SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO:

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

SUBMISSION BY THE AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING

30 JANUARY 2007

INTRODUCTION

On 26 April 2006 the Australian Government announced a series of reforms to private health insurance to come into effect on 1 April 2007 to support innovation and improve choice in health care funded through private health insurance. It also announced that the regulatory framework governing private health insurance would be clarified and simplified, with the aim of imposing the minimum compliance requirements necessary to achieve the Government's policy objectives and protect the interests of consumers.

The legislation was last subject to major change in 1995. The current reforms will allow the private health sector to continue to evolve in line with contemporary clinical practice to meet consumer expectations.

The changes are consistent with the Australian Government's commitment to choice in health care. Over the last decade, the Government has implemented significant measures to enhance choice, certainty and the value of private health insurance and the sustainability of the private health care sector. These measures include the 30% Rebate, the increased rebate for older Australians, No Gap and Known Gap arrangements and Lifetime Health Cover.

A strong and vibrant private health sector complements and balances the delivery of health services through the public system, which in turn is underwritten by the universal access provided by Medicare. The Australian Government has a strong ongoing commitment to Medicare, and the proposed legislation does not in any way weaken this commitment.

The Bills will give effect to the reforms announced in April by:

- allowing private health insurance to provide and include in risk equalisation arrangements benefits for out-of-hospital services, including chronic care management for conditions such as diabetes and asthma, under broader health cover policies;
- requiring insurers to provide standard product information to help people compare policies and to understand their entitlements;
- eliminating Lifetime Health Cover penalties for fund members who have retained their hospital cover for more than ten years continuously;
- providing a framework for ensuring the quality and safety of services covered by private health insurance.

The concept of broader health cover is the key change that will affect the delivery of private health services. Hospital cover will expand to cover out-of-hospital services that substitute for or prevent hospitalisation. This is an important innovation. It will remove the legislative barrier to health insurers paying benefits for out-of-hospital medical services, which has been a significant impediment to the development of flexible health care products that better reflect contemporary clinical practice and meet consumers' growing needs and expectations. While some services such as general practice services will be excluded, broader health cover provides substantial scope for health insurers to work with industry partners to deliver services such as dialysis and chemotherapy more efficiently and effectively.

The Bills also consolidate the regulatory framework into one primary piece of legislation, and replace the current system of regulation through conditions of registration imposed on insurers with a transparent set of product standards. This will result in much clearer and simpler regulation for private health insurers and service providers.

The legislative package also:

- provides for the transition from the current regulatory regime;
- repeals redundant parts of the *National Health Act 1953* and amends a range of other Acts to reflect the new regime;
- imposes application and listing fees on the sponsors of prostheses; and
- amends the Acts imposing levies on private health insurers.

The proposed legislation reflects the considered and constructive input from the private health sector in what has been an extensive consultation process. Consistent with the importance of this process, the Minister for Health and Ageing has indicated the Government will consider amendments that are consistent with the Government's policy objectives. The proposed legislation does not detract from people's entitlements under Medicare. It will allow the private health sector to evolve in line with clinical practice and consumer expectations and will thereby ensure that consumers can continue to make a genuine health care choice between the private and public sectors.

THE EXISTING REGULATORY FRAMEWORK

Health Insurance Business

Health insurance is regulated by the *National Health Act 1953* and the *Health Insurance Act 1973*. This is different from other types of insurance, which are governed by the *Insurance Act 1973*. The only organisations lawfully able to provide health insurance business are those registered under the *National Health Act 1953* (referred to in the Act as "registered health benefits organizations" (RHBOs)).

Organisations may apply to the Private Health Insurance Administration Council (PHIAC) for registration as a health fund. Health funds can register as either open or restricted membership organisations. Membership of restricted membership organisations can be limited to an employment group, professional association or union.

Once registered, an RHBO can conduct health insurance business, which must be carried out through a health benefits fund. RHBOs can only engage in other business if the purpose is incidental to the conduct of the health benefits fund.

RHBOs can register on a not-for-profit or for-profit basis. Any surplus generated from the business of a not-for-profit RHBO must remain in the health benefits fund to be used for the benefit of contributors.

Prudential Regulation

PHIAC was established as the prudential regulator of health funds in 1989. It is a body corporate responsible to the Minister for Health and Ageing and has the power to:

- obtain regular reports from insurers;
- examine the financial affairs through inspection of records;
- appoint inspectors to investigate the financial affairs of the funds;
- establish solvency standards;
- review the value of assets;
- appoint administrators;
- approve the voluntary winding-up of insolvent health funds; and
- impose a levy on all other health funds to help meet those liabilities in the event of a fund not being able to meet its liabilities to contributors.

The solvency standard, which came into force in 2001, protects members from the collapse of a RHBO. The solvency requirement is determined by considering the various risks which could impact on the security of the fund's members' entitlements, and requires the provision of a prudent level of reserves against such risks.

The capital adequacy standard, which also came into force in 2001, ensures that the RHBO has sufficient assets on hand to conduct health insurance business. This relates to the payment of benefits to members on a day-to-day basis as well as meeting obligations to creditors. This standard is based on an ongoing view of the RHBO. The RHBO must demonstrate that it has appropriate capital to finance its business plans, absorb short term adverse experience from time to time, and continue to remain solvent.

PHIAC may appoint an administrator if it is satisfied that there has been a breach of the solvency standard or the capital adequacy standard.

Conduct and Supervision of Health Insurance Business
RHBOs are subject to many conditions of registration. Most of these are specified in Division 3 of Part VI and Schedule 1 of the *National Health Act 1953*, although others are determined by the Minister under section 73B. The conditions cover matters such as:

- categories of membership;
- waiting periods for benefits;
- transfer arrangements between tables and funds;
- the types and levels of benefits; and
- requirements about contracting with hospitals and doctors.

The existing legislation includes provisions to enforce the conditions of registration. The Minister may seek explanations from RHBOs of their activities, carry out an investigation, seek enforceable undertakings, impose directions and seek Federal Court orders to ensure compliance (sections 73BEB to 73BEO). PHIAC may appoint an administrator if a RHBO has contravened any rule, condition or direction imposed under the *National Health Act 1953* (section 82XF).

Under section 73BEN an officer of a RHBO that has contravened, or failed to comply with a provision of the Act or the regulations, or a condition of registration, or a direction imposed under the Act may be subject to a pecuniary penalty of up to $10,000. The most drastic sanction is deregistration under section 73AAB if the

RHBO amends its constitution or rules in such a way that the health benefits fund cannot be conducted in accordance with the Act.

Health Insurance Products

Presently, health insurance products that provide hospital cover are known by the statutory term Applicable Benefit Arrangement (ABA). The ABA is the arrangement whereby the RHBO accepts whole or partial liability to pay fees and charges on behalf of contributors in respect of:

- some or all hospital treatment provided by a hospital or a day hospital facility; and/or
- some or all of the professional services that are rendered to the contributor by a medical practitioner while that hospital treatment is being provided. (Professional services are medical services where a Medicare benefit is payable).

In conducting health insurance business, RHBOs also offer ancillary products. Ancillary benefits, which are often referred to as ‘extras’, are amounts paid for or towards the costs of a wide range of services, including dental, optometry and optical, physiotherapy, ambulance services, and aids, equipment and appliances.

ISSUES WITH THE CURRENT FRAMEWORK

The regulatory framework for private health insurance has grown and changed over time, but has not been subject to a comprehensive review for many years. As a result it has become increasingly burdensome, complex and outdated.

Legal Complexity

While the *National Health Act 1953* contains the main regulatory requirements for RHBOs, that Act needs to be read in conjunction with the *Health Insurance Act 1973,* as many requirements draw on elements of both Acts. In many cases terms used in one Act rely on definitions in the other; while in some cases the same concept is defined differently in the two Acts.

Significant elements of the requirements placed on private health insurers are not in primary legislation but in determinations made under the *National Health Act 1953*. While these are now registered on the Federal Register of Legislative Instruments, their existence is not always obvious and they are not always easy to locate.

The complexity of the legislation is exacerbated by the inclusion of many permissive provisions which are unnecessary, such as those purporting to allow health insurers to contract with service providers and undertake other activities which any corporate body can carry out. Such provisions are not required for the effective regulation of the private health insurance industry.

Finally, much of the language and many of the concepts used throughout the legislative framework is outdated. For example, terms such as ‘registered health benefits organization’ and ‘applicable benefits arrangements’ do not reflect contemporary corporate arrangements and parlance used to describe private health insurance and insurance products.

This situation is burdensome both to industry and government, and significantly complicates rather than clarifies the requirements placed on business.

Following recommendations of the *Report of the Taskforce on Reducing the Regulatory Burdens on Business – Rethinking Regulation*, the Australian Government is committed to further reducing red tape for business. This is one of the aims of the new legislation.

Scope of Coverage
Changes in clinical practice over the last two decades have resulted in a mismatch between contemporary health care activities and the legislative framework designed to regulate them.

Almost half of the Australian population is covered by private health insurance and the number of Australians covered continues to rise. It is important that the structure and content of the regulatory regime allows private health insurers to meet people's expectations that the product they buy will match their health care needs.

Private health insurance is presently offered as either 'hospital' or 'ancillary' insurance, reflecting what was historically a clear distinction between complex medical services provided inside the four walls of a hospital and simpler medically-related services provided in the community. As technology has evolved to allow many elements of what was once a hospital service to be provided in the community, this distinction is less and less relevant.

However, the regulation of private health insurance has not adapted to this change. Patients are finding that their insurance policy does not cover services which no longer require hospital admission if these services are provided outside hospital. While RHBOs would like to cover these services, the legislation prevents them from doing so.

Regulatory Focus
The legislative framework is based on conditions of registration imposed on RHBOs under the *National Health Act 1953*, augmented by additional conditions made by the Minister. This worked effectively in a period when insurance products were homogenous and relatively simple. However, it is a clumsy and indirect way of setting product standards for an evolving and competitive market. It focuses on the product provider even though the outcome the Government is seeking is to mandate aspects of health insurance products. This indirect approach makes it more difficult to achieve the desired regulatory outcomes in a clear and transparent way.

POLICY REFORM TO ENHANCE CHOICE, CERTAINTY AND THE VALUE OF PRIVATE HEALTH CARE

The legislative package gives effect to the reforms announced by the Government on 26 April 2006 to improve innovation and choice in private health care. It also addresses the problems with the regulatory framework outlined above.

The key elements of the proposed legislation are outlined below. A more detailed explanation is contained in Attachment A. Most of the new framework is incorporated in the main Bill, the *Private Health Insurance Bill 2006*.

Product and Insurer Regulation
The new regulatory regime will focus the regulation of health insurance directly on products rather than on conditions of registration imposed on insurers. At the heart of the new system is a clear and comprehensive set of product standards applying to complying health insurance products including hospital treatment, general (or ancillary) treatment, or a combination of both.

To protect the interests of consumers, health insurance policies must meet requirements in relation to:

- community rating requirements;
- premium and benefit requirements;
- waiting period and portability requirements;
- quality assurance requirements; and
- any requirements set out in the Private Health Insurance (Complying Product) Rules.

Related to product regulation, the legislation will impose a number of obligations on health insurers. It will be an offence to carry on health insurance business without being registered under the legislation and under the new arrangements insurers will have to be Australian Securities and Investment Commission registered corporations. Beyond registration, the principal obligation on health insurers will be to have health benefits funds for the conduct of health insurance business.

Health Benefits Funds
The current legislation requires RHBOs to have a health benefits fund. However, the legislation does not include a clear set of rules for the establishment, operation, merger and termination of these funds. The new framework will achieve these ends, which will assist prudential supervision by PHIAC and help support industry rationalisation.

The assets of the health benefits fund can only be used to meet the liabilities arising from the health insurance business, or any health related business, as well as management costs. However, insurers registered to operate on a for-profit basis may withdraw money for other purposes if the capital adequacy and solvency standards are not breached.

Broader health cover
Under complying products, health insurers will be able to choose to offer broader health cover. These products will cover out-of-hospital services that substitute for or prevent hospitalisation, and which can safely be delivered outside of a hospital setting. This is a significant innovation. It involves removing the legislative barrier to health insurers paying benefits for out-of-hospital medical services. This has been the key impediment to the development of flexible health care products that better reflect contemporary clinical practice and meet consumers' needs and expectations.

Broader health cover will allow for the best care to be provided in the most suitable location for the insured person. These changes mean that patients will be able to receive benefits for services that do not require admission to hospital. For example:

- an insured person with cataracts (a common reason for elderly people to be admitted to hospital) can have the surgical procedure done safely and effectively in a low acuity setting; and
- chemotherapy, the second most common reason for admission to hospital, can be more conveniently (and just as safely) provided in the community, either in people's homes or in a low acuity facility.

The proposed broader health cover arrangements are not expected to impose additional costs on consumers or the health system. Replacing hospitalisation with care in other settings, when it is clinically appropriate and convenient for consumers, has scope to reduce hospital costs and out-of-pocket expenses for consumers.

The new arrangements will cover a wide range of services, especially in relation to chronic disease management. However, the existing restriction on insurers paying benefits for out-of-hospital GP and specialist consultations that attract a Medicare rebate will continue. Broader health cover will not extend to the costs of accommodation in residential aged care services.

It is important to note that broader health cover arrangements will not limit the clinical freedom of medical practitioners. The legislation includes an explicit safeguard for this.

In practice, if a patient chooses to use their private health insurance to cover their treatment out-of-hospital, the Medicare benefit arrangements for broader health cover will mirror those for equivalent in-hospital services. Broader health cover will also attract the Government's private health insurance rebates.

Standard Information

Consumers will benefit from new standard product information requirements. Health insurers will be required to maintain and publish up-to-date information about their products including premiums, waiting periods, exclusions, hospital and medical gaps and excesses. Any change to a health insurance product will need to be reflected in an updated standard information statement.

Private health insurers will also be required to respond to information requests about their products, to give advance warning of detrimental changes, and to give information about the Private Health Insurance Ombudsman (PHIO). Product information will also need to be provided to the PHIO for publication on a new website. The website will enable consumers to compare different products and to better understand their policy entitlements.

The legislation also requires that private health insurers give the Department, PHIAC and the PHIO product information so that the Department and PHIAC can monitor compliance with the legislation and so that the PHIO can perform its functions.

Lifetime Health Cover
The new framework also includes changes to remove the Lifetime Health Cover loading from people who have paid a loading for ten continuous years. If a person has the loading removed and then leaves private health insurance and rejoins in the future, he or she will pay a loading as if they never had an exemption.

The new legislation also simplifies the Lifetime Health Cover rules. Presently, there are 17 different rules for determining a person's Lifetime Health Cover base day. This is complex and burdensome to administer. This complexity means that many new entrants to private health insurance who have arrived in Australia since 2000 may get the loading that the person behind the counter of the health fund thinks is a fair thing, rather than what the law requires.

The proposed legislation gets rid of the complexities and is much easier to follow. It has a flow chart setting out five possible Lifetime Health Cover base days.

Quality and Safety
New minimum safety and quality requirements for privately insured health services will come into operation from 1 July 2008. These requirements will ensure that all privately insured services are provided by accredited facilities and/or suitably qualified providers.

Enforcement
The majority of the offence provisions that currently exist in private health insurance legislation have been included in the main Bill. However, some new offences have been included. Where possible, these offences are modelled on existing Commonwealth law in the interests of consistency.

A number of strict liability offences have been included, generally relating to an insurer's failure to comply with an obligation to provide information. These have been cast as strict liability offences because failure to comply with the requirement would have a significant detrimental effect on the administration of the legislation, and proof of intent not to comply would be very difficult to obtain. It is important to have these strict liability offences to create a deterrent to non-compliance.

The proposed legislation also contains an offence provision relating to non-compliance with the core business requirement of only offering health insurance policies that comply with the legislation. The proposed legislation provides a defence of due diligence for chief executive officers and directors if they can demonstrate they have put in place systems intended to prevent the sale of non-complying policies.

The new framework also imposes on directors of health insurers the duty that already exists under the *Life Insurance Act 1995* of exercising due diligence to make sure insurers comply with the legislation in the interests of policy holders. The legislation makes clear that the duty imposed on directors does not detract from the duties they have as directors under the *Corporations Act 2001*.

HOW THE NEW REGULATION WILL WORK

The *Private Health Insurance Bill 2006* is arranged in order of the potential number of interested readers. Provisions dealing with the private health insurance rebate and Lifetime Health Cover are first, followed by product regulation, health insurer regulation, enforcement and then a range of administrative matters. In contrast, this overview follows the structure of the official guide to the legislation, as set out in the diagram on the next page:

1. Regulating Health Insurance Business;
2. Regulating Health Insurance Products;
3. Health Insurance Incentives;
4. Regulatory Oversight;
5. Enforcement; and
6. Miscellaneous Provisions.

This overview is not exhaustive. It focuses on the provisions of greatest relevance to the private health sector and those that are new. Key existing provisions that will migrate to the new consolidated framework are also highlighted. A more detailed explanation of the provisions can be found in the Explanatory Memorandum.

1. Regulating Health Insurance Business

The fundamental rules around health insurance business are set out in Part 4-2 of the *Private Health Insurance Bill 2006*, including the definition and scope of health insurance business, the requirements for carrying it out and the offences for breaching the rules.

All organisations engaging in health insurance business will continue to be required to be registered by PHIAC under Part 4-3. This continues the requirement under section 67 of the *National Health Act 1953*.

An insurer must at all times have one or more health benefits funds through which it conducts all of its health insurance business. The meaning of a health benefits fund and the rules for its establishment, operation, restructuring, and termination are set out in Part 4-4.

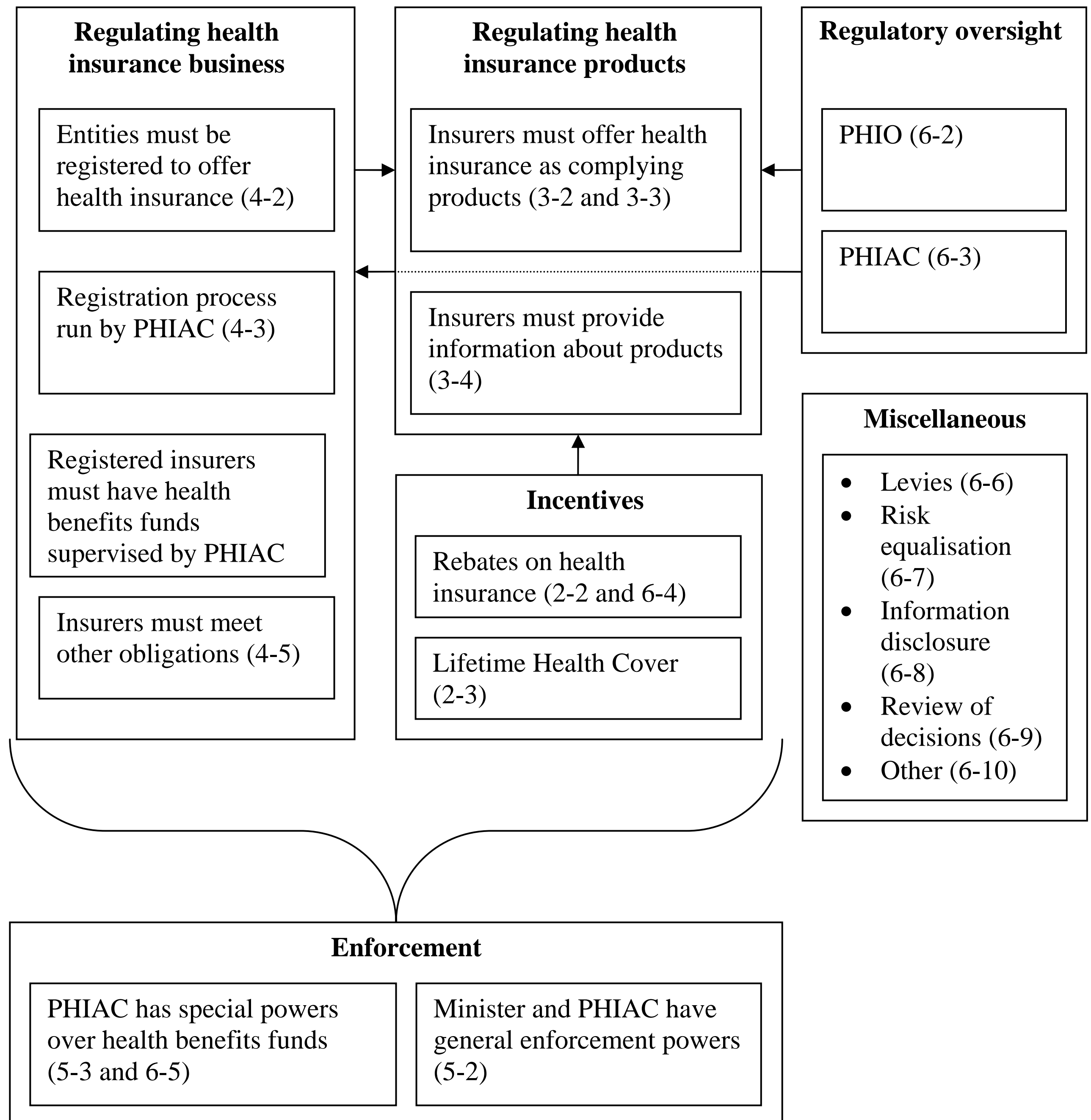
Part 4-5 sets out other insurer obligations, including:

- appointing an actuary with statutory powers (under Division 160);
- complying with any rules made under the Private Health Insurance (Insurer Obligations) Rules which may establish prudential standards (under Division 163);
- ensuring that disqualified persons do not act as a director or senior manager of the insurer (under Division 166);
- providing certain information to PHIAC and the Department, including notifying of changes to the rules governing the conduct of an insurer's health insurance business and changes to the person acting as its chief executive officer (under Division 169); and
- complying with other provisions (under Division 172), including any PHIAC requirements on the insurer, prohibitions on certain limitations within agreements with medical practitioners, provision of data to the Department under the Private

Health Insurance (Data Provision) Rules; and restrictions on payments of pecuniary penalties imposed on a director or officer of the insurer.

STRUCTURE OF THE BILL

(Part numbers are shown in brackets)



What is Health Insurance Business?

Meaning of *health insurance business*

Health insurance business is defined under section 121-1 as the business of undertaking liability by way of insurance for the cost of or provision of hospital treatment or general treatment. This definition replicates the current regime under section 67 of the *National Health Act 1953*.

Section 121-15 provides that health insurance business include an 'employee health benefits scheme', that is, any arrangement under which a company pays for all or part of the costs of hospital treatment or general treatment of its employees or contractors. Consequently, any company doing this is acting illegally unless it is an insurer registered with PHIAC.

However, subsection 121-15(3) allows an employer to pay for an employee's or contractor's health insurance premium, and/or 'top up' the difference between a benefit payable under a health insurance policy and the amount payable by the employee or contractor.

Exemptions from the definition of health insurance business include:

- accident and sickness insurance business, as long as liability is not undertaken for a liability to pay fees or charges for hospital treatment or general treatment (under section 121-20);
- liability insurance business, such as third party motor vehicle insurance or worker's compensation insurance (under section 121-25); and
- any other business specified in the Private Health Insurance (Health Insurance Business) Rules (under section 121-30).

The diagram in section 115-10 is a guide to determining whether a business is health insurance business.

Meaning of *hospital treatment*

Hospital treatment is defined in section 121-5. This definition has changed from the current regime by allowing services that may not be provided within the walls of a hospital to be considered as hospital treatment. However, the treatment must be provided by or under the management or control of a person who is authorised by a hospital to provide the treatment. Furthermore, the treatment must be provided at a hospital, or be provided or arranged with the direct involvement of a hospital.

The Minister has the power to declare a facility to be a *hospital* under subsection 121-5(6), having regard to matters set out in subsection 121-5(7). Subsection 121-5(8) requires that any such declaration states whether the hospital is a private or public hospital. These provisions set out a more transparent regime for determining hospitals than that currently in section 3 of the *Health Insurance Act 1973*.

Meaning of *general treatment*

General treatment is defined in section 121-10. It is analogous to 'ancillary health benefits' as defined in section 67 of the *National Health Act 1953*. Payments for professional services for which a Medicare benefit is payable continue to be

prohibited for general treatment under the new legislation unless allowed by the Private Health Insurance (Health Insurance Business) Rules.

A new type of treatment, *Hospital-substitute treatment*, is included in the proposed legislation and is defined in the Dictionary at Schedule 1. Hospital-substitute treatment should be viewed as a subset of general treatment rather than a separate type of treatment and allows for the payment of a benefit for services that substitute for hospital treatment and are provided by non-hospital providers.

Registration

Under section 68 of the *National Health Act 1953*, all organisations that engage in health insurance business must register as a private health insurer with PHIAC. This requirement and the registration process continue in the proposed legislation under Division 118, along with new injunction powers to prevent breaches of the requirement.

The process for registering as an insurer is set out in Part 4-3. Organisations that wish to engage in health insurance business will now be required to be corporations registered under the *Corporations Act 2001*. Such an organisation can apply to PHIAC under section 126-10 to be registered and must specify whether or not it wishes to be registered as a for-profit insurer or restricted access insurer. The applicant must also provide a copy of the rules proposed for the conduct of its health insurance business and *health related business* (as defined under section 131-15) to PHIAC and the Secretary of the Department.

PHIAC may request further information from the applicant under section 126-15 and can consider any matters it thinks fit other than those it is prohibited from considering under subsection 126-20(3). PHIAC must consider certain things in deciding the application under subsection 126-20(2).

Under subsection 126-20(4) PHIAC must refuse an application if the proposed rules allow improper discrimination as defined in section 55-5, after first consulting the Secretary of the Department.

Under subsection 126-20(5), an application for registration may be granted subject to certain terms and conditions. Registration may be backdated to before the date of the application, but any terms and conditions imposed will only apply from the date of notification of the registration.

An insurer granted registration as a restricted access insurer must under subsection 126-20(6) maintain its constitution so that:

- it describes the restricted group to which it provides insurance;
- it prevents the insurer from providing insurance to anyone else; and
- it prevents the insurer from ceasing to insure a person because they no longer belong to the restricted group.

An insurer may apply to change its registration category to or from a for-profit insurer or to or from a restricted access insurer under section 126-40.

PHIAC must cancel the registration of an insurer under section 126-45 if the insurer has not conducted health insurance business during the preceding 12 months or if the insurer's health benefits fund has been terminated. This addresses the lack of a process in the *National Health Act 1953* for deregistering insurers who have not contravened an obligation under that Act or had their health benefits fund wound up under that Act.

Health Benefits Funds

The *National Health Act 1953* uses the concept of a 'health benefits fund' to represent the financial structure of assets and liabilities of the health insurance business of an insurer. However, the rules concerning the operation of the fund under that Act are not sufficient for efficient regulatory oversight. The rules only extend generally to the depositing of income (section 68), the duties of an insurer regarding the application of the fund's assets (section 73AAC), the rules for payments out of the fund (section 73AAD), allowed financial transactions (section 73AAE) and mergers of funds (section 82ZP).

Part 4-4 of the proposed legislation provides more detailed rules for health benefits funds. The structure and rules for the operation of health benefits funds are based on the rules for statutory funds of life companies as set out in Part 4 of the *Life Insurance Act 1995*. The rules are designed to draw a clear distinction between the interests of the insurer and those of the people insured, and to simplify PHIAC's task in applying prudential standards.

A health benefits fund is defined under Division 131 as a fund related solely to some or all of an insurer's health insurance business but may also include some or all of an insurer's health related businesses as long as the dominant purpose of the fund is the insurer's health insurance business, as set out in section 134-10. This will mean that all of an insurer's businesses that relate to health can be operated through the same financial structure. Many insurers currently operate their businesses in this way.

The kind of businesses allowed as health related business must not be health insurance business but can be any one or a combination of:

- health related goods or service provision – to allow an insurer to operate clinics and hospitals;
- health insurance for those in Australia who are not eligible for Medicare – such as overseas student insurance and overseas visitor insurance; and
- health related financial products that assist insured people to meet their health costs – such as 'savings' products sold in conjunction with complying health insurance products.

It is a requirement under section 34-1 that an insurer must at all times have at least one health benefits fund (notified to PHIAC under section 134-5) through which it conducts all of its health insurance business. An insurer can have more than one health benefits fund for their health insurance business under section 134-1, but it cannot have more than one health benefits fund in a particular risk equalisation jurisdiction unless the health benefits funds were established before commencement of the Act and run by a registered organization under the *National Health Act 1953*.

However, in order to allow insurers the flexibility to formulate business structures

appropriate to their circumstances, insurers can have one additional health benefits fund in a jurisdiction if it is established after the commencement of the Act through a restructuring of funds under Division 146, or if specified in Rules under subsection 134-1(4).

For example, an insurer may have existing at the commencement of the Act a 'nationally branded' fund that includes policies from several risk equalisation jurisdictions as well as separate 'state branded' health benefits funds with policies from those same jurisdictions. The insurer is allowed to restructure the national fund such that it splits the fund into smaller 'new' funds constituted by the policies from the individual jurisdictions while keeping the existing separate 'state branded' health benefits funds.

Assets of a Health Benefits Fund
Under section 137-1 the assets of a health benefits fund must be kept distinct from any other health benefits fund operated by an insurer. The assets of a health benefits fund consist of payments of private health insurance premiums for policies of that fund, any income of a health related business of the fund, any income derived from the investment of the assets of the fund as set out in section 137-20, and other income required to be paid under section 137-5.

An insurer can make capital payments to a health benefits fund under subsection 137-5(2) as long as the insurer is not required to make the payment under subsection 137-5(1) and the payment is not part of the assets of another of the insurer's health benefits funds (unless the payment is approved by PHIAC).

Assets of a health benefits fund also include any other money, assets or investments obtained or held by the insurer due to the expenditure or application of money or assets of the fund or that have been transferred to the fund. However, subsection 137-1(5) allows an insurer registered as a for-profit insurer to expend or apply the money or assets of the fund for purposes other than the purposes of the fund. Any resulting assets or investments are not assets of the fund. In this way, for-profit insurers can make investments or apply capital to other businesses independent of their health insurance business.

Expenditure of a Health Benefits Fund
Under subsection 137-10(2), unless the insurer is registered as a for-profit insurer, the assets of a health benefits fund can only be expended for the purposes of:
- meeting the liabilities of the complying health insurance policies referred to it, or for other liabilities or expenses incurred in the business of the fund whether related to the fund's health insurance business or health related business;
- making investments to further the business of the fund as set out in section 137-20; or
- distributing any remaining assets of a health benefits fund terminated under Division 149.

Subsection 137-10(5) provides that the expenditure rules under subsection 137-10(2) do not apply to an insurer that is registered as a for-profit insurer as long as any expenditure of the health benefits fund's assets is not inconsistent with capital

adequacy and solvency standards applying to the fund or any directions given to the insurer in relation to these standards.

Regardless of an insurer's registration status, the borrowing against, mortgaging or charging of assets of a health benefits fund is prohibited except under subsection 137-10(3)(a) where an insurer enters into a mortgage or charge for the purpose of securing a bank overdraft or for some other purpose permitted by the Private Health Insurance (Health Benefits Fund Administration) Rules.

The transferring of assets from one health benefits fund to another through the restructuring, merging, acquisition or termination of a health benefits fund is not affected by the provisions under section 137-10. This is also the case for any direction given to the insurer regarding divestment of business under subsection 134-10(2).

Restructure, Merger and Acquisition of Health Benefits Funds
The provisions under Division 146 allow an insurer to restructure, merge or acquire a health benefits fund. The rules for restructures, mergers and acquisitions are designed to protect the interests of consumers while allowing a simple and consistent mechanism through which the industry can rationalise its business.

The main mechanism for restructuring, merging or acquiring a health benefits fund is changing the health benefits fund to which a policy is *referable* (as defined under Schedule 1). An insurer restructures its health benefits funds under subsection 146-1(1) by gaining approval through application to PHIAC to make the policies of one health benefits fund referable to another existing or new health benefits fund.

Subsection 146-1(3) requires PHIAC to impose a fairness test in deciding if an application for restructuring should be approved. If PHIAC considers that the restructure of a health benefits fund will result in unfairness to the group(s) of existing or potential policy holders subject to the restructure, it cannot approve the application.

If PHIAC does not consider that the restructure will result in unfairness, then it must approve the restructure under subsection 146-1(2) if it is satisfied that the division of assets and liabilities is reasonable and that the restructure would not result in a breach of solvency or capital adequacy standards by either health benefits fund.

An insurer may only acquire another insurer's health benefits fund through the operation of section 146-5, by making all of the policies that are referable to the transferor insurer's health benefits fund referable to the transferee insurer's health benefits fund. Such an acquisition only needs notification to PHIAC under subsection 146-5(5) to be effective.

However, an application for the acquisition must be made to PHIAC under subsection 146-5(2) if a new health benefits fund is established for the purpose of the acquisition, or a solvency or capital adequacy direction is in force in relation to the health benefits fund to be acquired. PHIAC must approve such an application under subsection 146-5(3) if it is satisfied that:

- the allocation of assets and liabilities to a new health benefits fund is reasonable; or
- that an insurer acquiring a fund under a solvency or capital adequacy direction is able to meet the direction.

Any acquisition of a health benefits fund must comply with section 134-1 limiting the number of health benefits funds that can exist in relation to a particular risk equalisation jurisdiction.

Termination of Health Benefits Funds

An insurer can apply to PHIAC under Division 149 to terminate each of its health benefits funds. This essentially allows an insurer to cease its health insurance business.

An application for termination of an insurer's health benefits funds must be approved by PHIAC under section 149-10 as long as the insurer is not being wound up under the *Corporations Act 2001*, each of its health benefits funds is solvent, and the termination will not result in unfairness to policy holders with policies referrable to a health benefits fund when those policy holders are viewed as a group.

PHIAC may appoint a terminating manager other than the insurer to conduct the termination, as set out in subsection 149-10(2). The terminating manager is given the power under section 149-30 to manage the fund in place of any officer of the insurer with management responsibility.

Under subsection 149-20(2), once an insurer has been notified of approval of the termination it has 60 days to notify each policy holder of its funds, PHIAC, and the public of the day it has nominated as the day it will no longer renew policies that are referrable to its health benefits funds (the ***termination day***). The termination day can be no earlier than 90 days from the last notice given.

An insurer that has been notified of approval of termination is prohibited under subsection 149-20(1) from:

- providing policies to anyone other than a current policy holder;
- applying the assets of the health benefits fund in any way except for reasons allowed under subsection 137-10(2) – unless termination has been completed and the remaining assets have been redistributed to a for-profit insurer under section 149-45; or
- changing its registration category to a for-profit insurer.

In order to protect the interests of policy holders, subsection 149-20(4) requires an insurer to accept any valid claims for benefits under any of its policies up to 12 months from the expiry of the last policy referable to any of the insurer's health benefits funds.

All of an insurer's health benefits funds are terminated under section 149-40 after the 12 month period has finished, and all policy holder liabilities, liabilities for payments due to the termination process or any other liabilities of the health benefits funds are discharged.

Any remaining assets of the funds are either distributed under section 149-45 to the insurer if it is registered as a for-profit insurer, or else returned to PHIAC for payment into the risk equalisation pool.

Under section 149-55, after termination has been completed the terminating manager must provide a report to PHIAC on the termination process which may recommend an application be made to the Federal Court for the winding up of the insurer. As long as the insurer is not conducting any other business, the terminating manager (if directed by PHIAC) or PHIAC may make the application to Court under section 149-60 to wind up the insurer in accordance with the *Corporations Act 2001*.

At any point in the termination process PHIAC or the terminating manager may apply to the Federal Court to end the termination process under section 149-35. The Court may request the terminating manager to issue a report on the termination process, and if an order is made to end the termination the Court may give directions for the resumption of the management of the health benefits funds.

The Solvency and Capital Adequacy Standards of Health Benefits Funds
In order to protect the interests of insured persons, PHIAC has the power to set standards in relation to solvency and capital adequacy under Division 140 and Division 143. These provisions are based on the existing rules for standards set out in Part VI Divisions 3A and 3B in *National Health Act 1953* and include:

- the establishment of solvency and capital adequacy standards for health benefits funds in the Private Health Insurance (Health Benefits Fund Administration) Rules;
- a power for PHIAC to grant exemptions from the standards for particular insurers, subject to conditions; and
- a power for PHIAC to give directions to an insurer to comply with the standards.

Duties and Liabilities of Directors
Division 152 deals with the duties and liabilities of an insurer's directors in relation to the policy holders of the insurer's health benefits funds. Section 152-1 imposes a duty on directors to take reasonable care and use due diligence to see that the insurer complies with Part 4-4, and provides that directors are liable to the fund for a breach of the duty that leads to a loss to the fund. These provisions are based on sections 48-50 of the *Life Insurance Act 1995.*

Other Obligations of Private Health Insurers
Part 4-5 sets out a range of other insurer obligations.

Under Division 160 insurers must appoint an actuary (subject to approval by PHIAC) who can access financial information and attend certain meetings of the insurer, and can act independently of the insurer and report to PHIAC if the actuary becomes aware of possible contraventions of the Act that may significantly affect policy holders. These provisions are based on Part 6 Division 3 of the *Life Insurance Act 1995*.

Division 163 requires insurers to comply with any Private Health Insurance (Insurer Obligations) Rules establishing prudential standards in relation to the conduct of insurers. The standards set out matters in relation to how insurers should conduct

their business so that they keep themselves financially sound, do not cause systemic instability, and carry out their affairs with integrity, prudence and professional skill. PHIAC can direct insurers to take action to comply with the standards as in the *Life Insurance Act 1995* (section 230B of that Act). Insurers also commit an offence under Division 166 if they allow disqualified persons to act as directors or senior managers.

Insurers are required under Division 169 to provide to PHIAC a variety of information to assist in PHIAC regulatory duties, including copies of reports given to policy holders; and annual financial and statistical information. Insurers are also required to provide to PHIAC and the Department details of changes to the organisation's rules and details of its current chief executive officer.

Division 172 deals with miscellaneous obligations of insurers, including continuing a general obligation to comply with any requirements of PHIAC in the performance of its functions as currently required under section 82M of the *National Health Act 1953*.

The regulation of hospital purchaser-provider agreements has not been carried over from the current regulatory regime, allowing the industry more flexibility in its contractual agreements. However, a requirement that insurers not enter into any agreements with medical practitioners that limit a practitioner's freedom to identify and provide appropriate treatments has been included in the new legislation (section 172-5) in order to safeguard the clinical authority of medical practitioners.

Under section 73AB of the *National Health Act 1953*, insurers are required as a condition of registration to provide Hospital Casemix Protocol data to the Department. While this is not a specific requirement under the new regime, insurers are obligated under section 172-10 to provide to the Department information that relates to the treatment of policy holders and information the insurer receives from a hospital. The specific requirements for the provision of this data will be specified in Rules.

Key Transitional Provisions

Hospitals
Under the new legislation hospitals must apply to the Minister to be declared hospitals. Public and private hospitals that were declared hospitals under the *National Health Act 1953* and the *Health Insurance Act 1973* are taken to be hospitals under the new Act until 1 July 2008 at which time they will have to be declared hospitals under the new Act. This provides 15 months for hospitals to meet the requirements of the new Act. These provisions are in section 15 of the Transitional Bill.

Hospital Outreach Services
Outreach services determined under section 5D of the *National Health Act 1953* are taken to be hospital treatment until 1 July 2008 under section 16 of the Transitional Bill. After this time such services can be covered under broader health cover products.

Registered Organizations
Section 18 of the Transitional Bill allows registered organizations under the *National*

Health Act 1953 to be taken as private health insurers under the new Act. This will remain in place until 1 July 2008. This provides time for private health insurers to meet registration requirements under the proposed *Private Health Insurance Act 2006*. Sections 19 and 20 of the Transitional Bill include provisions for registered for-profit organizations and restricted membership organizations.

Health Benefits Funds
Section 21 of the Transitional Bill ensures a registered organization's health benefits fund under the *National Health Act 1953*, including its assets and liabilities, becomes a health benefits fund under the new Act. Section 22 deals with mergers and acquisitions.

2. Regulating Health Insurance Products

Chapter 3 of the Bill regulates the operation, sale and enforcement of complying health insurance products. All health insurance products must adhere to the requirements in this chapter to protect the interests of consumers and insurers.

The new regime is a key change from current regulation which focuses on the registration of the entity providing the insurance rather than the insurance product itself. The new Bill more appropriately provides rules that are explicitly tied to the content of the product. However, the new rules for products are substantially based on current legislation to the degree that current products that comply with current legislation should also comply with the new regime.

Basic Rules about Complying Health Insurance Products

Definition and Requirements
Section 63-1 requires that health insurance products offered by private health insurers must be complying health insurance products. Section 63-5 defines a complying health insurance product as all the policies of insurance issued by an insurer that cover the same treatments with the benefits worked out in the same way and the same other terms and conditions. Section 63-10 lists these requirements including community rating.

Insurers must, under Part 3-4, give consumers and the Government standardised up to date information about their products. They must also provide other insurers with relevant information that enables the efficient transfer of an insured person from one insurer to another under Division 99.

Community Rating Requirements
Division 66 establishes community rating as one requirement for a policy to be classed as a complying health insurance policy. The principle of community rating is set out in Division 55 and is based on the community rating requirements in sections 73AAH, 73AAI and 73AAJ of the *National Health Act 1953*. Community rating supports equal access to private health insurance by prohibiting insurers from improperly discriminating between people because of their health status or other reasons. Private health insurers must adhere to the principle of community rating or risk having their ability to offer the private health insurance rebate as a premium reduction withdrawn under Division 206.

Improper discrimination is defined in subsection 55-5(2). Subsection 55-5(3) and section 55-10 create exceptions to the definition for restricted access insurers and closed products.

A restricted access insurer is one registered under sections 126-20(6) and (7) which only makes insurance available to people who are members of a particular group. A closed product is defined in section 55-10 as one which the insurer is no longer making available to anyone.

Other exceptions to improper discrimination include:
- paragraph 55-5(2)(c), which allows an exception for age discrimination for lifetime health cover as defined in Part 2-3;
- paragraph 55-5(2)(d), which allows exceptions for geographical discrimination for premiums (paragraph 66-10(2)(a)) and benefits (section 66-20); and
- paragraph 55-5(2)(g), which allows exceptions for benefits discrimination for permitted limits on general benefits (section 66-15).

Premium Requirements and Approvals
The premium requirements and approvals for complying health insurance policies are in sections 66-5 and 66-10. These requirements and the approval process are based on the current regulatory regime in the *National Health Act 1953*.

The premium payable for an insurance policy is the same as determined by the Minister under section 66-10 in relation to the product to which the policy belongs, except for variations set out in subsection 66-5(1) relating to:
- the application of lifetime health cover;
- premium discounts allowed by subsection 66-5(2); or
- a combination of these variations.

Section 66-10 requires insurers to charge the same amount for each policy that covers:
- one person (whether a child or adult);
- two or more children;
- two adults;
- one adult and one or more children;
- two adults and one or more children; or
- three or more adults and other persons.

The categories of persons to which a different premium can be applied to a policy now include children on their own. This will accommodate some situations where parents may not need to hold a policy due to health insurance coverage by other means, eg Defence personnel. Situations where policies can be charged a different amount for three or more adults has been included in order to accommodate industry's desire to be able to offer this type of product.

Applications must be approved under subsection 66-10(3) unless the Minister is satisfied that the proposed change would be contrary to the public interest. If an application is refused the Minister must table the reasons in both houses within 15 sitting days under subsection 66-10(6). This replicates the relevant parts of section 78 of the *National Health Act 1953*.

Coverage Requirements
Division 69 sets out the coverage requirements for complying health insurance policies. These requirements are new in form, but are partly modelled on existing requirements for applicable benefits arrangements and tables of ancillary benefits in Schedule 1 of section 72AAF of the *National Health Act 1953*.

The types of allowed cover for complying health insurance policies are set out in subsection 69-1(1). An insurance policy can only offer cover for:

- *hospital treatment* only (as defined in section 121-5); or
- hospital treatment and *general treatment* (as defined in section 121-10); or
- general treatment only, but not including *hospital-substitute treatment* (as defined in the Dictionary at Schedule 1).

Coverage under these definitions only extends to treatments specified in a complying health insurance policy, subject to the Private Health Insurance (Complying Product) Rules and the benefit requirements in Division 72. The Rules may mandate or prohibit coverage for other treatments.

For the purposes of broader health cover, hospital treatment encompasses all hospital services provided under the management or control of a person authorised by a hospital to provide the treatment. General treatment includes services by providers other than hospitals as hospital-substitute treatment, as well as chronic disease management programs.

Division 102 ensures that all insurers will offer at least one hospital product to consumers by requiring that any insurer offering cover for general treatment must also offer a product that covers hospital treatment. This requirement is changed from the exiting rule in paragraph (bd) of Schedule 1 of the *National Health Act 1953* by not requiring that the policy cover all episodes of hospital treatment.

The insurer rules which define products and benefits must be notified to PHIAC and the Secretary of the Department when the insurer first applies for registration under Division 126. Subsequent changes must be notified to the Secretary under section 169-10, and may be disallowed by the Minister if the Minister is satisfied that the change might or would result in a breach of the Act. This replicates the existing regime under section 78 of the *National Health Act 1953*.

Benefit Requirements
The benefits that are required or prohibited under complying health insurance policies are set out in Division 72.

The provision of benefits for accommodation in an aged care service is prohibited by subparagraph 72-1(1)(c)(i), as is the provision of benefits for pharmaceutical benefits scheme co-payments subparagraph 72-1(1)(c)(ii) unless the charges are a part of an episode of hospital treatment. This replicates the current regulatory regime. However, benefits for pharmaceutical co-payments has been changed so that an insurer no longer has to be covering 100% of the hospital treatment in order to pay such a benefit. In this way, those persons with policies that include exclusions, excesses and co-payments for benefits may now be able to have their product cover pharmaceutical co-payments.

The minimum benefit requirements for policies that cover hospital treatment are listed in the table in subsection 72-1(2) as:

Item 1
If a Medicare benefit is not payable for a particular hospital treatment that is rehabilitation, psychiatric or palliative care, then the minimum benefit specified in the Private Health Insurance (Complying Product) Rules must be provided. This maintains the current requirement for all products to cover rehabilitation, psychiatric and palliative care as set out in Schedule 1 of the *National Health Act 1953*.

Item 2
If a Medicare benefit is payable for a particular hospital treatment covered under the insurance policy, then a benefit must be provided that covers the portion of the charge that exceeds 75% of the schedule fee up to 100% of the schedule fee. This does not prevent a payment of a benefit above the schedule fee.

Item 3
Hospital-substitute treatments are treated in the same way as hospital treatments under Item 2, with the addition of prohibiting payments of benefits if a Medicare benefit of at least 85% of the schedule fee has already been provided for the treatment. An insured person may choose not to use their insurance to cover their treatment and rather take advantage of their Extended Medicare Safety Net entitlements.

Item 4
If a Medicare benefit is payable for a particular hospital treatment and/or hospital-substitute treatment covered under the insurance policy that involves the provision of a prosthesis listed in the Private Health Insurance (Prostheses) Rules, then the minimum benefit for the prosthesis that is specified under the Rules must be provided.

Item 5
If the Private Health Insurance (Complying Product) Rules specify that there must be a benefit for a particular treatment, the benefit payable must be at least at the level specified in the Rules. This item enables the continuation of the default benefits currently determined under paragraph (bj) of Schedule 1 of the *National Health Act 1953*.

Equality in the Provision of Benefits
Section 72-5 provides that any product with a benefit for a particular hospital treatment or hospital-substitute treatment provided by a particular health care provider must ensure that any charges to the policy holder not covered by the policy do not vary between insured persons based on the amount of benefits already claimed by persons insured by the insurer or for any other reason. This will ensure that all policy holders under a product who receive the same treatment by a particular provider will also face the same out of pocket expenses, if any.

The current regime does not preclude the practice of risk sharing through a capping of payment levels in agreements between an insurer and provider. Such arrangements undermine consumer expectations of equal benefits for equal treatments under the same policy.

Waiting Period Requirements
Complying health insurance policies can apply waiting periods for the payment of benefits under Division 75, which sets maximum waiting periods for benefits for hospital treatment or hospital-substitute treatment.

Under subsection 75-1(1) the maximum waiting period for benefits for obstetric treatment or treatment for a *pre-existing condition* (as defined in section 75-15) is 12 months (with the exception of treatment that is rehabilitation, psychiatric or palliative care), while the maximum for any other benefit is 2 months. This replicates the current rules for waiting periods in Schedule 1 of the *National Health Act 1953*.

Portability Requirements
Complying health insurance policies must meet the portability requirements in Division 78, which replicate and simplify the current portability requirements in Schedule 1 of the *National Health Act 1953*. These requirements ensure that an insured person can move between complying health insurance policies provided by different insurers without having to serve new waiting periods for old benefits. This also protects insurers from consumers who change policies after a short time to access lower co-payments or excesses. These requirements only apply to hospital treatment and hospital-substitute treatment.

Under subsection 78-1(2), any insured person that transfers to a new policy may have up to the maximum waiting period applied to any benefit not covered under their old policy. Any benefit covered under the old insurance policy which is covered under the new policy can have no more than the balance of any applicable waiting period applied.

Subsection 78-1(3) ensures there can be no reduction in the amount of benefits for any period other than periods allowed under subsection 78-1(2).

If an insured person's old insurance policy has higher excesses or co-payments than the person's new insurance policy, subsection 78-1(4) allows an insurer to charge the higher amount as if the person was a newly insured person under section 75-1.

Subsection 78-1(5) provides that any contractual agreements between the old or new insurer and particular health care providers should not be taken into account in considering whether treatments or benefits were or are covered under an old or new policy.

Quality Assurance
The Government has announced that new safety and quality requirements for privately insured health services will come into operation from 1 July 2008. Division 81 provides for details of these requirements to be set out in the Private Health Insurance (Accreditation) Rules.

Enforcement under Part 3-3
Under the current regulatory regime, enforcement of product requirements is achieved through the registration of an insurer, which precludes a practical enforcement regime for minor breaches of the Act. Enforcement provisions in the new legislation are now centred more appropriately on the product.

Division 84 allows enforcement of Part 3-3 of the Bill. Section 84-1(1) contains offence provisions for advertising, offering or insuring under non-complying insurance policies. Subsection 84-1(2) requires a court in setting a penalty to consider the impact on the health fund's capital adequacy and the potential for this to lead to increased premiums.

Section 84-5 makes directors and chief executive officers liable for breaches if they do not exercise due diligence to ensure that adequate systems were in place to prevent the offence. If an insurer is in breach of responsibilities regarding non-complying policies then section 84-10 allows for an application to the Federal Court for an injunction to restrain this activity.

Section 84-15 provides remedies for people affected by non-complying policies. This includes a power for the court to make insurers in breach of sections 63-1 or 84-1 take specified action to ensure that the policies comply and/or that insurers ensure that policy holders are in a position they would have been in had the policy been complying.

Giving Information to Consumers
Under Division 93 private health insurers must inform consumers on aspects of their policies. This requirement will enable consumers to be better informed of their policies and make more informed choices about their health cover. This is a new requirement in response to consumer feedback and the experiences of the Private Health Insurance Ombudsman (PHIO) of reasons for complaint, most of which stem from consumers not being aware of their entitlements under their policy.

Section 93-1 specifies that insurers must keep up-to-date standard information statements on each complying health insurance product it makes available and under which it insures people. A standard information statement is described in subsection 93-5(1) and may contain provisions allowed under the Rules in subsection 93-5(2). Penalties for breaches of section 93-1 are in subsection 93-1(4).

Section 93-10 ensures that an insurer must provide a standard information statement to a policy holder who requests it. Insurers also have obligations to give up-to-date information statements to newly insured policy holders under section 93-5.

Section 93-20 ensures that insurers provide standard information statements to policy holders at least every 12 months under subsection 93-20(1). Information must also be provided to consumers if there is a proposed change to the policy rules which may have a detrimental affect on policy holders under subsection 93-20(2). Any policy holder request for benefit or coverage information must be supplied by the insurer as soon as practicable under subsection 93-20(3).

If an insurer makes a change to a health benefits fund to which a complying insurance policy is referable as part of a restructure of its business under Division 146, the insurer must inform the policy holder of the new fund to which that policy is referable under subsection 93-20(4). This must take place before the change takes effect.

Insurers must inform policy holders of any detrimental changes to the insurer's rules under section 93-25 (unless the change required an updated standard information statement under subsection 93-20(2)). Section 93-30 provides offence provisions for breaches of Division 93.

Giving information to the Department, PHIAC and the Private Health Insurance Ombudsman

Under Division 96 private health insurers must provide information to the Secretary of the Department, PHIAC and the PHIO if requested. Insurers must provide standard information statements when requested under 96-1, when issuing new products under 96-5, and when updating statements under 96-10.

Private health insurers must also provide additional information when requested under section 96-15. The request must be in writing and specify the time required for the provision of the information under subsection 96-15(2). The request may also specify the manner of provision and form of the information under subsection 96-15(3). Section 96-20 provides offence and penalty provisions for failure to meet information requests.

3. Health Insurance Incentives

Chapter 2 of the Bill deals with incentives for people to purchase private health insurance. Part 2-2 covers private health insurance rebates, and Part 2-3 covers lifetime health cover.

Rebates on Private Health Insurance Premiums

Division 20 sets out the rules around the premium reduction scheme, under which persons may register with their insurer to receive reduced premiums for complying health insurance policies from 1 July 2007. Division 23 deals with the incentive payments scheme. The rules are the same in substance as the current *Private Health Insurance Incentives Act 1998.*

Sections 23-10 and 26-5 provide that if the person aged over 65 leaves the policy, the higher rebate or payment continues for other persons covered under the policy unless another person who is not a dependent child becomes covered under the policy. These provisions are identical in their effect to the current sections 4-12 and 12-7 of the *Private Health Insurance Incentives Act 1998.*

Many provisions of an administrative nature contained in the *Private Health Insurance Incentives Act 1998* are now included in Part 6-4 of the Bill.

Lifetime Health Cover (LHC)

The rules around LHC are set out in Part 2-3 of Chapter 2. Apart from two significant changes, they are the same as the current rules set out in Schedule 2 of the *National Health Act 1953.*

The Government's commitment to removing lifetime health cover loadings after ten years of continuous cover is embodied in section 34-10. For the purpose of calculating the ten years, permitted days without hospital cover or periods when a person is taken to have hospital cover are disregarded.

The other major change involves simplifying how the day on which a person must have hospital cover or face a LHC loading is determined. (This is a person's LHC base day, described in the NHA as a person's "Schedule 2 application day".) The current clause 5 of Schedule 2 to the NHA defines 17 different possible "Schedule 2 application days". This provision is replaced with the diagram at subsection 34-25(1) which has five possible LHC base days and will apply to anybody seeking to purchase a complying health insurance policy after 1 July 2007.

Subsection 34-25(4) provides that if a person is insured on 1 July 2007 and has already had a 'Schedule 2 application day' defined, that day will continue to be used in calculating his or her loading as long as he or she remains insured.

Another change in expression which does not affect existing policy relates to the allowed breaks in hospital cover people may have before additional loadings are imposed ('permitted days without hospital cover'). Under sections 2 and 3 of Schedule 2 of the *National Health Act 1953* a person may not have hospital cover for 730 days, and is then permitted to not have hospital cover for a further 364 days before an additional loading is imposed.

The new section 34-20 sets permitted days without hospital cover at 1094 days, but section 34-5 then imposes a loading on the first following day.

Key Transitional Provisions

Status of Existing Products
Under the main Bill, insurers must offer complying health insurance products. Section 10 of the Transitional Bill makes applicable benefits arrangements or ancillary tables under the *National Health Act 1953* complying health insurance products under the PHI Act. This will be in place until 1 July 2008 to allow insurers sufficient time to meet the new product requirements. However, if an insurer changes a product in any way before 1 July 2008, it must meet the new standards under the PHI Act.

Sections 11 to 14 deal with transitional issues for premium requirements, benefits requirements for prosthesis, waiting periods and quality assurance requirements.

Incentives and Lifetime Health Cover
Division 1 of the Transitional Bill ensures that the *Private Health Insurance Incentives Act 1998* continues to operate until 30 June 2007 for registration by individuals, and 30 June 2008 for payments of claims. Sections 5 to 7 of the Transitional Bill deal with the Incentives Act.

Sections 8 and 9 of the Transitional Bill deal with lifetime health cover. Section 8 ensures that the lifetime health cover amounts calculated under the *National Health Act 1953* continue until a new amount is calculated under the PHI Act. Section 9

ensures that permitted days without cover under the *National Health Act 1953* are calculated as part of 10 years of continuous cover under the PHI Act.

Division 3 of the Transitional Bill maintains an insurer's status as a participating insurer under the *Private Health Insurance Incentives Act 1998*. Sections 47 to 51 deal with transitional matters concerning participating insurers, applications for participating insurers, audit and request powers, and debt recovery.

4. Regulatory Oversight

The Private Health Insurance Ombudsman
Division 238 establishes the PHIO and sets out its functions. The PHIO protects the interests of people covered by private health insurance by:
- resolving complaints;
- investigating the practices of private health insurers, brokers and health care providers;
- mediating between insurers and providers; and
- disseminating information about the rights of insured people.

The provisions related to the PHIO are based on the current regime in Part VIC of the *National Health Act 1953*.

The Private Health Insurance Administration Council (PHIAC)
PHIAC has functions and powers relating largely to the regulation of private health insurers. In addition to this, Part 6-3 allows the Minister to make subordinate legislation regarding the external management and terminating management of health benefit funds in the Private Health Insurance (Council) Rules.

In performing its role, PHIAC must take all reasonable steps to achieve an appropriate balance between the following objectives:
- foster an efficient and competitive health insurance industry;
- protect the interests of consumers; and
- ensure the prudential safety of individual private health insurers.

The functions of PHIAC are outlined in section 264-10. PHIAC has the power under section 246-20 to do all things necessary or convenient to be done for, or in connection with the performance of its functions.

PHIAC is required to provide the Minister with a report, for presentation to the Parliament, on the operations of private health insurers during every financial year. The report must include information outlined in subsection 264-15(2) for each health benefits fund conducted by the private health insurer.

The provisions related to PHIAC are based on the current regime in Part VIAA of the *National Health Act 1953*.

5. Enforcement

Chapter 5 of the Bill contains two enforcement regimes. The first general enforcement regime is set out in Part 5-2 and is based on Division 5 – Enforcement

and Remedies of Part VI of the current *National Health Act 1953*. The second regime set out in Part 5-3 enforces the health benefits fund requirements contained in Part 4-4, and is based on Divisions 2 and 3 of Part VIA of the current *National Health Act 1953*.

General Enforcement
Part 5-2 allows the Minister to take a range of actions to enforce an insurer's obligations under the Act, as listed in section 185-5. In a change from the current regime in the *National Health Act 1953*, PHIAC is also empowered to take most of these actions under section 185-10 to enforce obligations related to risk equalisation, health benefits funds and prudential standards.

The actions include:
- setting performance indicators in the Private Health Insurance (Complying Product) Rules (Division 188) (Minister only);
- seeking an explanation of an insurer's operations (Division 191);
- investigating an insurer's operations (Division 194);
- accepting an enforceable undertaking from an insurer (Division 197);
- the Minister or PHIAC giving a direction to an insurer (Division 200);
- seeking a declaration of contravention and an order from the Federal Court (Division 203); and
- revoking an insurer's participation in the premium reduction scheme under Part 2-2 (Division 206) (Minister only).

Enforcement of Health Benefits Fund Requirements
Part 5-3 allows PHIAC to appoint an inspector to investigate the affairs of an insurer and appoint an external manager to a health benefits fund. PHIAC's power under the current *National Health Act 1953* to appoint an administrator to an insurer has been removed.

Inspectors
PHIAC may appoint an inspector under section 214-1 if it suspects either:
- that the affairs of the insurer are being or will be carried on in a way not in the interests of policy holders of a health benefits fund; or
- a breach of the health benefits fund requirements under Part 4-4.

An inspector has power under section 214-5 to ask persons to produce documents, provide reasonable assistance, and appear for examination, and under section 214-20 may enter premises with consent or under a warrant to access documents.

An inspector must report to PHIAC (section 214-25), and PHIAC may publish the report if it has given a copy to the insurer and believes publication to be in the public interest (section 214-30).

External Managers
Under sections 217-10 and 217-15 PHIAC may appoint an external manager to a health benefits fund if it believes it is in the interests of policy holders to do so, and if either:
- PHIAC is satisfied the insurer has contravened the solvency standard; or

- PHIAC is satisfied the insurer has contravened a solvency, capital adequacy or prudential direction; or
- the directors of the insurer have sought an external manager for the fund; or
- a ground specified in the Private Health Insurance (Health Benefits Fund Enforcement) Rules applies.

Once appointed an external manager displaces the insurer as the manager of the fund under section 217-20.

The main duties of the external manager are set out in section 217-25, and include examining the affairs of the fund and forming an opinion as to the course of action that is most likely to allow policy holders to continue to be covered by the fund or another fund to which the business may be transferred.

The Private Health Insurance (Health Benefits Fund Enforcement) Rules may set out procedures for external managers to use in developing a voluntary deed of arrangement for managing the future affairs of the fund (section 217-45).

In a report to PHIAC the external manager must under section 217-50 recommend the course of action that is most likely to allow policy holders to continue to be covered by the fund or another fund to which the business may be transferred, and may recommend:

- seeking a Federal Court order to implement a scheme of arrangement for the business of the fund; or
- seeking a Federal Court order to appoint a terminating manager for the fund; or
- handing control of the fund back to the insurer.

If PHIAC accepts the external manager's recommendation it may direct the external manager to apply to the Federal Court as necessary (subsection 217-55(2)). If PHIAC decides on another course of action it may apply to the Court for an order to implement a scheme of arrangement or appoint a terminating manager (subsection 217-55(4)).

6. Miscellaneous

Private Health Insurance Levies

There are four private health insurance levies imposed under respective Acts. Part 6-6 of the main Bill deals specifically with collection of the levies and additional matters relating to administration.

Section 304-10 lists each of the levies (titles of Acts reflect proposed amendment by their respective amendment Bills):

- collapsed insurer levy (imposed under the *Private Health Insurance (Collapsed Insurer Levy) Act 2003*);
- complaints levy (imposed under the *Private Health Insurance (Complaints Levy) Act 1995*);
- Council administration levy (imposed under the *Private Health Insurance (Council Administration Levy) Act 2003*); and
- risk equalisation levy (imposed under the *Private Health Insurance (Risk Equalisation Levy) Act 2003*).

Division 307 outlines the collection and recovery of private health insurance levies. Section 307-1 provides that a private health insurance levy becomes due and payable on the day specified as the payment day in a determination made by the Minister. Subsection 307-5(1) imposes a late payment penalty on private health insurers and subsection 307-5(2) outlines how the penalty is calculated.

Division 310 outlines requirements of private health insurers in relation to returns, requesting information and keeping records.

Risk Equalisation

Part 6-7 continues the present Health Benefits Reinsurance Trust Fund established under the *National Health Act 1953* and renames it the Risk Equalisation Trust Fund. Section 318-10 allows the Minister to make Rules setting out the overall risk equalisation policy framework, while section 318-15 allows PHIAC to make Rules relating to the administration of the Fund, the operation of the risk equalisation levy and the records to be kept by insurers.

Disclosure of Information

Part 6-8 deals with disclosure of information and sets penalties for offences, and is largely based on section 135A of the *National Health Act 1953*. Provision is also made for the Private Health Insurance (Information Disclosure) Rules to specify what may or may not be disclosed.

The provisions set out:

- what is authorised disclosure;
- to whom the authorised disclosure can be made; and
- to whom it applies.

Protected information in subsection 323-1(2) is defined as that obtained by a person in the course of performing duties, functions, or exercising powers under the Act, or obtained by certain authorised disclosures. It can also relate to a person other than the person who obtained it.

An *authorised disclosure* in subsection 323-1(3) can be made by a person if it is within the parameters defined in sections 323-5 to 323-35, including within the course of official duties; sharing information about insurers among agencies or in other instances; in the public interest; Secretary or Council disclosure if authorised by affected person; court proceedings; and PHIAC's public information and agency cooperation functions.

Subsections 323-1 and 323-40 to 323-55 create offences for the soliciting of, obtaining, use, offering to supply, and disclosure of unauthorised or protected information.

Review of Decisions

Part 6-9 sets out which decisions made by the Minister, the Medicare CEO, PHIAC, and the PHIO are reviewable by the Administrative Appeals Tribunal.

Other
Sections 333-1 and 333-5 allow delegation of functions or powers by the Minister and Secretary.

The Minister may delegate functions or powers under the Act to the Secretary of the Department, an SES employee in the Department, PHIAC, the Medicare Australia CEO, an employee of Medicare Australia or an APS employee in the Department. The Secretary of the Department may also delegate to an APS employee in the Department.

Approved forms are covered in sections 333-10 and 333-15 and outline what is required in a form and who may approve it.

Rule making by the Minister or PHIAC is dealt with from sections 333-20 to 333-25. The tables define under which provisions the Minister or PHIAC may make Private Health Insurance Rules.

Section 333-30 allows regulations to be made by the Governor-General.