 per cent of benefits paid across the industry		No change to current arrangements
Service providers	No impact	Nil		No change to current arrangements
Patients and consumers	Compliance costs would continue to be factored into premiums	Nil		No change to current arrangements
Govt/ taxpayers	The existing regulatory arrangements are complex to administer	Departmental resources would continue to be diverted to discuss legislative interpretation		No change to current arrangements
			Net benefit	**No net benefit**

Cost-benefit analysis of Option 3E – Clarifying and simplifying the existing legislative framework

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Compliance costs would be expected to reduce due to legislation being easier to understand and interpret	Nil	It is expected that compliance costs could be reduced to under 1% of benefits paid	
Service providers	Providers are not able to develop efficient alternatives to hospital services as these services do not attract a PHI benefit	Nil		No change to current arrangements
Patients and consumers	Potential downward pressure on premium prices if compliance costs reduce	Nil	Potential for premium prices to be moderated	.
Govt/ taxpayers	Govt policy will be more transparent	Departmental costs to rework the legislation	Simplified legislation. Policy objectives would be more apparent	
			Net benefit	**Potentially reduced costs. More efficient regulatory framework**

Cost-benefit analysis of Option 3F – Clarifying and simplifying the existing legislative framework and adding measures from option 1B

Stakeholders	Impact	Costs	Benefits	Net Benefit
Private health insurers	Insurers would be able to develop more innovative products in a more efficient regulatory framework	The cost of regulation compliance is currently $81.28 million (1% of benefits paid)		
Service providers	Service providers would be able to develop more innovative products in a more efficient regulatory framework	Nil		
Patients and consumers	Consumers would have access to more innovative products and be able to get information more easily about the range and benefits of individual products	Nil	More flexible products and better, mandated forms of information	.
Govt/ taxpayers	Government policy would be more transparent	Departmental costs to rework the legislation	Simplified legislation. Policy objectives would be more apparent	
			Net benefit	**Improved business opportunities.** **More efficient regulatory framework**

Options – consultations with stakeholders

The Department of Health and Ageing conducted confidential consultations on private health insurance issues. Feedback from stakeholders has informed the development of the Regulation Impact Statement.

Formal consultations have taken place in relation to all of the options canvassed below with:

- **Insurance industry**

Individual private health insurers and their industry representatives (Australian Health Insurance Association and the Health Insurance Restricted Membership Association of Australia);

- **Service providers**

Private hospitals and their industry representatives (Australian Private Hospitals Association, Catholic Health Australia and the Australian Health Services Alliance), and the Australian Medical Association;

- **Statutory bodies**

The Private Health Insurance Advisory Council and the Private Health Insurance Ombudsman;

- **Consumers**

Consumers Health Forum.

Components – Stakeholder comments

NB: (1) If stakeholders did not comment expressly on an option the relevant box will be left blank. Stakeholders are not identified individually on the basis that comments were provided in a confidential setting. An aggregated position for groups of stakeholders will be presented below.

(2) Comments from other government agencies are not included, as individual portfolios provided co-ordination comments on the Cabinet Submission.

Components	**Insurance industry**	**Service providers**	**Consumers**	**Statutory bodies**
Options recommended for action in the RIS – in the context of a package of measures	Broadly supported those proposals in Components 1, 2 & 3 which are recommended	Broadly supported those proposals in Components 1, 2 & 3 which are recommended	Broadly supported those proposals in Components 1, 2 & 3 which are recommended	Broadly supported those proposals in Components 1, 2 & 3 which are recommended
Component 1 – improved private health insurance products				
Option 1A – status quo				
Option 1B – broadened hospital product	Supported this option which would increase the flexibility of product design and better meet consumer needs and expectations		Cautious about the boundary between broadened hospital tables products and ancillaries	
Option 1C - removing lifetime heath cover loadings	Expressed some support for		Considered favourably	
Option 1D – introducing safety and quality standards for all service providers	Interested in how these standards would be identified or determined	Ranging levels of support across the industry	Supported this option	
Component 2 – enhanced private health insurance choices				
Option 2A – maintain status quo				
Option 2B – providing standard product information	Considered how some standard information might be gathered and the need for efficacy in the information	Some support for this option. Interested in considering the practicalities for collecting information		Supported the option. Agencies consider that such information should assist consumers in identifying products that best meet their individual needs

Option 2C – private health insurance consumer website				
Component 3 – appropriate regulation				
Risk equalisation				
Option 3A – status quo				
Option 3B – industry model for risk equalisation	Support for industry model			Noted that industry favoured its own model
Option 3C – demographic risk equalisation	Less support for this model			
Appropriate regulation				
Option 3D – status quo				
Option 3E – simplifying regulation	Supported this approach			Supported this approach
Option 3F – simplifying regulation and new measures added	Supported this approach			Supported this approach

Glossary

Private Health Industry Peak Organisations

Australian Health Insurance Association (AHIA)
The AHIA is the peak group representing 26 “open” health funds throughout Australia, which collectively cover more than 94% of the total private health insurance industry.

Australian Medical Association (AMA)
The Australian Medical Association (AMA) is an independent organisation representing doctors.

Australian Private Hospitals Association (APHA)
The APHA is a peak national body representing private hospital interests in Australia.

Catholic Health Australia (CHA)
Catholic Health Australia is the largest non-government provider grouping of health, hospital, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services.

Consumers Health Forum (CHF)
The CHF was established in 1987 and is an independent, member-based, non-government organisation for health consumers.

Health Insurance Restricted Membership Association of Australia (HIRMAA)
The Health Insurance Restricted Membership Association of Australia (HIRMAA) represents the interests of restricted membership private health funds. There are 14 member funds of HIRMAA. All member funds operate as not-for-profit organisations.

Statutory Authorities

Private Health Insurance Administration Council (PHIAC)
The Private Health Insurance Administration Council is an independent Statutory Authority that regulates the private health insurance industry. It also collects and disseminates financial and statistical data regarding health funds, as well as information about private health insurance to enable consumers to make informed choices.

Private Health Insurance Ombudsman (PHIO)
The Private Health Insurance Ombudsman is an independent body established to resolve complaints about private health insurance and to be the umpire in dispute resolution at all levels within the private health insurance industry.

The Ombudsman's services are available to health funds, hospitals, medical practitioners and consumers.

Private Health Insurance Products

30%, 35% and 40% Government Rebates

Families and individuals that pay private health insurance premiums are eligible for the Federal Government’s 30% Rebate on private health insurance. Medicare Australia

administers both the payment to the health funds for reduced premiums and the alternative payments directly to contributors.

Registered Health Benefits Organisations (RHBOs) – i.e. – health funds
Health funds can be segmented into two membership types – i.e. – open membership funds or restricted membership funds. An open membership fund means that anybody can apply for health insurance, whilst a restricted membership fund only allows membership to people who belong to a particular organisation or community. Of the forty funds operating in Australia, thirty-six are not-for-profit organisations and fifteen have restricted memberships.

Community Rating
Community rating is a regulatory requirement and has long been a central tenet of Government policy for private health insurance. Community rating enables all Australians to have equal access and use of private health insurance no matter what their health, sexual, religious or other specified status may be.

Community rating differentiates private health insurance from most other types of insurance by not allowing risk rating to occur.

Hospital Cover
There are various types of private health insurance hospital cover. Some health fund policies give full cover against the costs of hospital and medical charges. Others, for lower premiums, will require consumers to meet part of the costs. Also, consumers can elect to pay a lower premium in return for agreeing not to be covered for some conditions, or to only receive limited benefits for a certain condition, or to pay a set amount towards the cost of hospital treatment. Options include:

Exclusionary products
Consumers are not covered for treatment as a private patient in a public or private hospital for particular conditions. For example, if a private health insurance policy excludes knee replacements, and the consumer goes into hospital as a private patient for one of this condition, the health fund will not pay any benefits towards hospital and medical costs.

Front-end deductible (FED) (also known as an excess)
An FED is an amount of money the consumer agrees to pay for a hospital stay before health fund benefits are payable.

Co-payment
With a co-payment, the consumer agrees to pay an agreed amount each time a service is provided. The total amount of co-payment paid in a year is often limited to a set maximum amount.

Restricted benefits
If a policy has restricted benefits for some conditions covered for treatment as a private patient, consumers may face considerable out-of-pocket costs if treated for these conditions.

Ancillary Cover
Health insurance funds offer benefits for various goods and services such as for dental, optical and physiotherapy health services under their ancillary tables. Individual health funds have considerable scope to determine the nature of the goods and services that attract

ancillary benefits and any limitations on such benefits. However, the Government does require that these tables be community rated.

Default benefits
There are two levels of default benefit which are payable when an alternative contractual arrangement is not in place between a health fund and a hospital provider: the *basic default benefit* and the *second tier default benefit*. The basic default benefit is payable by health funds to both public and private hospitals and private day hospital facilities for shared ward accommodation and same day accommodation. The second tier default benefit is payable to private hospitals and day hospital facilities when they meet certain administrative and quality criteria.

Gaps
The medical 'gap' is the difference between fees charged by doctors for in-hospital medical services and the combined health insurance and Medicare benefits. For in-hospital medical services, Medicare provides a rebate of 75% of the Medicare Benefit Schedule (MBS) fee. Health funds are required to cover the remaining 25% of the MBS fee.

When a doctor charges an amount in excess of the MBS fee, legislation allows health funds to pay benefits above the MBS thereby eliminating or reducing the out-of-pocket payment required from the patient, if:

- the doctor is participating in the health fund's gap cover scheme; or
- a negotiated agreement exists between the doctor who provides the service and the health fund; or
- a negotiated agreement exists between the doctor who provides the service and a hospital, and that hospital in turn has an agreement with the health fund.

Informed Financial Consent
Informed financial consent is the consent to treatment obtained by a medical practitioner from a patient, prior to that treatment whenever possible, where the practitioner has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs. Medical specialists who participate in health funds' gap cover arrangements are required to provide informed financial consent prior to treatment where possible.

Portability
Under portability arrangements, it is possible to transfer to a similar level of cover with another health fund without loss of original entitlements, provided that these entitlements are included in the new cover. However, normal waiting periods apply for higher benefit levels or benefits for additional services which were not available under the previous cover.

Pre-existing Ailment
A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months prior to the member joining a hospital table or upgrading to a higher level of cover.

Private Patient in a Public Hospital
Private patients that elect to be treated in a public hospital have an option to choose their own doctor when possible. Such patients will be charged for hospital accommodation costs and doctors fees. Medicare pays 75% of the MBS fee. Funds will pay at least the remaining 25% of the MBS fee for doctor's charges and can pay more if the health fund has an agreement with the doctor. Health funds will also cover some or all hospital accommodation costs.

Private Patient in a Private Hospital
As a private patient in a private hospital consumers have the option to choose their own doctor when possible, and are responsible for all hospital and doctors' charges. Medicare pays 75% of the MBS fee for these doctors' charges. Health funds will pay at least the remaining 25% of the MBS fee for doctor's charges and can pay more if the doctor is participating in gap cover. Some or all hospital accommodation costs will be covered.

Waiting Periods
Persons joining a health fund or upgrading to a higher table of benefits are generally subject to waiting periods of 12 months for pre-existing ailments, 12 months for obstetric conditions and 2 months in other cases. These periods are the maximum, and are set by the Government. However funds are free to waive such requirements should they wish. For example, some health funds waive the two month waiting period during recruitment drives.

People transferring between funds must be given credit for any equivalent waiting period that they have served with their previous fund.

Health funds are able to determine their own waiting periods for ancillary tables. The rules relating to transfers provide that, if a person transfers to a table of comparable ancillary cover, any service towards a waiting period should be counted towards the membership of the new product.

PRIVATE HEALTH INSURANCE BILL 2006

NOTE ON STRICT LIABILITY OFFENCE PROVISIONS

Strict liability offences are found in the following Divisions and generally relate to a failure to comply with an obligation to provide information:

93	Failure to maintain up to date information about insurance products
93	Failure to provide information about insurance products or policies to insured persons or persons seeking to become insured
96	Failure to provide information about insurance products or policies to the Private Health Insurance Ombudsman, the Council or the Secretary of the Department
99	Failure to provide transfer certificates to persons ceasing insurance or transferring to a new insurer, or seek a transfer certificate from a former insurer
169	Failure to provide financial and statistical information to the Council
169	Failure to keep the Council and the Secretary of the Department informed of changes to the Chief Executive Officer of a registered private health insurer
194	Failure to provide information to assist in an investigation of an insurer's practices
241 and 244	Failure to report to the Ombudsman on action taken in response to a recommendation
250	Failure to produce information to the Ombudsman relating to a complaint
256	Failure to comply with a direction by the Ombudsman to publish or give to insured people information related to the Ombudsman's functions
282	Failure to provide information related to the private health insurance premiums reduction or incentives payment schemes to the Medicare Australia CEO
310	Failure to retain information about an obligation to pay a private health insurance levy and the amount of the levy
310	Failure to provide information related to obligation to pay a private health insurance levy to the Council or the Secretary of the Department
313	Failure to return an identity card to the Council after a person has ceased to be an authorised officer

These have been cast as strict liability offences because proof of intent to fail to comply with the requirement would be very difficult to obtain. However, failure to comply would have a significant detrimental effect on the administration of the Act or consumer protection and it is important to have offences to create a deterrent to non-compliance.

The highest maximum penalty for the offences is 60 penalty units.

NOTES ON CLAUSES

CHAPTER 1 – INTRODUCTION

PART 1-1 INTRODUCTION

Division 1 – Preliminary

Clause 1-1 Short title

This clause sets out the short title of the Bill.

Clause 1-5 Commencement

This clause provides for the Bill to commence on 1 April 2007.

Clause 1-10 Identifying defined terms

This clause explains that many terms in the Bill are defined in the Dictionary, and that most of the terms defined there are asterisked when they first appear in a provision of the Bill, but are not asterisked in headings, notes, examples or guides. **Subclause (5)** provides that the fact that a term is not asterisked should not be taken into account in deciding whether or not to apply a definition or other interpretation provision, and **subclause (6)** sets out a list of terms that are used commonly throughout the Bill and are not asterisked.

Division 3 – Overview of this Bill

Clauses 3-1 to **3-30**

These clauses provide a simple explanation of what is dealt with by the Bill and in each Chapter of the Bill.

Division 5 – Constitutional matters

This Division clarifies the operation of the Bill under the Constitution.

Clause 5-1 Meaning of *insurance*

This clause provides that a reference to *insurance* in the Bill is a reference to insurance within the meaning of paragraph 51(xiv) of the Constitution.

Clause 5-5 Act not to apply to State insurance within that State

This clause provides that the Bill does not apply to State insurance that does not extend beyond the limits of the State concerned.

Clause 5-10 Compensation for acquisition of property

This clause provides that if the operation of the Bill would result in an acquisition of property from a person otherwise than on just terms (within the meaning of paragraph 51(xxxi) of the Constitution) the Commonwealth is liable to pay a reasonable amount of compensation to the person. If agreement cannot be reached on the amount of compensation, the person may take action in the Federal Court.

CHAPTER 2 – INCENTIVES

PART 2-1 INTRODUCTION

Division 15 – Introduction

Clause 15-1 What this Chapter is about

This clause explains that Chapter 2 covers incentives to encourage people to have private health insurance, including premium reductions, payments in return for payment of premiums, and the lifetime health cover scheme.

PART 2-2 PREMIUMS REDUCTION AND INCENTIVES PAYMENT SCHEMES

Division 20 – Introduction

Clause 20-1 What this Part is about

This clause says that there are two incentives schemes – one set out in Division 23 under which people paying premiums for complying private health insurance policies (within the meaning of Chapter 3) can have the premiums they pay reduced, and one set out in Division 26 under which people who pay premiums can receive payments from the Commonwealth.

Clause 20-5 Private Health Insurance (Incentives) Rules

This clause provides that matters relating to the premiums reduction and incentive payment schemes may also be dealt with in the Private Health Insurance (Incentives) Rules if the provisions in the Part indicate this.

Division 23 – Premiums reduction scheme

Subdivision 23-A Amount of reduction

Clause 23-1 Reduction in premiums

This clause provides for the premium that a person would otherwise pay for a complying health insurance policy for the 2007-08 and later financial years to be reduced if the person is a participant in the scheme under clause 23-15.

Subclause (2) provides the amount of premium reduction is the sum of:

- 30% of the premium payable under the policy for the days on which nobody covered by the policy was aged 65 years or more;
- 35% of the premium payable under the policy for the days on which somebody covered by the policy was aged 65 years or more but nobody was aged 70 years or more; and
- 40% of the premium payable under the policy for the days on which somebody covered by the policy was aged 70 years or more.

Subclause (3) provides if a person was registered (or eligible to apply for registration) before 1 January 1999 under the *Private Health Insurance Incentives Act 1997* (1997 Act), the amount of the premiums reduction is the greater of the amount worked out under subclause (2) and the incentive amount under clause 23-5. The 1997 Act provided for payment of means-tested fixed amounts in respect of premiums for health insurance policies. This clause gives effect to a commitment the Government made in 1998 that nobody would be disadvantaged by the introduction of the 30% rebate.

Subclause (4) provides for the pro-rating of amounts under this clause if the premium is payable for only part of a financial year, and **subclause (5)** provides that a premium reduction is not allowed under this clause if a payment has been made under Division 26 in respect of the premium.

Clause 23-5 Meaning of *incentive amount*

This clause provides that the *incentive amount* (for the purpose of subclause 23-1(3)) is the amount payable under the 1997 Act, and provides for pro-rating of that amount for policies covering only part of a financial year.

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

This clause protects the entitlements to a 35% or 40% rebate of people aged less than 65 years covered by a policy including a person aged 65 years or more if that person leaves the policy.

Subclauses (1) and **(2)** provide that if the person aged 65 years or more leaves the policy the premium reduction continues at 35% or 40% as long as no person who is not a dependent child becomes covered by the policy. A dependent child no longer receives the benefit of this provision once they cease to be a dependent child, as they are never separately entitled to the benefit.

Subclause (3) provides that subclause (1) does not apply if it would lead to a lower premium reduction than would otherwise apply under clause 23-1, and **subclause (4)** provides that this clause covers policies where the premium was reduced by 35% or 40% under either the *Private Health Insurance Incentives Act 1998* or this Part.

Subdivision 23-B Participation in the premiums reduction scheme

Clause 23-15 Registration as a participant in the premiums reduction scheme

Subclause (1) provides that a person may apply to a private health insurer to participate in the scheme in respect of a complying health insurance policy if:

- the insurer is a participating private health insurer (within the meaning of clause 279-5); and
- the person is covered under the policy or the person (or their employer as a fringe benefit) paid a premium under the policy; and
- the person meets any eligibility requirements set in the Private Health Insurance (Incentives) Rules.

Subclause (2) requires an insurer that receives an application to notify the Medicare Australia CEO within 14 days or any other time approved by the CEO.

Subclauses (3) and **(4)** provide that the Medicare Australia CEO must register the applicant if the CEO is satisfied the person is eligible to participate in the scheme in respect of the policy, and must notify the insurer of the registration.

Clause 23-20 Refusal to register

If the Medicare Australia CEO refuses to register a person, this clause requires the CEO to notify the applicant and the private health insurer concerned of the refusal and the reasons for the refusal within 14 days of the notice to the CEO under clause 23-15. If a refusal is not

notified within that period the applicant is taken to be registered. A refusal to register is a reviewable decision under Part 6-9 of the Bill.

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

Subclause (1) requires that if a person registered or eligible for registration under the Private Health Insurance Incentives Act 1997 becomes aware that the number or type of people covered under a policy has changed in such a way that the registered person ought reasonably to expect that the incentive amount would change, the registered person must notify the private health insurer that issued the policy within 30 days of the change. Failure to do so is an offence under **subclause (2)** with a penalty of 60 penalty units. **Subclause (3)** provides that the offence is not a continuing offence.

Subclause (4) requires a private health insurer to notify the Medicare Australia CEO in the approved form of each notice under subclause (1).

Clause 23-30 Participants who want to withdraw from scheme

Subclause (1) provides that a participant must notify the relevant private health insurer if the person no longer wishes to be registered, and **subclause (2**) requires the private health insurer to notify the Medicare Australia CEO in the approved form of each notice under subclause (1).

Subclause (3) requires the Medicare Australia CEO to revoke the person's registration if notified under subsection (2).

Clause 23-35 Revocation of registration

Subclause (1) provides that if the Medicare Australia CEO is satisfied a person is not eligible to participate in the premiums reduction scheme the CEO must revoke the registration and notify the person and the private health insurer concerned within 28 days of the revocation. A refusal to register is a reviewable decision under Part 6-9 of the Bill.

Subclause (2) provides that revocation does not affect a person's right to make another application for registration.

Subclause (3) requires the Medicare Australia CEO to notify the relevant insurer of the revocation of a person's registration within 28 days.

Clause 23-40 Variation of registration

This clause requires a private health insurer to notify the Medicare Australia CEO if the treatments covered by a policy for which a person is registered change (eg the policy only covered hospital treatment but is extended to cover general treatment, or covered hospital and general treatment but hospital cover is dropped). After receiving such a notice the CEO must vary the registration and notify the insurer.

Clause 23-45 Retention of applications by private health insurers

This clause requires a private health insurer to retain an application for registration under subclause 23-15(1) for five years in any form approved in writing by the Medicare Australia CEO, and provides that an application retained in such a form must be received in courts and tribunals as if it was the original. The similar requirement under Division 11 of the *Private*

Health Insurance Incentives Act 1998 to retain records is preserved under clause 7 of the Transitional and Consequentials Bill.

Division 26 – The incentive payments scheme

Subdivision 26-A Amount of incentive payment

Clause 26-1 Payment in relation to premiums

Subclause (1) provides that a person is entitled to a payment under the scheme if he or she has paid the premium under a complying health insurance policy for any part of the 2007-08 or a subsequent financial year (or if his or her employer has paid the premium as a fringe benefit), the premium was not reduced under Division 23, and the person meets any eligibility requirements set in the Private Health Insurance (Incentives) Rules.

Subclause (2) provides that the amount payable is the sum of:

- 30% of the premium paid under the policy by a person (or the person's employer as a fringe benefit) for the days on which nobody covered by the policy was aged 65 years or more;
- 35% of the premium paid under the policy by a person (or the person's employer as a fringe benefit) for the days on which somebody covered by the policy was aged 65 years or more but nobody was aged 70 year or more; and
- 40% of the premium paid under the policy by a person (or the person's employer as a fringe benefit) for the days on which somebody covered by the policy was aged 70 years or more.

Subclause (3) provides if a person was registered (or eligible to apply for registration) before 1 January 1999 under the *Private Health Insurance Incentives Act 1997* (1997 Act), the amount of the premiums reduction is the greater of the amount worked out under subclause (2) and the incentive amount under clause 23-5. The 1997 Act provided for payment of means-tested fixed amounts in respect of premiums for health insurance policies. This clause gives effect to a commitment the Government made in 1998 that nobody would be disadvantaged by the introduction of the 30% rebate.

Subclause (4) provides that the amount payable under this Division is reduced by the amount of any tax offset received for the premium under Subdivision 61-H of the *Income Tax Assessment Act 1997*.

Subclause (5) requires a private health insurer to give a person paying a premium a receipt in the approved form on request, unless the premium for the policy had been reduced under Division 23.

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

This clause protects the entitlements to a 35% or 40% rebate of people aged less than 65 years covered by a policy including a person aged 65 years or more if that person leaves the policy.

Subclauses (1) and **(2)** provide that if the person aged 65 years or more leaves the policy the amount payable under clause 26-1 is worked out as if the person was still covered by the policy, as long as no person who is not a dependent child becomes covered by the policy. A

dependent child no longer receives the benefit of this provision once they cease to be a dependent child, as they are never separately entitled to the benefit.

Subclause (3) provides that subclause (1) does not apply if it would lead to a lower premium reduction than would otherwise apply under clause 26-1, and **subclause (4)** provides that this clause covers policies where the premium was reduced by 35% or 40% under either the *Private Health Insurance Incentives Act 1998* or this Part.

Subdivision 26-B Claiming payments under the incentive payments scheme

Clause 26-10 Claim for payment under incentive payments scheme

This clause says that a person must make a claim in the approved form to be paid an amount under clause 26-1. The claim must be sent to or lodged at a Medicare Australia office or a place approved by the Medicare Australia CEO, and be lodged in the financial year to which the claim relates or the next financial year.

Clause 26-15 Withdrawal of claim

This clause allows a person who has made a claim to withdraw it by writing sent to or lodged at a Medicare Australia office or a place approved by the Medicare Australia CEO.

Clause 26-20 Determination of claim and payment of amount

This clause requires the Medicare Australia CEO to decide on a claim within 14 days. If the claim is granted, it must be paid, and if it is not granted, the CEO must give the claimant a notice setting out reasons for the refusal.

Clause 26-25 Reconsideration of decision refusing a claim

Subclauses (1) to **(3)** allow an applicant whose claim has been rejected under clause 26-20 to apply to the Medicare Australia CEO for reconsideration of the decision within 28 days (or such other time as the CEO allows) of being notified of the decision. The application for reconsideration must be in writing and set out the reasons for the application.

Subclauses (4) to **(7)** provide that an application for reconsideration must be considered by the Medicare Australia CEO who must affirm or revoke the decision within 28 days. If the CEO revokes the decision to refuse the claim, this is taken to be a decision granting the claim. The CEO must give the applicant a notice stating the decision and the reasons for the decision. If the Medicare Australia CEO has not made a decision within 28 days the original decision is taken to have been affirmed. A decision affirming the original decision is a reviewable decision under Part 6-9 of the Bill.

Clause 26-30 Claimants to keep information up to date

This clause requires a person who has made a claim under clause 26-10 to notify the Medicare Australia CEO within 30 days of anything happening that affects the claimant's entitlement to a payment or a change in the premium or frequency of premium payments. Failure to notify is an offence under **subclause (2)** with an offence of 60 penalty units. **Subclause (3)** provides that the offence is not a continuing offence.

PART 2-3 LIFETIME HEALTH COVER

Division 31 – Introduction

Clause 31-1 What this Part is about

This clause explains that people are encouraged to take out hospital cover by the time they are 30 years old, and maintain it thereafter. If they do not they will have to pay higher premiums. This scheme is known as lifetime health cover.

Clause 31-5 Private Health Insurance (Lifetime Health Cover) Rules

This clause provides that matters relating to lifetime health cover may also be dealt with in the Private Health Insurance (Lifetime Health Cover) Rules if the provisions in the Part indicate this.

Division 34 – General rules about lifetime health cover

Clause 34-1 Increased premiums for person who is late in taking out hospital cover

Subclause (1) requires a private health insurer to increase the premium payable for hospital cover for an adult if the adult did not have hospital cover on his or her lifetime health cover base day.

Subclause (2) provides a formula for working out the amount of the increase as:

$$\left[\text{Lifetime health cover age} - 30\right] \times 2\% \times \text{Base rate}$$

where the *base rate* is the premium that would be payable other than an increase under this Part or a discount permitted under subclause 66-5(2), and the *lifetime health cover age* is the adult's age on the 1 July before the day on which they took out hospital cover.

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

Subclause (1) requires a private health insurer to increase the premium payable for hospital cover for an adult if the adult ceases to have hospital cover after his or her lifetime health cover base day.

Subclause (2) provides a formula for working out the amount of the increase as:

$$\text{Years without hospital cover} \times 2\% \times \text{Base rate}$$

where the *base rate* is as defined in clause 34-1, and *years without hospital cover* is the number of years calculated by dividing by 365 the number of days the adult did not have hospital cover (other than permitted days without hospital cover under clause 34-20) and rounding up to the nearest whole number.

Subclause (3) provides that an increase in premium under this clause is additional to one worked out under clause 34-1.

Clause 34-10 Increased premiums stop after 10 years' continuous cover

Subclauses (1) and **(2)** require an insurer to stop increasing the amount of premium payable for hospital cover under this Part if the premium has been increased for a continuous period of:

- ten years (including a period covered by an applicable benefits arrangement under the *National Health Act 1953*); or
- a period of ten years interrupted only by permitted days without hospital cover under clause 34-20 or days during which a person is taken to have had hospital cover under paragraphs 34-15(2) (b) or (c) (none of which count to the period of ten years).

Subclause (3) provides that the premiums payable for hospital cover must start to be increased again if the adult ceases to have hospital cover and then takes it up again, if the intervening days are not permitted days without hospital cover. **Subclause (4)** provides that subclauses (1) and (2) apply in respect of any later ten year period of continuous cover.

Subclause (5) defines *old Schedule 2* in subclause (1) as Schedule 2 of the *National Health Act 1953*.

Clause 34-15 Meaning of *hospital cover*

Subclause (1) provides that *hospital cover* is that part of a complying health insurance product that covers hospital treatment, and that an adult has hospital cover if he or she is insured under a complying health insurance policy that covers hospital treatment.

Subclause (2) provides that an adult is taken to have hospital cover:

- at any time he or she was covered by an applicable benefits arrangement under the *National Health Act 1953*; or
- at any time he or she holds a gold card (as defined in **subclause (3)**); or
- at any time he or she is in a class specified in the Private Health Insurance (Lifetime Health Cover) Rules.

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

This clause defines *permitted days without hospital* cover for an adult as days on which cover was suspended by the private health insurer (in accordance with any requirements set out in the Private Health Insurance (Lifetime Health Cover) Rules), and days on which the adult was overseas that are part of a continuous period of more than one year, and the first 1094 days (three years less one day) on which the adult did not have hospital cover. The Private Health Insurance (Lifetime Health Cover) Rules may specify days that are not to be treated as permitted days without hospital cover.

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

Subclause (1) provides a diagram to work out a person's lifetime health cover base day.

Subclauses (2) and **(3**) define a *new arrival* and a person's *medicare eligibility day* for the purposes of the diagram.

Subclause (4) provides that if a person's Schedule 2 application day (the equivalent under the *National Health Act 1953* of the lifetime health cover base day) had arrived before 1 April 2007, and the person had hospital cover on 1 April 2007, the person's lifetime health

cover base day is taken to be his or her Schedule 2 application day as long as he or she retains hospital cover.

Clause 34-30 When a person is overseas

This clause provides that a person in taken to be overseas if he or she lives on Norfolk Island, or lives overseas and returns to Australia during that period for less than 90 days. A person who lives overseas and returns to Australia for at least 90 days is taken to have returned from overseas.

Division 37 – Exceptions to the general rules about lifetime health cover

Clause 37-1 People born on or before 1 July 1934

This clause exempts from the lifetime health cover scheme people aged over 65 when the scheme was first introduced in 2000.

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

This clause provides that people aged over 31 and overseas on 1 July 2000 are taken to have had hospital cover on their lifetime health cover base day.

Clause 37-10 Hardship cases

This clause preserves the right of people covered by a determination under clause 10 of Schedule 2 to the *National Health Act 1953* to be treated as if they had hospital cover on 1 July 2000.

Clause 37-15 Increases cannot exceed 70% of base rates

This clause caps increases in premiums under this Part at 70%.

Clause 37-20 Joint hospital cover

This clause provides that if more than one adult is covered under the same hospital cover and the premium payable for at least one of the adults is increased under this Part, the increase in premiums payable for the cover is worked out by dividing the base rate for the cover by the number of adults it covers, working out the increase if any for each adult, and adding the results together.

Division 40 – Administrative matters relating to lifetime health cover

Clause 40-1 Notification to insured people etc.

Subclauses (1) and **(2**) require private health insurers to comply with any requirements in the Private Health Insurance (Lifetime Health Cover) Rules about providing information to adults with hospital cover, adults seeking to purchase hospital cover and other insurers about increases in premiums payable for hospital cover under this Part.

Subclause (3) provides that the Rules may require or permit an insurer to provide information in the form of an age notionally attributed to a person as the age from which they will be treated as having continuous hospital cover.

Subclause (4) requires insurers to keep separate records in relation to each adult covered by a joint hospital cover.

Subclause (5) requires insurers to notify other adults covered by a joint hospital cover when an adult ceases to be covered by the cover. Clause 333-1 provides how insurers may comply with this requirement for adults who live at the same address.

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

This clause requires private health insurers to comply with any requirements in the Private Health Insurance (Lifetime Health Cover) Rules relating to what evidence about a person's hospital coverage or age should be accepted for the purpose of this Part.

CHAPTER 3 – COMPLYING HEALTH INSURANCE PRODUCTS

PART 3-1 INTRODUCTION

Division 50 – Introduction

Clause 50-1 What this Chapter is about

This clause describes what is covered in Chapter 3.

Clause 50-5 Private Health Insurance (Complying Product) Rules, Private Health Insurance (Prostheses) Rules and Private Health Insurance (Accreditation) Rules

This clause provides that matters relating to complying health insurance products may also be dealt with in the Private Health Insurance (Complying Product) Rules, the Private Health Insurance (Prostheses) Rules and the Private Health Insurance (Accreditation) Rules if the provisions in the Chapter indicate this.

PART 3-2 COMMUNITY RATING

Division 55 – Principle of community rating

Clause 55-1 What this Part is about

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

Clause 55-5 Principle of community rating

Subclause (1) prohibits a private health insurer from taking or failing to take any action, or in making a decision, having regard to or failing to have regard to, any matter that would result in the insurer improperly discriminating between people who are insured or wish to be insured under a complying health insurance policy of the insurer.

Subclause (2) defines improper discrimination.

Subclause (3) provides that discrimination by a restricted access insurer (registered under clause 126-20) is not improper to the extent to which the discrimination relates to ensuring that it does not make available complying health insurance products to people that the insurer's constitution prohibits it from covering.

Clause 55-10 Closed products

This clause allows a private health insurer to refuse to make available to a particular person a complying health insurance product it is no longer making available to anyone.

PART 3-3 REQUIREMENTS FOR COMPLYING HEALTH INSURANCE PRODUCTS

Division 60 – Introduction

Clause 60-1 What this Part is about

This clause explains that complying health insurance products are the only kinds of insurance that private health insurers are allowed to make available as part of their health insurance business, and that the Part sets out the requirements an insurance policy must meet to be a complying health insurance policy.

Division 63 – Basic rules about complying health insurance products

Clause 63-1 Obligation to ensure products are complying products

This clause requires a private health insurer to ensure that the only kind of insurance it makes available as part of its health insurance business is insurance in the form of complying health insurance products.

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

Subclause (1) provides that a *complying health insurance product* is a product made up of complying health insurance policies, and **subclause (2)** defines a product as all the policies issued by a private health insurer that cover the same treatments, provide benefits worked out in the same way, and whose other terms and conditions are the same as each other.
Subclause (3) provides that policies in the same product may have different premiums.

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

This clause defines a *complying health insurance policy* as an insurance policy that meets the requirements under this Part, together with any requirements in the Private Health Insurance (Complying Product) Rules.

Division 66 – Community rating requirements

Clause 66-1 Community rating requirements

This clause provides that a policy meets the community rating requirements if it prohibits the insurer from breaching the principle in relation to a person insured under the policy, has no terms or conditions which would allow improper discrimination, and meets the premium requirements in clause 66-5, including the discount provision in subclause 66-5(2). However, if the product is a new product the requirement under subclause 66-5(1) that premiums be approved under clause 66-10 does not apply.

Clause 66-5 Premium requirement

Subclause (1) states that premiums payable under an insurance policy meet the requirement under clause 66-1 if the amount payable is approved under clause 66-10 as the relevant amount for the policy, except for a difference because of lifetime health cover or discounts allowed under subclause (2) or both.

Subclause (2) provides that premiums may be discounted for people who:

- pay at least 3 months in advance; or
- pay by payroll deduction; or
- pay by pre-arranged automatic transfer from an account; or
- belong to a contribution group under the rules of the insurer; or
- for whom the insurer is not required to pay a State or Territory levy

as long as the same discount is available for the same reason to any person, and the percentage discount does not exceed the maximum specified in the Private Health Insurance (Complying Product) Rules.

Clause 66-10 Minister's approval of premiums

Subclause (1) requires a private health insurer wishing to change the premiums for a complying health insurance product to apply to the Minister for approval in the approved form at least 60 days before the change is proposed to come into effect.

Subclause (2) provides that the proposed changed amount must be the same for each policy in the product issued to people living in the same risk equalisation jurisdiction (defined in clause 146-1) and under which:

- only one person is insured; or
- two adults and non-one else is insured; or
- two or more people are insured, none of whom is an adult; or
- two or more people are insured, only one of whom is an adult; or
- three or more people are insured, only two of whom are adults; or
- three of more people are insured, at least three of whom are adults.

(The last category reflects industry practice of covering young adults under their parents' policy.)

Subclause (3) requires the Minister to approve the changes unless he or she is satisfied that a change that would increase the amount or amounts would be contrary to the public interest, and **subclause (6)** requires the Minister to table the reasons for refusing to approve a change in each House of Parliament within 15 sitting days of the refusal. **Subclause (7)** explains that an approval by the Minister is not a legislative instrument. This is because the instrument applies to the particular proposed change and hence is not of a legislative character.

Subclause (4) provides that a changed amount approved by the Minister has effect from the day specified in the approval as the date of effect until replaced by another amount approved under this clause.

Subclause (5) provides that the amount approved by the Minister for each kind of policy under subclause (2) is the relevant amount for that kind of policy for the purpose of subclause 66-5(1).

Clause 66-15 Entitlement to benefits for general treatment

This clause allows private health insurers to determine the amount of benefits payable to under a complying health insurance product for general treatment (other than hospital-substitute treatment) in a period by reference to the amount of benefits already claimed for that kind of treatment in that period.

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

This clause allows private health insurers to pay different amounts of benefit for the same treatment under different complying health insurance policies within a complying health insurance product if the difference is only because the persons insured under the policies live in different risk equalisation jurisdictions.

Division 69 – Coverage requirements

Clause 69-1 Coverage requirements

Subclause (1) states that an insurance policy meets the coverage requirements of this Division if the only things it covers are:

- specified treatments that are hospital treatment; or
- specified treatments that are hospital treatment and specified treatments that are general treatment; or
- specified treatments that are general treatment but none that are hospital-substitute treatment.

Broader health cover products will be covered by the second item (paragraph (1)(b)).

Subclauses (2) and **(3)** provide for the Private Health Insurance (Complying Product) Rules to include or exclude cover for particular treatments.

Clause 69-5 Meaning of *cover*

Subclause (1) provides that an insurance policy *covers* a treatment if the insurer under the policy assumes liability for some or all of the loss arising out of a liability to pay fees or charges relating to the provision of a good or service that is or includes the treatment.

Subclause (2) provides that a policy may also cover a treatment if the insurer directly provides, or arranges for the provision, of a good or service that is or includes the treatment, and **subclause (3)** states that this Part applies to any good or service provided in this way as if it were a benefit provided under the policy. These provisions allow insurers to provide dental clinics and similar services for insured persons.

Division 72 – Benefit requirements for policies that cover hospital treatment

Clause 72-1 Benefit requirements

Subclause (1) provides that an insurance policy that covers hospital treatment meets the benefits requirements of this Division if

- it meets the requirements in the table in subclause (2) and any requirements in the Private Health Insurance (Complying Product) Rules; and
- the insurer's rules meet the requirement in clause 72-5; and
- the policy does not provide benefits for residential aged care, the cost of co-payments under the Pharmaceutical Benefit Scheme (except where the drugs are provided as part of

hospital treatment), and any other treatment excluded by the Private Health Insurance (Complying Product) Rules.

Subclause (2) lists five items for which there must be a benefit and the level of the benefit.

Item 1 covers the non-medical element of hospital treatment that is one or more of psychiatric care, rehabilitation, and palliative care and requires payment of a benefit of at least the amount set out in the Private Health Insurance (Complying Product) Rules. This item is intended to replicate the requirement under paragraphs 1(bf) and (bg) in Schedule 1 of the *National Health Act 1953*.

Item 2 covers that element of hospital treatment covered under the policy for which a medicare benefit is payable, and requires payment of a benefit of at least any difference between the 75% medicare benefit and the schedule fee. This item is intended to replicate the requirement under paragraph 1(ea) in Schedule 1 of the *National Health Act 1953*.

Item 3 covers that element of hospital-substitute treatment covered under the policy for which a medicare benefit is payable, and requires payment of a benefit of at least any difference between the 75% medicare benefit and the schedule fee, as long as a medicare benefit of an amount that is at least 85% of the schedule fee has not been claimed for the treatment. This will allow patients to elect to use their community Medicare entitlements (including the Extended Medicare Safety Net) to cover hospital substitute treatment if they wish.

Item 4 covers prostheses listed in the Private Health Insurance (Prostheses) Rules and provided as part of hospital treatment or hospital substitute treatment covered under the policy in circumstances in which a medicare benefit is payable or in circumstances set out in the Rules. The benefit payable must be at least the amount set out in the Rules and no more than the maximum amount (if any) set out in those Rules. This item is intended to replicate the requirement under paragraphs 1(bl) and (bm) in Schedule 1 of the *National Health Act 1953*.

Item 5 covers any treatment that the Private Health Insurance (Complying Product) Rules specify there must be a benefit for, and requires payment of a benefit of at least the amount set out in the Private Health Insurance (Complying Product) Rules for that treatment. This item will permit the continuation of the default benefits currently determined under paragraph (bj) in Schedule 1 of the *National Health Act 1953*.

Clause 72-5 Rules requirement in relation to provision of benefits

This clause sets out the rules requirement for the purposes of subclause 72-1(1). It provides that the amount payable by a person insured under a complying health insurance product and receiving treatment from a health care provider (other than a medical practitioner) under an agreement or arrangement with the insurer must not vary according to the frequency with which the provider treats people insured under the product. This is intended to prevent price volume agreements or similar arrangements between insurers and providers resulting in different co-payments for patients treated at different times.

Subclause (3) provides that the Private Health Insurance (Complying Product) Rules may modify the requirements under this clause and that the rules requirement is taken to be met if the conditions in the Rules are met. This provision is intended to give the Government

flexibility in adapting the requirements to ensure a fair balance between the interests of insurers and insured persons as contracting arrangements evolve.

Clause 72-10 Minimum benefits for prostheses

Subclause (1) provides that Private Health Insurance (Prostheses) Rules made for the purpose of item 4 in the table in subclause 72-1(2) must only list a prosthesis if a successful application has been made to the Minister under this clause.

Subclauses (2) and **(3)** provide that a person may apply to the Minister in the approved form, accompanied by the application fee imposed by the proposed Private Health Insurance (Prostheses Application and Listing Fees) Act, to have a prosthesis listed in the Private Health Insurance (Prostheses) Rules.

Subclause (4) requires the Minister to inform the applicant of his or her decision whether or not to grant the application, and to provide reasons for a refusal.

Subclause (5) requires the Minister, if the application is granted and the applicant pays to the Minister within 14 days of being informed of the decision the initial listing fee imposed by the proposed Private Health Insurance (Prostheses Application and Listing Fees) Act, to:

- list the prosthesis in the Private Health Insurance (Prostheses) Rules; and
- set out a minimum benefit for the prosthesis; and
- if the Minister considers it appropriate, set out a maximum benefit for the prosthesis

on the next occasion that the Minister makes or varies the Rules.

Clause 72-15 Ongoing listing fee for prostheses

This clause requires an applicant for listing to pay the ongoing listing fee specified in the proposed Private Health Insurance (Prostheses Application and Listing Fees) Act within 14 days of the ongoing list fee imposition day under that Act, and allows the Minister to remove the prosthesis from the list in the Private Health Insurance (Prostheses) Rules if the fee is not paid.

Division 75 – Waiting period requirements

Clause 75-1 Waiting period requirements

Subclause (1) provides that an insurance policy meets the waiting period requirements of this Division if the maximum waiting periods for a person who did not transfer to the policy are:

- 12 months for a benefit for either hospital treatment or hospital-substitute treatment that is either obstetric treatment or treatment for a pre-existing condition (other than psychiatric care, rehabilitation or palliative care); and
- 2 months for a benefit for either hospital treatment or hospital-substitute treatment that is psychiatric care, rehabilitation or palliative care; and
- 2 months for any other benefit for hospital treatment or hospital-substitute treatment.

The requirement for a maximum two months waiting period for psychiatric care, rehabilitation or palliative care replicates the requirements of paragraph 1(ja) of Schedule 1 of the *National Health Act 1953*.

Subclause (2) provides that the Private Health Insurance (Complying Product) Rules may modify the requirements in subclause (1) in relation to any or all private health insurers, benefits or insured persons. This provision is intended to give the Government flexibility in

adapting the waiting period regime to emerging patterns of care to ensure a fair balance between the interests of insurers and insured persons and persons joining insurance.

Clause 75-5 Meaning of *waiting period*

This clause defines a *waiting period* in relation to a benefit as a length in time during which a person is not entitled to the benefit. The waiting period begins when a person becomes insured and ends at the time specified in the policy.

Clause 75-10 Meaning of *transfers*

This clause provides that a person *transfers* to a new policy from an old policy if they were either:

- insured under the old policy at the time they became insured under the new policy; or
- they ceased to be insured under the old policy seven days (or such longer time as the new insurer allows) before becoming insured under the new policy; and
- the old policy was a complying health insurance policy; and
- the person's premium payments under the old policy were up to date.

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

Subclause (1) defines a *pre-existing condition* for a person insured under a policy as an ailment, illness or condition if, in the opinion of a medical practitioner appointed by the insurer, the signs or symptoms of the ailment, illness or condition existed at any time in the six months ending on the day on which the person became insured under the policy.

Subclause (2) requires the medical practitioner appointed by the insurer under subclause (1) to have regard to any information on the ailment, illness or condition provided by the treating practitioner.

Subclause (3) provides that if a person is transferred from one policy to another by an insurer replacing one complying health insurance product with another, the day on which the person is taken to have become insured under the policy is the day he or she became insured under the first policy.

Division 78 – Portability requirements

Clause 78-1 Portability requirements

Subclause (1) states than an insurance policy meets the portability requirements of this Division if it meets the requirements in subclauses (2), (3) and (4).

Subclause (2) provides that a policy meets the requirement if the waiting period for a person transferring to the (new) policy from another (old) policy is:

- no longer than the maximum waiting periods set out in clause 75-1 for a benefit for hospital treatment or hospital-substitute treatment that was not covered under the old policy; or
- the balance of any unexpired waiting period under clause 75-1 for a benefit for hospital treatment or hospital-substitute treatment that was covered under the old policy.

Subclause (3) provides that a policy meets the requirement if the policy does not impose on a person transferring to the new policy from the old policy any period (other than a waiting period under subclause (2)) during which the amount of benefit for any particular hospital

treatment or hospital-substitute treatment is less than the amount the person would be eligible for during any other period. This subclause is intended to prevent the application of benefit limitation periods for persons transferring to a new policy.

Subclause (4) provides that if the old policy imposed higher excesses or co-payments than the new policy, these may be continued under the new policy for a period no longer than the maximum waiting periods set out in clause 75-1.

Subclause (5) provides that the existence or otherwise of contracts between the insurer and particular health care providers or groups of health care providers under either of the policies is to be disregarded in working out whether a treatment was covered by an old policy (under subclauses (2) or (4)) or whether the amount of a benefit under a new policy during a period is less than the amount it would be during another period (under subclause (3)).

Subclause (6) provides that the Private Health Insurance (Complying Product) Rules may modify the requirements in this clause in relation to any or all private health insurers, benefits or insured persons. This provision is intended to give the Government flexibility in adapting the portability regime to emerging patterns of care to ensure a fair balance between the interests of insurers and insured persons and persons transferring between insurers.

Division 81 – Quality assurance requirements

Clause 81-1 Quality assurance requirements

This clause provides that an insurance policy meets the quality assurance requirements of this Division if the policy prohibits the payment of benefits for treatments that do not meet the standards in the Private Health Insurance (Accreditation) Rules. Section 13 of the proposed Transitional and Consequential Amendments Act provides that this clause does not apply until 1 July 2008.

Division 84 – Enforcement of this Part

Clause 84-1 Offence: advertising, offering or insuring people under non-complying policies

Subclause (1) states that a person commits an offence if

- the person advertises a product, or offers a person insurance under a policy, or insures a person under a policy, or arranges for another person to do one of these things; and
- the policy, or a policy in the product, covers hospital treatment or general treatment or both; and
- the policy is not a complying health insurance policy

with a maximum penalty of imprisonment for 5 years or 1,000 penalty units or both.

(A reference in this subclause to a person includes both a natural person and a corporate person. The penalty for a corporate person is five times the number of penalty units set out in the offence.)

Subclause (2) provides that in imposing a penalty on a private health insurer for an offence under subclause (1) a court must have regard to the possible impact of a penalty on the insurer's capital adequacy, solvency and premium levels, and must not impose a penalty if satisfied that doing so would adversely affect capital adequacy or solvency or would be likely to lead to increased premiums.

Clause 84-5 Offence: directors liable if systems not in place to prevent breaches

This clause states that a director or a chief executive officer of a private health insurer commits an offence, with a maximum penalty of imprisonment for 5 years or 1,000 penalty units or both, if the insurer commits an offence under clause 84-1 and the director or chief executive officer failed to exercise due diligence to ensure that adequate systems were in place to prevent the insurer from committing the offence.

Clause 84-10 Injunction in relation to non-complying policies

Subclauses (1), (2) and **(3)** empower the Federal Court, on application by the Minister, the Council or another person, to grant an injunction either:

- restraining an insurer from engaging in conduct that contravenes or would contravene clause 63-1 (ensuring products are complying health insurance products) or would be an offence under clause 84-1; or
- requiring an insurer to do a thing if a refusal or failure to do so contravenes or would contravene clause 63-1 or would be an offence under clause 84-1.

Subclauses (4), (5) and **(6)** allow the Court to grant interim injunctions or discharge or vary injunctions, and prevent the Court from seeking undertakings from applicants as to damages as a condition of an interim injunction.

Subclauses (7) and **(8)** provide that the Court may grant injunctions whether or not the insurer has previously engaged in conduct or refused to do a thing, and whether or not it appears that the insurer intends to engage in conduct or refuse to do a thing.

Clause 84-15 Remedies for people affected by non-complying policies

This clause allows the Federal Court, on application by the Minister, to order an insurer that has either engaged in conduct that contravenes clause 63-1 (ensuring products are complying health insurance products) or is an offence under clause 84-1, or by refusal or failure to do a thing has engaged in conduct that contravenes clause 63-1 or is an offence under clause 84-1 to:

- take specified action to ensure that an insurance policy becomes a complying health insurance policy; or
- take specified action to ensure that a person insured under an insurance policy is put in the position they would have been in had the policy been a complying health insurance policy.

PART 3-4 OBLIGATIONS RELATING TO COMPLYING HEALTH INSURANCE PRODUCTS

Division 90 – Introduction

Clause 90-1 What this Part is about

This clause explains that this Part sets out obligations on private health insurers to provide information to people insured and seeking to become insured under complying health insurance products, as well as to the Department, the Council and the Private Health Insurance Ombudsman.

Division 93 – Giving information to consumers

Clause 93-1 Maintaining up to date standard information statements

Subclause (1) requires a private health insurer to ensure that it always maintains an up to date standard information statement for each complying health insurance product that it makes available or under which it insures people.

Subclause (2) provides that a standard information statement is up to date at a particular time if it is accurate at that time.

Subclause (3) provides that an insurer commits an offence if there is no standard information statement for a complying health insurance product of the insurer. The penalty is 60 penalty units. **Subclause (4)** provides that an insurer commits an offence if there is a standard information statement for a complying health insurance product but it is not up to date. The penalty is 60 penalty units. **Subclause (5)** provides that these are strict liability offences.

Clause 93-5 Meaning of *standard information statement*

Subclause (1) defines a *standard information statement* for a complying health insurance product as a statement that contains the information and is in the form set out in the Private Health Insurance (Complying Product) Rules.

Subclause (2) provides that the Private Health Insurance (Complying Product) Rules may set out methods by which standard information statements are to be made available to people who ask for information about complying health insurance products.

Clause 93-10 Making standard information statements available

This clause requires a private health insurer to ensure that if a person asks an officer, employee or agent of an insurer for information about a complying health insurance product he or she is told about the standard information statement and how to obtain it, and is given an up to date standard information statement if he or she asks for it.

Clause 93-15 Giving information to newly insured people

This clause requires a private health insurer to ensure that, when an adult first becomes insured under a complying health insurance policy of the insurer, he or she is given an up to date standard information statement for the product the complying health insurance policy is in, details about what the policy covers and the benefits it provides, and a statement identifying the health benefits fund to which the policy is referable. An insurer can comply with this request in relation to a policy covering more than one adult by providing the statement to only one of the adults.

Clause 93-20 Keeping insured people up to date

Subclause (1) requires a private health insurer to ensure that an adult insured under a complying health insurance policy of the insurer is given the standard information statement for the product the policy is in at least once every 12 months.

Subclause (2) requires a private health insurer to ensure that, if a proposed change to the insurer's rules is or may be detrimental to a person's interests and will require an update to the standard information statement, each adult is informed about the proposed change a

reasonable time before it takes effect, and is given the updated standard information statement as soon as is practicable.

Subclause (3) requires a private health insurer to ensure that, if an adult insured under a complying health insurance policy of the insured asks an officer, employee or agent of an insurer for information about what the policy covers and the benefits it provides, the adult is given the information as soon as practicable.

Subclause (4) requires a private health insurer to ensure that, if the health benefits fund to which a complying health insurance policy is referable changes as the result of Division 146, each adult insured under the policy is given a statement before the change takes effect identifying the health benefits fund to which the policy will become referable.

Subclause (5) provides that an insurer can comply with this request in relation to a policy covering more than one adult by providing the statement or the information to only one of the adults.

Clause 93-25 Giving advance notice of detrimental changes to rules

This clause requires a private health insurer to ensure that an adult insured under a complying health insurance policy of the insurer is informed about any proposed changes to the insurer's rules (other than a change to which subclause 93-25(2) applies), which is or might be detrimental to the interests of an insured person a reasonable time before the change takes effect. An insurer can comply with this request in relation to a policy covering more than one adult by informing only one of the adults.

Clause 93-30 Failure to give information to consumers

Subclauses (1) and **(2)** provide that a private health insurer and a director of a private health insurer respectively commit an offence if the insurer does not comply with clauses 93-10, 93-15, 93-20 or 93-25. The penalty is 60 penalty units and **subclause (3)** provides that these are strict liability offences.

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

Clause 96-1 Giving standard information statements on request

This clause requires a private health insurer to ensure that, if the Secretary of the Department, the Council or the Private Health Insurance Ombudsman ask the insurer for the standard information statement for a complying health insurance product of the insurer, the insurer must give the person who made the request an up to date copy of the standard information statement as soon as practicable by the method specified by the person.

Clause 96-5 Giving standard information statements for new products

This clause requires a private health insurer to ensure that a copy of the standard information statement for a complying health insurance product is given to the Secretary of the Department, the Council or the Private Health Insurance Ombudsman no later than the first day on which the insurer first makes the product available.

Clause 96-10 Giving updated standard information statements

This clause requires a private health insurer to ensure that, if the standard information statement for a complying health insurance product is updated, a copy of the updated statement is given to the Secretary of the Department, the Council or the Private Health Insurance Ombudsman as soon as practicable.

Clause 96-15 Giving additional information on request

Subclause (1) provides that the Secretary of the Department, the Council or the Private Health Insurance Ombudsman may ask a private health insurer for specified information about a complying health insurance product or products, or a complying health insurance policy, of the insurer.

Subclauses (2) and **(3)** stipulate that the request must be in writing and specify the time by which the information is to be given, and may specify the manner and form in which the information is to be given.

Subclause (4) requires the insurer to comply with the request within the time specified in the request or any longer time allowed by the requestor.

Clause 96-20 Failure to give information to the Department, the Council or Private Health Insurance Ombudsman

Subclause (1) provides that a private health insurer commits an offence if the insurer does not comply with clauses 96-1, 96-5, 96-10 or 96-15. The penalty is 60 penalty units and **subclause (2)** provides that these are strict liability offences.

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

This clause provides that the Private Health Insurance (Complying Product) Rules may set out any or all of:

- information in relation to complying health insurance products;
- persons to whom the information is to be given (which may include the Secretary of the Department, the Council or the Private Health Insurance Ombudsman);
- the time within which, or intervals at which, the information is to be given;
- the manner and form in which the information is to be given.

Division 99 – Transfer certificates

Clause 99-1 Transfer certificates

Subclause (1) requires a private health insurer to give a certificate (in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules) to a person ceasing to be insured under a complying health insurance policy who does not become insured under another complying health insurance policy of the insurer.

Subclauses (2) and **(3)** provides that a private health insurer who insures under a complying health insurance policy a person who is transferring from a complying health insurance policy of another insurer must, unless the person provides within seven days of becoming insured a transfer certificate obtained under subclause (1), ask the old insurer for a certificate in the approved form and within the period set out in the Private Health Insurance

(Complying Product) Rules. The old insurer must comply with the request (whether or not the request has been made in the approved form and within the period set out in the Rules) and give the new insurer a certificate in the approved form within the period set out in the Rules.

Subclause (4) provides that an insurer commits an offence if the insurer is required to do something under subclauses (1), (2) or (3) and the insurer does not do it. The penalty is 60 penalty units and **subclause (5)** provides that these are strict liability offences.

Division 102 – Private health insurers to offer cover for hospital treatment

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

This clause requires a private health insurer making available a complying health insurance product covering general treatment to also make available a complying health insurance product covering hospital treatment. This is intended to prevent insurers only offering products covering general treatment.

CHAPTER 4 – PRIVATE HEALTH INSURERS

PART 4-1 INTRODUCTION

Division 110 – Introduction

Clause 110-1 What this Chapter is about

This clause explains entities are only allowed to carry on health insurance business if they are registered, and that registered entities face a number of obligations. The principal obligation is to have health benefits funds for the conduct of health insurance business.

PART 4-2 CARRYING ON HEALTH INSURANCE BUSINESS

Division 115 – Introduction

Clause 115-1 What this Part is about

This clause explains that only entities registered under Part 4-3 as private health insurers can carry on health insurance business, and that other entities can be prevented from carrying on health insurance business.

Clause 115-5 Private Health Insurance (Health Insurance Business) Rules

This clause provides that matters relating to the carrying on of health insurance business may also be dealt with in the Private Health Insurance (Health Insurance Business) Rules if the provisions in the Part indicate this.

Clause 115-10 Whether a business etc. is health insurance business

The diagram in this clause shows how to work out whether a business or arrangement is health insurance business.

Division 118 – Prohibition of carrying on health insurance business without registration

Clause 118-1 Carrying on health insurance business without registration

Subclause (1) provides that it is an offence with a penalty of 40 penalty units for a person to carry on health insurance business if the person is not a private health insurer.

Subclause (2) provides that the offence is committed on each day a person contravenes subclause (1).

Clause 118-5 Injunctions

Subclause (1) empowers the Federal Court to grant an injunction, on application by the Minister, the Council or any other person, if the Court is satisfied that a person has engaged, or is proposing to engage, in conduct that contravenes or would contravene clause 118-1.

Subclauses (2) and **(4)** allow the Court to grant an interim injunction, and rescind or vary injunctions.

Subclause (3) prevents the Court from seeking undertakings from applicants as to damages as a condition of an interim injunction.

Subclause (5) provides that the Court's power to grant an injunction restraining a person for engaging in conduct may be exercised whether or not it appears to the Court that the person intends to continue to engage, or engage again, in that conduct.

Subclause (6) provides that the Court's power to grant an injunction requiring a person to do an act or thing may be exercised whether or not it appears to the Court that the person intends to refuse or fail, or continue to refuse or fail, to do that thing or whether the person has previously refused or failed to do that act or thing.

Division 121 – What is health insurance business?

Clause 121-1 Meaning of *health insurance business*

Subclause (1) provides that *health insurance business* is:
- the business of undertaking liability, by way of insurance; or
- an employee health benefit scheme

that relates in a way referred to in subclause (2) to hospital treatment or general treatment.

Subclause (2) provides that the liability must relate to:
- loss arising out of a liability to pay fees or charges relating to provision in Australia of such treatment; or
- the provision in Australia of such treatment; or
- the happening of an occurrence connected with the provision in Australia of such treatment; or
- the happening of an occurrence in Australia that ordinarily requires the provision of such treatment

and **subclause (3)** provides that for the purpose of the last point it does not matter whether payment of benefits is dependent on:
- treatment or benefit being provided to the insured;
- the insured requiring such treatment or benefit;
- fees and charges being payable by the insured in relation to the provision of such treatment or benefit.

These subclauses are intended to capture within the scope of health insurance business insurance products that are structured to pay a benefit commensurate with the costs of treatment without reference to such costs actually being incurred.

Clause 121-5 Meaning of *hospital treatment*

Subclause (1) defines *hospital treatment* as treatment that is intended to manage a disease, injury or condition and is provided to a person by a person authorised by a hospital or under the management or control of such a person, and is either provided at a hospital or is provided or arranged with the direct involvement of a hospital. This definition is intended to cover the provision of elements of an episode of hospital care outside the physical boundary of a hospital as long as a hospital is involved in the delivery of the services.

Subclause (2) provides that hospital treatment also includes any treatment included in the Private Health Insurance (Health Insurance Business) Rules.

Subclause (3) provides that references to treatment in subclauses (1) and (2) include a reference to any of, or any combination of, the services listed in this subclause.

Subclause (4) provides for the Private Health Insurance (Health Insurance Business) Rules to exclude specified treatment from being hospital treatment.

Subclauses (5) and **(6)** provide for the Minister to declare a facility to be a hospital, or revoke such a declaration. (Refusals to make declarations and revocation of declarations are reviewable decisions under Part 6-9.)

Subclause (7) provides that in making or revoking a declaration under subclause (6) the Minister must have regard to:

- the nature of the facility; and
- the range of services provided or proposed to be provided; and
- whether any necessary State or Territory approvals have been obtained; and
- whether the accreditation requirements of an appropriate accrediting body have been met; and
- whether undertaking have been made (or complied with) relating to providing private health insurers with information (specified in the Private Health Insurance (Health Insurance Business) Rules) about treatment of policy holders; and
- any other matters specified in the Private Health Insurance (Health Insurance Business) Rules.

Declarations of a hospital under this clause will replace the present declarations of private hospitals and recognized hospitals under section 23EA and subsection 3(1) respectively of the *Health Insurance Act 1973* and declarations of day hospital facilities under section 5B of the *National Health Act 1953*.

Subclause (8) provides that the Minister must declare a hospital as either a public hospital or a private hospital.

Clause 121-10 Meaning of *general treatment*

Subclauses (1) and **(2)** provide that *general treatment* is treatment (including the provision of goods and services but excluding hospital treatment) intended to manage or prevent a disease, injury or condition, and includes any treatment specified in the Private Health Insurance (Health Insurance Business) Rules.

Subclause (3) provides that general treatment excludes:
- services for which a medicare benefit is payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise; and
- any treatment specified in the Private Health Insurance (Health Insurance Business) Rules.

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

Subclause (1) defines an arrangement as an *employee health benefits scheme* if it provides for an employer to arrange payment for the whole or part of the fees and charges that an employee of, or a person providing services to, the employer incurred in relation to hospital treatment or general treatment if the employer is a constitutional corporation, a body corporate incorporated in a Territory, or carries on business in a Territory.

Subclause (2) widens the scope of the clause by providing that it does not matter if the arrangement:
- involves undertaking liability by way of insurance; or
- is a minor part of the employer's business; or
- does not require the beneficiary to pay any contributions or contributions that reflect the value of the benefits; or
- provides for the employer to make payments in relation to treatment provided to a person other than the employee or the person providing services; or
- allows a discretion whether to make payments.

Subclause (3) excludes from being an employee health benefits scheme an arrangement under which the employer will pay or reimburse employees or persons providing services for one or both of:
- premiums payable for complying health insurance policies; or
- the difference between benefits payable under complying health insurance policies and the fees or charges for health services.

The subclause also provides that an arrangement is not an employee health benefits scheme if the Private Health Insurance (Health Insurance Business) Rules provide that it is not, or if it constitutes State insurance within the meaning of paragraph 51(xiv) of the Constitution.

Clause 121-20 Exception: accident and sickness insurance business

Subclause (1) excludes from the definition of health insurance business accident and sickness insurance defined as the business of undertaking liability, by way of insurance, to pay a lump sum or make periodic payments on the happening of a personal accident, disease or sickness.

Subclause (2) provides that accident and sickness insurance does not include:
- liability undertaken with respect to loss arising out of a liability to pay fees or charges in relation to the provision in Australia of hospital treatment or general treatment; or
- business of a kind specified in the Private Health Insurance (Health Insurance Business) Rules.

Clause 121-25 Exception: liability insurance business

This clause excludes from the definition of health insurance business the business of undertaking liability, by way of insurance, with respect to any loss arising out of a liability to pay compensation or damages including liabilities arising from use of a motor vehicle or because of events occurring in connection with a person's employment.

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

This clause excludes from the definition of health insurance business business of a kind specified in the Private Health Insurance (Health Insurance Business) Rules.

PART 4-3 REGISTRATION

Division 126 – Registration

Clause 126-1 What this Part is about

This clause explains that the Private Health Insurance Administration Council ("the Council") has the power to register as private health insurers corporations registered for the purpose of the Corporations Law.

Clause 126-5 The Private Health Insurance (Registration) Rules

This clause provides that matters relating to the registration of private health insurers may also be dealt with in the Private Health Insurance (Registration) Rules if the provisions in the Part indicate this.

Clause 126-10 Applying for registration

Subclause (1) provides that a company within the meaning of the *Corporations Act 2001* or a registered body under that Act, which is also a constitutional corporation, may apply to the Council for registration as a private health insurer.

Subclause (2) requires that the application must be in the approved form and accompanied by a copy of the rules proposed to govern the health insurance business, and indicate if the applicant wishes to be registered as a for profit insurer and a restricted access insurer.

Subclause (3) provides that the applicant must also provide a copy of the rules to the Secretary of the Department.

Clause 126-15 Requesting further information

This clause allows the Council to ask the applicant for further information within 90 days after the application is made.

Clause 126-20 Deciding the application

Subclause (1) empowers the Council to grant the application (subject to any terms and conditions it thinks fit) or refuse it. (A decision to refuse or to apply terms and conditions is reviewable under Part 6-9.)

Subclauses (2) and **(3)** provide that in deciding the application Council must consider:

- whether the applicant will be able to comply with the Act; and
- such other matters as the Private Health Insurance (Registration) Rules require;

and may consider other matters it thinks fit, except matters excluded by the Private Health Insurance (Registration) Rules.

Subclause (4) requires Council, after consulting the Secretary of the Department, to refuse the application if the rules of the applicant permit improper discrimination.

Subclause (5) states that if Council grants the application, then:
- the applicant is taken to have been registered as a private health insurer from the date specified by Council;
- if the registration is subject to terms and conditions, those are taken to have applied from the date on which the applicant is notified of the grant;
- if the applicant sought registration as a for profit insurer it is taken to be registered as such; and
- if the applicant sought registration as a restricted access insurer it is taken to be registered as such subject to subclause (6).

Subclause (6) provides that the constitution of a restricted access insurer must describe the restricted access groups to whom the insurer's products will be available, prohibit the insurer from insuring anybody else, and prohibit the insurer from ceasing to insure someone because they have ceased to belong to the restricted access group.

Subclause (7) defines a restricted access group as a group of people who:
- are or were employed in a particular profession, trade, industry or calling or by a particular employer or an employer in a class of employers; or
- are or were members of a particular profession, professional association or union; or
- are or were members of the Defence Force or part of the Defence Force; or
- are or were members of a group described in the Private Health Insurance (Registration) Rules

and includes the partners and dependent children of people who belong to the group.

Clause 126-25 Notifying the decision

This clause requires Council after making a decision to notify the applicant in writing of the grant and of any terms and conditions or of the refusal, notify the Secretary in writing within seven days of the grant or refusal, and publish in the Gazette a notification within a month of the grant or refusal.

Clause 126-30 Council can be taken to refuse application

This clause provides that Council is taken to have refused the application for the purposes of Part 6-9 if it does not notify the applicant of its decision by the latest of:
- 90 days after the application was made; or
- 90 days after a copy of the rules was provided to the Secretary of the Department; or
- 90 days after further information was provided to the Council under clause 126-15.

Clause 126-35 Council to maintain record of registrations etc.

This clause requires Council to maintain on its website an up to date record of all private health insurers including registration status and contact details, and to make the record available to a person in writing information from the record that the person requests.

Clause 126-40 Changing registration status

Subclauses (1) and **(2)** allow private health insurers, by notifying the Council in the approved form, to change their status from for profit insurer to not for profit insurer or *vice versa*.

Subclauses (4) and **(5)** allow private health insurers, by notifying the Council in the approved form, to change their status from restricted access insurer to other insurer or *vice versa*.

Subclauses (3) and **(6)** require Council to notify changes of status to the Secretary of the Department, the Private Health Insurance Ombudsman and (in relation to profit status) the Commissioner of Taxation.

Clause 126-45 Cancellation of registration

Subclause (1) requires Council to cancel the registration of a private health insurer if it has not conducted health insurance business for 12 months, its health benefits funds have been terminated under Division 149.

Under **subclause (2)** Council must notify the insurer in writing of the cancellation, notify the Secretary in writing within seven days, and publish in the Gazette a notification within a month.

PART 4-4 HEALTH BENEFITS FUNDS

Division 131 – Introduction

Clause 131-1 What this Part is about

This clause explains that private health insurers must have health benefits funds operated in accordance with the requirements of this Part, in particular the solvency and capital adequacy requirements. Directors of insurers may be personally liable for contraventions of the requirements.

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

This clause provides that matters relating to health benefits funds may also be dealt with in the Private Health Insurance (Health Benefits Fund Policy) Rules or the Private Health Insurance (Health Benefits Fund Administration) Rules if the provisions in the Part indicate this.

Clause 131-10 Meaning of *health benefits fund*

This clause defines a *health benefits fund* as a fund established in the records of a private health insurer that relates solely to either:

- its health insurance business or part of that business; or
- its health insurance business or part of that business, and its health-related business, or part of that business.

Clause 131-15 Meaning of *health related business*

This clause defines *health related business* as one or more of:

- providing goods or services (or both) to manage or prevent diseases, injuries or conditions; or
- undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare for the costs of health services in Australia; or
- providing financial services to assist people insured under complying health insurance products to meet costs associated with health services; or
- any other business specified in the Private Health Insurance (Health Benefits Fund Policy) Rules

but excludes business that is health insurance business or business specified in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Division 134 – The requirement to have health benefits funds

Clause 134-1 Private health insurers must have health benefits funds

Subclause (1) requires a private health insurer to have at least one health benefits fund at all times, and **subclause (2)** says that an insurer must not have more than one health benefits fund in respect of a risk equalisation jurisdiction.

Subclause (3) provides an exemption from subclause (2) if each fund in a risk equalisation jurisdiction (other than a fund established through a restructure under Division 146) is a fund that existed before the Bill commenced and was conducted by a registered health benefits organization under the *National Health Act 1953*. This will allow an insurer to acquire the funds conducted by other insurers and continue to operate them as distinct bodies.

Subclause (4) provides an exemption from subclause (2) in circumstances specified in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Clause 134-5 Notifying the Council when health benefits funds are established

This clause requires a private health insurer establishing a health benefits fund to notify Council, in the approved form, of the date of the establishment of the fund and anything else specified in the Private Health Insurance (Health Benefits Fund Administration) Rules, unless the fund is established under Division 146.

Clause 134-10 Inclusion of health-related businesses in health benefits funds

Subclause (1) requires the dominant purpose of a health benefits fund conducted by a private health insurer that includes both health insurance business and health-related business to be health insurance business.

Subclause (2) empowers Council if it is satisfied that an insurer is contravening subclause (1) to direct the insurer to divest the fund of health-related business to the extent necessary to ensure compliance with subclause (1).

Division 137 – The operation of health benefits funds

Clause 137-1 Assets of health benefits funds

Subclause (1) requires a private health insurer to keep the assets of a health benefits fund distinct and separate from the assets of other health benefits funds and other assets of the insurer, and **subclause (2)** requires the insurer to maintain a separate bank account for each health benefits fund.

Subclause (3) defines the assets of a health benefits fund as:

- the balance of money credited to the fund under clause 137-5;
- assets of the insurer obtained as a result of the expenditure or application of money credited to the fund;
- investments held by the insurer as a result of the expenditure or application of money credited to the fund;
- other money, assets or investments of the insurer transferred to the fund.

Subclause (4) provides that assets or investments obtained by the application of assets of a fund are themselves assets of the fund.

Subclause (5) provides that assets or investments obtained by the expenditure or application of assets of the fund are not assets of the fund if the insurer conducting the fund is registered as a for profit insurer and the expenditure or application was not done for the purposes of the fund. This allows for profit insurers to draw money from the fund for other purposes, such as investment elsewhere or return to shareholders.

Subclause (6) clarifies that nothing in the Bill is intended to make an insurer or its directors trustees of a health benefits fund of the insurer.

Clause 137-5 Payments to health benefits funds

Subclause (1) requires a private health insurer to credit to a health benefits fund particular amounts, including premiums payable for policies referable to the fund and income from investments of the assets of the fund.

Subclauses (2) and **(3)** allow a private health insurer to make a capital payment to a health benefits fund, being an amount that is not required to be paid to the fund under subclause (1). Any part of the assets of another health benefits fund cannot be credited to a fund without Council's written approval.

Clause 137-10 Expenditure and application of health benefits funds

Subclause (1) provides that a private health insurer must not apply or deal with the assets of a health benefits fund except in accordance with this Division, and **subclause (2)** limits the application of the assets of a fund to:

- meeting liabilities or expenses incurred for the purpose of the business of the fund; or
- making investments under clause 137-20; or
- a distribution when a fund is terminated under Division 149.

Subclause (2) also provides that a fund must not deal with its assets for purposes specified in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Subclause (3) prohibits an insurer from mortgaging or charging the assets of a fund except to secure a bank overdraft or for purposes specified in the Private Health Insurance (Health Benefits Fund Administration) Rules, and **subclause (4)** prohibits an insurer borrowing money for the business of a fund except in accordance with the Private Health Insurance (Health Benefits Fund Administration) Rules.

Subclause (5) provides that subclause (2) does not apply to an insurer registered as a for profit insurer, which may apply the assets of a fund for any purpose not inconsistent with the solvency standard, the capital adequacy standard or a solvency or capital adequacy direction given to the insurer.

Subclause (6) provides that the clause does not apply to the transfer of assets from one health benefits fund to another under Division 146 or a divestiture of assets directed by the Council under subclause 134-10(2).

Clause 137-15 Effect of non-compliance with section 137-10

Subclause (1) sets out the general principle that a transaction entered into in contravention of clause 137-10 is of no effect unless either:

- the Federal Court has made an order under subclause (2); or
- it is part of a class of transactions specified in the Private Health Insurance (Health Benefits Fund Administration) Rules.

Subclauses (2) and **(3)** empower the Federal Court, on application by a party to the transaction, to declare it to be effective as long as the Court is satisfied that the applicant entered into the transaction in good faith and without knowledge of the contravention.

Subclauses (4) and **(5)** provide that the Court in deciding on an application under subclause (2) may have regard to any hardship that would be caused to the applicant if the order was not made, and may have regard to other matters.

Subclause (6) empowers the Federal Court, on application by the Council, to declare that a transaction that contravened clause 137-10 but was included in Rules made under subclause (1) is of no effect. **Subclause (7)** provides that the Court may not make an order under subclause (6) if it is satisfied that the effect of the order would be to cause hardship to a person who entered into the transaction in good faith and without knowledge of the contravention.

Clause 137-20 Investment of health benefits funds

Subclause (1) allows a private health insurer to invest assets of a health benefits fund in any way likely to further the business of the fund. However, **subclause (2)** provides that nothing in the Bill authorises a private health insurer from making an investment it would otherwise be prohibited from making or would not have the power to make, and paragraph (2)(c) provides than an insurer must not make or retain an investment prohibited by the Private Health Insurance (Health Benefits Fund Administration) Rules.

Subclause (3) provides that a transaction is not ineffective because it contravenes paragraph (2)(c).

Clause 137-25 Restriction on restructure, merger, acquisition or termination of health benefits funds

Subclause (1) provides that a private health insurer must not change the health benefits fund to which a policy is referable except under Division 146, and **subclause (2)** provides that an insurer must not terminate a fund except in accordance with Division 149.

Subclause (3) provides that this clause does not prevent a liquidator from doing anything authorised or required by law.

Clause 137-30 Operation of health-related businesses through health benefits funds

This clause requires a private health insurer conducting health-related business through a health benefits fund to comply with any requirements relating to the conduct of that business set out in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Division 140 – The solvency standard for health benefits funds

Clause 140-1 Purpose of Division

This clause explains that the purpose of the Division is to establish and require private health insurers to comply with solvency standards for health benefits funds.

Clause 140-5 Council to establish solvency standard

This clause provides that the Private Health Insurance (Health Benefits Fund Administration) Rules may establish a solvency standard, which may set different standards for health benefits funds conducted by different private health insurers or in different classes, or may apply to a health benefits fund only as specified in the standard.

Clause 140-10 Purpose of solvency standard

This clause explains that the purpose of the solvency standard is to ensure as far as practicable that a private health insurer will be able to meet out of a health benefits fund's assets all liabilities referable to the fund as they become due.

Clause 140-15 Compliance with solvency standard

Subclause (1) requires every private health insurer to comply with the solvency standard as it applies to the insurer.

Subclause (2) allows Council to declare in writing that the solvency standard does not apply to a particular insurer in particular circumstances or for a particular period or both, and **subclause (3)** allows Council to impose conditions to be complied with by any insurer receiving the benefit of a declaration. **Subclause (4)** provides that the declaration no longer applies to the insurer if the insurer does not comply with a condition.

Subclause (5) allows Council to revoke or vary a declaration under subclause (2) or a condition under subclause (3) if satisfied that it is no longer required, and **subclause (6)** allows an insurer to request Council to make a revocation or variation. Council must decide on a request within 28 days of receiving it, and under **subclause (7)** is taken to have refused the request if it does not make a decision within that time. **Subclause (8)** requires Council to give an applicant written notice of a decision on a request, including the reasons for refusing a request.

Decisions or refusals under subclauses (2), (3), (5) or (8) are reviewable under Part 6-9.

Subclause (9) explains, for the benefit of the legislation-reading public, that notices under subclauses (2), (3), (5) or (8) are not legislative instruments. This is because they apply only to the particular circumstances of a particular insurer. **Subclause (10)** provides that a reference to a declaration or condition includes a reference to a varied declaration or condition.

Clause 140-20 Solvency directions

Subclause (1) empowers Council to give solvency directions to a private health insurer if it is satisfied that there are reasonable grounds for believing that the insurer might not be able to meet the liabilities of a health benefits fund out of the assets of the fund as they fall due.

Subclause (2) defines solvency directions as directions that Council opines are reasonably necessary to ensure as far as practicable that a private health insurer will be able to meet out the liabilities of a health benefits fund out of the assets of the fund as they fall due.

Subclause (3) allows Council to give a solvency direction to a private health insurer even if the insurer is meeting the solvency standard when the direction is given, and there are reasonable grounds to believe that the insurer will continue to meet the standard while the direction is in force.

Subclause (4) requires a private health insurer to comply with a solvency direction.

Subclauses (5) and **(6)** provide that a solvency direction continues in force for the period specified in the direction, but not exceeding three years, and allow Council to issue a further direction in the same terms to take effect immediately a direction expires.

Subclause (7) allows Council to revoke or vary a direction under subclause (1) if satisfied that it is no longer required, and **subclause (8)** allows an insurer to request Council to revoke or vary a direction. Council must decide on a request within 28 days of receiving it, and under **subclause (9)** is taken to have refused the request if it does not make a decision within that time. **Subclause (10)** requires Council to give an applicant written notice of a decision on a request, including the reasons for refusing a request.

Refusals under subclauses (8) and (9) are reviewable under Part 6-9.

Division 143 – The capital adequacy standard for health benefits funds

Clause 143-1 Purpose of Division

This clause explains that the purpose of the Division is to establish and require private health insurers to comply with a standard to maintain the capital adequacy of the health benefits funds they conduct.

Clause 143-5 Council to establish capital adequacy standard

This clause provides that the Private Health Insurance (Health Benefits Fund Administration) Rules may establish a capital adequacy standard, which may set different standards for health benefits funds conducted by different private health insurers or in different classes, or may apply to a health benefits fund only as specified in the standard.

Clause 143-10 Purpose of capital adequacy standard

This clause explains that the purpose of the capital adequacy standard is to ensure as far as practicable that there are sufficient assets in a health benefits fund conducted by a private health insurer to provide adequate capital for the conduct of the fund in accordance with the Act.

Clause 143-15 Compliance with capital adequacy standards

Subclause (1) requires every private health insurer to comply with the capital adequacy standard as it applies to the insurer.

Subclause (2) allows Council to declare in writing that the capital adequacy standard does not apply to a particular insurer in particular circumstances or for a particular period or both,

and **subclause (3)** allows Council to impose conditions to be complied with by any insurer receiving the benefit of a declaration. **Subclause (4)** provides that the declaration no longer applies to the insurer if the insurer does not comply with a condition.

Subclause (5) allows Council to revoke or vary a declaration under subclause (2) or a condition under subclause (3) if satisfied that it is no longer required, and **subclause (6)** allows an insurer to request Council to make a revocation or variation. Council must decide on a request within 28 days of receiving it, and under **subclause (7)** is taken to have refused the request if it does not make a decision within that time. **Subclause (8)** requires Council to give an applicant written notice of a decision on a request, including the reasons for refusing a request.

Decisions or refusals under subclauses (2), (3), (6) or (7) are reviewable under Part 6-9.

Subclause (9) explains that notices under subclauses (2), (3), (5) or (8) are not legislative instruments. This is because they apply only to the particular circumstances of a particular insurer. **Subclause (10)** provides that a reference to a declaration or condition includes a reference to a varied declaration or condition.

Clause 143-20 Capital adequacy directions

Subclause (1) empowers Council to give capital adequacy directions to a private health insurer if it is satisfied that there are reasonable grounds for believing that the assets of a health benefits fund conducted by a private health insurer will not provide adequate capital for the conduct of the fund in accordance with the Act.

Subclause (2) defines capital adequacy directions as directions that Council opines are reasonably necessary to ensure as far as practicable that the assets of a fund conducted by a private health insurer will provide adequate capital for the conduct of the fund in accordance with the Act.

Subclause (3) allows Council to give a capital adequacy direction to a private health insurer even if the insurer is meeting the capital adequacy standard when the direction is given, and there re reasonable grounds to believe that the insurer will continue to meet the standard while the direction is in force.

Subclause (4) requires a private health insurer to comply with a capital adequacy direction.

Subclauses (5) and **(6)** provide that a capital adequacy direction continues in force for the period specified in the direction, but not exceeding three years, and allow Council to issue a further direction in the same terms to take effect immediately a direction expires.

Subclause (7) allows Council to revoke or vary a direction under subclause (1) if satisfied that it is no longer required, and **subclause (8)** allows an insurer to request Council to revoke or vary a direction. Council must decide on a request within 28 days of receiving it, and under **subclause (9)** is taken to have refused the request if it does not make a decision within that time. **Subclause (10)** requires Council to give an applicant written notice of a decision on a request, including the reasons for refusing a request.

Refusals under subclauses (8) and (9) are reviewable under Part 6-9.

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

Clause 146-1 Restructure of health benefits funds

Subclause (1) allows a private health insurer to restructure its health benefits funds by making all of the insurance policies that are referable to a fund and belong to a policy group referable to another fund (whether existing or proposed) as long as:

- the insurer applies in writing in the approved form to the Council for approval; and
- the Council approves the restructure in writing; and
- the insurer complies with any requirements imposed in the Private Health Insurance (Health Benefits Fund Administration) Rules in relation to the restructure.

Subclauses (2) and **(3)** require Council to approve the restructure if satisfied that the proposed division of assets and liabilities between the funds is reasonable and the restructure will not result in a breach of the solvency or capital adequacy standard. However, Council cannot approve the restructure if it considers that it would result in unfairness to either the policy holders of a fund existing before the restructure or a fund as it would exist after the restructure, or if the insurer is being wound up when the application is made. A refusal to approve a restructure is reviewable under Part 6-9.

Subclause (4) provides that the Private Health Insurance (Health Benefits Fund Administration) Rules may provide for criteria for approving or refusing to approve applications under subclause (1), requirements to notify people of the outcomes of applications, a number of administrative matters, and requirements for insurers to provide information to Council following restructures.

Subclause (5) defines a policy group as all the insurance policies that are referable to the fund and whose policy holders have addresses located in the same risk equalisation jurisdiction, and **subclause (6)** defines a risk equalisation jurisdiction as an area provided for in the Private Health Insurance (Health Benefits Fund Administration) Rules.

Clause 146-5 Merger and acquisition of health benefits funds

Subclause (1) provides that two or more private health insurers may transfer a health benefits fund or funds from one insurer to another by making the policies referable to the transferring insurer referable to the health benefit fund or funds of the transferee insurer.

Subclause (2) provides that a transfer under subclause (1) cannot take place without the Council's written approval if it involves the establishment of a new health benefits fund or funds, or a solvency or capital adequacy direction is in force in relation to a transferring insurer.

Subclause (3) provides that Council can only approve the transfer if the insurers apply to the Council, in the approved form, for approval and if:

- the allocation of assets and liabilities to any new health benefits fund is reasonable; and
- if a solvency or capital adequacy direction is in force, the transferee insurer will be able to take action to allow the direction to be revoked.

A refusal to approve a transfer is reviewable under Part 6-9.

Subclause (4) provides that the Private Health Insurance (Health Benefits Fund Administration) Rules may provide for criteria for approving or refusing to approve applications under subclause (3), requirements to notify people of the outcomes of

applications, a number of administrative matters, and requirements for insurers to provide information to Council following transfers.

Subclause (5) requires the transferee insurer to notify Council within 28 days after the transfer takes place, in a notice complying with any requirements in the Private Health Insurance (Health Benefits Fund Administration) Rules.

Division 149 – Termination of health benefits funds

Subdivision 149-A Approving the termination of health benefits funds

Clause 149-1 Applying for termination

This clause allows a private health insurer to apply to the Council in the approved form for approval of the termination of each of its health benefits funds.

Clause 149-5 Requesting further information

This clause allows the Council to seek further information from the applicant within 28 days of receiving the application under clause 149-1.

Clause 149-10 Deciding the application

Subclause (1) provides that the Council must approve the termination is it is satisfied that the insurer is not being wound up, each of its health benefits funds meets the solvency standards, the termination will not result in unfairness to the policy holders of the fund or funds, and it is satisfied as to any matters specified in the Private Health Insurance (Health Benefits Fund Policy) Rules.

Subclause (2) provides that if Council approves the application it must notify the insurer in writing. It may also appoint a person other than the insurer as the terminating manager of the funds, and if it does must also notify the insurer of the person appointed. **Subclause (3)** requires the Council to notify the applicant if it refuses the application. A refusal to approve a termination is reviewable under Part 6-9.

Clause 149-15 Council can be taken to refuse application

This clause provides that the Council is taken to have refused the application for the purposes of Part 6-9 if it does not notify the applicant of its decision within 90 days of the application, or within 90 days after receiving additional information sought under clause 149-5.

Subdivision 149-B Conducting the termination of health benefits funds

Clause 149-20 Conduct of funds during termination process

Subclause (1) prevents an insurer after being notified that termination has been approved from:

- entering into an insurance policy with a person who it is not already insuring; or
- in the case of a for profit insurer, applying assets of the fund other than under subclause 137-10(2) unless clause 149-45 applies; or
- changing its registration status from not for profit to for profit.

This prevents insurers from accepting new business or drawing money from the fund other than for meeting liabilities or expenses incurred for the purpose of the business of the fund or making investments under clause 137-20.

Subclause (2) requires an insurer (within 60 days of being notified that termination has been approved) to provide written notice of the termination day (after which it will not renew policies) to each policy holder of its funds and to the Council and notify the termination day in a national newspaper or newspaper circulating where the insurer carries on business. The termination day must be at least 90 days after any notice required in this subclause.

Subclause (3) prevents the insurer from renewing any insurance policies after the termination day.

Subclause (4) requires the insurer to accept any valid claim for benefits made up to 12 months after the expiry of the last policy referable to any of the funds being terminated.

Clause 149-25 Insurers etc. to give reports to Council

This clause requires an insurer (or a terminating manager if one has been appointed) to report to Council within 28 days after the termination day setting out details of the assets and liabilities of the funds on that day.

Clause 149-30 Terminating managers displace management of funds

This clause provides that if a terminating manager has been appointed to a fund, management of the fund vests in the terminating manager for so long as the appointment is in force or until the termination is completed, and any officer of the insurer responsible for the management of the fund before the terminating manager was appointed is divested of that management.

Subdivision 149-C Ending the termination of health benefits funds

Clause 149-35 Power to end termination

Subclauses (1) and **(2)** provide that during the termination of the health benefits funds of a private health insurer the Council or the terminating manager may apply to the Federal Court for an order ending the termination.

Subclause (3) allows the Court before making an order to direct the terminating manager to provide a report on a relevant fact or matter.

Subclause (4) allows the Court in making an order ending the termination to give directions for the resumption of the management and control of the health benefits funds by the insurer.

Subdivision 149-D Completing the termination of health benefits funds

Clause 149-40 Completion of the termination process

This clause provides that the termination of the health benefits funds of a private health insurer is complete if 12 months have passed since the expiry of the last policy referable to any of the funds being terminated and to the extent possible having regard to the assets of the funds:

- liabilities to policy holders have been discharged; and
- any amounts of collapsed insurer levy that the Council has paid to the insurer or the terminating manager have been repaid; and
- any other liabilities of the funds have been discharged.

Clause 149-45 Distribution of remaining assets after completion of the termination process

This clause provides that if there are any residual assets of the funds after the termination process is completed, then:

- a for profit insurer may apply the assets other than for the purposes of the fund; and
- a not for profit insurer is liable to pay the Council an amount equal to the assets.

Clause 308-5 requires that amount to be credited to the Risk Equalisation Trust Fund.

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

Subclause (1) provides that if an insurer contravenes the Bill in relation to a health benefits fund that it conducts in a way that results in a loss to the fund and the termination of the fund is completed, then the persons who were officers of the insurer when the contravention occurred are jointly and severally liable to pay to the Council (for payment to the Risk Equalisation Trust Fund) an amount equal to the loss. **Subclause (2)** provides that a person is not liable under subclause (1) if he or she can prove that he or she exercised due diligence to prevent the contravention.

Subclause (3) empowers the Federal Court, on application by the Council, to order any person liable under subclause (1) to pay to the Council (for payment to the Risk Equalisation Trust Fund) the whole or any part of the loss.

Clause 149-55 Report of terminating manager

This clause requires the terminating manager to report to Council on the termination of the funds as soon as practicable after the termination is completed. If the manager opines that the insurer is no longer carrying on any business the manager may recommend that an application be made under clause 149-60 for the winding up of the insurer.

Clause 149-60 Applying for winding up

This clause allows the Council, or the terminating manager if directed by the Council, to apply to the Federal Court for an order that a private health insurer be wound up under the *Corporations Act 2001* if:

- the termination of the health benefits funds of the insurer has been completed;
- the manager's report under clause 149-55 recommends that an application for winding up be made;
- the insurer is not carrying on any business after the termination of the funds.

Division 152 – Duties and liabilities of directors etc.

Clause 152-1 Duties and liability of directors in relation to health benefits funds

Subclauses (1) and **(2)** provide that a director of a private health insurer has a duty to the policy holders of a health benefits fund conducted by the insurer to take reasonable care and use due diligence to see that the insurer complies with this Part in the investment, administration and management of the assets of the fund.

Subclause (3) provides that a director is not guilty of a breach of the duty if the director has taken reasonable steps to make sure the insurer has systems in place to ensure compliance with this Part.

Subclause (4) provides that if a director is guilty of a breach of the duty imposed by subclause (1) in relation to an act or omission of an insurer that results in a loss to a health benefits fund conducted by the insurer the director is liable to pay the insurer an amount equal to the loss. **Subclause (5)** provides for joint and several liability if two or more persons are liable under subsection (4) in relation to the same act or omission.

Subclause (6) provides than an action to recover an amount under subclause (4) may be brought by the insurer or, with the approval of Council, a policy holder of the health benefits fund involved. Under **subclause (7)** Council's approval may be conditional on the persons or number of persons who may join the action as plaintiffs.

Subclause (8) explains that this section does not affect the duties of directors under the *Corporations Act 2001*.

Clause 152-5 Notices to remedy contraventions

Under **subclauses (1)** and **(2)** the Council may given a private health insurer which has contravened this Part a written notice requiring the insurer to take specified action to remedy the contravention within a specified period, which must be at least one month after the giving of the notice but may be extended under **subclause (4)**.

Subclause (3) states that the action specified in the notice must be such action as Council thinks appropriate and reasonable to overcome the effects of the contravention.

Subclause (5) requires an insurer to comply with the notice.

Clause 152-10 Liability of directors in relation to non-compliance with notices

Subclause (1) provides that if a private health insurer has been notified by the Council under clause 152-5 in respect of a contravention that has resulted in a loss to a health benefits fund and has not complied with the notice, the persons who are directors of the insurer when the contravention occurred are jointly and severally liable to pay to the insurer an amount equal to the loss.

Subclause (2) provides that a person is not liable under subclause (1) if he or she can prove that he or she exercised due diligence to ensure that the insurer complied with the notice.

Subclause (3) provides than an action to recover an amount under subclause (1) may be brought by the insurer or, with the approval of Council, a policy holder of the health benefits fund involved. Under **subclause (4)** Council's approval may be conditional on the persons or number of persons who may join the action as plaintiffs.

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

This clause provides that the Council may bring an action in the name of a private health insurer to recover an amount the insurer is entitled to recover under this Division.

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

This clause provides that a person cannot be liable under both clause 152-1 and clause 152-10 for the same act or omission of a private health insurer.

PART 4-5 OTHER OBLIGATIONS OF PRIVATE HEALTH INSURERS

Division 157 – Introduction

Clause 157-1 What this Part is about

This clause explains that private health insurers have several obligations other than the health benefits funds obligations relating to the conduct of their business.

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

This clause provides that matters relating to obligations of private health insurers may also be dealt with in the Private Health Insurance (Insurer Obligations) Rules or the Private Health Insurance (Data Provision) Rules if the provisions in the Part indicate this.

Division 160 – Appointed actuaries

Clause 160-1 Appointment

Subclauses (1) and **(2)** require a private health insurer to have an appointed actuary, and replace the appointed actuary within six weeks if a person ceases to be the appointed actuary.

Subclause (3) provides that a person may only be appointed if he or she is eligible for appointment (under clause 160-5).

Subclauses (4) and **(5)** provide that an insurer may ask the Council to approve the appointment of a particular person, and that the Council may approve the appointment if the Council is satisfied that the person has fitting qualifications and experience. Refusal to approve a person is reviewable under Part 6-9.

Subclause (6) provides that the appointment of a person as the insurer's actuary cannot take effect if somebody else is still appointed.

Clause 160-5 Eligibility for appointment

Subclause (1) provides that a person is eligible for appointment as a private health insurer's actuary if the person meets the requirements specified in the Private Health Insurance (Insurer Obligations) Rules.

Subclauses (2) provides that a person is not eligible if Council has made a declaration to that effect in accordance with the Rules.

A declaration is reviewable under Part 6-9.

Clause 160-10 Notification of appointment etc.

This clause requires a private health insurer to notify the Council in accordance with the Private Health Insurance (Insurer Obligations) Rules if a person is appointed under clause 160-1 or ceases to be the appointed actuary of the insurer.

Clause 160-15 Cessation of appointment

This clause provides that a person ceases to be the appointed actuary of a private health insurer in the circumstances set out in the Private Health Insurance (Insurer Obligations) Rules.

Clause 160-20 Compliance with the Private Health Insurance (Insurer Obligations) Rules

This clause requires the appointed actuary of a private health insurer to comply with the Private Health Insurance (Insurer Obligations) Rules in the performance of duties or the exercise of powers.

Clause 160-25 Powers of appointed actuary

Subclause (1) empowers the appointed actuary of a private health insurer to have access to any information or document of the insurer that is reasonably necessary for the proper performance of the actuary's functions and duties, and **subclause (2)** requires an officer or employee of the insurer to answer questions or produce documents necessary to enable access to any information or document under subclause (1).

Subclauses (3) and **(4)** provide that an insurer and an officer or employee commit an offence with a penalty of 30 penalty units if they fail to comply with a requirement under subclauses (1) and (2) respectively.

Subclause (5) provides that an appointed actuary of a private health insurer is entitled to attend any meeting of the directors of the insurer and speak on any matter under consideration at the meeting that relates to the solvency or capital adequacy of a health benefits fund conducted by the insurer, or any advice provided by the actuary or any matter on which he or she will be required to provide advice.

Subclause (6) provides that an appointed actuary of a private health insurer is entitled to attend any annual general meeting of members of the insurer or any other meeting of members at which annual accounts or financial statements or any other matter relevant to the actuary's duties under the Bill will be considered.

Clause 160-30 Actuary's obligations to report

Subclause (1) requires the appointed actuary of a private health insurer to draw to the attention of the insurer (or its directors or an officer) any matter where the actuary thinks action is required to avoid a contravention of the Act.

Subclause (2) requires the appointed actuary to inform the Council in writing if he or she thinks there are reasonable grounds for believing that the insurer or a director of the insurer may have contravened this Bill or any other law and that the contravention may significantly affect the interests of policy holders of the insurer.

Subclause (3) provides that if the appointed actuary of a private health insurer has drawn to the attention of the insurer (or its directors or an officer) a matter under subclause (1) and a reasonable time has passed but no action has been taken, the actuary must inform the Council in writing.

Subclause (4) provides that if the appointed actuary of a private health insurer thinks that

- the directors of the insurer have failed to take action to enable the actuary to speak at or attend meetings under subclauses 160-25(5) or (6); or

- an officer or employee of the insurer has engaged in conduct to prevent the actuary from speaking at or attending meetings under subclauses 160-25(5) or (6)

the appointed actuary may inform the Council.

Subclause (5) provides that the obligation to inform the Council in writing under subclauses (2) and (3) continues even if a person ceases to be the appointed actuary before he or she has informed the Council.

Clause 160-35 Qualified privilege of appointed actuary

This clause confers qualified privilege on a person who is or has been the appointed actuary of a private health insurer in respect of any statement made by him or her for the performance of functions as an appointed actuary. This privilege is additional to any other privilege conferred on the person under any other law.

Division 163 – Prudential standards

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

Subclause (1) provides that the Private Health Insurance (Insurer Obligations) Rules may establish prudential standards with which private health insurers must comply. **Subclause (2)** defines prudential matters as matters relating to the conduct by private health insurers of their affairs so as to keep themselves in a sound financial position and not lead to instability in the private health insurance system, or carry out their affairs with integrity, prudence and professional skill, but does not include matters relating to the solvency or capital adequacy of health benefits funds.

Subclause (3) provides that a prudential standard may impose different requirements for different classes of private health insurers, in different situations or in respect of different activities, and **subclause (5)** provides that the standard takes effect on the day it is established in the Private Health Insurance (Insurer Obligation) Rules or such later day as set out in the Rules.

Subclause (4) provides that a prudential standard may provide for the Council to exercise discretion under the standard, including in varying the standard in its application to a particular private health insurer or class of private health insurers.

Clause 163-5 Compliance with prudential standards

This clause requires private health insurers to comply with the prudential standards.

Clause 163-10 Notice of breaches of prudential standards etc.

Subclause (1) provides that a private health insurer commits an offence with a penalty of 200 penalty units if it becomes aware of a breach by it of a prudential standard or any other matter that materially affects its financial position and fails to notify the Council in writing as soon as practicable.

Subclause (2) provides that if an individual commits an offence against subclause (1) because of Part 2.4 of the *Criminal Code* or an offence against Part 2.4 of the Code in relation to an offence under subclause (1), he or she is punishable on conviction by a fine of up to 40 penalty units.

Subclause (3) provides that a notification to the Council under subclause (1) of a breach of a prudential standard must not include personal information about a policy holder.

Clause 163-15 Directions to comply with standards

Subclause (1) provides that the Council may direct a private health insurer in writing to comply with all or part of a standard or take specified action within a specified time if the Council is satisfied that the insurer has breached a prudential standard or is likely to breach a standard in a way that is likely to give rise to a prudential risk.

Subclause (2) requires an insurer to comply with a direction under subclause (1) despite anything in its constitution or any contract or arrangement to which it is a party.

Subclause (3) allows the Council to revoke a direction by written notice to the insurer if it considers the direction is no longer necessary.

Decisions to give directions and refusals to revoke them are reviewable under Part 6-9.

Clause 163-20 Failure to comply with directions

Subclause (1) provides that a private health insurer commits an offence with a penalty of 300 penalty units if it contravenes a direction under clause 163-15.

Subclause (2) provides that if an individual commits an offence against subclause (1) because of Part 2.4 of the *Criminal Code* or an offence against Part 2.4 of the Code in relation to an offence under subclause (1), he or she is punishable on conviction by a fine of up to 40 penalty units.

Division 166 – Disqualified persons

Clause 166-1 Private health insurers not to allow disqualified persons to act as directors

Subclause (1) provides that a private health insurer commits an offence with a penalty of 250 penalty units if it allows a disqualified person to be or act as a director or senior manager.

Subclause (2) provides that an offence is not committed under subclause (1) if the insurer contacted the Council a reasonable period before allowing the person to act as a director or senior manager and was advised that the person was not disqualified.

Clause 166-5 Disqualified persons must not act for private health insurers

This clause provides that a disqualified person commits an offence, with a penalty of 120 penalty units or imprisonment for two years or both, if he or she is or acts as director or senior manager of a private health insurer.

Clause 166-10 Effect of non-compliance

This clause provides that a failure to comply with clauses 166-1 or 166-10 does not affect the validity of an appointment or transaction.

Clause 166-15 Who is a *disqualified person*?

Subclause (1) provides that a person is a *disqualified person* if:

- the person has been convicted of an offence against or arising out of this Act, the current or former Corporations Law, or any corresponding law of a foreign country; or
- the person has been convicted of an offence against or arising out of a law in force in Australia, or any corresponding law of a foreign country, if the offence involves dishonest conduct relating to a financial sector company; or
- the person has been or becomes bankrupt, applies for relief under a bankruptcy law or compounds with his or her creditor; or
- is disqualified by the Council.

Subclause (2) states that a reference in subclause (1) to a person who has been convicted includes a reference to a person who has had an order made against them under section 19B of the *Crimes Act 1914* or any corresponding law of a foreign country. This section allows a court to find an offence proven but not proceed to enter a conviction as long as the person agrees to certain conditions.

Subclause (3) provides that nothing in this clause affects the operation of Part VIIC of the *Crimes Act 1914* relating to spent convictions.

Clause 166-20 Council may disqualify persons

Subclauses (1) and **(2)** empower the Council to disqualify persons (with effect from the day the disqualification is made) if it is satisfied that a person is not a fit and proper person to be or act as a director or senior manager of a private health insurer.

Subclause (3) allows the Council to revoke a disqualification on application or on its own initiative.

Disqualifications and refusals to revoke disqualifications are reviewable under Part 6-9.

Subclauses (4) and **(5)** require the Council to give a person written notice of a disqualification, revocation or refusal to make a revocation and must also notify the insurer (if the person involved is or is acting as director or senior manager of a private health insurer) and publish particulars in the *Gazette*.

Clause 166-25 Council may determine that persons are not disqualified

Subclause (1) empowers the Council (on application or on its own initiative) to determine that a person covered by clause 166-15 is not a disqualified person.

Subclause (2) requires that the Council must not make a determination under subclause (1) unless it is satisfied that the person is highly unlikely to be a prudential risk to any private health insurer.

Subclause (3) requires the Council to either make or refuse to make a determination on application, and give the applicant notice of a refusal. **Subclause (4)** allows the Council to make determinations conditional, and **subclause (5)** states that a determination takes effect from the date it is made.

Subclause (6) requires the Council after making a determination to notify the person concerned and any affected private health insurer.

Subclause (7) requires Council's notifications of refusals or conditional determinations to state the reasons for the refusal or conditions.

Subclause (8) allows Council to revoke a determination by notifying the person concerned and any affected private health insurer.

Refusals to make determinations, decisions to impose conditions on determinations, and revocations are reviewable under Part 6-9.

Division 169 – Reporting and notification requirements

Clause 169-1 Copies of reports to policy holders

This clause requires a private health insurer to that makes a report to its policy holders to provide a copy to the Council (if required to do so by the Private Health Insurance (Insurer Obligation) Rules) within a month (or longer if allowed by the Council).

Clause 169-5 Information to be given the Council annually

Subclauses (1) and **(2)** require a private health insurer to provide to the Council within three months of the end of each financial year (or longer if allowed by the Council) financial and other information required by the Council (or set out in the Private Health Insurance (Insurer Obligation) Rules) for the purpose of compiling Council's report under clause 264-15. The information must be certified correct as required in the Rules.

Subclause (3) provides that an insurer commits an offence if the insurer does not comply with this clause. The penalty is 60 penalty units and **subclause (4)** provides that these are strict liability offences.

Clause 169-10 Private health insurers to notify any changes to rules

This clause requires a private health insurer that proposes to change its rules (other than a premium rule to which clause 66-10 applies) must notify the Secretary of the Department in the approved form before the change comes into effect. The Minister may direct the insurer not to make the change if he or she is satisfied it might or would result in a breach of the Act, and must give the Secretary and the Council a copy of a direction.

Clause 169-15 Private health insurers to notify Department and Council about current chief executive officer

Subclauses (1) and (2) require an applicant for registration as a registered private health insurer to notify the name and contact details of its chief executive officer in the approved form to the Secretary of the Department and the Private Health Insurance Administration Council, and require a private health insurer to notify any changes in the name and contact details of its chief executive officer in the approved form to the Secretary of the Department and the Council before the change takes effect.

Subclause (3) provides that a private health insurer commits an offence if the insurer does not notify changes as required under subclause (2). The penalty is 60 penalty units and **subclause (4)** provides that these are strict liability offences.

Division 172 – Miscellaneous

Clause 172-1 Private health insurers to comply with Council's requirements

This clause requires private health insurers to comply with the requirements imposed by the Council in the performance of its functions within a reasonable time.

Clause 172-5 Agreements with medical practitioners

This clause provides that any agreement between a private health insurer and a medical practitioner for the provision of services to people insured by the insurer must not limit the practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

Clause 172-10 Private health insurers to give information to Secretary

This clause requires private health insurers to provide to the Secretary of the Department in accordance with the Private Health Insurance (Data Provision) Rules information set out in the Rules relating to treatment provided to insured persons, including information of that kind received from a hospital. This clause is intended to require insurers to continue to provide the hospital casemix protocol information presently provided under section 73AB of the *National Health Act 1953*.

Clause 172-15 Restrictions on payment of pecuniary penalties etc.

This clause prevents a private health insurer from using its money for:

- payment of a pecuniary penalty imposed on a director or officer because of an offence under the Act; or
- payment of an amount that a director or officer or former director or officer is liable to pay under Division 149, 152, 203 or 293; or
- reimbursing a director or officer or former director or officer for payment of such penalties or amounts.

CHAPTER 5 – ENFORCEMENT

PART 5-1 INTRODUCTION

Division 180 – Introduction

Clause 180-1 What this Chapter is about

This clause explains that the Minister and the Council may take action under this Chapter against private health insurers who do not comply with the Act.

PART 5-2 GENERAL ENFORCEMENT METHODS

Division 185 – What this Part is about

Clause 185-1 Introduction

This clause explains that this Part gives the Minister and the Council a range of powers to find out if a private health insurer is complying with its obligations under the Act, and to encourage or compel insurers to comply.

Clause 185-5 Meaning of *enforceable obligation*

This clause provides that an *enforceable obligation* includes a provision of the Act, the Private Health Insurance Rules or the regulations, a direction given to a private health insurer under the Act, and a provision in a restricted access insurer's constitution intended to ensure compliance with subclause 126-20(6) limiting who can be insured by the insurer.

Clause 185-10 Meaning of *Council-supervised obligation*

This clause provides that a *Council-supervised obligation* includes a provision of the Act, the Private Health Insurance Rules, the regulations or a direction given to a private health insurer under the Bill to the extent to which they relate to risk equalisation, health benefits funds or prudential standards.

Division 188 – Performance indicators

Clause 188-1 Performance indicators

This clause provides that the Private Health Insurance (Complying Product) Rules may set out performance indicators to be used by the Minister in monitoring private health insurers' compliance with the community rating principle and requirements in Part 3-2.

Division 191 – Explanation of private health insurer's operations

Clause 191-1 Minister or Council may seek an explanation from a private health insurer

Subclause (1) provides that if either the Minister or the Council believe (based on available information) that a private health insurer may have contravened an enforceable obligation or a Council-supervised obligation, the Minister or the Council (the writer) may write to the insurer explaining the writer's concerns and seeking an explanation of the insurer's operation in relation to those concerns to be provided within a specified period.

Subclause (2) requires the insurer to respond within the period specified by the writer, or such longer period as the writer allows. **Subclause (3)** requires the writer, if refusing a request by an insurer for a longer period to respond, to state the reasons for refusing.

A refusal to extend a period of time under subclause (3) is reviewable under Part 6-9.

Clause 191-5 Writer must respond to insurer's explanation

This clause requires the writer (either the Minister or the Council) that has sought an explanation under clause 191-1 to respond to the insurer's explanation informing the insurer whether or not the writer is satisfied with the explanation, and if not what further steps the writer intends to take.

Division 194 – Investigation of private health insurer's operations

Clause 194-1 Minister or Council may investigate a private health insurer

This clause empowers either:

- the Minister, at any time and for any reason; or
- the Council, if it considers a private health insurer may have contravened a Council-supervised obligation or has concerns about the insurer's compliance with a Council-supervised obligation

to begin an investigation of the operations of a private health insurer by giving a notice under this Division or authorising a person under clause 194-25.

Clause 194-5 Notice to give information

Subclause (1) provides for the Minister or the Council (the notice-giver) to give a person who is or has been an officer, employee or agent of a private health insurer (or an entity that was a private health insurer in the preceding year) a notice requiring the person to provide specified information within a specified period about a specified area of the insurer's operations to the notice-giver or a person specified in the notice.

Subclauses (2) and **(3)** allow the notice-giver to require the information orally or in writing and on oath or affirmation.

Subclause (4) provides that the person required to give the information is not excused from providing it on the basis that it might tend to incriminate him or her, but also provides that the information is not admissible in evidence against the person in any proceedings other than prosecution for providing false or misleading information.

Clause 194-10 Notice to produce documents

Subclause (1) provides for the Minister or the Council to give a person who is or has been an officer, employee or agent of a private health insurer (or an entity that was a private health insurer in the preceding year) a notice requiring the person to produce at a specified time and place records, books, accounts and other documents of the insurer that are in the person's custody or control and relate to a specified area of the insurer's operations.

Subclause (2) provides that the person required to produce a document is not excused from producing it on the basis that it might tend to incriminate him or her, but also provides that the production of the document is not admissible in evidence against the person in any proceedings other than prosecution for providing false or misleading information.

Clause 194-15 Notice to give evidence

Subclause (1) provides for the Minister or the Council (the notice-giver) to give a person who is or has been an officer, employee or agent of a private health insurer (or an entity that was a private health insurer in the preceding year) a notice requiring the person to attend at a specified time and place and give evidence about a specified area of the insurer's operations to the notice-giver or a person specified in the notice.

Subclauses (2) and **(3)** allow the notice-giver to require the evidence orally or in writing and on oath or affirmation.

Subclause (4) provides that the person is not excused from answering a question on the basis that the answer might tend to incriminate him or her, but also provides that the answer is not admissible in evidence against the person in any proceedings other than prosecution for providing false or misleading information.

Clause 194-20 Offences in relation to investigation notices

Subclause (1) provides that a person commits an offence if he or she does not comply with a requirement in a notice under clauses 194-5, 194-10 or 194-15, and **subclause (2)** provides

that a person commits an offence if he or she fails to be sworn or make an affirmation when required to do so under clauses 194-5 or 194-15. The penalty for both offences is 10 penalty units, and **subclause (3)** provides that these are strict liability offences.

Clause 194-25 Authorisation to examine books and records etc.

Subclause (1) provides for the Minister or the Council to authorise a person to examine and report on the records, books, accounts and other documents of a private health insurer (or an entity that was a private health insurer in the preceding year). **Subclause (2)** requires a person authorised under subclause (1) to have full and free access to any premises on which the records, books, accounts and other documents are kept and allows the person to take extracts from or copies of the records, books, accounts and other documents.

Clause 194-30 Minister may consult Council

This clause provides that the Minister may consult the Council if issues arise concerning a Council-supervised obligation during the course of an investigation conducted by the Minister, and may request the Council to take over any part of the investigation related to those issues.

Clause 194-35 Minister or Council must notify outcome of investigation

This clause requires the Minister or the Council (the investigator) after completing an investigation to notify the private health insurer or former insurer whether or not the investigator is satisfied with the performance of the insurer, and if not what steps the investigator intends to take.

Division 197 – Enforceable undertakings

Clause 197-1 Minister or Council may accept written undertakings given by a private health insurer

Subclause (1) provides that the Minister may accept a written undertaking given by a private health insurer at the Minister's request if the Minister considers that compliance with the undertaking will improve the insurer's performance or be likely to ensure that the insurer will cease to be in contravention of an enforceable obligation.

Subclause (2) provides that the Council may accept a written undertaking given by a private health insurer at the Council's request if the Council considers that compliance with the undertaking will be likely to improve the insurer's operations in relation to its Council-supervised obligations.

Subclause (3) allows an insurer to withdraw or vary the undertaking with the consent of the Minister or the Council (the acceptor) respectively.

Clause 197-5 Enforcement of undertakings

Subclause (1) provides that if an acceptor considers a private health insurer that has given an undertaking has contravened any of its terms, the acceptor may apply to the Federal Court for an order under subclause (2).

Subclause (2) empowers the Court, if it is satisfied that the insurer has contravened a term of the undertaking, to order the insurer to comply and, if there is a contravention of an

enforceable obligation, make any other order of a kind set out in Division 203 that the Court considers appropriate.

Division 200 – Ministerial and Council directions

Clause 200-1 Minister or Council may give directions

Subclauses (1) and **(2)** provide that if at any time and for any reason:

- the Minister considers that it will assist in the prevention of improper discrimination; or
- the Minister considers that there appears to be a contravention of an enforceable obligation involving improper discrimination by a private health insurer; or
- the Council considers that it will assist in the prevention of contraventions of Council-supervised obligations; or
- the Council considers that there appears to be a contravention of a Council-supervised obligation

the Minister or the Council may give a direction to a private health insurer requiring it to modify its day-to-day operations, or its rules, or (in the case of a restricted access insurer) its constitution. A direction by the Minister or the Council is a reviewable decision under Part 6-9.

Subclause (3) provides that a direction under subclauses (2) or (3) may require reconsideration of an application or claim made to the insurer before the direction took effect, and **subclause (4)** provides that an insurer in reconsidering an application or claim under subclause (3) must deal with it as if the direction was in force at the time the application or claim was first made.

Subclause (5) requires a direction by the Minister or the Council to be published on the Department's website or the Council's website respectively within five working days of being made.

Clause 200-5 Direction requirements

This clause requires a direction to a private health insurer to be given in writing, signed by the person giving the direction and served on the insurer's chief executive officer.

Division 203 – Remedies in the Federal Court

Clause 203-1 Minister or Council may apply to the Federal Court

Subclause (1) provides that if the Minister is satisfied that a private health insurer has contravened an enforceable obligation, the Minister may apply to the Federal Court for a declaration of the contravention, and one or more of:

- an order imposing a pecuniary penalty under clause 203-10;
- a compensation order under clause 203-15;
- an adverse publicity order under clause 203-20;
- any other order that the Minister considers will redress the contravention.

Subclause (2) provides that if the Council is satisfied that a private health insurer has contravened a Council-supervised obligation, the Council may apply to the Federal Court for a declaration of the contravention, and one or both of:

- an order imposing a pecuniary penalty under clause 203-10;
- any other order that the Council considers will redress the contravention, other than a compensation order or an adverse publicity order.

Clause 203-5 Declarations of contravention

This clause provides that if the Federal Court is satisfied a private health insurer has contravened an enforceable obligation it must make a declaration of contravention specifying the enforceable obligation that was contravened, the insurer that contravened, the conduct that constituted the contravention and, if the Court is satisfied that an officer of the insurer failed to take reasonable steps to prevent the contravention, the officer.

Clause 203-10 Pecuniary penalty order

Subclause (1) provides that if the Court has made a declaration of contravention that specifies an officer, it may order the officer to pay the Commonwealth a pecuniary penalty of up to 1,000 penalty units. **Subclause (3)** provides that the penalty is a civil debt due to the Commonwealth.

Subclause (2) provides that the Court must not make an order under subclause (1) if it is satisfied that a court has ordered the officer to pay damages in the nature of punitive damages in respect of the contravention or the officer's failure.

Clause 203-15 Compensation order

Subclause (1) provides that if the Court has made a declaration of contravention on application by the Minister, the Court may order the private health insurer specified to compensate an individual for any injury or loss suffered as a result of the contravention.

Subclauses (2) and **(3)** provide that the order must specify the amount of compensation and that it may be enforced as if it were a judgment of the Court.

Clause 203-20 Adverse publicity order

This clause provides that if the Court has made a declaration of contravention on application by the Minister, the Court may order the private health insurer specified to do either or both of:

- disclose in a way to specified persons specified information to correct or counter the effect of the contravention;
- publish in a specified way an advertisement in specified terms to correct or counter the effect of the contravention .

The order may be enforced as if it were a judgement of the Court.

Clause 203-25 Other order

This clause provides that if the Court has made a declaration of contravention on application by the Minister or the Council, the Court may make any order that the applicant seeks, and it may be enforced as if it were a judgement of the Court.

Clause 203-30 Time limit for declarations and orders

This clause provides that proceedings under this Division must be started within six years of the contravention.

Clause 203-35 Civil evidence and procedure rules for declarations and orders

This clause provides that the Court must apply the rules of evidence and procedure for civil matters in proceedings under this Division.

Clause 203-40 Civil proceedings after criminal proceedings

This clause provides that the Court must not make a pecuniary penalty order against an officer under clause 203-10 if the officer has been convicted of an offence constituted by conduct substantially the same as the conduct which would have led the Court to impose a pecuniary penalty.

Clause 203-45 Criminal proceedings during civil proceedings

Subclause (1) provides that proceedings for a pecuniary penalty order against an officer under clause 203-10 are stayed if criminal proceedings are started against the officer for an offence constituted by conduct substantially the same as the conduct which would lead the Court to impose a pecuniary penalty. **Subclause (2)** provides that the proceedings are dismissed if the officer is convicted of the offence but may otherwise be resumed.

Clause 203-50 Criminal proceedings after civil proceedings

This clause provides that criminal proceedings may be started against a person for conduct substantially the same as the conduct constituting a contravention of an enforceable obligation regardless of whether a declaration of contravention has been made under clause 203-5 that specifies the person or an order has been made against the person under this Division.

Clause 203-55 Evidence given in proceedings for penalty not admissible in criminal proceedings

This clause provides that evidence of information given or documents produced by an officer of a private health insurer is nor admissible in criminal proceedings against the officer if:

- the officer previously gave the evidence or produced the documents in proceedings for a pecuniary penalty order against the officer under clause 203-10; and
- the conduct alleged to constitute the offence is substantially the same as the conduct to which the Court had regard in satisfying itself that the officer failed to take reasonable steps to prevent the insurer contravening an enforceable obligation.

This protection does not apply to criminal proceedings against the officer for providing false evidence in the proceedings for the pecuniary penalty order.

Clause 203-60 Minister or Council may require person to assist

Subclause (1) empowers the Minister in writing to require a person to give all reasonable assistance in connection with:

- an application by the Minister for a declaration of contravention under clause 203-5 in relation to a private health insurer or an officer of the insurer or an application for a pecuniary penalty order under clause 203-10; or
- criminal proceedings begun by the Minister against a private health insurer or an officer of the insurer for an offence against this Act

and provides that the person commits an offence with a penalty of 5 penalty units if they do not comply.

Subclause (2) empowers the Council in writing to require a person to give all reasonable assistance in connection with an application by the Council for a declaration of contravention under clause 203-5 in relation to a private health insurer or an officer of the insurer or an application for a pecuniary penalty order under clause 203-10, and provides that the person commits an offence with a penalty of 5 penalty units if they do not comply.

Subclause (3) provides that the Minister or Council must not require a person to assist in connection with an application for a declaration of contravention unless it appears that somebody other than the person required to assist may have contravened an enforceable obligation, and the Minister or Council believe that the person can give information relevant to the application.

Subclause (4) provides that the Minister must not require a person to assist in connection with criminal proceedings if it appears to the Minister that the person is unlikely to be a defendant in the proceedings and the person required to assist is an employee or agent (including a banker or auditor) of the insurer.

Subclause (5) provides that the Minister or Council may require a person to assist regardless of whether an application for a declaration of contravention or order has been made or criminal proceedings have begun.

Subclause (6) provides that a person who is or has been a lawyer for a person suspected of a contravention or a likely defendant in criminal proceedings cannot be required to assist.

Subclause (7) allows the Minister or the Council to apply to the Court to order the person to comply with the requirement to assist in a specific way.

Clause 203-65 Relief from liability for contravening an enforceable obligation

Subclause (1) provides that the Federal Court may relieve a person wholly or partly from liability arising out of a contravention or a failure to take reasonable steps to prevent a contravention if it appears to the Court that the person has acted honestly and ought fairly to be excused.

Subclauses (2) and **(3)** allow a person who thinks that proceedings will or may be brought against them under this Division may apply to the Court for relief, and provide that the Court may grant relief as if the proceedings had been begun,

Subclause (4) provides that a reference in subclause (1) to the Court is a reference to the judge alone for the purpose of a case tried by a judge and jury, and the relief granted includes withdrawing the case in whole or part from the jury and directing judgement to be entered for the defendant.

Clause 203-70 Powers of Federal Court

This clause provides that the powers conferred on the Court by this Bill do not affect any other power of the Court.

Division 206 – Revoking entitlement to offer rebate as a premium reduction

Clause 206-1 Revocation of status of participating insurer

This clause allows the Minister by notice given to a private health insurer to revoke the insurer's status as a participating insurer, which is able to offer premium reductions to insured people under Division 23, if the insurer:

- has repeatedly failed to comply with subclause 26-1(5) requiring it to issue receipts for payment of premiums; or
- has failed to comply with a condition of participation in the premiums reduction scheme under Division 23 set out in the Private Health Insurance (Incentives) Rules; or
- refuses or fails to comply with a direction given by the Minister under Division 200 or the principle of community rating in clause 55-5.

A revocation is a reviewable decision under Part 6-9.

PART 5-3 ENFORCEMENT OF HEALTH BENEFITS FUND REQUIREMENTS

Division 211 – Introduction

Clause 211-1 What this Part is about

This clause explains that to protect the interests of policy holders and ensure that health benefits funds are operated in accordance with Part 4-4, specific powers and processes are required additional to the general powers under Part 5-2. These are appointing inspectors to investigate the affairs of private health insurers, and external managers to manage health benefits funds. These processes may lead to the appointment of a terminating manager to a fund.

Clause 211-5 Purpose of this Part

This clause explains that the Part provides for:

- supervision of the business, affairs and property of health benefits funds to ensure that they care carried on and managed in the interests of policy holders and in accordance with Part 4-4; and
- the external management of health benefits funds in a way consistent with the interests of policy holders; and
- the orderly termination of health benefits funds in a way consistent with the interests of policy holders.

Clause 211-10 The Private Health Insurance (Health Benefits Fund Enforcement) Rules

This clause provides that enforcement of the requirements for health benefits funds is also be dealt with in the Private Health Insurance (Health Benefits Fund Enforcement) Rules if the provisions in the Part indicate this.

Clause 211-15 Limitation on external management and termination of health benefits funds

This clause provides that despite the provisions of any other law of the Commonwealth or a State or Territory a health benefits fund can only be placed under external management or dealt with as a fund under external management under Division 217, and can only be terminated in accordance with Division 149.

Division 214 – Investigations into affairs of private health insurers

Clause 214-1 Investigation of private health insurers by inspectors

Subclause (1) provides that the Council may in writing appoint an inspector to investigate the affairs of a private health insurer if the Council has reason to suspect a contravention of Part 4-4 or to suspect that the affairs of the insurer are not, or are about to be not, carried on in the interests of the policy holders of a health benefits fund of the insurer.

Subclause (2) requires the appointment to specify what the Council suspects and why, and the scope of the investigation, and **subclause (3)** provides that an inspector may be a person engaged or appointed under the *Public Service Act 1999* or an authority of the Commonwealth.

Clause 214-5 Powers of inspectors

Subclause (1) empowers an inspector to require in writing a person who the inspector believes to have some knowledge of the affairs of the private health insurer under investigation:

- to produce to the inspector any or all of the records under the person's custody or control that relate to the insurer; or
- to give the inspector all reasonable assistance in the person's power in connection with the investigation; or
- appear before the inspector for examination concerning relevant matters within the knowledge of the person

within the period specified in the notice (which must be 14 days or more).

Subclause (2) allows an inspector to take possession of records produced under subclause (1) for as long as the inspector thinks necessary, and to take copies or extracts of the records, but **subclause (3)** requires the inspector to allow a person to inspect the records if the person would have been able to inspect them if the insurer was not holding them.

Subclause (4) provides that a person who complies with a requirement of an inspector under subclause (1) does not incur any liability to any other person because of that compliance.

Clause 214-10 Person may be represented by lawyer

This clause allows a lawyer acting for a person being examined by an inspector to attend the examination and, as allowed by the inspector, address the inspector and examine the person in relation to matters on which the person has been questioned.

Clause 214-15 Compliance with requirements of inspectors

Subclause (1) provides that a person is guilty of an offence with a penalty of 30 penalty units or imprisonment for six months or both if the person refuses or fails to comply with a requirement of an inspector under clause 214-5, and **subclause (2)** provides that a person is only required to comply to the extent that he or she is capable of doing to.

Subclause (3) states a person being examined by an inspector is not excused from answering a question because the answer might tend to incriminate the person, and **subclause (4)** provides that if the person before answering the question informs the inspector that it might incriminate the person neither the question or the answer can be used in criminal proceedings (other than proceedings relating to an offence under subclause (1)).

Clause 214-20 Access to premises

Subclauses (1) and **(2)** provide that an inspector who is empowered to investigate all or part of the affairs of a private health insurer and enters premises under subclause (3) or under a warrant under subclause (5) may exercise search powers in relation to records that the inspector reasonably believes to relate to the affairs of the insurer.

Subclause (3) allows an inspector to enter any premises with the consent of the occupier to carry out the functions.

Subclause (4) allows an inspector to apply for a warrant to enter premises if the inspector believes on reasonable grounds records are held there relating to the private health insurer whose affairs the inspector is investigating.

Subclause (5) provides that a Magistrate may grant the warrant if satisfied by information on oath or affirmation that there are reasonable grounds to believe records relating to the affairs of the insurer concerned are held on the premises and the issue of a warrant is reasonably required for the purposes of the Act. A warrant may be in the form set out in the Private Health Insurance (Health Benefits Fund Enforcement) Rules.

Subclause (6) states that the warrant authorises the inspector, with any necessary assistance, or enter premises using necessary and reasonable force when the warrant specifies to exercise the functions of an inspector under this clause.

Subclauses (7) and **(8)** provide that a person commits an offence with a penalty of 30 penalty units or imprisonment for six months or both if the person without reasonable excuse obstructs or hinders an inspector exercising functions under this clause.

While the entry and search powers in this clause are exceptional powers, they are necessary to ensure compliance with the proposed Act. Inability by an inspector to gain access to all relevant documents would impede the inspector's ability to make a proper assessment of the state of the insurer under investigation. The Council in considering an inspector's report compiled on the basis of partial information could not be assured that any decision it took was in the interests of insured persons. The search and entry powers conform to the principles outlined in the report by the Senate Standing Committee for the Scrutiny of Bills entitled "Fourth Report of 2000: Entry and Search Provisions in Commonwealth Legislation".

Clause 214-25 Reports of inspectors

Subclause (1) requires an inspector to report in writing to the Council on completion of the investigation and meet any directions of the Council to provide reports, and allows him or her to report during the investigation.

Subclause (2) provides that the inspector's report on the completion of the investigation must include the inspector's recommendations as to:

- whether the private health insurer should be permitted to continue to conduct a particular health benefits fund;

- whether the insurer's affairs should be reorganised to allow it to conduct the fund better, and if so how;
- such other matters affecting the insurer or the policy holders as the inspector thinks fit.

Subclause (3) provides that if the investigation covered:
- whether the insurer is or was about to be unable to meet its liabilities in relation to the fund; or
- whether the insurer's affairs are or are about to be carried on in a way not in the interests of the policy holders

the inspector must also report his or her opinion on these matters and the facts on which that opinion is based.

Subclause (4) precludes the inspector from including in a report recommendations relating to criminal proceedings or opinions that a person has committed a criminal offence, but **subclause (5)** requires the inspector to state an opinion that criminal proceedings ought to be instituted or that a person has committed a criminal offence in writing to the Council.

Clause 214-30 Dissemination of reports

Subclauses (1) and **(2)** require the Council to give a copy of an inspector's report under clause 214-25 to the private health insurer to which it relates, unless the Council thinks that a copy should not be provided having regard to proceedings that have been or might be instituted.

Subclause (3) provides that if the Council has given a copy of the report to the insurer it may, if it thinks it in the public interest, publish the whole or part of a report.

Subclause (4) allows a court hearing proceedings against an insurer or another person in respect of matters dealt with in a report to order that a copy of the report be provided to the insurer or other person.

Clause 214-35 Liability for publishing reports etc.

Subclause (1) protects from any action or proceeding a person publishing in good faith a copy of or a fair extract from an inspector's report published under subclause 214-30(3).

Subclause (2) protects from any action or proceeding an inspector in respect of providing to Council a report under clause 214-25 or giving Council an opinion under subclause 214-25(5) as long as the inspector acted in good faith.

Subclause (3) provides that an action is taken to have been made in good faith if the person making it is nor actuated by ill will or any other improper motive.

Clause 214-40 Delegation by inspectors

Subclause (1) allows an inspector to delegate in writing any of his or her powers to a person engaged or appointed under the *Public Service Act 1999* or an authority of the Commonwealth.

Subclause (2) requires a delegate to produce the instrument of delegation (or a copy) to any person who may be affected by the exercise of the delegated powers and who asks to see the instrument.

Clause 214-45 Records not to be concealed etc.

Subclause (1) provides that a person commits an offence with a penalty of 30 penalty units or imprisonment for six months or both if the person engages in conduct that results in the concealment, destruction, mutilation or alteration of the records of a private health insurer whose affairs are being investigated.

Subclause (2) provides a defence if the person did not act with intent to defeat the purpose of the Bill or delay or obstruct the investigation.

Division 217 – External management of health benefits funds

Subdivision 217-A Preliminary

Clause 217-1 Purpose of Division

This clause explains that the purpose of the Division is to permit a health benefits fund under external management to be managed so as to maximise the chances that the policy holders of the fund continue to be covered by that fund or another fund to which the business is transferred, and if that is not possible, safeguard the financial interests of the policy holders of the fund if the fund is terminated.

Clause 217-5 The basis of the law relating to external management

Subclause (1) provides that the external management of a health benefits fund is regulated by this Division and by various provisions in the *Corporation Act 2001* applying subject to modifications set out in this Act or the Private Health Insurance (Health Benefits Fund Enforcement) Rules made under **subclause (4)**.

Subclause (2) provides that any other law of the Commonwealth or a State or Territory that would apply to the external management of a fund no longer applies.

Subclause (3) provides that any provisions of the *Corporations Act 2001* listed in subclause (1) apply to the external management of a fund as if:

- a reference to the company were a reference to the fund;
- a reference to the administrator was a reference to the external manager appointed under clause 217-10; and
- a reference to the Court were a reference to the Federal Court.

Subdivision 217-B Appointment of external managers

Clause 217-10 Council may appoint external managers

Subclause (1) empowers the Council to appoint in writing an external manager to a health benefits fund if the grounds specified in subclauses 217-15(1) and (2) are satisfied. Under **subclause (2)** the person appointed must be an official liquidator under the *Corporations Act 2001* and must not be a person related to the fund. **Subclause (3)** states that the appointment takes effect from the date specified in the appointment.

Clause 217-15 Grounds of appointment of external managers

Subclause (1) provides that the Council must not appoint an external manager to a health benefits fund unless the Council believes it is in the interests of the policy holders of the fund.

Subclause (2) further provides that the Council must not appoint an external manager to a health benefits fund unless:

- the Council is satisfied on reasonable grounds that the private health insurer has contravened the solvency standard under clause 140-15 in its conduct of the fund; or
- the Council is satisfied on reasonable grounds that the insurer has contravened a solvency direction, a capital adequacy direction or a prudential direction that the Council has given to the insurer; or
- a request for external management of the fund is made to the Council by a resolution of the directors of the insurer; or
- a ground specified in the Private Health Insurance (Health Benefits Fund Enforcement) Rules is made out.

Subclause (3) allows the Council, in making decisions under subclause (1) or a decision under the Rules under subclause (2) that require a particular state of mind, to have regard to information in its own records or any report or return made to it including an inspector's report under clause 214-25.

Clause 217-20 External managers to displace management of funds

This clause provides that if an external manager has been appointed to a fund, management of the fund vests in the external manager for so long as the appointment is in force, and any officer of the insurer responsible for the management of the fund before the external manager was appointed is divested of that management.

Subdivision 217-C Duties and powers of external managers

Clause 217-25 Duties of external managers

Subclause (1) sets out the main duties of an external manager of a health benefits fund as being:

- to examine the business, affairs and property of the fund and ascertain its assets and liabilities; and
- if the business of the fund has been mixed with other business, apportion the assets and liabilities between the fund and the other business; and
- to form an opinion as to which course of action maximises the chance that the policy holders of the fund continue to be covered by that fund or another fund to which the business is transferred; and
- make a final report to the Council recommending that course of action.

Subclause (2) requires the external manager to manage the day-to-day administration of the fund as efficiently and economically as possible.

Clause 217-30 Additional powers of external managers

Subclause (1) provides that the additional powers of an external manager under the provisions of Division 8 of Part 5.3A of Chapter 5 of the *Corporations Act 2001* (conferred under clause 217-5(1)), do not include the power to remove or appoint directors of the private health insurer and execute a document, bring or defend proceedings, or do anything else, in an insurer's name.

Subclause (2) provides that for the purpose of the protection of people dealing with an external manager under section 442F of the *Corporations Act 2001*, the assumptions

contained in sections 128 and 129 of that Act are taken to apply, subject to any modifications in the Private Health Insurance (Health Benefits Fund Enforcement) Rules.

Clause 217-35 Protection of property during external management

Subclause (1) provides that the provisions of Division 6 of Part 5.3A of Chapter 5 of the *Corporations Act 2001* (conferred under clause 217-5(1)) relating to the protection of property during external management, do not include section 440A containing rules about how a company under external management can be wound up. Such rules are not appropriate for the purposes of this Part, as the Bill already contains its own rules about how a fund under external management can be wound up.

Subclause (2) states that where an external manager or Court is considering (under section 440D of the *Corporations Act 2001*) whether or not to allow a legal proceeding to continue while the fund is under external management, the external manager or the Court must consider whether the action in question relates to the property of the fund whether such proceedings would be materially detrimental to the interests of policy holders of the fund.

Clause 217-40 Rights of chargee, owner or lessor of property of fund under external management

Subclause (1) provides that the provisions of Division 7 of Part 5.3A of Chapter 5 of the *Corporations Act 2001* (conferred under clause 217-5(1)) relating to the rights of chargees, owners or lessors of the property of a fund during external management, do not include section 441A and selected words in subsection 441D(1) are not to be included in the applied Division. Section 441A relates to situations were there is a charge over all, or substantially all, of the property of a company or there are two or more charges.

Subclause (2) states that nothing in the applied Division 7 prevents the external manager or the Court from agreeing to the enforcement of a charge if satisfied that the charge does not relate to the property of the fund and enforcement of the charge would not be materially detrimental to the interests of the policy holders of the fund.

Subdivision 217-D Procedure relating to voluntary deeds of arrangement

Clause 217-45 Matters that may be included in the Private Health Insurance (Health Benefits Fund Enforcement) Rules

Subclause (1) requires that the Private Health Insurance (Health Benefits Fund Enforcement) Rules may

- provide for the external managers of health benefits funds to convene meetings of creditors and policy holders of funds to consider the possible execution by the responsible private health insurers of voluntary deeds of arrangement; and set out
- the details of how the meetings are to be conducted; and
- the kind of recommendations that made be made to the Council; and
- the actions the Council may take in response.

Subclause (2) explains that this clause does not limit the scope of the Private Health Insurance (Health Benefits Fund Enforcement) Rules for the purposes of other provisions in this Part.

Subdivision 217-E External managers' reports to Council

Clause 217-50 External managers to give reports to Council

Subclauses (1) and **(2)** require an external manager, as soon as practicable but within three months or such longer time as the Council determines, to conclude the examination of the health benefits fund and make a final written report to the Council.

Subclause (3) requires the external manager in the report to Council to recommend a course of action that maximises the chance that the policy holders of the fund continue to be covered by that fund or another fund to which the business is transferred, and set out the reasons for that recommendation.

Subclause (4) provides that the external manager may recommend:

- subject to a Federal Court order, that the responsible insurer for the fund implement a scheme of arrangement concerning the business of the fund; or
- subject to a Federal Court order, that a terminating manager be appointed to the fund; or
- that the external management cease and the business of the fund be resumed by responsible insurer.

Subclause (5) requires that the external manager must recommend that the Council approve the execution of a voluntary deed of arrangement if the Private Health Insurance (Health Benefits Fund Enforcement) Rules so provide.

Subclause (6) provides without limitation that a scheme or arrangement ordered by the Court may provide for:

- the continuation of the business of the fund on terms set out in the scheme; or
- the transfer of the business of the fund on terms set out in the scheme to another private health insurer; or
- execution of a deed in the same form as a voluntary deed of arrangement rejected at a meeting of creditors and policy holders under clause 217-45.

Clause 217-55 Dealing with reports given to the Council

Subclause (1) requires that in deciding whether or not to approve a course of action recommended in a report under subclause 217-50(3) the Council may seek further information from the external manager and engage any person to assist it in evaluating the assessments in the report. In reaching a decision the Council must have regard to the external manager's report and any additional information provided by the external manager or by any person engaged to assist Council.

Subclause (2) provides that if the Council is satisfied that a course of action recommended by the external manager will be in the interests of the policy holders of the health benefits fund, the Council must by written notice inform the external manager and direct him or her to apply to the Federal Court if required to obtain an order to give effect to the recommendation.

Subclause (3) provides that if the Council is not satisfied that a course of action recommended by the external manager will be in the interests of the policy holders of the fund, it may take a different course of action that it is satisfied will be in the interests of the policy holders of the fund. Under **subclause (4)** these courses of action include the Council applying to the Federal Court for orders giving effect to a scheme of arrangement for the

business of the fund or appointing a terminating manager to the health benefits funds of the responsible insurer.

Clause 217-60 Court orders in respect of schemes of arrangement

Subclause (1) requires an external manager to apply to the Federal Court for an order giving effect to a scheme of arrangement recommended under subclause 217-50(4) if directed to do so by the Council.

Subclause (2) provides that on an application under subclause (1), or an application by the Council under subclause 217-55(4), for an order giving effect to a scheme of arrangement the Council and any other interested person are entitled to be heard, and the Court may make such orders as it considers will be in the interests of the policy holders of the health benefits fund concerned.

Subclause (3) provides that an order under this clause is binding on all persons and takes effect despite anything in the constitution or other rules of the responsible insurer for the fund concerned.

Subclause (4) explains that, to avoid doubt, a Court order is not required to give effect to a voluntary deed of arrangement approved by the Council or to terminate an external management.

Subdivision 217-F Miscellaneous

Clause 217-65 When an external management begins and ends

This clause provides that an external management of a health benefits fund begins when an external manager is appointed under clause 217-10 to administer the fund, and ends when either:

- the Council terminates the appointment of the external manager and does not appoint a replacement; or
- a voluntary deed of arrangement relating to the fund is executed; or
- the Council notifies the external manager that it has accepted his or her recommendation that the external management cease; or
- the Federal Court makes an order under clause 217-60 giving effect to a scheme of arrangement for the business of the fund; or
- a terminating manager of the fund is appointed.

Clause 217-70 Effect of things done during external management of health benefits funds

This clause provides that anything done in good faith by or with the consent of the external manager of a health benefits fund is valid and effectual and not liable to be set aside in a termination of a fund.

Clause 217-75 Disclaimer of onerous property

Subclause (1) provides that for the purpose of determining the power of an external manager to disclaim onerous property under the provisions of Division 7A of Part 5.6 of Chapter 5 of the *Corporations Act 2001*, those provisions apply as if the external manager were the liquidator of the company and references to the company's creditors were references to the policy holders of a health benefits fund.

Subclause (2) provides that a disclaimer by an external manager has the same effect and the external manager is under the same obligations for the purposes of this Bill as if the disclaimer had been made under Division 7A of Part 5.6 of Chapter 5 of the *Corporations Act 2001*.

Division 220 – Ordering the termination of health benefits funds

Clause 220-1 Applications by external managers to the Federal Court

Subclause (1) requires an external manager to apply to the Federal Court for an order appointing a terminating manager recommended under subclause 217-50(4) if directed to do so by the Council.

Subclause (2) provides that the Council and any other person likely to be affected by the termination are entitled to be heard on the application.

Clause 220-5 Orders made on applications for appointments of terminating managers

Subclause (1) empowers the Federal Court, on an application by the external manager under subclause 220-1(1) or the Council under subclause 217-55(4), to make an order for the appointment of a terminating manager of the health benefits funds of a private health insurer and any related orders, and **subclause (2)** requires that the Court must not make such an order unless it considers the order will be in the interests of the policy holders of the funds.

Clause 220-10 Binding nature of Court orders

This clause provides that an order under clause 220-5 is binding on all persons and takes effect despite anything in the constitution or other rules of the responsible insurer for the fund concerned.

Clause 220-15 Notice of appointments

This clause provides that if the Federal Court orders the appointment of a terminating manager of the health benefits funds of a private health insurer the Council must notify the insurer in writing of the person appointed.

CHAPTER 6 – ADMINISTRATION

PART 6-1 INTRODUCTION

Division 230 – Introduction

Clause 230-1 What this Chapter is about

This clause lists the subjects covered by the Chapter.

PART 6-2 PRIVATE HEALTH INSURANCE OMBUDSMAN

Division 235 – Introduction

Clause 235-1 Principal object of this Part

This clause explains that the Part establishes the Office and sets out the powers and functions of the Private Health Insurance Ombudsman to protect the interests of people covered by private health insurance by assisting people to resolve complaints, investigating the practices of private health insurers and brokers and health care providers, mediating between insurers

and providers, and disseminating information about the rights and obligations of insured people.

Clause 235-5 Private Health Insurance (Ombudsman) Rules

This clause provides that matters relevant to this Part are also dealt with in the Private Health Insurance (Ombudsman) Rules if the provisions in the Part indicate this.

Division 238 Establishment and functions

Clause 238-1 Establishment of office of Private Health Insurance Ombudsman

This clause provides that there is to be a Private Health Insurance Ombudsman for the purposes of this Act.

Clause 238-5 Functions of Private Health Insurance Ombudsman

This clause sets out the functions of the Private Health Insurance Ombudsman.

Division 241 Complaints

Subdivision 241-A Relevant complaints

Clause 241-1 Who may make a complaint

This clause provides that a complaint may be made to the Private Health Insurance Ombudsman for or on behalf of:

- a person who was insured (or seeking to be insured) at the time of the incident giving rise to the complaint; or
- a private health insurer ; or
- a health care provider; or
- a private health insurance broker.

Clause 241-5 Persons against whom complaints may be made

This clause provides that a complaint may be made to the Private Health Insurance Ombudsman against:

- a private health insurer ;
- a health care provider;
- a private health insurance broker.

Clause 241-10 Grounds for complaint

Subclause (1) provides that a complaint may be made about any matter arising out of or connected with a private health insurance arrangement or Chapter 2 of the Act.

Subclause (2) provides that a complaint against a health care provider, as well as being about a matter in subclause (1), must also be about either or both of:

- the application of a private health insurance arrangement to a service or good provided, manufactured or supplied by the provider;
- a private health insurance arrangement to which the provider is or was a party

and must also be:

- made against a private health insurer ; or
- made by a private health insurer or a person insured under a private health insurance policy; or

- if the complaint is made by another provider or a broker, a private health insurer or a person insured under a private health insurance policy must also be a complainant.

Subclause (3) provides that the Private Health Insurance (Ombudsman) Rules may specify matters about which complaints cannot be made.

Subdivision 241-B Dealing with complaints

Clause 241-15 Initial receipt of complaint

This clause allows the Private Health Insurance Ombudsman on receiving a complaint to tell the subject about the complaint and request information from the subject under Division 250.

Clause 241-20 Ways of dealing with complaints

This clause empowers the Private Health Insurance Ombudsman to deal with a complaint by:
- conducting mediation under Division 247; or
- referring the complaint to the subject of the complaint under Subdivision 241-C; or
- investigating the complaint under Subdivision 241-D

as long as the complainant agrees to the action and the matter is not excluded from the Ombudsman's scope under Rules made under subclause 241-10(3).

However, the Ombudsman must not pursue mediation or investigation if the complainant withdraws the complaint.

Clause 241-25 Referral to the Australian Competition and Consumer Commission

Subclause (1) allows the Private Health Insurance Ombudsman to refer a complaint to the Australian Competition and Consumer Commission if he or she opines it could be dealt with more effectively or conveniently by the Commission.

Subclauses (2) and **(3)** prevent the Ombudsman from referring the complaint unless the complainant agrees or if the complaint is dropped.

Subclause (4) compels the Ombudsman to notify the complainant of the matter's referral and to forward to the Australian Competition and Consumer Commission any information or documents relating to the complaint.

Subclause (5) allows the Australian Competition and Consumer Commission to investigate matters referred by the Ombudsman. If an investigation proceeds, the Australian Competition and Consumer Commission must report back to the Ombudsman within 30 days after the referral on the conduct of the investigation and any findings.

Subclause (6) compels the Australian Competition and Consumer Commission to provide the Ombudsman with a written notice within 30 days after the referral explaining any decision not to investigate a referred matter.

Clause 241-30 Referral to other bodies

Subclause (1) allows the Private Health Insurance Ombudsman to refer complaint matters to other bodies when it considers that they could deal with them more effectively or conveniently.

Subclauses (2) and **(3)** prevent the Ombudsman from referring the complaint unless the complainant agrees or if the complaint is dropped.

Clause 241-35 Deciding not to deal with a complaint

Subclause (1) allows the Private Health Insurance Ombudsman to decide not to deal, or not to continue to deal, with a complaint. If the Ombudsman makes such a decision, he or she must inform the complainant of the decision and the reasons for it, and, if requested by the complainant, provide this information in writing.

Subclause (2) allows the Ombudsman to decide not to take any action in relation to a complaint if the related incident occurred more than 12 months before the complaint was made.

Subclause (3) allows the Ombudsman to decide not to deal with a complaint if he or she is satisfied that the complainant has not taken reasonable steps to negotiate a settlement.

Subclause (4) allows the Ombudsman to decide not to deal, or not to continue to deal, with a complaint if the complainant does not agree to a related matter being referred to another body under clause 241-30.

Subclause (5) sets out the reasons why the Ombudsman may decide not to deal, or not to continue to deal, with a complaint. These include complaints about commercial negotiations or clinical matters.

Subdivision 241-C Referral to subjects of complaints

Clause 241-40 Referral to the subject of the complaint

Subclause (1) allows the Private Health Insurance Ombudsman to request the subject of a complaint to investigate the matter and to report back on the result and any action to be taken as a consequence.

Subclause (2) and **(3)** allow the subject to ask the Ombudsman for an extension before the end of the period specified in the request. The Ombudsman must provide reasons if they refuse such a request.

A refusal to extend the period is a reviewable decision under Part 6-9.

Subdivision 241-D Investigation of complaints

Clause 241-45 Investigation of complaint

This clause allows the Private Health Insurance Ombudsman to investigate a complaint if it is not resolved by mediation under Division 247 or if the Ombudsman is not satisfied with the outcome of a referral under Subdivision 241-C.

Clause 241-50 Minister may direct Private Health Insurance Ombudsman to investigate, or to continue to investigate, a complaint

Subclause (1) permits a complainant to write to the Minister seeking a direction for the Private Health Insurance Ombudsman to investigate, or to continue to investigate, a complaint.

Subclause (2) compels the Ombudsman to investigate, or continue to investigate, following a direction from the Minister. The Ombudsman must also report back to the Minister on the findings of the investigation.

Subdivision 241-E Recommendations and reports

Clause 241-55 Recommendations as a result of referral or investigation

Subclause (1) permits the Private Health Insurance Ombudsman to make recommendations following the receipt of a report from the subject of a complaint or after investigating the complaint.

Subclause (2) permits the Ombudsman to recommend that a private health insurer and/or service provider and/or private health insurance broker take a specific course of action in relation to a complaint.

Subclause (3) allows the Ombudsman to request that the person to whom the recommendation was made, or an officer of that person, report within a specified period on the action proposed to be taken.

Subclause (4) provides that the person to whom the recommendation was made, or an officer of that person, commits an offence if the request under subclause (3) is not complied with. The penalty is 30 penalty units and **subclause (5)** provides that this is a strict liability offence.

Clause 241-60 Report to Minister on outcome of investigation under Subdivision 241-D

Subclauses (1) and **(2)** allow the Private Health Insurance Ombudsman to report to the Minister on the outcome of any investigation of a complaint.

Subclause (3) permits the Ombudsman to recommend general changes in regulatory practice or industry practices and/or possible means of dealing with specific problems relating to a complaint.

Subclause (4) permits the Ombudsman to make recommendations under subclause (3) concerning a health care provider or providers only to the extent to which the recommendations relate to a private health insurance arrangement or class of arrangements.

Subclause (5) provides that, before reporting to the Minister, the Ombudsman must inform the subject of the complaint of the intention to make the report and the nature of any criticism of the subject's conduct to be included in the report, and invite and include in the report the subject's comments on the criticism.

Subdivision 241-F Miscellaneous

Clause 241-65 Complainant to be kept informed

This clause requires the Private Health Insurance Ombudsman to keep the complainant informed about the handling of the complaint. The Ombudsman must provide written notice to the complainant of any action taken by a private health insurer, health care provider or health insurance broker as a consequence of the complaint, and any recommendations under clause 241-55.

Division 244 Investigations

Subdivision 244-A Investigations

Clause 244-1 Initiating investigations

Subclause (1) empowers the Private Health Insurance Ombudsman to investigate on his or her own initiative the practices and procedures of a private health insurer or private health insurance broker.

Subclause (2) allows the Ombudsman to investigate the practices and procedures of a health care provider if the investigation is connected with a private health insurance arrangement and where the Ombudsman considers that such an investigation is necessary or appropriate to consider a matter effectively.

Clause 244-5 Investigations at Minister's request

Subclause (1) empowers the Minister to request the Private Health Insurance Ombudsman to investigate the practices and procedures of a private health insurer or private health insurance broker.

Subclause (2) permits the Minister to request the Ombudsman to investigate the practices and procedures of a health care provider if the investigation is connected with a private health insurance arrangement and where the Minister considers that such an investigation is necessary or appropriate to consider a matter effectively.

Subclause (3) provides that the Ombudsman must conduct an investigation if the Minister requests it.

Subdivision 244-B Recommendations and reports

Clause 244-10 Recommendations as a result of investigation

Subclauses (1) and **(2)** enable the Private Health Insurance Ombudsman to make recommendations after conducting an investigation under this Division. The Ombudsman may recommend that a private health insurer take a specific course of action, or make changes to its rules, or both. The Ombudsman may also recommend that a health care provider or private health insurance broker take a specific course of action.

Subclause (3) allows the Ombudsman to request the person to whom the recommendation was made, or an officer of that person, to report within a specified period on the action proposed to be taken.

Subclause (4) provides that the person to whom the request was made, or an officer of that person, commits an offence if the request under subclause (3) is not complied with. The penalty is 30 penalty units and **subclause (5)** provides that this is a strict liability offence.

Clause 244-15 Report to Minister on outcome of investigations under this Division

Subclause (1) provides that the Private Health Insurance Ombudsman may after completing an investigation under clause 244-1, and must after completing an investigation under clause 244-5, report to the Minister on the outcome, including any recommendations made to the subject of the investigation, and any mediation conducted. The subclause also provides that the Ombudsman's recommendations to the Minister may include general changes in

regulatory practice or industry practices, or possible means of dealing with specific problems related to the subject of the investigation.

Subclause (2) allows the Ombudsman to make recommendations under subclause (1) concerning health care provider(s) only to the extent to which the recommendations relate to a private health insurance arrangement(s) or to goods manufactured or supplied by that kind of health care provider.

Subclause (3) provides that, before reporting to the Minister under this section, the Ombudsman must inform the subject of the complaint of the intention to make the report and the nature of the criticism, and invite and include in the report the subject's comments on the criticism.

Clause 244-20 Consultation with Australian Competition and Consumer Commission

This clause obliges the Private Health Insurance Ombudsman to consult with the Australian Competition and Consumer Commission, and to have regard to any resulting advice before reporting under clause 244-15, when the Ombudsman considers that there might have been conduct in the nature of a restrictive trade practice for the purposes of the *Trade Practices Act 1974*.

Division 247 Mediation

Clause 247-1 Conducting mediation

Subclause (1) allows the Private Health Insurance Ombudsman to try to settle a complaint under Division 241 by mediating between the complainant and the subject of the complaint.

Subclause (2) permits the Ombudsman to try to resolve a matter being investigated under Division 244 by mediating between a private health insurer and a health care provider.

Subclause (3) provides that a party's participation in mediation may be voluntary or required by a direction by the Ombudsman under clause 247-5.

Clause 247-5 Participating in mediation may be compulsory

Subclause (1) allows the Private Health Insurance Ombudsman to direct the subject of a complaint under Division 241, or a private health insurer or health care provider that is the subject of an investigation under Division 244, to participate in mediation.

Subclause (2) provides that the Private Health Insurance (Ombudsman) Rules may specify matters to which the Ombudsman is to have regard when deciding whether or not to give a direction under subclause (1).

Subclause (3) provides that the direction must be in writing and name either or both the subject of the complaint and an officer(s) of that subject. The direction must also be given to those named in it and specify the time and place of the mediation. Mediation must not be earlier than 14 days after the day on which the direction is given.

Subclause (4) provides that the person named in the direction, or a representative if the person is a medical practitioner, commits an offence with a penalty of 30 penalty units if they

fail to participate in part or all of the mediation when the other party attends or was willing to attend.

Clause 247-10 Medical practitioners may appoint representatives

This clause allows a medical practitioner that is directed by the Private Health Insurance Ombudsman to participate in mediation under clause 247-5 to appoint a representative to participate on his or her behalf. The appointment must be in writing, signed by the medical practitioner, and made before the mediation starts.

Clause 247-15 Conduct of compulsory mediation

Subclause (1) provides that where the Private Health Insurance Ombudsman directs a party to participate in mediation, the mediation must be conducted by the Ombudsman or someone appointed by the Ombudsman under clause 247-25.

Subclause (2) provides that mediation in which a party is directed to participate ceases if the parties agree to settle the matter, or if the Ombudsman concludes that the matter cannot be settled by mediation.

Subclause (3) provides that the Private Health Insurance (Ombudsman) Rules may specify matters to which the Ombudsman is to have regard before concluding that a matter cannot be settled by mediation.

Subclause (4) provides that a person appointed by the Ombudsman to conduct mediation must, as soon as practicable after the mediation is conducted or should have been conducted, report to the Ombudsman about whether the mediation was conducted, the reasons for its failure if it failed, and the terms of settlement if one was reached.

Clause 247-20 Admissibility of things said in mediation

This clause provides that, whether a party is directed to participate in mediation or not, evidence of anything said, or any admission made during the mediation, is not admissible in any court, or any proceedings before a person authorised by a Commonwealth or State or Territory law, or by the consent of the parties, to hear evidence.

Clause 247-25 Appointment of mediators

Subclause (1) allows the Private Health Insurance Ombudsman to appoint a person to conduct mediation in which a person is or will be directed to participate.

Subclause (2) provides that the Private Health Insurance (Ombudsman) Rules may specify matters to which the Ombudsman is to have regard when appointing a mediator.

Subclause (3) provides that the person is appointed for the period specified by the Ombudsman in the instrument of appointment.

Subclause (4) provides that (subject to the requirements of Division 323 dealing with disclosure of information) the appointed mediator is not personally liable to any action or proceeding for damages in relation to anything done in good faith for the purpose of the mediation.

Division 250 Information-gathering

Clause 250-1 Information-gathering

Subclause (1) enables the Private Health Insurance Ombudsman to request the subject of a complaint, or an officer of the subject, to give the Ombudsman specified records relating to the complaint within a period specified in the request.

Subclause (2) provides that when investigating under Division 244 and mediating under Division 247, the Ombudsman may request the subject of an investigation, or an officer of that subject, to give the Ombudsman information relating to the practices and procedures being investigated that are specified in the request and within a period specified in the request.

Subclause (3) permits the Ombudsman to make one or more information-gathering requests under subclauses (1) and (2) at any time while the Ombudsman is dealing with the complaint or investigation.

Subclause (4) allows a person to whom an information-gathering request is made to ask the Ombudsman to extend the period specified in the request.

Subclause (5) requires the Ombudsman to give reasons for refusing to extend the period.

A refusal to extend the period is a reviewable decision under Part 6-9.

Subclause (6) specifies that a person is not excused from producing information under subclause (1) on the grounds that doing so might incriminate the person or make them liable to a penalty. However, anything associated with the giving or production of the record is not admissible in evidence against the person in any proceedings, other than proceedings for providing false or misleading information.

Subclause (7) provides that the person to whom the information request was made commits an offence if the request under subclauses (1) or (2) is not complied with by the end of the period specified in the request, or the extended period. The penalty is 30 penalty units and **subclause (8)** provides that this is a strict liability offence.

Clause 250-5 Limits on information-gathering

Subclause (1) provides that in requesting information from the subject of a complaint, the Private Health Insurance Ombudsman must not request records that relate to the subject's dealings with the complainant unless the complainant consents.

Subclause (2) specifies that in requesting information from a private health insurer, or an officer of a private health insurer, the Ombudsman must not request information or records that relate to a particular individual who is or is seeking to be insured unless the individual consents.

Subclause (3) requires that in requesting information from a health care provider, or an officer of a health care provider, the Ombudsman must not request information or records that relate to a particular individual who is or was a patient of the health care provider unless the individual consents.

Subclause (4) provides that in requesting information from a private health insurance broker, or an officer of a private health insurance broker, the Ombudsman must not request information or records that relate to a particular individual who is or was a client of the broker unless the individual consents.

Clause 250-10 Disclosure of personal information

This clause provides that if a person provides a record, information or a document to the Private Health Insurance Ombudsman reasonably believing that this would assist the Ombudsman in performing his or her functions, the giving of the record, information or document is taken to be authorised by law.

Division 253 Provisions relating to the Private Health Insurance Ombudsman

Clause 253-1 Appointment of the Private Health Insurance Ombudsman

This clause provides for the Minister to appoint the Private Health Insurance Ombudsman, by written instrument, and in accordance with any Private Health Insurance (Ombudsman) Rules. The Ombudsman may be appointed on a full-time or part-time basis and holds office on the terms and conditions (if any) related to matters not covered by the Act that are determined by the Minister.

Clause 253-5 Validity of appointments

This clause specifies that the appointment of a person as the Ombudsman is not invalid merely because of a defect or irregularity in connection with the appointment.

Clause 253-10 Acting appointments

Subclause (1) allows the Minister to appoint a person to act as the Private Health Insurance Ombudsman during a vacancy in the office, or during any or all periods when the Ombudsman is absent from duty, or from Australia, or is unable to perform the duties of the office.

Subclause (2) provides that anything done by a person purporting to act as the Ombudsman under this clause is not invalid merely because the person was not acting in the office of Ombudsman in accordance with subclause (1).

Clause 253-15 Remuneration and allowances

This clause provides for the Remuneration Tribunal to set the Private Health Insurance Ombudsman's remuneration and for him or her to be paid allowances as specified in the Private Health Insurance (Ombudsman) Rules. If no determination of the Remuneration Tribunal is in operation, the Ombudsman is to be paid the remuneration specified in the Rules.

Clause 253-20 Outside employment

This clause requires that a person who holds the office of Private Health Insurance Ombudsman on a full-time basis not engage in any other paid employment without the Minister's written approval. Anyone who holds the office on a part-time basis must not engage in any paid employment that, in the Minister's opinion, conflicts with the proper performance of the Ombudsman's functions.

Clause 253-25 Leave of absence

This clause allows full-time Private Health Insurance Ombudsman office holders access to recreation leave determined by the Remuneration Tribunal, and to leave of absence other than recreational leave on terms and conditions determined by the Minister in writing.

Clause 253-30 Resignation

This clause allows the Private Health Insurance Ombudsman to resign by giving the Minister a written resignation.

Clause 253-35 Termination of appointment

This clause allows the Minister to terminate the Private Health Insurance Ombudsman's appointment for misbehaviour, physical or mental incapacity, and requires the Minister to terminate the appointment for bankruptcy, unapproved leave or unapproved outside employment or failure to comply with clause 253-40.

Clause 253-40 Disclosure of interest by Private Health Insurance Ombudsman

This clause requires the Private Health Insurance Ombudsman to give written notice to the Minister of a material personal interest in a matter that the office is considering or about to consider.

Clause 253-45 Statutory agency etc. for purposes of Public Service Act

This clause requires that staff engaged to assist the Private Health Insurance Ombudsman be appointed under the *Public Service Act 1999*. The Ombudsman and the assisting staff together constitute a Statutory Agency, with the Ombudsman the head of the agency.

Clause 253-50 Annual report

Subclause (1) requires the Private Health Insurance Ombudsman to prepare and give to the Minister an annual report for presentation to the Parliament as soon as practicable after the end of each financial year. Section 34C of the *Acts Interpretations Act 1901* requires the report to be given to the Minister within six months, and for the Minister to table it within 15 sitting days.

Subclause (2) specifies the elements that must be included in the report.

Clause 253-55 Delegation

This clause provides that the Private Health Insurance Ombudsman may, by writing, delegate to a staff member any or all of the Ombudsman's powers and functions.

Clause 253-60 Private Health Insurance Ombudsman and staff not personally liable

This clause specifies that neither the Private Health Insurance Ombudsman nor members of staff are personally liable to an action or proceeding for damages in exercising the Ombudsman's powers and functions in good faith.

Division 256 Miscellaneous

Clause 256-1 Protection from civil actions

This clause provides that civil actions cannot be taken against a person in respect of statements, information or documents given in good faith to the Private Health Insurance Ombudsman in connection with complaints under Division 241 or investigations under Division 244.

Clause 256-5 Victimisation

This clause provides that a person who subjects or threatens to subject another person to detriment because they have made or are proposing to make a complaint commits an offence with a penalty of imprisonment for six months.

Clause 256-10 Giving information about the Private Health Insurance Ombudsman

Subclauses (1) and **(2)** allow the Private Health Insurance Ombudsman to direct private health insurers to publish, or give to adults insured by the insurer, information specified in a direction that relates to the Ombudsman's functions.

Subclause (3) provides that an insurer can comply with this request in relation to a policy covering more than one adult by providing the statement to only one of the adults.

Subclause (4) provides that a private health insurer commits an offence if the direction under subclause (1) is not complied with. The penalty is 60 penalty units and **subclause (5)** provides that these are strict liability offences.

PART 6-3 PRIVATE HEALTH INSURANCE ADMINISTRATION COUNCIL

Division 261 Introduction

Clause 261-1 What this Part is about

This clause explains that the Council continues in existence to regulate private health insurers through administering Chapter 4 and Part 5-3.

Clause 261-5 The Private Health Insurance (Council) Rules

This clause provides that matters relevant to this Part are also dealt with in the Private Health Insurance (Council) Rules if the provisions in the Part indicate this.

Division 264 Continuation, purposes, functions and powers

Clause 264-1 Continuation of the Council

This clause provides that the Council, which was established under the *National Health Act 1953*, will continue in existence by force of this Act. The Council is a body corporate with power to deal in property, can sue and be sued, and must have a common seal to be used under the authorisation of the Council. Courts and people acting judicially must take judicial notice of the seal.

Clause 264-5 Objectives of the Council

This clause requires the Council in carrying out its functions to take all reasonable steps to achieve an appropriate balance between the objectives of fostering an efficient and

competitive industry, protecting the interests of consumers, and ensuring the prudential safety of individual private health insurers.

Clause 264-10 Functions of the Council

This clause sets out the functions of the Council.

Clause 264-15 Report on private health insurers

Subclause (1) requires the Council to prepare and give to the Minister for presentation to Parliament, as soon as practicable after 30 September in each year, a report on the operations of private health insurers during the financial year ending on 30 June in that year.

Subclause (2) specifies the elements that must be included in the report in respect of each health benefits fund conducted by a private health insurer.

Clause 264-20 Powers

This clause provides that the Council has power to do all things necessary or convenient to performing its functions.

Clause 264-25 Directions by Minister

This clause allows the Minister to direct the Council by legislative instrument. The Minister must consult the Council before giving such a direction and the Council must comply with it.

Division 267 Constitution and administration

Clause 267-1 Constitution of the Council

This clause sets out the membership of the Council as including a Commissioner and from two to four other members, and states that vacancies in the membership will not affect the performance of the Council's functions and powers.

Clause 267-5 Appointment of members

This clause sets out the requirements for the appointment of members. Subclause (7) prohibits the appointment of a person who is a director, officer or employee of a private health insurer.

Clause 267-10 Meetings of the Council

This clause sets out when meetings of the Council must be convened, and how they are to be conducted.

Clause 267-15 Delegation by the Council

This clause allows the Council to delegate by writing to the Chief Executive Officer or another member of staff of the Council any or all of its functions and powers, except those under the *Commonwealth Authorities and Companies Act 1997*.

Clause 267-20 Modification of the *Commonwealth Authorities and Companies Act 1997*

This clause explains that section 14 of the *Commonwealth Authorities and Companies Act 1997* requiring the preparation of annual budgets for submission to the Minister does not apply to the Council.

Division 270 Members

Clause 270-1 Terms and conditions etc.

This clause provides that the Private Health Insurance (Council) Rules may specify the terms and conditions of members and their periods of appointment.

Clause 270-5 Validity of appointments

This clause provides that appointments are not invalid because of a defect or irregularity in the appointment.

Clause 270-10 Acting Commissioner

Subclause (1) allows the Minister to appoint an acting Commissioner during a vacancy in the office of Commissioner, or during any or all periods when the Commissioner is absent from duty, or from Australia, or is unable to perform the duties of the office. A person appointed to act as Commissioner must not act in that position for more than 12 months.

Subclause (2) provides that anything done by a person purporting to act as Commissioner under this clause is not invalid merely because the person was not acting in the office of Commissioner in accordance with subclause (1).

Clause 270-15 Deputy Commissioner to act as Commissioner in certain circumstances

Subclause (1) requires that the Deputy Commissioner act as Commissioner during a vacancy in the office if no-one has been appointed to act in the position, or during any or all periods when the Commissioner or acting Commissioner is absent from duty, or from Australia, or is unable to perform the duties of the office.

Subclauses (2) and **(3)** require that the Deputy Commissioner not act as Commissioner for more than 12 months. Anything done by the person acting as Commissioner is not invalid because the occasion for the person to act as Commissioner had not arisen or had ceased.

Clause 270-20 Powers and duties of persons acting as Commissioner

Subclauses (1) and **(2)** provide that, subject to a direction by the Commissioner, persons acting as Commissioner have all the powers and functions of the Commissioner under this Act, and things done by such persons are taken to have been done by the Commissioner.

Subclause (3) provides that the exercise of a power or function by an acting Commissioner does not prevent the exercise of the power or function by the Commissioner, and s**ubclause (4)** provides that if the exercise of a power or function by the Commissioner under this or another Act depends on the opinion, belief or state of mind of the Commissioner, the power or function may be exercised on the basis of the opinion, belief or state of mind of the acting Commissioner.

Clause 270-25 Remuneration and allowances of members

This clause provides for the Remuneration Tribunal to set the Council members' remuneration and for them to be paid allowances as specified in the Private Health Insurance (Council) Rules. If no determination of the Remuneration Tribunal is in operation, members are to be paid the remuneration specified in the Rules.

Clause 270-30 Leave of absence

This clause allows a full-time Commissioner to be granted leave of absence, other than recreational leave determined by the Remuneration Tribunal, on terms and conditions specified in the Private Health Insurance (Council) Rules. The Commissioner may grant another member leave to be absent from a meeting or meetings of the Council.

Clause 270-35 Resignation

This clause allows a member of the Council to resign by giving the Minister a written resignation.

Clause 270-40 Termination of appointment

This clause allows the Minister to terminate a member's appointment for misbehaviour or physical or mental incapacity, and provides that the Minister must terminate an appointment for bankruptcy, unapproved leave or unapproved outside employment, or failure to comply with clause 270-45.

Clause 270-45 Disclosure of interests

This clause requires a member who has a direct or indirect pecuniary interest in a matter being considered or about to be considered by the Council to disclose the interest to a meeting of the Council. The disclosure must be made as soon as possible and must be recorded in the minutes. The member must not be present during any deliberation by the Council on the matter and must not take part in any decision by Council with respect to the matter.

Division 273 Chief Executive Officer and staff

Clause 273-1 Chief Executive Officer

This clause requires that the Council appoint a Chief Executive Officer. The Council may determine the terms and conditions of the appointment in respect of matters not provided for by this Part and may terminate the appointment at any time. The Chief Executive Officer must hold the office on a full-time basis, and an appointment is not invalid because of a defect or irregularity with the appointment.

Clause 273-5 Duties of Chief Executive Officer

This clause specifies that the Chief Executive Officer is to manage the affairs of the Council and must act in accordance with the policy and directions given by the Council.

Clause 273-10 Conflict of interests

This clause requires that the Chief Executive Officer not be present at a meeting of the Council when a decision is being taken with relation to the office of the Chief Executive Officer. If the Chief Executive Officer has a direct or pecuniary interest in a matter related to his or her duties, he or she is required to disclose the nature of the interest to the Commissioner as soon as possible.

Clause 273-15 Staff and consultants

This clause permits the Council to employ staff and to engage consultants under agreements as necessary to assist the Council in the performance of its functions and the exercise of its powers. The Commissioner may arrange with an Agency Head for the services of officers or employees in the Agency to be made available to the Council.

Clause 273-20 Remuneration and allowances of Chief Executive Officer

This clause provides for the Remuneration Tribunal to set the Chief Executive Officer's remuneration and for him or her be paid allowances as specified in the Private Health Insurance (Council) Rules. If no determination of the Remuneration Tribunal is in operation, the Chief Executive Officer is to be paid the remuneration specified in the Rules.

Clause 273-25 Leave of absence of Chief Executive Officer

This clause allows the Council to grant the Chief Executive Officer leave of absence, other than recreational leave determined by the Remuneration Tribunal, on terms and conditions specified in the Private Health Insurance (Council) Rules.

PART 6-4 ADMINISTRATION OF PREMIUMS REDUCTION AND INCENTIVE PAYMENT SCHEMES

Division 276 – Introduction

Clause 276-1 What this Part is about

This clause explains that Part 2-2 provides for a premiums reduction scheme and an incentive payments scheme, and that this Part provides for private health insurers to be reimbursed for premiums that were reduced under the premiums reduction scheme in Division 23 and for a range of administrative matters in relation to both schemes.

Division 279 – Provisions applying only to premiums reduction scheme

Subdivision 279-A Reimbursement of private health insurers for premiums reduced under scheme

Clause 279-1 Participating insurers may claim reimbursement

This clause allows a private health insurer to claim reimbursement under clause 279-10 from the Medicare Australia CEO for each month during which it is a participating insurer.

Clause 279-5 Participating insurers

Subclause (1) provides that a private health insurer may apply to the Minister in the approved form to become a participating insurer for the purposes of this Part, and **subclause (2)** provides that if the Minister approves the application the insurer is a participating insurer.

Subclause (3) requires the Minister to approve an application unless:

- the insurer's status as a participating insurer has previously been revoked under subclause 206-1(1) as part of enforcement action under the Bill; and
- the Minister is satisfied that the insurer is continuing, or will continue, with the conduct that led to the revocation.

Subclauses (4) and **(5)** require the Minister to notify the applicant within 28 days of the date of the decision of whether the application has been approved or rejected, and provide reasons

for rejection as part of the notice. A decision rejecting the application is a reviewable decision under Part 6-9.

Clause 279-10 Requirements for claims

This clause requires a private health insurer to make a claim in respect of a month in the approved form to the Medicare Australia CEO in the first seven days of the following month, and requires the CEO, if he or she decides the claim is correct, to pay it under clause 279-15.

Clause 279-15 Amounts payable to the private health insurer

This clause provides that the amount payable to an insurer in respect of a month is the sum of the amounts by which premiums in respect of that month were reduced by the operation of the premiums reduction scheme set out in Division 23. The amount must be paid to the insurer, in the way determined in writing by the Medicare Australia CEO, in the first 15 days of the following month.

Clause 279-20 Notifying private health insurers if amount is not payable

This clause provides that if the Medicare Australia CEO considers a claim is incorrect he or she may refuse the claim or pay only that part that is considered correct, and must notify the insurer of the decision and the reason. The CEO is taken to have decided a claim is correct if he or she does not notify the insurer of a decision it is incorrect on or before the day on which it would otherwise have been payable under clause 279-15.

Clause 279-25 Additional payment if insurer claims less than entitlement

This clause allows a private health insurer to apply to the Medicare Australia CEO for payment of an additional amount in respect of a month if the amount originally claimed under clause 279-10 was less than the sum of the amounts by which premiums in respect of that month were reduced by the operation of the premiums reduction scheme set out in Division 23.

Clause 279-30 Additional payment if insurer makes a late claim

This clause allows a private health insurer to apply to the Medicare Australia CEO for payment of an additional amount in respect of a month if the insurer did not make a claim under clause 279-10 during the first seven days of the following month. The claim may be for an amount not exceeding the sum of the amounts by which premiums in respect of that month were reduced by the operation of the premiums reduction scheme set out in Division 23.

Clause 279-35 Content and timing of application

This clause requires an application by a private health insurer under clauses 279-25 or 279-30 to be made in the approved form, and up to three years after the end of the first month included in the application.

Clause 279-40 Decision on application

This clause sets out the process for dealing with applications under clauses 279-25 and 279-30.

Subclauses (1) and **(2)** provide that the Medicare Australia CEO must pay the additional amount if satisfied that:

- the additional amount sought is correct; and
- it would be reasonable to grant the application

or may refuse the application, or decide to pay only part of it, if satisfied that:

- the additional amount sought is incorrect; or
- it would not be reasonable to grant the application.

Subclauses (3) and **(4)** require the CEO to notify the insurer of the decision and the reasons for the decision.

Subclause (5) provides that the CEO is taken to have accepted the application if the CEO does not notify the insurer to the contrary within three months of receiving the application, and **subclause (6)** provides that if the CEO is taken to have made a decision under subclause (5) he or she is taken to have notified the insurer.

Clause 279-45 Reconsideration of decisions

This clause allows a private health insurer who has had a claim rejected or reduced under clauses 279-20 or 279-40 to apply for reconsideration.

Subclauses (1) and **(2)** allow the insurer to make a request to the Medicare Australia CEO for reconsideration, setting out the reasons for the request, within 28 days of the CEO notifying the original decision.

Subclause (3) requires the CEO as soon as practicable to reconsider the decision and either affirm it, vary it, or revoke it and make a fresh decision. A decision on reconsideration is a reviewable decision under Part 6-9.

Subclause (4) states that a variation to the original decision or a fresh decision by the CEO is taken to have had effect from the time the original decision was made.

Subclause (5) requires the CEO to notify the insurer of the decision under subclause (3) and the reasons for the decision, and **subclause (6)** provides that the CEO is taken to have revoked the original decision if the CEO does not notify the insurer of the decision on reconsideration within 28 days of receiving the request.

Subdivision 279-B Powers of Medicare Australia CEO in relation to participating insurers

Clause 279-50 Audits by Medicare Australia CEO

Subclauses (1) and **(2)** provide that the Medicare Australia CEO may audit the accounts and records of a private health insurer that is or has been a participating insurer under the premiums reduction scheme to the extent to which the records deal with persons participating in the scheme, reductions of premiums under the scheme, or receipt of money from the Medicare Australia CEO under the scheme. **Subclause (3)** requires the Medicare Australia CEO to give notice of the audit to the insurer.

Subclauses (4) and **(5**) require the private health insurer to ensure that the Medicare Australia CEO has full and free access to relevant material, and empowers the person carrying out the audit to make copies or take extracts from the material.

Subclause (6) allows the Medicare Australia CEO to require a private health insurer within a specified period at the end of a financial year to produce an audit certificate as to the correctness of the accounts and records for the financial year that relate to the matters set out in subclause (2).

Clause 279-55 Medicare Australia CEO may require production of applications

This clause empowers the Medicare Australia CEO, with at least one month's notice, to require a private health insurer to produce applications for participation in the scheme (or copies of applications) that have been retained under clause 23-45, and requires the Medicare Australia CEO to pay the insurer reasonable compensation for making copies.

Division 282 – Provisions applying to premiums reduction scheme and incentive payment scheme

Subdivision 282-A When and how payments can be recovered

Clause 282-1 Recovery of payments

Subclause (1) lists amounts that are recoverable as debts to the Commonwealth, including 150% of some payments made to private health insurers and interest payable on debts under clause 282-5, and **subclause (2)** identifies from whom the amount is recoverable.

Subclause (3) provides that the amounts are recoverable regardless of whether a person has been convicted of an offence in relation to the payment.

Clause 282-5 Interest on amounts recoverable

This clause states that interest is payable on amounts recoverable under clause 282-1 and begins to accrue either:

- three months (or such longer time as the Medicare Australia CEO allows) after the Medicare Australia CEO serves a notice on a person (including the person's legal personal representative) or a private health insurer claiming an amount as a debt due to the Commonwealth; or
- from the time a person or an insurer defaults on an arrangement to repay an amount

at the rate of 15 per cent per annum, or a lower rate if one is set in the Private Health Insurance (Incentives) Rules.

Subclause (4) provides that in any court proceedings for the recovery of an amount due to the Commonwealth the court may order interest to have been payable from a later day than the day set out in this clause.

Clause 282-10 Medicare Australia CEO may set off debts against amounts payable

This clause allows the Medicare Australia CEO to set off an amount recoverable as a debt to the Commonwealth against an amount that would otherwise be payable to a person or a private health insurer under Part 2-2. If the Medicare Australia CEO decides to make such a set-off in respect of a person the CEO must serve on the person (or the person's legal personal representative) a notice of the decision.

Clause 282-15 Reconsideration of certain decisions under this Division

Subclause (1) provides that a person may apply to the Medicare Australia CEO for reconsideration of:

- a decision that an amount is recoverable as a debt due to the Commonwealth if it was paid under Division 26 and the person was not entitled to it or it was made in respect of premium that was later refunded;
- a decision that interest is payable on an amount recoverable from an individual; or
- a decision to set off a debt against an amount otherwise payable to an individual.

Subclauses (2) and **(3)** provide that the application must be made in writing, with reasons, within 28 days of being notified of the decision or such longer time as the Medicare Australia CEO allows.

Subclause (4) requires the Medicare Australia CEO on receiving an application to reconsider the decision and either affirm or revoke it. Under **subclause (5)** revocation is taken as a decision either to waive the debt or not to set it off.

Subclause (6) and **(7)** require the Medicare Australia CEO to notify the applicant of the decision on reconsideration with reasons for the decision within 28 days of receiving the application, and **subclause (8)** states that the Medicare Australia CEO is taken to have affirmed the original decision if the applicant has not been notified of a decision on reconsideration within 28 days.

A decision on reconsideration is a reviewable decision under Part 6-9.

Subdivision 282-B Miscellaneous

Clause 282-20 Notification requirements – private health insurers

Subclauses (1) and **(2)** empower the Medicare Australia CEO to require a private health insurer to provide information specified in the notice, in the approved form, about a person who is covered at any time during a financial year by a complying health insurance policy issued by the insurer, or who paid premiums under a policy.

Subclause (3) provides that an insurer commits an offence if the insurer is given a notice under subclause (1) and fails to comply with it. The penalty is 20 penalty units and **subclause (4)** provides that this is a strict liability offence.

Clause 282-25 Use etc. of information relating to another person

This clause provides that a person commits an offence with a penalty of imprisonment for one year if the person uses, records or discloses any information about the affairs of another person that was acquired under or for the purposes of Part 2-2 or this Part, other than in performing a function or obligation or exercising a power under those Parts.

Clause 282-30 Information to be provided to the Commissioner of Taxation

This clause requires the Medicare Australia CEO to provide to the Commissioner of Taxation within 120 days after the end of each financial year such information as the Commissioner of Taxation determines, but provides that the Commissioner of Taxation cannot require the Medicare Australia CEO to provide the tax file number of any person or any information about the physical, psychological or emotional health of any person.

Clause 282-35 Delegation

This clause empowers the Medicare Australia CEO to delegate in writing his or her powers under Part 2-2 or this Part to an employee of Medicare Australia. The Minister may delegate his or her powers under the general delegation power in clause 333-5.

Clause 282-40 Appropriation

This clause appropriates the Consolidated Revenue Fund for the purpose of payments under Part 2-2 or this Part.

PART 6-5 EXTERNAL MANAGERS AND TERMINATING MANAGERS

Division 287 – Introduction

Clause 287-1 What this Part is about

This clause explains that the Part provides for several matters relating to external management of health benefits funds under Division 217 and terminating management under Division 149.

Clause 287-5 The Private Health Insurance (Management) Rules

This clause provides that matters relating to external management and terminating management of health benefits funds may also be dealt with in the Private Health Insurance (Management) Rules if the provisions in the Part indicate this.

Division 290 – Powers of managers

Clause 290-1 Powers of managers

This clause provides that while a health benefits fund is under external management or terminating management, the manager has power to:

- control, carry on and manage the business, affairs and property of the fund;
- terminate or dispose of all or any part of the business or dispose of any property;
- do any thing (including executing documents or bringing or defending proceedings) in the name of the responsible private health insurer for the purpose of the business of the fund;
- perform any other function or exercise any power that the insurer or its officers could perform or exercise if the fund was not under external management or terminating management

and suspends the rights of the insurer or its officers to exercise these powers while the fund is under external management or terminating management.

Clause 290-5 Officers etc. not to perform functions etc. while fund is under management

Subclause (1) provides that a person (other than the manager of a health benefits fund under external management or terminating management) commits an offence with a penalty of 30 penalty units, or imprisonment for six months, or both if:

- the person performs or exercises, or
- purports to perform or exercise

any function or power of:

- an officer of the responsible insurer for the fund, or
- a receiver, or receiver and manager of any assets of the fund

if the function or power is a function or power of the manager and the person does it without the manager's written approval.

Subclause (2) explains that subclause (1) does not imply that an officer of the insurer is removed from office, and **subclause (4)** clarifies that a person is not an officer of an insurer merely because he or she is an employee. The Dictionary defines an officer.

Subclause (3) provides that clauses 149-30 and 217-20 (which provide for managers to displace the officers of insurers responsible for the management of funds) do not limit this clause.

Clause 290-10 Managers act as agents of private health insurers

This clause provides that a manager exercising a power as manager of a health benefits fund is taken to be acting as the agent of the responsible insurer for the fund. This clause does not allow the insurer to direct the manager in the exercise of his or her powers.

Division 293 – Information concerning, and records and property of, health benefits funds

Clause 293-1 Directors etc. to help managers

Subclause (1) requires each director of the responsible insurer for a health benefits fund under external management or terminating management as soon as practicable after the management begins to:

- give the manager all records in the director's possession that relate to the business of the fund (other than records the director is entitled to retain against the manager or the insurer); and
- tell the manager of the location of other records known to the director.

Subclause (2) and **(3)** require each director and officer of the responsible insurer for a fund under external management or terminating management to give the manager a statement about the business, property, affairs and financial circumstances of the fund. The statement must be made within seven days (or longer as allowed by the manager) and comply with the manager's requirements as to form and contents.

Subclause (4) requires a director or officer of the responsible insurer to attend on the manager and give the manager information about the business, property, affairs and financial circumstances of the fund as the manager reasonably requires.

Subclause (5) provides that a person commits an offence with a penalty of 30 penalty units or imprisonment for six months or both if the person does not comply with the requirements of this clause.

Clause 293-5 Managers' rights to certain records

Subclauses (1) and **(2)** provide that a person (other than a secured creditor of the responsible insurer for a health benefits fund) is not entitled to retain possession of records against the manager of the fund or enforce a lien on the records (although the lien otherwise stands). The manager is entitled to inspect and copy records held by a secured creditor at any reasonable time.

Subclauses (3) and **(4)** empower a manager to give a person notice of at least three days to deliver to the manager specified records that are in the person's possession.

Subclauses (5) and **(6)** provide that a person commits an offence with a penalty of 30 penalty units or imprisonment for six months or both if the person does not comply with a notice under subclause (3), unless the person is entitled to retain the records against the manager and the insurer.

Clause 293-10 Only manager can deal with property of fund under management

Subclause (1) provides that a transaction or dealing affecting the property of a health benefits fund under external management or terminating management entered into by the responsible insurer or a person purportedly on behalf of the fund or the insurer is void unless:

- it was entered into by the manager; or
- the manager consented to the transaction or dealing beforehand; or
- it was ordered by the Federal Court or a State or Territory Supreme Court.

Subclause (3) provides that an order of the Federal Court made after a transaction or dealing may affect the operation of subclause (1).

Subclause (2) provides that subclause (1) does not apply to a payment by an Approved Deposit Institution (such as a bank or credit union) made in good faith and in the ordinary course of its banking business while the external management or terminating management is under way but before the first of:

- the ADI being notified by the manager of the external management or terminating management; or
- the manager advertising the external management or terminating management in a national newspaper or newspaper circulating where the insurer carries on business.

Subclause (4) provides that a person commits an offence with a penalty of 30 penalty units or imprisonment for six months or both if:

- the person is an officer of the responsible insurer for a fund under external management or terminating management, or the receiver or receiver and manager of any of the assets of the fund; and
- the person purported to enter into a transaction or dealing on behalf of the responsible insurer that is void because of the operation of this clause, or was in any way concerned in or a party to the transaction or dealing.

Clause 293-15 Order for compensation where officer involved in void transaction

Subclause (1) provides that if a court finds a person guilty of an offence against clause 293-10 and is satisfied that the health benefits fund under external management or terminating management concerned has suffered a loss because of the transaction involved in the offence, the court may order the person to pay compensation to the responsible insurer for the fund. **Subclause (2)** provides that an order under subclause (1) may be enforced as a judgement of the court.

Subclause (3) provides that the court may relieve a person wholly or partly from liability to pay compensation if it appears to the court that the person has acted honestly and ought fairly to be excused.

Subclauses (4) and **(5)** allow a person who thinks that proceedings will or may be brought against him or her under this clause to apply to the Federal Court for relief, and provide that the Court may grant relief as if the proceedings had been begun.

Subclause (6) provides that a reference in subclause (3) to the court is a reference to the judge alone for the purpose of a case tried by a judge and jury, and the relief that may be granted includes withdrawing the case in whole or part from the jury and directing judgement to be entered for the defendant.

Division 296 – Provisions incidental to appointment of managers

Clause 296-1 Remuneration of managers

This clause provides that the Council may determine the remuneration and allowances for a manager to be paid out of the assets of the health benefits fund under external management or terminating management unless the Council determines otherwise.

Clause 296-5 Council may give directions to managers

This clause empowers the Council to give a manager written directions (with which the manager must comply) concerning the exercise of his or her powers. While the directions will usually be general, they may take into account the specific circumstances of the health benefits fund under external management or terminating management, and may include directions requiring the provision of interim reports.

Clause 296-10 Termination of appointments of managers

Subclause (1) provides that the Council may terminate the appointment of a manager with effect from the date specified in the instrument.

Subclauses (2) and **(3)** provide that if the appointment of an external manager is terminated, the Council may appoint a replacement manager to carry on the external management. If it does not, then the power to control, carry on and manage the business, affairs and property of the health benefits fund vests again in the officers of the responsible insurer.

Subclause (4) provides that if the appointment of a terminating manager is terminated, the Council must appoint a replacement manager to carry on the terminating management unless the Federal Court has ordered an end to the termination under clause 149-35 or the termination is complete and the manager has reported to the Council under clause 149-55.

Clause 296-15 Acts of managers valid etc.

Subclause (1) provides that the acts of a manager of a health benefits fund are valid despite any defect or irregularity found later in his or her appointment.

Subclauses (2) and **(3)** protect persons dealing with the fund in good faith without any knowledge of the defect of irregularity in the appointment of the manager.

Clause 296-20 Indemnity

This clause indemnifies a manager of a health benefits fund against any action, claim or demand by a person in relation to anything done (or not done) in good faith in exercising the powers of a manager under the Act.

Clause 296-25 Qualified privilege

This clause confers qualified privilege on a person who is or has been the manager of a health benefits fund in respect of any statement made by him or her for the performance of duties as a manager.

Division 299 – Miscellaneous

Clause 299-1 Time for doing act does not run while act prevented by this Division

This clause provides that if Division 149, Part 5-3 or this Part prevented an act from being done, the time for doing the act under a law, agreement or instrument is extended by the time that those provisions prevented it from being done.

Clause 299-5 Continued application of other provisions of Act

This clause provides that the appointment of an external manager or terminating manager to a health benefits fund does not affect the continued application of the rest of the Act other than:

- in the case of external management, the provisions of Division 217; or
- in the case of terminating management, the provisions of Divisions 149 or 220

in relation to the fund or the rights and obligations of persons in relation to the responsible insurer for the fund.

Clause 299-10 Modifications of this Act in relation to health benefits funds under management

This clause allows the Private Health Insurance (Management) Rules to set out modifications of how Chapter 3 of the Act relates to health benefits funds under external management or terminating management, including different modifications according to the nature of the funds concerned, as long as the modifications do not modify a provision that creates an offence or include a new provision that creates an offence. This provision is intended to give the Government flexibility in adapting the health benefits funds regime to ensure a fair balance between the interests of insurers and insured persons in unforeseen circumstances.

Clause 299-15 Order of Court to be binding on all persons

This clause provides that an order of the Court made under Division 149, Part 5-3 or this Part is binding on all persons and has effect notwithstanding anything in the constitution or rules of a private health insurer or health benefits fund to which the order relates.

Clause 299-20 Jurisdiction of Federal Court

This clause confers on the Federal Court jurisdiction to hear, determine and make orders on or in relation to applications under Division 149, Part 5-3 or this Part.

Clause 299-25 Private Health Insurance (Management) Rules dealing with various matters

This clause provides that the Private Health Insurance (Management) Rules may

- provide for matters in relation to meetings required or permitted to be held under Division 217; and
- stipulate the form and contents of any document required or permitted to be given to the Council or an external manager or terminating manager of a health benefits fund under a provision of Division 217 or 149.

PART 6-6 PRIVATE HEALTH INSURANCE LEVIES

Division 304 – Introduction

Clause 304-1 What this Part is about

This clause explains that the Part deals with the collection and administration of private health insurance levies imposed by levy Acts.

Clause 304-5 The Private Health Insurance (Levy Administration) Rules

This clause provides that matters relating to the collection and administration of private health insurance levies may also be dealt with in the Private Health Insurance (Levy Administration) Rules if the provisions in the Part indicate this.

Clause 304-10 Meaning of *private health insurance levy*

This clause defines a *private health insurance levy* as each of:

- levy imposed under the *Private Health Insurance (Collapsed Insurer Levy) Act 2003* (*collapsed insurer levy*);
- levy imposed under the *Private Health Insurance Complaints Levy Act 1995* (*complaints levy*);
- levy imposed under the *Private Health Insurance (Council Administration Levy) Act 2003 (Council administration levy)*;
- levy imposed under the *Private Health Insurance (Risk Equalisation Fund Levy) Act 2003 (risk equalisation levy).*

Division 307 – Collection and recovery of private health insurance levies

Clause 307-1 When private health insurance levy must be paid

Subclause (1) provides that a private health insurance levy must be paid:

- on the day specified by the Minister in a determination made by legislative instrument for a collapsed insurer levy or any other levy imposed on a supplementary levy day; and
- otherwise on a day specified in the Private Health Insurance (Levy Administration) Rules.

Subclauses (2) and **(3)** provide that in determining a day for a collapsed insurer levy or any other levy imposed on a supplementary levy day (other than a complaints levy) the Minister must take into account advice from the Council, and must table in the Parliament advice from the Council in relation to a collapsed insurer levy day.

Clause 307-5 Late payment penalty

This clause provides that if a private health insurance levy remains wholly or partly unpaid after it is due and payable, a late payment penalty becomes payable calculated at the rate specified in the Private Health Insurance (Levy Administration) Rules (which must be higher than 15%) on the amount unpaid for the period between when the amount was due and payable and when it is paid.

Clause 307-10 Payment of levy and late payment penalty

This clause provides that complaints levy and late payment penalty in respect of complaints levy must be paid to the Commonwealth, and other levies and associated late payment penalties must be paid to the Council for the purposes set out in the table in subclause (2).

The Consolidated Revenue Fund is appropriated for the purpose of making payments to the Council.

Clause 307-15 Recovery of levy and late payment penalty

This clause provides that a private health insurance levy and any late payment penalty are debts due to the Commonwealth and may be recovered as a debt by court action by the Commonwealth for complaints levies and associated late payment penalties, or the Council for other levies and associated late payment penalties.

Clause 307-20 Waiver of late payment penalty for levies other than collapsed insurer levy

This clause provides that an amount of late payment penalty may be waived by either:

- the Minister in relation to late payment penalties associated with the complaints levy; or
- the Council in relation to late payment penalties associated with the Council administration levy or risk equalisation levy

if the Minister or the Council consider that there are good reasons for doing so.

Clause 307-25 Waiver of collapsed insurer levy and late payment penalty for that levy

Subclauses (1) and **(2)** provide that a private health insurer may apply in writing in the approved form for waiver of a collapsed insurer levy or late payment penalty for that levy.

Subclauses (3) and **(4)** allow the Minister to waive the whole or part of a collapsed insurer levy and late payment penalty for that levy, having taken into account advice from the Council, if satisfied that payment by the insurer would have a significant adverse affect on the insurer's ability to comply with solvency standards or directions under Division 140, or capital adequacy standards or directions under Division 143. A decision under subclause (3) is reviewable under Part 6-9.

Subclauses (5) and **(6)** require the Minister to notify the insurer of his or her decision in writing within 28 days of the day the decision is made.

Division 310 – Returns, requesting information and keeping records

Clause 310-1 Returns must be lodged with Council and Department

Subclauses (1) and **(2)** require a private health insurer to lodge a return for each census day (as set out in the relevant levy Act) for each private health insurance levy except the risk equalisation levy.

Subclause (3) requires that the return must be in the approved form and be lodged within 28 days of the census day with:

- the Secretary of the Department for the complaints levy; and otherwise
- the Council.

Subclause (4) provides that a private health insurer commits an offence if the insurer fails to lodge the return. The penalty is 60 penalty units and **subclause (5)** provides that this is a strict liability offence.

Clause 310-5 Insurer must keep records

Subclauses (1) to **(3)** require a private health insurer to:

- retain records relating to whether the insurer is required to pay a private health insurance levy, and if so how much;
- for seven years (or less if allowed under the Private Health Insurance (Levy Administration) Rules);
- from the later of the day on which the records were created or 1 July 2004;
- in an electronic form or a form approved by the Council.

Subclause (4) provides that a private health insurer commits an offence if the insurer fails to comply with subclauses (1) to (3). The penalty is 60 penalty units and **subclause (5)** provides that this is a strict liability offence.

Subclause (6) provides that nothing in this clause is taken to have required an insurer to do anything before the Act comes into force. However, the Transitional and Consequential Bill provides at clause 51 that the obligations of registered health benefits organizations under section 83I of the *National Health Act 1953* to maintain levy related records continue as if that section had not been repealed.

Clause 310-10 Council may request information from insurer

Subclause (1) provides that if the Council reasonably believes that an insurer has information relating to whether the insurer is required to pay a private health insurance levy (other than a complaints levy), and if so how much, the Council may request the insurer to provide specified information in a specified period.

Subclause (2) provides that if the Secretary of the Department reasonably believes that an insurer has information relating to whether the insurer is required to pay a complaints levy, and if so how much, the Secretary may request the insurer to provide specified information in a specified period.

Subclause (3) provides that a request under subclauses (1) and (2) must be served on the chief executive officer, specify the manner in which the information is to be given and state that failure to comply is an offence, and may require the information to be verified by statutory declaration.

Subclause (4) provides that a private health insurer commits an offence if the insurer fails to comply with subclauses (1) or (2). The penalty is 60 penalty units and **subclause (5)** provides that this is a strict liability offence.

Division 313 – Power to enter premises and search for documents

This Division includes entry, search and seizure provisions. While these are exceptional powers, they are necessary to ensure compliance with the proposed Act. In the absence of the powers insurers could conceal records and evade their liability to pay levies necessary for the administration of the Act, including risk equalisation arrangements and the operation of the Council and he Private Health Insurance Ombudsman. The powers within this Division conform to the principles outlined in the report by the Senate Standing Committee for the Scrutiny of Bills entitled “Fourth Report of 2000: Entry and Search Provisions in Commonwealth Legislation”.

Clause 313-1 Authorised officer may enter premises with consent

Subclauses (1) to **(2)** empower a person who is a staff member of the Council or is authorised by the Minister (an *authorised officer*) to enter premises to search for, inspect, take extracts from or make copies of documents (*search powers*) relating to whether the insurer is required to pay a private health insurance levy, and if so how much (*levy-related documents*) if the occupier of the premises consents and if the officer shows the occupier his or her identity card.

Subclause (3) requires the authorised officer before obtaining consent to inform the occupier that he or she may refuse consent, and **subclause (4)** provides that entry by the authorised officer is not lawful if the consent was not voluntary.

Subclause (5) requires the authorised officer to leave the premises if asked to do so by the occupier.

Clause 313-5 Authorised officer may enter premises under warrant

Subclause (1) provides that an authorised officer who believes there may be levy-related documents on premises may apply to a magistrate for a warrant authorising the officer to enter the premises to exercise search powers in relation to the documents.

Subclause (2) provides that the magistrate may issue a warrant if satisfied by information on oath or affirmation that there are reasonable grounds for believing levy-related documents to be on the premises.

Subclauses (3) and **(4)** provide that the warrant must authorise one or more authorised officers (who do not need to be named) to enter the premises to exercise search powers in relation to the documents, state when entry is authorised, and authorise officers to use necessary and reasonable assistance and force.

Clause 313-10 Announcement before entry

This clause requires an authorised officer, before entering premises under a warrant, to announce he or she is authorised to enter the premises and give any person on the premises the opportunity to allow the authorised officer to enter without the use of force.

Clause 313-15 Executing a warrant to enter premises

Subclauses (1) and **(2)** provide that if a warrant is being executed to enter premises and the occupier is present, the authorised officer must make a copy of the warrant available to the occupier, show him or her the officer's identity card, and inform him or her of his or her rights and responsibilities under subclauses (3) to (6).

Subclauses (3) and **(4)** provides that the occupier, or a readily available person nominated by the occupier, is entitled to observe the execution of the warrant, as long as he or she does not impede that execution. **Subclause (5)** provides that the right to observe under subclause (3) does not prevent the execution of the warrant in two or more areas of the premises at the same time.

Subclause (6) provides that the occupier commits an offence if he or she does not provide the authorised officer (and any assistant) with all reasonable facilities and assistance in executing the warrant. The penalty is 60 penalty units.

Clause 313-20 Identity cards

This clause requires:
- the Council to issue authorised officers with an identity card in the approved form, including a recent photograph of the officer, and
- the authorised officer to carry the identity card at all times when exercising powers or performing functions as an authorised officer under this Division.

Subclause (2) provides that a person who has been issued with an identity card and ceases to be an authorised officer commits an offence if he or she does not return the card to the Council as soon as practicable. The penalty is 1 penalty unit and **subclause (3)** provides that this is a strict liability offence.

PART 6-7 PRIVATE HEALTH INSURANCE RISK EQUALISATION TRUST FUND

Division 318 – Private Health Insurance Risk Equalisation Trust Fund

Clause 318-1 Private Health Insurance Risk Equalisation Trust Fund

This clause provides that the Health Benefits Reinsurance Trust Fund established under section 73BC of the *National Health Act 1953* continues in existence as the Private Health Insurance Risk Equalisation Trust Fund (the *Risk Equalisation Trust Fund*).

Clause 318-5 Amounts to be paid into the Risk Equalisation Trust Fund

Subclause (1) provides that amounts to be paid into the Risk Equalisation Trust Fund are:
- amounts appropriated by the Parliament;
- amounts received from the States or Territories for payment to the Fund;
- amounts received from private health insurers as risk equalisation levy or late payment penalty;
- amounts received by the Council for payment to the Fund, under paragraph 149-45(b), being the excess assets of terminated health benefits funds conducted by a not for profit private health insurer; and amounts of compensation for loss payable by officers under subclause 149-50(1);
- the proceeds from investment of Fund money.

Subclause (2) provides for the Consolidated Revenue Fund to be appropriated for paying to the Risk Equalisation Trust Fund amounts received from the States or Territories; amounts received from private health insurers as risk equalisation levy or late payment penalty; and amounts received by the Council under paragraph 149-45(b) or subclause 149-50(1).

Clause 318-10 Operation of the Risk Equalisation Trust Fund

Subclause (1) provides for the Private Health Insurance (Risk Equalisation Policy) Rules to set out requirements for the operation of the Risk Equalisation Trust Fund.

Subclause (2) provides for the Rules to specify the method for working out the amount to be paid out of the Fund to a private health insurer and the method for working out the amount to be paid into the Fund by private health insurers as a risk equalisation levy.

Subclause (3) provides that if the Minister changes the Private Health Insurance (Risk Equalisation Policy) Rules, the Council must be notified by the Minister as soon as practicable.

Clause 318-15 Administration of the Risk Equalisation Trust Fund

This clause provides that the Private Health Insurance (Risk Equalisation Administration) Rules may set out requirements relating to the administration of the Risk Equalisation Trust Fund and risk equalisation levy, including the kinds of records to be kept by insurers who are required to pay the risk equalisation levy and the form in which those records are to be kept.

PART 6-8 DISCLOSURE OF INFORMATION

Division 323 – Disclosure of information

Clause 323-1 Prohibition on disclosure of information

Subclause (1) provides that a person commits an offence, with a penalty of imprisonment for two years or 120 penalty units or both, if:

- they have or had a duty, function or power under this Act; and
- they disclose protected information which has not been authorised for disclosure to another person.

Subclause (2) defines protected information as information that:

- relates to a person other than the person who obtained it; and was either
- obtained by a person in the course of performing duties or functions, or exercising powers under this Act; or was
- obtained by a person by an authorised disclosure under clause 323-10, 323-15 or 323-20.

This means that information obtained by a person by an authorised disclosure under clauses 323-25, 323-30, or 323-35 (covering disclosure expressly or impliedly authorised by the subject, disclosure to a court or disclosure by the Council as part of its public information or agency cooperation functions under clause 264-10) is not to be treated as protected information.

Subclause (3) defines authorised disclosure of information as that made by a person under clauses 323-5 to 323-35 in this Division.

Clause 323-5 Authorised disclosure: official duties

This clause provides for the purposes of subclause 323-1(3) that a person may disclose information if the disclosure is made in the course of performing a duty or function, or exercising a power, under this Act, or for the purpose of enabling a person to perform functions under the *Medicare Australia Act 1973.*

Clause 323-10 Authorised disclosure: sharing information about insurers among agencies

Subclause (1) provides for the purposes of subclause 323-1(3) that a person listed in **subclause (2)** may disclose information to another such person if the information relates to:

- a private health insurer;
- an applicant to become a private health insurer;

- a person carrying on health insurance business; and/or
- a director or officer of one of these persons.

The information may not be information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be disclosed under this clause. The disclosure must be made in accordance with any requirements in the Rules.

Clause 323-15 Authorised disclosure: sharing information about insurers other than among agencies

Subclause (1) provides for the purposes of subclause 323-1(3) that a person may disclose information to another person if the information relates to:

- a private health insurer;
- an applicant to become a private health insurer;
- a person carrying on health insurance business; and/or
- a director or officer of one of these persons.

The information may not be information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be disclosed under this clause, and the disclosure must be:

- made in accordance with any requirements in the Rules; and
- must be a kind of disclosure certified by the Minister by written instrument to be in the public interest; and
- must comply with any conditions specified in the certificate by the Minister under subclause (2).

Subclause (2) provides for the Minister to specify conditions in a certificate relating to the application of the certificate.

Subclause (3) explains that the certificate made by the Minister is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003* as it only applies to particular disclosures.

Clause 323-20 Authorised disclosure: public interest

Subclause (1) provides for the purposes of subclause 323-1(3) that a person may disclose information to another person that does not relate to:

- a private health insurer; or
- an applicant to become a private health insurer; or
- a person carrying on health insurance business; or
- a director or officer of one of these persons.

The information may not be information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be disclosed under this clause, and the disclosure must be:

- made in accordance with any requirements in the Rules; and
- must be a kind of disclosure certified by the Minister by written instrument to be in the public interest; and
- must comply with any conditions specified in the certificate by the Minister under subclause (2).

Subclause (2) provides for the Minister to specify conditions in a certificate relating to the application of the certificate.

Subclause (3) explains that the certificate made by the Minister is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003* as it only relates to particular disclosures.

Clause 323-25 Authorised disclosure: by the Secretary or Council if authorised by affected person

This clause provides for the purposes of subclause 323-1(3) that the Secretary or the Council may disclose information to a person who is expressly or impliedly authorised by the person to whom the information relates to obtain it.

Clause 323-30 Authorised disclosure: court proceedings

This clause provides for the purposes of subclause 323-1(3) that a person who has or has at any time had a duty, function or power under this Act, may disclose to a court information that relates to another person for the purposes of an action or proceeding before the court to which that other person is a party.

Clause 323-35 Authorised disclosure: Council's public information and agency cooperation functions

This clause provides for the purposes of subclause 323-1(3) that the Council may disclose information to the extent necessary to perform the Council's public information functions under subclause 264-10(5) and agency co-operation functions under subclause 264-10(6).

Clause 323-40 Offence: disclosure of information obtained by certain authorised disclosures

This clause provides that a person commits an offence, with a penalty of imprisonment for two years or 120 penalty units or both, if:

- they obtain information by way of an authorised disclosure under clauses 323-10 to 323-20; and
- they disclose information which has not been authorised for disclosure.

Clause 323-45 Offence: soliciting disclosure of information

This clause provides that a person commits an offence with a penalty of imprisonment for two years or 120 penalty units or both, if:

- the person solicits the disclosure of information from another person; and
- the information is, or was originally, protected information; and
- the person knows or ought reasonably to know that the information is, or was originally, protected information; and
- the disclosure would not be an authorised disclosure.

Clause 323-50 Offence: use etc. of unauthorised information

This clause provides that a person commits an offence with a penalty of imprisonment for two years or 120 penalty units or both, if:

- information is disclosed to the person and the information is, or was originally, protected information; and
- the person knows that the information is, or was originally, protected information; and
- the person knows or ought reasonably to know that the disclosure is not an authorised disclosure; and
- the person solicited the disclosure of the information or discloses or uses the information.

Clause 323-55 Offence: offering to supply protected information

This clause provides that a person commits an offence with a penalty of imprisonment for two years or 120 penalty units or both, if:

- the person offers to supply information about another person; or
- holds himself or herself out as being able to supply information that is protected information; and
- the person knows that the information is protected information; and
- supply of the information would not be an authorised disclosure.

PART 6-9 REVIEW OF DECISIONS

Division 328 – Review of decisions

Clause 328-1 What this Part is about

This clause explains that several kinds of decisions made under this Act by the Medicare CEO, the Council, the Minister and the Private Health Insurance Ombudsman that are reviewable by the Administrative Appeals Tribunal.

Clause 328-5 AAT review of decisions

This clause provides that an application may be made to the Administrative Appeals Tribunal for review of the decisions made under the provisions of the Act set out in the table.

PART 6-10 MISCELLANEOUS

Division 333 – Miscellaneous

Clause 333-1 Delegation by Minister

Subclause (1) empowers the Minister to delegate in writing all or any of his or her functions or powers under the Bill, other than under clause 66-10, to the Secretary of the Department, an SES officer or acting SES officer of the Department, or the Council.

Without limiting subclause (1), **subclause (2)** allows the Minister to delegate in writing all or any of his or her functions or powers under Part 2-2 or Part 6-4 to the Secretary, the Medicare Australia CEO, an employee of Medicare Australia or an APS employee in the Department.

Subclause (3) requires delegates to comply with any directions of the Minister in performing delegated functions or exercising delegated powers.

Clause 333-5 Delegation by Secretary

Subclause (1) empowers the Secretary to delegate in writing all or any of his or her functions or powers under the Bill to an APS employee in the Department.

Subclause (2) requires delegates to comply with any directions of the Secretary in performing delegated functions or exercising delegated powers.

Clause 333-10 Approved forms

This clause provides that a statement, notice, application or other document is in the approved form if:

- it is in the form approved in writing by the person specified in the table at the end of subclause (1) as the approver; and
- it contains a declaration signed by a person or persons as the form requires;
- it contains the information that the form requires and any further information required by the approver in the form or otherwise; and
- it is given in the required manner.

Subclause (2) provides that if a statement, notice, application or other document is provided using the approved form and signed and given as required it is taken to be in the approved form for the purposes of subclause (1) if it contains the information required by the approver.

Subclauses (3) and **(4)** provide that an approved form may contain more than one statement, notice, application or other document, and that the approver may approve a different form for different private health insurers, and **subclause (5)** prevents the Medicare Australia CEO from approving a form that requires the tax file number of a person or any information about the physical, psychological or emotional health of a person.

Clause 333-15 Signing approved forms

This clause provides that a person required to do something in an approved form must sign a declaration if the form requires it, or have the declaration signed by on the person's behalf if allowed by the form.

Clause 333-20 Private Health Insurance Rules made by the Minister

This clause allows the Minister to make Private Health Insurance Rules by legislative instrument as set out in the table.

Clause 333-25 Private Health Insurance Rules made by the Council

This clause allows the Council to make Private Health Insurance Rules by legislative instrument as set out in the table.

Clause 333-30 Regulations

This clause empowers the Governor-General to make regulations for the purposes of the Act.

SCHEDULE 1 – DICTIONARY

Item 1 – Dictionary

The entries in the Dictionary either define terms or reference to where else they are defined.

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

This Bill (the Transitional and Consequential Bill) provides for the transition from the current regulatory regime to the new Private Health Insurance Bill. It also provides for the repeal of redundant Parts of the *National Health Act 1953* and *Health Insurance Act 1973* and makes amendments to a range of other Acts, mainly to reflect changes in the definitions of insurers and the products they offer.

PART 1 – PRELIMINARY

Clause 1 Short title

This sets out the short title of the Bill

Clause 2 Commencement

This clause sets out when the Bill and various provisions within it commence.

Clause 3 Schedule(s)

This clause specifies that each Act that is specified in a Schedule to this Bill is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this Bill has effect according to its terms.

Clause 4 Definitions

This clause defines terms used in the Bill. In particular, *new Act* means the proposed Private Health Insurance Act and *commencement time* means the time when the new Act commences.

PART 2 – TRANSITIONAL PROVISIONS RELATING TO CHAPTER 2 OF THE NEW ACT

Division 1 – Premiums reduction and incentive payment schemes

This Division, together with Schedule 3, allows the *Private Health Insurance Incentives Act 1998* (the 1998 Act) to apply with amendments under this Part until 30 June 2007 in relation to application for registration, and until 30 June 2008 in relation to payments of claims. Part 2-2 of the new Act will begin to apply from 1 July 2007.

Clause 5 Application of Part 2-2 of the new Act

This clause provides that Part 2-2 of the new Act applies to financial years beginning on or after 1 July 2007.

Clause 6 Application of the *Private Health Insurance Incentives Act 1998* from the commencement time to repeal

This clause provides for the ongoing operation of the 1998 Act until 30 June 2008.

Subclause (1) provides for how references to terms in the 1998 Act are to be understood from 1 April 2007 until 30 June 2008.

Subclause (2) provides that the changed meanings of terms under subclause (1) can continue after the repeal of the 1998 Act on 30 June 2008 because of the operation of this Part or section 8 of the *Acts Interpretation Act 1901*.

Clause 7 Continued application of section 11-50 of the *Private Health Insurance Incentives Act 1998*

Under section 11-50 of the 1998 Act insurers must retain applications for a period of 5 years. **Subclause (1)** requires insurers to continue to retain the applications for this period despite the repeal of the 1998 Act. **Subclause (2)** provides that the Medicare Australia CEO may continue to approve the form under which applications can be kept.

Division 2 – Lifetime health cover

Clause 8 Application of Part 2-3 of the new Act

This clause provides that premiums payable for hospital cover that are increased under lifetime health cover provisions in the *National Health Act 1953* before 1 April 2007 continue to apply until a new premium amount is calculated under the new Act.

Clause 9 Calculating 10 years' continuous cover under section 34-10 of the new Act

This clause allows a person's permitted days without cover and periods when they are taken to have hospital cover under the *National Health Act 1953* to be considered in working out periods of 10 years' continuous cover under clause 34-10 of the new Act.

PART 3 – TRANSITIONAL PROVISIONS RELATING TO COMPLYING HEALTH INSURANCE PRODUCTS

Clause 10 Status of existing applicable benefits arrangements and tables of ancillary benefits

Under the new Act insurers must offer complying health insurance products instead of applicable benefits arrangements and tables of ancillary benefits under the *National Health Act 1953*. **Subclauses (1)** and **(2)** provide that any applicable benefits arrangement or table of ancillary benefits in place before the commencement of the new Act is taken to be a complying health insurance product for the period until 30 June 2008. This allows insurers a transition period to ensure that their products comply with the new Act.

Subclause (3) provides that if the premiums, treatments or benefits of a product subject to this transition are changed in any way the new product must meet the complying health insurance product requirements under the new Act at the time of the change.

Clause 11 Premium requirement

This clause provides that if:

- an applicable benefits arrangements or a table of ancillary benefits under the *National Health Act 1953* is taken to be a complying health insurance product under clause 10 of this Bill; and
- the treatments or benefits of the product change in such a way it needs to comply with the new Act to be a complying health insurance product;

it is taken to comply if it meets all the requirements for a complying health insurance product except the requirement in section 66-5 for premiums to be approved by the Minister, as long as the premium does not change.

Clause 12 Benefit requirements: listing of no gap and gap permitted prostheses

This clause provides that if a prosthesis was a no gap prosthesis or a gap permitted prosthesis for the purpose of the *National Health Act 1953* before the commencement time the Minister may list the prosthesis in the Private Health Insurance (Prostheses) Rules under the new Act without an application being made under subsection 72-10(2) of the new Act. The person who was the sponsor of the prosthesis for the purposes of the *National Health Act 1953* is taken to be responsible for paying the ongoing listing fee under section 72-15 of the new Act.

Clause 13 Waiting periods

This clause ensures that people who have served all or part of their waiting period for an applicable benefits arrangement or table of ancillary benefits under the *National Health Act 1953* do not have to serve that period or part of the period again if their policy is taken to be a complying health insurance product under the new Act.

Clause 14 Quality assurance requirements

This clause provides that quality assurance requirements under the new Act do not apply until July 2008. This delayed commencement is intended to allow sufficient time for the Government to consult with insurers and service providers on the Rules to be made to give effect to the requirements.

PART 4 – TRANSITIONAL PROVISIONS RELATING TO CHAPTER 4 OF THE NEW ACT

Division 1 – Carrying on health insurance business

Clause 15 Hospitals

This clause provides that despite the repeal of sections of the *Health Insurance Act 1973* and the *National Health Act 1953,* facilities which were declared as hospitals under these Acts are taken to be public or private hospitals under the new Act until 1 July 2008. This provides a period of 15 months for hospitals to make an application to the Minister to be declared a hospital under the new Act. The Minister's powers to revoke declarations under the previous Acts are maintained.

Clause 16 Hospital treatment – outreach services

The definition of hospital treatment under the new Act includes services provided at a location other than a hospital, as long as it is provided or arranged with the direct involvement of a hospital. Under section 5D of the *National Health Act 1953* services of this nature could be determined by the Minister to be an outreach service.

This clause provides for outreach services determined under section 5D to be treated as hospital treatment under the new Act until 1 July 2008. The Minister's power to revoke a determination under section 5D of the *National Health Act 1953* will remain despite the repeal of this section.

Clause 17 Employee health benefits schemes

This clause allows arrangements declared as not being employee health benefits schemes under section 67 of the *National Health Act 1953* to continue under the new Act, but empowers the Minister to revoke the declaration even though section 67 has been repealed.

Division 2 – Registration

Clause 18 Registered organizations taken to be private health insurers

This clause allows organisations registered as registered organizations under the *National Health Act 1953* to be taken as private health insurers under the new Act until 1 July 2008. This clause ceases to apply if an organisation registers under Part 4-3 of the new Act. This provides a significant period of time for existing insurers to meet registration requirements under the new Act, including the requirement under section 126-10 to be a constitutional corporation registered under the *Corporations Act 2001*.

Subclause (3) clarifies that an organisation taken to be a private health insurer under subclause (1) can be deregistered by the Minister under the new Act.

Clause 19 Registered organizations established for profit

This clause allows a registered organization conducted for profit under the *National Health Act 1953* to be taken to be registered as a for profit insurer under the new Act. This does not prevent the for profit insurer from ceasing to be registered as such under the new Act.

Clause 20 Restricted membership organizations

This clause allows an existing restricted membership organization registered under the *National Health Act 1953* to be taken to be registered as a restricted access insurer under the new Act. This does not prevent the restricted access insurer from ceasing to be registered as such under the new Act.

Division 3 – Health benefits funds

Clause 21 Existing health benefits funds

This clause clarifies that the health benefits fund conducted by a registered organization under the *National Health Act 1953* that existed before the commencement of the new Act, including all of its assets and liabilities, is taken to be a health benefits fund under the new Act.

Clause 22 Applications for approval of mergers

This clause provides that undecided applications for mergers made under the *National Health Act 1953* are taken to be applications under section 146-5 of the new Act. This ensures that applicant organisations do not need to reapply because of the commencement of the new Act.

PART 5 – TRANSITIONAL PROVISIONS RELATING TO CHAPTER 5 OF THE NEW ACT

Division 1 – General enforcement methods

Clause 23 Continued application of Division 5 of Part VI of the *National Health Act 1953*

This clause provides that Division 5 of Part VI of the *National Health Act 1953* (the old enforcement provisions) continue to apply despite the repeal of that Division in respect of any breach of that Act and any enforcement action initiated under that Act.

Any direction given or undertaking made under the old enforcement provisions in force at the time the new Act commences continue and may be enforced under the old enforcement provisions.

Division 2 – Enforcement of health benefits fund requirements

Clause 24 Investigations into affairs of registered organizations

Subclause (1) provides that if:

- the Minister had appointed an inspector under section 82R of the *National Health Act 1953*; or
- the Council had appointed an inspector under paragraph 82R(1)(c) of the *National Health Act 1953* (because of an audit report on compliance with the *Private Health Insurance Incentives Act 1998*); and
- the investigation is not complete at the commencement of the new Act

then the investigation is to be completed under Part VIA of the *National Health Act 1953* as if that Part had not been repealed.

Subclause (2) provides that if:

- the Council had appointed an inspector under section 82R (other than under paragraph 82R(1)(c) of the *National Health Act 1953*; and
- the investigation is not complete at the commencement of the new Act

then Division 214 of the new Act applies.

Clause 25 Administration of funds and registered organizations

This clause allows an appointed administrator to continue to perform their duties under the *National Health Act 1953* if they were appointed before the commencement of the new Act and the administration is not completed. The functions and powers of the administrator and the Council in relation to the administration continue under Part VIA of the *National Health Act 1953* as if that Part had not been repealed.

Clause 26 Winding up of funds and registered organizations

This clause ensures that any administration related to the winding up of a fund or registered organization made under a Federal Court order or Council approval under Part VIA of the *National Health Act 1953*, which has not been completed before the commencement of the new Act, can continue under that Part as if that Part had not been repealed.

PART 6 – TRANSITIONAL PROVISIONS RELATING TO CHAPTER 6 OF THE NEW ACT

Division 1 – Private Health Insurance Ombudsman

Subdivision A Preliminary

Clause 27 Definitions

This clause defines terms used in the Part. In particular:

- *new Ombudsman* means the Statutory Agency of the PHIO established by Part 6-2 of the new Act;
- *old Ombudsman* means the corporation known as the PHIO established under the *National Health Act 1953*.

Subdivision B Assets, liabilities and legal proceedings

Clause 28 Vesting of assets of old Ombudsman
and
Clause 29 Vesting of liabilities of old Ombudsman

These clauses provide for the vesting of the assets and liabilities of the old Ombudsman immediately before the commencement time in the Commonwealth.

Clause 30 Certificates relating to vesting of land

This clause allows a land registration official of a State or Territory to register a transfer of land from the old Ombudsman to the Commonwealth on the basis of a certificate signed by the Minister.

Clause 31 Certificates relating to vesting of assets other than land

This clause allows an assets registration official of a State or Territory to register a transfer of assets other than land from the old Ombudsman to the Commonwealth on the basis of a certificate signed by the Minister.

Clause 32 Substitution of Commonwealth as a party to pending proceedings

This clause provides that if the old Ombudsman was a party to proceedings under way in any court or tribunal before the commencement time, the Commonwealth is substituted as a party to the proceedings.

Clause 33 Transfer of custody of old Ombudsman records

This clause provides that any records and documents held by the old Ombudsman are transferred into the custody of the new Ombudsman at the commencement time.

Subdivision C Reference to, and things done by or in relation to, old Ombudsman

Clause 34 References in instruments

Subclauses (1) and **(2)** provide that an instrument in force before the commencement time that refers to the old Ombudsman has effect from commencement time as if it referred to the new Ombudsman, unless the instrument relates to assets and liabilities under clauses 27 or 28, in which case the reference is taken as a reference to the Commonwealth.

Subclause (3) provides that an instrument in force before the commencement time that refers to a member of the staff of the old Ombudsman has effect from commencement time as if it referred to a member of the staff of the new Ombudsman under section 253-45 of the new Act.

Clauses (4) and **(5)** allow the Minister, by writing other than legislative instrument, to declare that:

- a reference under subclause (1) to the new Ombudsman is a reference to the Commonwealth;
- a reference under subclause (2) to the Commonwealth is a reference to the new Ombudsman;
- a reference under subclause (3) to a member of staff of the new Ombudsman is a reference to the new Ombudsman.

Subclause (6) allows the Private Health Insurance (Transition) Rules to provide that an instrument containing a reference specified in paragraph (4)(a) has effect as if the reference were a reference to somebody other than the Commonwealth, the new Ombudsman, or a member of the staff of the new Ombudsman.

Clause 35 Operation of laws

Subclause (1) provides that a thing done by the old Ombudsman before the commencement time under any law of the Commonwealth is taken to have been done by the new Ombudsman.

Subclause (2) provides that a thing done by the old Ombudsman before the commencement time under the *National Health Act 1953* is taken to have been done under the corresponding provision of the new Act (without changing the time it was actually done).

Subclause (3) provides that the new Ombudsman may handle a complaint made to the old Ombudsman before the commencement time as if it had been made under the new Act, even if it could not be made under the new Act.

Subclause (4) provides that the new Ombudsman may handle complaints under the new Act that arose under the *Private Health Insurance Incentives Act 1998*, even though that Act has been repealed.

Subclauses (5) and **(6)** allow the Minister, by writing other than legislative instrument, to determine that subclause (1) either does not apply, or applies as if the reference to the new Ombudsman were a reference to the Commonwealth.

Subclause (7) allows the Private Health Insurance (Transition) Rules to provide for a thing specified in a determination under paragraph (5)(a) to be taken to have been done by somebody other than the Commonwealth or the new Ombudsman.

Subclause (8) explains, for the avoidance of doubt among the sceptical, that doing a thing includes making an instrument.

Clause 36 Financial statements and other reporting requirements

Subclause (1) provides that the new Ombudsman must provide a report required by law of the old Ombudsman for a period that ended after the commencement time. **Subclause (2)** provides that if the new Ombudsman is required to produce a report under subclause (1) and a similar report for the remainder of the period, the requirement can be met with one report. However, if the Ombudsman does not choose to do this **subclause (3)** requires the report under subclause (1) to be provided no more than four months after the commencement time.

Subclause (4) provides that if the old Ombudsman had not met a reporting requirement the new Ombudsman must do so.

Subdivision D Private Health Insurance Ombudsman and staff

Clause 37 Private Health Insurance Ombudsman

This clause provides that the Private Health Insurance Ombudsman holding office under section 82ZR of the *National Health Act 1953* is taken to have been appointed under section 253-1 of the new Act for the balance of his or her period of appointment on the same terms and conditions as the original appointment.

Clause 38 Transfer of staff

Subclause (1) provides that staff that transfer from the old to the new Ombudsman and were entitled to long-service leave entitlements should have their entitlements and time served for that purpose transferred in their entirety.

Subclauses (2) and **(3)** allow regulations to be made for transitional matters related to transferring staff from the old to the new Ombudsman, including staffing procedures. **Subclause (4)** ensures that these regulations have effect despite the *Public Service Act 1999*, and s**ubclause (5)** specifies the kinds of processes and policies included as staffing procedures under this clause.

Subdivision E Miscellaneous

Clause 39 Appropriation of money

Subclause (1) provides that references in an Appropriation Act (defined in **subclause 3**) to the old Ombudsman are to be read as references to the new Ombudsman.

Subclause (2) provides that if an amount of money vests in the Commonwealth under clause 30 an equal amount may be paid out of the Consolidated Revenue Fund (which is appropriated accordingly) for the purposes of the new Ombudsman.

Clause 40 Exemption from stamp duty and other State or Territory taxes

This clause provides that no State or Territory stamp duty or other tax is payable in respect of the operation this Part, including particularly the transfer of assets or liabilities.

Clause 41 Constitutional safety net–acquisition of property

This clause provides that if the operation of the Bill would result in an acquisition of property from a person otherwise than on just terms (within the meaning of paragraph 51(xxxi) of the Constitution) the Commonwealth is liable to pay a reasonable amount of compensation to the person. If agreement cannot be reached on the amount of compensation, the person may take action in the Federal Court.

Clause 42 Certificates taken to be authentic

This clause provides that a document that appears to be a certificate given under this Part is to be taken to be authentic and properly given unless demonstrated otherwise.

Clause 43 Delegation by Minister

This clause allows the Minister to delegate all or any of his or her powers and functions under this Part to the new Ombudsman, and requires the new Ombudsman to comply with any directions by the Minister in exercising the delegated powers.

Division 2 – Private Health Insurance Administration Council

Clause 44 Members of the Council

This clause provides that a member of the Council holding office under section 82D of the *National Health Act 1953* continues to hold office under section 267-5 of new Act on the same terms and conditions and for the unexpired period of the original appointment.

Clause 45 Chief Executive Officer

This clause provides that the Chief Executive Officer of the Council holding office under section 82PH of the *National Health Act 1953* continues to hold that office under section 273-1 of the new Act on the same terms and conditions and for the unexpired period of the original appointment.

Clause 46 Staff and consultants

This clause ensures that staff and consultants employed or engaged by the Council under the *National Health Act 1953* continue to be employed on the same terms and conditions under section 273-15 of the new Act.

Division 3 – Administration of premiums reduction and incentive payment scheme

Clause 47 Application of Part 6-4 of the new Act

This clause provides that Part 6-4 of the new Act, under which a private health insurer that is a participating insurer may claim reimbursement for amounts by which premiums are reduced under Division 23 of the new Act, applies from 1 July 2007.

Clause 48 Transition to participating insurer under the new Act

This clause maintains an insurer's status as a participating insurer under the *Private Health Insurance Incentives Act 1998* under the new Act, but allows an insurer to apply to become a participating insurer under the new Act from 1 July 2007. The Minister may still revoke an insurer's status under the new Act.

Clause 49 Applications to become a participating insurer before 1 July 2007

Section 14-10(1)(c) of the *Private Health Insurance Incentives Act 1998* refers to the public officer as the signatory for applications. However, the public officer is not defined in the new Act.

Subclause (1) replaces the public officer with the chief executive officer of a private health insurer as the signatory for an application to become a participating insurer.

Subclause (2) ensures that an insurer will not need to reapply to become a participating insurer under the new Act if an application under the *Health Insurance Incentives Act 1998* was considered before 1 July 2007 and the Minister treats the application as if it were an application under the new Act.

Clause 50 Continued application of Division 16

This clause allows the Medicare Australia CEO to continue to exercise audit powers and request applications from participating insurers despite the repeal of the *Private Health Insurance Incentives Act 1998*.

Clause 51 Continued application of Division 18

This clause allows the Medicare Australia CEO to continue to recover debts from a person or their estate, or set off debts against other amounts, despite the repeal of the *Private Health Insurance Incentives Act 1998.*

Division 4 – Private health insurance levies

Clause 52 Continued application of Part VID of the *National Health Act 1953* in relation to matters arising before commencement of the new Act

This clause provides that Part VID of the *National Health Act 1953* continues to apply after it is repealed to an amount of levy or late payment penalty to which it applied before repeal, and that a process undertaken under Division 4 of the Part to search for levy related documents may continue.

Clause 53 Continued application of section 83I of the *National Health Act 1953*

This clause provides that the requirement under section 83I of the *National Health Act 1953* for registered health benefits organizations to hold levy related documents for seven years continues in force as if the section had not been repealed.

Division 5 – Disclosure of information

Clause 54 Transitional provision relating to secrecy obligations

This clause allows people who obtained information under the *National Health Act 1953* to disclose it under the new Act, despite subsection 135A(1) of the National Health Act, if:

- the disclosure is part of their duties or functions under the new Act; or
- the disclosure could have been made under Part 6-8 of the new Act if it had been obtained under the new Act.

PART 7 – MISCELLANEOUS

Clause 55 Private Health Insurance (Transition) Rules

This clause provides for the Minister to make Private Health Insurance (Transition) Rules providing for matters identified in the Bill, or necessary or convenient to give effect to the Bill, including:

- matters of a transitional nature relating to the repeals or amendments made by the Bill; or
- matters relating to the transition from the *National Health Act 1953* to the new Act.

Clause 56 Regulations

This clause provides that the Governor-General may make regulations for the purposes of this Bill.

SCHEDULE 1 – REPEALS

Part 1 – Repeal of provisions

Health Insurance Act 1973

Item 1 repeals the definition of *agreement* in subsection 3(1) (the definitions section) of the Act consequential to the repeal of Part III of the Act under item 4.

Item 2 repeals paragraph (a) of the definition of *patient contribution* in subsection 3(1) of the Act which refers to a State covered by an agreement under Part III of the Act, repealed by item 4.

Item 3 repeals sections 3A and 3B which deal respectively with determinations by the Secretary that patients need acute care and certification by medical practitioners that patients who have been in hospital longer than 35 days still require acute care. Section 3B also establishes the Acute Care Advisory Committee to review certificates. The development of contracting arrangements between hospitals and insurers and the introduction of minimum default benefits determined by the Minister have effectively made both sections redundant.

Item 4 repeals Part III of the Act. Apart from section 23EA providing for the declaration of premises as private hospitals, the rest of the Part has not been effective since the expiry of the Medicare Agreements on 30 June 1998. The present Australian Health Care Agreements between the Commonwealth and the States and Territories dealing with public hospital funding are made under the *Health Care Appropriation Act 1998,* which includes the principles set out in Part III.

Item 5 repeals Schedule 2A of the Act, which sets out the Heads of Agreement for agreements made under Part III.

National Health Act 1953

Items 6 to **49** repeal redundant definitions in subsection 4(1) (the definitions section) of the Act.

Item 50 repeals subsection 4(1AA) which deals with pathology services provided to hospital patients.

Item 51 repeals sections 5A to 5G. Section 5B, dealing with the declaration of premises as day hospital facilities, is subsumed in section 121-5 of the proposed Private Health Insurance Act. The other sections are no longer required.

Item 52 repeals the reference in subsection 6(1) to the Minister's powers under subsection 78(4A), as this section will also be repealed.

Item 53 repeals Parts VI to VID, which together make up the bulk of the regulatory regime which will now be included in the proposed Private Health Insurance Act.

Item 54 repeals subsections 105AB(1A) to (6AE), dealing with review of decisions under the repealed Parts VI to VID.

Item 55 repeals section 134D, which provides that registered health benefits organizations continue to be liable to comply with the Act even though the time period for compliance with a requirement has passed.

Item 56 repeals subsections 135A(4A) and (12A), which respectively allow the Council to publish statistical or financial information and permit the Commissioner of the Council to divulge information under the section as though he or she was the Secretary of the Department.

Item 57 repeals paragraphs 139A(1)(aa) to (c) which provide for the Secretary to certify, for evidential purposes, that organizations were registered or subject to particular conditions of registration

Item 58 repeals subsections 140(2) and (3) which provide for the making of regulations for various private health insurance purposes.

Item 59 repeals Schedule 1 (setting conditions of registration for registered health benefits organizations) and Schedule 2 (setting the rules for Lifetime Health Cover).

Remuneration Tribunal Act 1973

Item 60 repeals paragraph 7(9)(ae) which allows the Tribunal to determine remuneration for members of the Acute Care Advisory Committee to be abolished under item 3.

Part 2 – Repeal of Acts

Private Health Insurance (ACAC Review Levy) Act 2003

Item 61 repeals the Act, which is no longer required following abolition of the Acute Care Advisory Committee under item 3.

Private Health Insurance Incentives Act 1998

Item 62 repeals the Act, as incentives are now dealt with in Part 2-2 of the proposed Private Health Insurance Act. This item commences on 1 July 2008.

Schedule 2 – Amendments

Age Discrimination Act 2004

Item 1 amends Schedule 2 to insert a reference to sections 23-1, 23-10, 26-1 and 26-5 and Part 2-3 of the *Private Health Insurance Act 2006.* This will ensure that there is an exemption covering reduction in premiums based on a person's age and increases in premiums based on a person's age of entry when taking out hospital cover under Lifetime Health Cover.

Item 2 amends Schedule 2 to repeal table item 10 which refers to the *Private Health Insurance Incentives Act 1998.* This repeal commences on 30 June 2008.

A New Tax System (Goods and Services Tax) Act 1999

Item 3 replaces the definition of *private health insurance* in section 195-1 with a definition referring to the proposed Private Health Insurance Act.

A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Act 1999

Items 4 to **8** amend section 4 of the Act to replace terms drawn from the *National Health Act 1953* with terms in the proposed Private Health Insurance Act. The effect is to maintain the current policy of imposing a Medicare levy surcharge on persons who either do not have private health insurance covering hospital treatment, or else have such insurance but with excesses of more than $500 for a policy covering one person, or $1,000 for other policies.

Education Services for Overseas Students Act 2000

Item 9 replaces a reference in paragraph 7(2)(b) to a registered health benefits organization under the *National Health Act 1953* with a reference to a private health insurer under the proposed Private Health Insurance Act in the definition of *course money* which an education provider receives from a student.

Financial Sector (Collection of Data) Act 2001

Item 10 replaces the current paragraph 7(2)(d) providing that registered organizations under the *National Health Act 1953* are not registrable corporations with a provision referring to a corporation that is a private health insurer under the proposed Private Health Insurance Act. As a result private health insurers are not required to comply with the Act.

Financial Transaction Reports Act 1988

Item 11 amends the definition of *insurance business* in subsection 3(1) to refer to health insurance business carried on under the proposed Private Health Insurance Act, with the result that financial transactions carried on as part of health insurance business are not reportable under the Act.

Freedom of Information Act 1982

Item 12 amends Schedule 3 to include a reference to the disclosure of information provisions in the proposed Private Health Insurance Act, meaning that if the disclosure of documents would be an offence under sections 323-1 and 323-40 of the Private Health Insurance Act those documents are exempt from the Act.

Health Insurance Act 1973

Items 13 to **26** amend section 3 (the definitions section) of the Act.

Items 13, 14, 16, 17, 21, and **22** insert or amend definitions to refer to the proposed Private Health Insurance Act.

Items 15 and **23** insert definitions of *hospital service* and *public hospital service* respectively, following repeal under Schedule 1 of this Bill of Part III of the Act where these definitions are presently located.

Item 18 amends the definition of *nursing-home type patient* to refer to the care received and the status of the patient rather than the time the patient has been in hospital, and item 19 is a transitional provision stating that a person who was a nursing-home type patient immediately before the commencement of item 18 continues to be a nursing-home type patient under the proposed Private Health Insurance Act.

Item 20 amends the definition of *patient contribution* to remove a cross-reference to a State that is covered by an agreement, following the repeal of Part III of the Act under item 4 in Schedule 1.

Item 24 amends the definition of *recognized hospital* to provide that a recognised hospital is a hospital declared as a public hospital under subsection 121-5(8) of the proposed Private Health Insurance Act. While paragraph (a) of the current definition refers to recognized hospitals under an agreement, this has not been operative since the expiry of the Medicare Agreements made under Part III of the Act on 30 June 1998. Since then recognized hospitals have all been declared by the Minister under paragraph (b) of the definition.

Item 25 removes a note to subsection 3(1A) with a redundant reference to the *National Health Act 1953*.

Item 26 removes subsections 3(1B), (11) and (12) which contain redundant glosses on the definition of nursing-home type patient.

Item 27 replaces paragraph 10(2)(a) setting out when a 75% Medicare benefit is payable by reference to applicable benefits arrangements with a paragraph referring to hospital treatment and hospital-substitute treatment within the meaning of the proposed Private Health Insurance Act.

Items 28 and **29** amends sections 10AC and 10ACA to replace the exclusion from consideration under the family and single Medicare safety net respectively of services of the kind included in the definition of an applicable benefits arrangement under the *National Health Act 1953* with exclusion of services rendered to a person while hospital treatment is provided to the person (or hospital-substitute treatment if the person chooses to receive a benefit from a private health insurer).

Item 30 amends paragraph 14(2)(a) to replace a reference to a medical purchaser-provider agreement with a reference to an agreement between a private health insurer and another person following the repeal of Part VI of the *National Health Act 1953* which defined medical purchaser-provide agreements.

Item 31 amends subparagraphs 16A(5AA)(d)(iv) and (e)(i) to remove the references to day hospital facility, as the definition of a day hospital facility will be subsumed into the definition of private hospital under section 121-5 of the proposed Private Health Insurance Act.

Item 32 repeals subsections 20A(2A) to (2D) which allow a patient in a hospital to assign his or her Medicare benefit to different people in different circumstances, and replaces them with a new subsection (2A) which allows a person covered for hospital treatment or hospital-substitute by a private health insurer by agreement to assign his or her Medicare benefit to the insurer, a billing agent or another person.

Items 33 and **34** amend section 20B to extend from six months to two years the period following the provision of the professional service during which a claim for an assigned benefit may be made without consideration by the Minister. This will alleviate some administrative difficulties faced by Medicare Australia.

Item 35 amends section 39 to replace a reference to a contributor to an applicable benefits arrangement with a reference to the equivalent term in the proposed Private Health Insurance Act.

Item 36 deletes the reference in subsection 124W(1) to Part III of the Act, following the repeal of that Part under Schedule 1.

Items 37 and **38** amend section 126, which presently exempts from the ban on medical insurance under subsection (1) applicable benefits arrangements of registered health benefits organizations under the *National Health Act 1953*. The exemption in subsection (5A) is recast to refer to complying health insurance policies covering hospital treatment or hospital substitute treatment, and a definition of "cover" is added to subsection (7).

Items 39 to **41** amend section 128C following the move of the definition of public hospital service from Part III of the Act to subsection 3(1).

Items 42 and **43** amend subsections 129AA(1A) and 129AA(1B) to replace the reference to registered organization with a reference to private health insurer.

Item 44 recasts subsection 129AA(5A) to simplify the drafting and replace the reference to registered organization with a reference to private health insurer.

Items 45 to **50** replace references in various paragraphs of section 130 to registered organization with references to private health insurer.

Hearing Services Administration Act 1997

Item 51 repeals a redundant definition of a *dependant* in subsection 5(2).

Income Tax Assessment Act 1997

Item 52 replaces the reference in section 50-30 to a registered health benefits organization not carried on for the profit or gain of its individual members as a tax exempt entity with a reference to a private health insurer under the proposed Private Health Insurance Act.

Insurance Act 1973

Item 53 replaces the definition of *health insurance business* in the definition of insurance business in subsection 3(1) with a reference to health insurance business carried on by a private health insurer under the proposed Private Health Insurance Act, with the result that this business is exempt from the requirements of the Act.

Insurance Contracts Act 1984

Item 54 replaces the definition of insurance entered into or proposed to be entered into by a registered health benefits organization in paragraph 9(1)(b) with a definition of insurance entered into or proposed to be entered into by a private health insurer under the proposed Private Health Insurance Act, with the result that such contracts are exempt from the requirements of the Act.

Life Insurance Act 1995

Item 55 replaces a reference in the note to subsection 16ZB(2) to the *National Health Act 1953* with a reference to the proposed Private Health Insurance Act as the legislation that regulates jointly regulated friendly societies.

Item 56 replaces a reference to the definition of health insurance business in the Schedule to section 67 of the *National Health Act 1953* with a reference to Division 121 of the proposed Private Health Insurance Act.

Medibank Private Sale Act 2006

Items 57 to **59** amend the definitions of *contributor*, *registered health benefits organization* and *rules* in item 1 of Schedule 2 to the Act to change the reference to the *National Health Act 1953* to the *National Health Act 1953* immediately before the commencement of the proposed Private Health Insurance Act.

Items 60 and **62** to **65, 68** and **70** add the proposed Private Health Insurance Act to a list of provisions including the *Corporations Act 2001*, the *National Health Act 1953* and a rule of common law or equity which are referred to in various items of the Schedules to the Act.

Items 61, 66 and **67, 69** and **71** to **73** replace references in various items of the Schedules to the Act to sections 73AAC and 73AAD on the *National Health Act 1953* with a reference to section 137-10 of the proposed Private Health Insurance Act.

Medical Indemnity Act 2002

Item 74 adds to the list of legislation in paragraph 77(2)(c) the proposed Private Health Insurance Act, with the result that a person dealing with information under the Act does not commit an offence if in doing so he or she is performing a function under the Private Health Insurance Act.

Medicare Levy Act 1986

Items 75 to **79** amend section 4 of the Act to replace terms drawn from the *National Health Act 1953* with terms in the proposed Private Health Insurance Act. The effect is to maintain the current policy of imposing a Medicare levy surcharge on persons who either do not have private health insurance covering hospital treatment, or else have such insurance but with excesses of more than $500 for a policy covering one person, or $1,000 for other policies.

National Blood Authority Act 2003

Item 80 amends paragraph 10(3)(a) to remove a reference to section 23E of the *Health Insurance Act 1973* following the repeal of Part III and the relocation of definitions to subsection 3(1) in that Act.

National Health Act 1953

Items 81 to **88** insert or amend definitions in subsection 4(1) (the definitions section) of the Act.

Items 81 to **86** and **88** add definitions to subsection 4(1) of *complying health insurance policy*, *hospital*, *hospital treatment*, *hospital-substitute treatment*, *private health insurer*,

public hospital and *rules* (of a private health insurer) that refer to how or where these terms will be defined in the proposed Private Health Insurance Act. Item 87 inserts into the subsection the definition of *public hospital authority* which is removed from section 84 of the Act by item 92.

Items 89 and **90** replace references to registered organization and registered health benefits organization in subsections 50(1) and (4) dealing with payment of nursing home fund benefit with references to private health insurer.

Items 91 and **92** repeal the definitions of *public hospital* and *public hospital authority* in subsection 84(1) as these terms are now defined in subsection 4(1).

Item 31 and **94** remove the reference in paragraph 84AAA(1)(c) to a hospital being defined by reference to the *Health Insurance Act 1973*, as it is now defined in subsection 4(1), and the reference to a day hospital facility as this is now subsumed within the definition of a hospital; and amends the note at the end of subsection 84AAA(1) to refer to the term hospital being defined in subsection 4(1).

Items 95 replaces subsection 92B(2) with a new subsection providing that a private health insurer is not prevented from entering into a complying health insurance policy under which the insurer covers the cost of pharmaceutical benefits dispensed as part of an episode of hospital treatment or hospital-substitute treatment.

Item 96 to **102** amend the secrecy section of the Act (section 135A) to remove redundant subsections and replace redundant terms.

Item 103 removes the subsection number (1) in section 140 as subsections (2) and (3) were repealed by item 49 in Schedule 1.

Veterans' Entitlements Act 1986

Item 104 replaces subsection 93A(1) which defines *contributor* and *registered health benefits organisation* by reference to the *National Health Act 1953* with a new subsection that defines contributor and private health insurer by reference to the proposed Private Health Insurance Act.

Items 105 to **107** replace redundant references in section 93A to registered organization with references to private health insurer or insurer.

Schedule 3 – Amendments relating to transition from *Private Health Insurance Incentives Act 1998*

Income Tax Assessment Act 1936

Item 1 amends paragraph 16(4)(fb) to remove the reference to the *Private Health Insurance Incentives Act 1997* and add a reference to Parts 2-2 or 6-4 of the proposed Private Health Insurance Act.

Items 2 and **3** amend subsection 159J(6) to include a reference to both the proposed Private Health Insurance Act and the *Private Health Insurance Incentives Act 1998* for the period from 1 July 2007 to 1 July 2008, and remove the reference to the *Private Health Insurance Incentives Act 1998* after that time.

Items 4 to **7** amend section 264BB providing for people to claim a taxation rebate on their private health insurance premiums to replace terms drawn from the *National Health Act 1953* with terms defined in the proposed Private Health Insurance Act.

Income Tax Assessment Act 1997

Items 8 and **9** amend subsection 52-125 to include a reference to both the proposed Private Health Insurance Act and the *Private Health Insurance Incentives Act 1998* for the period from 1 July 2007 to 1 July 2008, and remove the reference to the *Private Health Insurance Incentives Act 1998* after that time.

Private Health Insurance Incentives Act 1998

These amendments relate to "turning off" the scheme in the period from 1 July 2007, after which Parts 2-2 and 6-4 of the proposed Private Health Insurance Act begin to operate, to 30 June 2008, when the Act will be repealed.

Item 10 amends paragraph 4-5(1)(a) to provide a person is not entitled to a payment under the Act in relation to premium paid beginning after 30 June 2007.

Items 11 and **12** amend section 11-10 to add a new subsection (2) providing that no-one is eligible to apply for registration under the premiums reduction scheme after 30 June 2007.

Item 13 adds a new subsection 12-5(7) providing that a premium reduction is not allowable under the scheme for premiums paid for a period beginning after 1 July 2007.

Item 14 amends subsection 12-10(2) to provide that a person cannot be a participant in the premiums reduction scheme for a financial year beginning after 30 June 2007.

Item 15 amends section 15-5 to make it clear that a health fund can only claim reimbursement under the Division for an amount of premium reduced because of the operation of the Chapter.

Item 16 amends subsection 15-23(2) to provide that applications by health funds for additional or late payments must be made by 30 June 2008.

PRIVATE HEALTH INSURANCE (PROSTHESES APPLICATION AND LISTING FEES) BILL 2006

NOTES ON CLAUSES

Clause 1 Short title

This clause sets out the short title of the Bill.

Clause 2 Commencement

This clause provides that the Bill commences at the same time as the proposed Private Health Insurance Act.

Clause 3 Imposition of application fees

This clause provides that the Private Health Insurance (Prostheses Application and Listing Fee) Rules may specify the application fee for applications made under section 72-10 of the proposed Private Health Insurance Act, and imposes the fee as a tax.

Clause 4 Imposition of listing fees

This clause provides that the Private Health Insurance (Prostheses Application and Listing Fee) Rules may specify the initial listing fee and ongoing listing fee for the purposes of sections 72-10 and 72-15 respectively of the proposed Private Health Insurance Act, and imposes the fees as a tax. The Rules may specify up to two days in any period of twelve months as ongoing listing fee imposition days.

Clause 5 Matters relating to application fees and listing fees

Subclause (1) provides for the Private Health Insurance (Prostheses Application and Listing Fee) Rules to specify different application fees under subclause 3(1), initial listing fees under subclause 4(1) or ongoing listing fees under subclause 4(3) for different circumstances.

Subclauses (2) and (3) sets maximum amount for an application, initial listing fee or ongoing listing fee as $2,000 in the financial year in which this Bill commences, and provide for the maximum amount of a fee in a later financial year to be worked out under clause 6.

Subclause (4) provides that the amount of a fee may be nil.

Subclause (5) provides that the fees do not have to bear any relationship to the cost of services provided.

Clause 6 Indexation of maximum fees

Subclause (1) provides for calculating a fee under clause 5 by multiplying the indexation factor for the financial year by the maximum amount of the fee in relation to the previous financial year.

Subclause (2) defines the index number, for the quarter, as the All Groups Consumer Price Index number and calculates the indexation factor for the financial year as the sum of the index numbers for the quarters in the year ending on the previous 31 March divided by the

sum of the index numbers for the quarters in the year ending on 31 March just before the start of the relevant financial year.

Subclause (3) provides that if the indexation factor for the financial year worked out under subclause (2) is 1 or less, then the maximum amount of an application fee or listing fee for an application made in the financial year is the previous year's maximum.

Clause 7 Person liable for fee

Subclause (1) provides that a person who makes an application under section 72-10 of the proposed Private Health Insurance Act is liable to pay the application fee at the time the application is made. **Subclause (2)** provides that if the Minister grants the application, the person who made the application is liable to pay the listing fee for the application when informed of the Minister's decision and the ongoing listing fee on each subsequent ongoing listing fee imposition day.

Subclause (3) provides that if a prosthesis was listed in the Rules in accordance with the section 12 of the Transitional and Consequential Bill, the person who was a sponsor of that prosthesis under the *National Health Act 1953* is liable to pay the ongoing listing fee.

Clause 8 Private Health Insurance (Prostheses Application and Listing Fee) Rules

This clause provides that the Minister may, by legislative instrument, make Private Health Insurance (Prostheses Application and Listing Fee) Rules for the purposes of this Act.

Clause 9 Regulations

This clause provides that the Governor-General may make regulations prescribing matters necessary or convenient for the purposes of carrying out or giving effect to this Act.

PRIVATE HEALTH INSURANCE (COLLAPSED ORGANIZATION LEVY) AMENDMENT BILL 2006

NOTES ON CLAUSES

Clause 1 Short title

This clause sets out the short title of the Bill.

Clause 2 Commencement

This clause sets out the commencement day for the various provisions in the Bill.

Clause 3 Schedule(s)

This clause provides that each Act specified in a Schedule to the Bill is amended or repealed as set out in the Schedule, and any other item in a Schedule has effect according to its terms.

Schedule 1 – Amendments

Private Health Insurance (Collapsed Organization Levy) Act 2003

Item 1 amends the title to replace "collapsed organization levy on registered health benefits organizations" with "collapsed insurer levy on private health insurers" following changes to terminology arising from the replacement of the *National Health Act 1953* by the proposed Private Health Insurance Act.

Item 2 amends section 1 to reflect the replacement of registered health benefits organizations under the *National Health Act 1953* with private health insurers in the proposed Private Health Insurance Act.

Items 3 and **4** repeal the definitions of *capital adequacy requirements* and *capital adequacy standard* in section 5.

Item 5 inserts a definition in section 5 of *collapsed insurer* as a private health insurer if:

- the Council has approved the termination of all of the insurer's health benefits funds under section 149-10 of the proposed Private Health Insurance Act; or
- the Council has appointed an external manager to one or more of a private health insurer's health benefits funds under section 217-10.
- the Federal Court has ordered the appointment of a terminating manager for all of the insurer's health benefits funds under section 220-5 of the proposed Private Health Insurance Act; or

Item 6 inserts into section 5 a definition of *collapsed insurer levy* as the levy imposed under section 7.

Item 7 inserts into section 5 a definition of *collapsed insurer levy day* as the day specified in a determination under section 7 of the Act.

Items 8 to **10** repeal the definitions of *collapsed organization*, *collapsed organization levy* and *collapsed organization levy day* in section 5.

Item 11 inserts into section 5 a definition of *complying health insurance policy* as defined in the proposed Private Health Insurance Act.

Item 12 replaces the reference to the *National Health Act 1953* in the definition of Council in section 5 with a reference to the proposed Private Health Insurance Act.

Item 13 repeals the definition of the *National Health Act* in section 5, as this is now redundant.

Item 14 inserts a definition of *private health insurer* in section 5 to have the same meaning as in the proposed Private Health Insurance Act.

Items 15 to **17** repeal the definitions of *registered health benefits organization, solvency requirements* and *solvency standard* in section 5.

Item 18 repeals section 6, and replaces it with a new section which describes the purpose of a collapsed insurer levy as being to meet the collapsed insurer's liabilities to the people insured under its complying health insurance policies that it is unable to meet itself.

Item 19 repeals section 7, and replaces it with a new section which imposes collapsed insurer levy. If a private health insurer is a collapsed insurer and the Minister determines that this section applies, a collapsed insurer levy is imposed on each private health insurer (other than an exempt insurer) on each collapsed insurer levy day for the levy determination. The Minister may determine the collapsed insurer levy day or days for the levy determination.

Item 20 repeals section 8, and replaces it with a new section which describes an exempt insurer. Subsection 1 provides that an insurer is exempt if it is the collapsed insurer or another insurer determined by the Minister. Subsection 2 provides that the Minister may make a determination if he or she is satisfied that imposition of the levy would significantly adversely affect the insurer's inability to comply with the solvency standard or capital adequacy standard under the proposed Private Health Insurance Act, or a solvency direction or capital adequacy direction made under Divisions 140 or 143 of that Act.

Item 21 replaces the references to organization throughout subsection 9(1) with references to insurer.

Item 22 repeals paragraph 9(1)(a) and inserts a new paragraph to replace the reference to the rate of levy being determined in writing by the Minister with a reference to it being determined by the Minister by legislative instrument.

Item 23 replaces the reference in subsection 9(2) to the organization's liabilities to its contributors with a reference to the insurer's liabilities to people insured under its complying health insurance policies.

Item 24 repeals subsections 9(3) and 9(4), and inserts a new subsection 3 which determines the rate of levy. It must be based on the number of complying health insurance policies on issue on the day determined by the Minister, may be different for complying health insurance policies under which different numbers of people are insured and may be set at zero.

Item 25 replaces the reference to organization in subsection 10(1), wherever it occurs, with a reference to insurer.

Item 26 replaces the reference to the organization's liabilities to its contributors in paragraph 10(1)(f) with a reference to the insurer's liabilities to people insured under its complying health insurance policies.

PRIVATE HEALTH INSURANCE COMPLAINTS LEVY AMENDMENT BILL 2006

NOTES ON CLAUSES

Clause 1 Short title

This clause sets out the short title of the Bill.

Clause 2 Commencement

This clause sets out the commencement day for the various provisions in the Bill.

Clause 3 Schedule(s)

This clause provides that each Act specified in a Schedule to the Bill is amended or repealed as set out in the Schedule, and any other item in a Schedule has effect according to its terms.

Schedule 1 – Amendments

Private Health Insurance Complaints Levy Act 1995

Item 1 amends the title to replace *businesses conducted by registered organizations* to *business conducted by private health insurers* to reflect the replacement of the *National Health Act 1953* by the proposed Private Health Insurance Act.

Item 2 amends the short title of the Act in section 1 from C*omplaints Levy* to *(Complaints Levy)*.

Item 3 replaces within the definition of health insurance business in subsection 3(1) the reference to section 67 of the *National Health Act 1953* with a reference to the proposed Private Health Insurance Act.

Item 4 inserts in subsection 3(1) a definition of *complaints levy day* as the day specified by the Private Health Insurance (Complaints Levy) Rules under proposed new subsection 5(2)

Item 5 inserts a definition in subsection 3(1) of *supplementary complaints levy day* as a day specified in a determination by the Minister under the proposed new section 5.

Item 6 repeals subsection 3(2) and replaces it with a new subsection which provides that other expressions used in this Act have the same meanings as in the proposed Private Health Insurance Act.

Item 7 repeals section 5, and replaces it with a new section, which imposes complaints levy on the conduct of health insurance business by private health insurers on each day specified in the Private Health Insurance (Complaints Levy) Rules as a complaints levy day for a financial year, and on each day determined by the Minister as a supplementary complaints levy day for a financial year. There may be no more than four complaint levy days and two supplementary complaint levy days for a financial year.

Item 8 repeals section 6, and replaces it with a new section. Proposed subsection (1) defines a complaints levy day as that specified in the Private Health Insurance (Complaints Levy) Rules and a supplementary complaints levy day as that determined by the Minister by legislative instrument.

Subsection (2) provides that the rate of levy must be based on the number of complying health insurance policies on issue, may be different for complying health insurance policies under which different numbers of people are insured, may be set at zero, and must not exceed:

- 50 cents a quarter in respect of complying health insurance policies under which only one person is insured; and
- $1 a quarter in respect of other policies.

These rates have not been increased since the Act was passed in 1995, and are now aligned with the rates in the Council Administration Levy Act passed in 2003.

Item 9 replaces the reference in section 7 to the registered organization conducting the health insurance business to each private health insurer conducting the health insurance business.

Item 10 repeals section 8, and replaces it with a new section under which the Minister may, by legislative instrument, make Private Health Insurance (Complaints Levy) Rules providing for matters required, permitted, necessary or convenient to carry out or give effect to this Act.

PRIVATE HEALTH INSURANCE (COUNCIL ADMINISTRATION LEVY) AMENDMENT BILL 2006

NOTES ON CLAUSES

Clause 1 Short title

This clause sets out the short title of the Bill.

Clause 2 Commencement

This clause sets out the commencement day for various provisions in the Bill.

Clause 3 Schedule(s)

This clause provides that each Act specified in a Schedule to the Bill is amended or repealed as set out in the Schedule, and any other item in a Schedule has effect according to its terms.

Schedule 1 – Amendments

Private Health Insurance (Council Administration Levy) Act 2003

Item 1 amends the title to replace the reference to "registered health benefits organizations" with a reference to "private health insurers" following changes to terminology arising from the replacement of the *National Health Act 1953* by the proposed Private Health Insurance Act.

Item 2 amends section 5 to insert a definition of *complying health insurance policy* as defined in the proposed Private Health Insurance Act.

Item 3 replaces the reference to the *National Health Act 1953* in the definition of Council in section 5 with a reference to the proposed Private Health Insurance Act.

Item 4 replaces the reference to the *regulations* in the definition of the Council administration levy day in section 5 with a reference to *Private Health Insurance (Council Administration Levy) Rules*.

Item 5 repeals the definition of the *National Health Act* in section 5, as this is now redundant.

Item 6 amends section 5 to insert a definition of *private health insurer* as defined in the proposed Private Health Insurance Act.

Item 7 repeals the definition of *registered health benefits organization* in section 5, as this is now redundant.

Item 8 amends subsection 6(1) to replace the reference to registered health benefits organization with a reference to private health insurer.

Item 9 amends subsection 6(1)(a) to replace the reference to the regulations with a reference to the Private Health Insurance (Council Administration Levy) Rules.

Item 10 amends subsection 6(1)(b) to replace the reference to the Minister determining the supplementary Council administration levy day in writing with a reference to determined by the Minister, by legislative instrument.

Item 11 amends subsection 6(2) to replace the reference to the regulations with a reference to the Private Health Insurance (Council Administration Levy) Rules.

Item 12 repeals subsection 6(4), as this is now redundant.

Item 13 amends subsection 7(1)(table item 1) to replace the reference to the regulations with a reference to the Private Health Insurance (Council Administration Levy) Rules.

Item 14 amends subsection (1) (table item 2) to replace the reference to the rate of levy being determined in writing by the Minister with a reference to it being determined by the Minister by legislative instrument.

Item 15 repeals subsection 7(2) and replaces it with a new subsection which provides:

- at paragraph (a) that the rate of levy must based on the number of complying health insurance policies on issue on
    - the census day specified in the Private Health Insurance (Council Administration Levy) Rules for levy imposed on a Council administration levy day, or
    - on the day determined by the Minister by legislative instrument as the census day for a supplementary Council administration levy day;
- at paragraphs (b) and (c) that the rate may be different dependent on the number of people the complying health insurance policy covers or may be set at zero; but
- under paragraph (d) must not exceed $2 annually for a policy where only one person is covered or $4 annually in respect of other policies.

Item 16 repeals subsection 7(3), as this is now redundant.

Item 17 inserts a new section 9A, providing for the Minister to make Private Health Insurance (Council Administration Levy) Rules for the purposes of the Act.

Item 18 is a transitional provision which provides that the total amount of levy imposed under the Act for financial year ending on 30 June 2007 must not exceed $2 for a policy where only one person is covered or $4 in respect of other policies, and that the number of levy days for the same year must not exceed six.

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

NOTES ON CLAUSES

Clause 1 Short title

This clause sets out the short title of the Bill.

Clause 2 Commencement

This clause sets out the commencement day for the various provisions in the Bill.

Clause 3 Schedule(s)

This clause provides that each Act specified in a Schedule to the Bill is amended or repealed as set out in the Schedule, and any other item in a Schedule has effect according to its terms.

Schedule 1 – Amendments

Private Health Insurance (Reinsurance Trust Fund Levy) Act 2003

Item 1 amends the title of the Act following the change in name from the Reinsurance Trust Fund to the Risk Equalisation Trust Fund under Part 6-7 of the proposed Private Health Insurance Act, and other changes to terminology in that Act.

Item 2 amends section 1 to reflect the change in name of the Reinsurance Trust Fund to the risk equalisation fund.

Item 3 replaces the reference in section 5 to the National Health Act in the definition of *Council* in section 5 with a reference to the proposed Private Health Insurance Act.

Item 4 repeals the definition of the *National Health Act* in section 5, as this is now redundant.

Item 5 amends section 5 to insert a definition of *private health insurer* as defined in the proposed Private Health Insurance Act.

Item 6 amends the definition of *registered health benefits organization* to reflect the proposed repeal of the National Health Act 1953.

Items 7 to **9** repeal the definitions of *Reinsurance Trust Fund*, *Reinsurance Trust Fund levy* and *Reinsurance Trust Fund levy day* in section 5, as these are now redundant.

Item 10 amends section 5 to include a definition of *risk equalisation levy* as a levy imposed under section 6.

Item 11 amends section 5 to include a definition of *risk equalisation levy day* as a day specified in the Private Health Insurance (Risk Equalisation Levy) Rules made under section 6.

Item 12 amends section 5 to include a definition of *Risk Equalisation Trust Fund* as the Private Health Insurance Risk Equalisation Trust Fund continued in existence under section Part 6-7 of the proposed Private Health Insurance Act.

Items 13 and **14** amend section 5 to replace the definition of a *supplementary Reinsurance Trust Fund levy day* with a definition of a *supplementary risk equalisation levy day* as a day specified by the Minister under section 6.

Item 15 repeals section 6, and replaces it with a new section, which imposes risk equalisation levy on each private health insurer on each day specified in the Private Health Insurance (Risk Equalisation Levy) Rules as a risk equalisation levy day, and on each day determined by the Minister as a supplementary risk equalisation levy day. There can be a maximum of four risk equalisation levy days and two supplementary risk equalisation levy days in a financial year.

Item 16 amends subsection 7(1) to replace the reference to the rate of Reinsurance Trust Fund levy with a reference to the rate of risk equalisation levy.

Item 17 repeals the table in subsection 7(1) and replaces it with a new table with references to the risk equalisation levy day and supplementary risk equalisation levy day (rather than Reinsurance Trust Fund levy day and Reinsurance Trust Fund supplementary levy day) and references to rates determined by the Council and the Minister by legislative instrument (rather than in writing).

Item 18 amends subsection 7(2) to require the Council and the Minister in setting the levy rate to comply with Private Health Insurance (Risk Equalisation Policy) Rules made under the proposed Private Health Insurance Act rather than follow principles determined under subsection 73BC(5B) of the *National Health Act 1953*.

Item 19 amends section 8 to omit all references to Reinsurance Trust Fund and substitute references to risk equalisation.

Item 20 adds a new section 10A empowering the Minister to make Private Health Insurance (Risk Equalisation Levy) Rules for the purpose of the Act.

Item 21 is a transitional provision which provides that the total number of days on which levy is imposed under the Act for the financial year ending on 30 June 2007 must not exceed six.