1996

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

PRIVATE HEALTH INSURANCE INCENTIVES BILL 1996

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Health and Family Services,
the Hon. Dr Michael Wooldridge, MP)

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PRIVATE HEALTH INSURANCE INCENTIVES BILL 1996

OUTLINE

The purpose of this Bill is to provide a financial incentive to low and middle income earners to purchase or retain private health insurance.

FINANCIAL IMPACT STATEMENT

The private health insurance incentives will cost an estimated total of $8 million in 1996-97, $491 million in 1997-98, $609 million in 1998-99 and $616 million in 1999-2000. These amounts include both amounts paid to the funds in return for lower premiums being charged to eligible members pursuant to this Bill and taxation rebates direct to claimants under the *Taxation Laws (Private Health Insurance Incentives) Amendment Bill*, as well as expected running costs.

NOTES ON CLAUSES

Part 1 - Preliminary

Division 1 - Preliminary

Clause 1-1 - Short title

This clause cites the title of the proposed legislation as the *Private Health Insurance Incentives Act 1996.*

Clause 1-2 - Commencement

This clause provides that the Act will commence on the day on which it receives Royal Assent.

Clause 1-3 - Definitions

This clause states that where definitions of expressions used in the Act are contained in the Dictionary at the end of the Act, they have the meanings given to them in the Dictionary.

Part 2 - The Incentives Scheme

Division 2 - Introduction

Clause 2-1 - What this part is about

This clause states that the Part deals with how people who are covered by private health insurance policies providing hospital cover, ancillary cover or both can participate in a scheme under which premiums payable under those policies are reduced.

Division 3 - Who is eligible to participate in the scheme?

Clause 3-1 - Eligibility to participate in the scheme

This clause sets out those persons who are eligible to participate in the incentive scheme. To be eligible to participate in respect of a financial year a person must be a member of a health fund that was a participating fund during that year and have the appropriate type of health insurance under clause 3-2. The person must also be eligible to apply under Division 4 in respect of that year and the income test under clause 3-3 or 3-4 must be satisfied for that year.

They must also be eligible to participate in Medicare as defined under section 3 or section 6 of the *Health Insurance Act 1973.*

Clause 3-2 - Appropriate private health insurance cover

This clause describes the type of health cover that meets the requirements of the legislation to allow members to register for the incentives.

(1) This subclause provides that appropriate cover to be eligible to receive the incentive is hospital cover or ancillary cover or both hospital and ancillary cover.

(2) This subclause defines "hospital cover" to mean an applicable benefits arrangement defined under clause 5A of the *National Health Act 1953* to which paragraph 5A(1)(a) of that Act applies where:

(i) the annual premium for policies covering only one person is not less than $250, or an alternative amount determined by the Minister; or

(ii) the annual premium for policies covering more than one person is not less than $500, or an alternative amount determined by the Minister.

(3) This subclause defines "ancillary cover" as whole or part cover for liability to pay fees and charges in respect of ancillary health benefits within the meaning of section 67 of the *National Health Act* 1953 where,

(i) the annual premium for policies covering only one person is not less than $125, or an alternative amount determined by the Minister; or

(ii) the annual premium for policies covering more than one person is not less than $250, or an alternative amount determined by the Minister.

(4) This subclause defines "annual premium" for the purposes of subclauses (2) and (3) to be the amount payable if the policy were to apply for one year, regardless of whether the policy in question actually applies for that period.

(5) This subclause provides that determinations of premiums made for the purpose of subparagraph (2)(b)(i) or (ii), or subparagraph (3)(b)(i) or (ii) are disallowable instruments for the purposes of clause 46A of the *Acts Interpretation Act 1901.*

(6) This subclause provides that "combined cover" means both hospital and ancillary cover.

Clause 3-3 - Income test - policies covering only one person

The purpose of this clause is to set out the income test for eligibility in respect of policies covering one person.

(1) This subclause states that the income test is satisfied if the sum of the taxable incomes of all the persons whose incomes are required to be taken into account by subclause (2) is less than the amount under subclause (4).

(2) This subclause provides that the persons whose taxable incomes are to be taken into account when determining eligibility for the scheme in respect of a policy covering one person are:

(a) if the person covered under the policy is not a dependent child, the incomes of that person and any partner of that person; or

(b) if the person covered under the policy is a dependent child, the incomes of each parent who is paying premiums for the policy or arranging for a third party to pay premiums for the policy and of any partner of each such parent.

(3) This subclause states that for the purposes of subclause (2), a person is the partner of another person only if the person is the partner of another person on the last day of the financial year in question.

(4) This subclause provides that the maximum amounts of taxable income are:

(a) if the only person covered by a policy is at all times during the financial year not a dependent child and is not the partner of another person - $35,000.

(b) if the only person covered by a policy is, at any time during the financial year, not a dependent child and is the partner of another person - $70,000.

(c) if the only person covered by a policy is, at any time during the financial year, a dependent child - $70,000.

Clause 3-4 - Income test-policies covering more than one person

The purpose of this clause is to set out the income test for eligibility in respect of policies covering more than one person.

(1) This subclause states that the income test is satisfied in respect of the financial year in question if the sum of the taxable incomes of all the persons whose incomes are required to be taken into account by subclause (2) is less than the amount under subclause (4).

(2) This subclause provides that the persons whose taxable incomes are to be taken into account in determining eligibility are each person covered by the policy who is not a dependent child, the partners (if any) of such persons and, if all persons covered by the policy are dependent children--each parent who is paying premiums for the policy or arranging for a third party to pay premiums for the policy and the partner (if any) of each such parent.

(3) This subclause provides that a person is the partner of another person for the purposes of subclause (2) only if the person is the partner of that person on the last day of the financial year in question.

(4) This subclause provides that the maximum amounts of taxable income for eligibility to participate in the scheme are for a policy covering less than 2 dependent children over the financial year--$70,000, or where the policy at any time covers 2 or more dependent children--$70,000 plus $3,000 each for the second and subsequent children.

Clause 3-5 - Meaning of *taxable income*

This clause defines *taxable income* for the purpose of clauses 3-3 and 3-4 as a person's taxable income within the meaning of the *Income Tax Assessment Act 1936* for the financial year in question and includes any share in the net income of a trust estate.

Division 4 - How do people participate in the scheme?

Clause 4-1 - Registration by Health Insurance Commission

This clause explains that people must be registered with the Commission to receive the incentive.

(1) This subclause provides that a person who is eligible to apply for registration for a financial year may apply under clause 4-3 to the health fund with which they are insured to be registered by the Commission in respect of that year.

(2) This subclause states that if a health fund receives an application for registration it must notify the Commission.

(3) This subclause states that when the Commission receives a notice from a health fund it must register the applicant unless the applicant is not eligible to participate in the incentives scheme or the notice contains incorrect information.

Clause 4-2 - Eligibility to apply for registration

This clause defines who is eligible to apply to register for the incentive.

(1) This subclause provides that any of the people covered by the policy (other than dependent children) are eligible to apply for registration in respect of the policy for the financial year. If the policy covers only dependent children, then any parent of any of the children covered is eligible to apply.

(2) This subclause provides that a person is not eligible to apply for registration in respect of a policy in respect of which somebody else has applied and the Commission has not refused to register that person or revoked that person's registration.

Clause 4-3 - Applications for registration

This clause sets out the requirements for applications to participate in the incentive scheme and the information which they must contain.

(1) This subclause requires that applications must be in a form approved by the Minister and must include a statutory declaration by the applicant that the applicant has estimated the sum of taxable incomes for that year for all of the people that must be taken into account under clause 3-3 or 3-4, and that the applicant believes that he or she will be eligible to participate in the scheme for that financial year.

(2) This subclause provides that an estimate under paragraph (1)(a) must be made in a way determined by the Minister in writing.

(3) This subclause provides that applications must state details, including the applicant's full name, date of birth, address and Medicare card number, whether the policy covers only one person or more than one person and the full name and date of birth of each other person covered under the policy, whether any people covered are dependent children, the full name and date of birth of all people not covered by the policy whose income must be taken into account when determining eligibility for the year in question, and any other information that has been determined in writing by the Minister.

(4) This subclause provides that for the purposes of paragraph 3(i) the Minister must not determine that the applicant must provide the tax file number of the applicant or another person, or any other information about the income of the applicant or any other person other than the fact that the applicant believes that the income test is satisfied for the year in question.

(5) This subclause provides that determinations under subclauses (2) and (3) are disallowable instruments.

(6) This subclause provides that applications may be made at any time before or during the financial year concerned.

(7) This subclause defines "tax file number" to accord with the definition in section 202A of the *Income Tax Assessment Act 1936*.

Clause 4-4 - Notifying the Health Insurance Commission

This clause sets out the process by which health funds must notify the Commission of an application under subclause 4-3 by one of their members.

(1) This subclause provides that if a fund receives an application on or before the 21st day of a month then the fund must notify the Commission of the application no later than the first business day of the following month. If a fund receives an application on or after the 22nd day of a month then the fund must notify the Commission of the application no later than the first business day of the second month after the day on which the application was made.

(2) This subclause provides that the application must be in such a form and contain such details as determined by the Managing Director.

(3) This subclause provides that the details determined by the Managing Director under subclause (2) may include, but are not limited to, the following:

- the full name of the applicant;
- the date of birth of the applicant;
- the address of the applicant;
- the Medicare number of the applicant;
- whether the policy covers only one person or more than one person;
- the full name and date of birth of each person covered under the policy (other than the applicant);
- whether any of those people covered are dependent children;
- the full name and date of birth of all people not covered by the policy, but whose income must be taken into account when determining eligibility for the year in question;
- whether the policy provides hospital or ancillary cover or both.

(4) This subclause provides that the Managing Director must not determine that the fund need provide the tax file number of any person, information about any person's income other than that the applicant believes the income test is satisfied for the financial year in question, or information about the physical, psychological or emotional health of any person.

(5) This subclause provides that the details determined by the Managing Director for the purposes of subclause (2) must not relate to any person other than the applicant, other people covered by the policy, or those whose income must be taken into account in determining eligibility for the incentive.

(6) This subclause provides that determinations under subclause (2) are disallowable instruments.

Clause 4-5 - Refusal to register

This clause deals with the Commission's refusal to register a person for the incentives scheme.

(1) This subclause states that if the Commission refuses to register an applicant then it must notify the applicant and the applicant's health insurance fund in writing. This written refusal must include the reason for refusal.

(2) This subclause states that if the Commission does not give notice of refusal within 14 days of notification of the application then the applicant is taken to be registered for the financial year in question.

Clause 4-6 - Revocation of registration

(1) This subclause provides that the Commission must revoke a person's registration for a particular policy for a particular year if the person becomes registered in respect of another policy for the same year or if the Commission receives a notice from the person's fund under clause 4-8 that the person is no longer eligible to participate in the scheme or if the Commission is satisfied that the person is not eligible to participate in the incentives scheme for that year.

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

Clause 4-7 - Notification requirements - registered persons

This clause sets out notification requirements for registered persons.

(1) This subclause provides that a registered person (the person registered in respect of a health insurance policy) must give written notice to the health fund in question if the estimated sum of the taxable incomes of persons whose income must be taken into account in respect of the policy for that year changes in such a way that the registered person knows or ought reasonably to expect that the income test will not be satisfied for that year.

(2) This clause requires the registered person to give written notice to the health fund if there is a change in a detail stated in the person's application relating to the number of people covered by the policy or to whether any of those people are dependent children and that change is such that the person ought reasonably to expect that this would change the annual incentive amount applicable to the policy.

(3) This subclause provides that registered persons may notify their fund in writing if they no longer wish to be registered in respect of the policy for that year.

Clause 4-8 - Notification requirements - health funds

(1) This subclause states that the fund must notify the Commission of each notice given to the fund under clause 4-7.

(2) This subclause provides that if the fund receives notice on or before the 21st day of a month it must notify the Commission on or before the first business day of the following month, and that if the fund receives notice on a day that is on or after the 22nd day of a month it must notify the Commission on or before the first business day of the second month after that day.

Clause 4-9 - Variation of registration

This clause details a fund's duties if a registered member changes their type of cover.

(1) This subclause provides that funds must notify the Commission if the type of cover provided to a registered person is varied.

(2) This subclause provides that on receipt of such a notice the Commission must vary the details of the registration accordingly.

Clause 4-10 - Retention of applications by health funds

(1) This subclause provides that a health fund must retain an application for registration under clause 4-3 for a period of 5 years from the day in which the application was made.

(2) This subclause provides that the fund may retain the application in any form (including electronic) approved in writing by the Managing Director.

(3) This subclause provides that an application retained in such form must be received in all courts and tribunals as evidence as if it were the original.

Division 5 - What effect does the scheme have on insurance premiums?

Clause 5-1 - Reduction in premiums

This clause imposes an obligation on the health funds to reduce the premiums payable by their members by the incentive amounts received in respect of those members from the Commission.

(1) This subclause requires that the amount of premium that would otherwise be payable under a private health insurance policy in respect of which a person is a participant in the incentives scheme for the financial year is to be reduced by:

(a) if the premium is paid for the full financial year--the annual incentive amount for the policy; or

(b) if the premium is paid in respect of a part of the financial year--the proportion of the annual incentive amount equal to the proportion of the year in respect of which the premium was paid.

(2) This subclause provides that subclause (1) does not apply to:

(a) payments made after a policy has ceased, during the financial year, to be a dependent child policy (clause 5-4 provides further explanation of dependent child policies); or

(b) payments made in respect of a period that ends before 1 July 1997; or

(c) where a payment is made in respect of a period that starts before 1 July 1997 and ends on or after that day, to that part of such a payment covering the period prior to 1 July 1997; or

(d) payments made in respect of a period that starts on or before 1 July 1997 and ends after 31 July 1997 (this situation is explained in clause 5-6).

Clause 5-2 - Participant in the incentives scheme

This clause identifies the circumstances in which a person is a participant in the incentives scheme for a financial year.

(1) This subclause provides that a person is a participant in the incentives scheme for a financial year in respect of a policy if they are registered under Division 4 in respect of that policy for that year or if they have applied for such registration and that registration has not been refused.

(2) This subclause provides that a person who was registered in respect of a policy on 30 June in one financial year is deemed to be a participant for the month of July in the subsequent financial year even if they have not submitted an application for the subsequent year.

Clause 5-3 - Annual incentive amounts

(1) This subclause provides that the annual incentive amount for a private health insurance policy is the relevant amount set out in the table of amounts according to the number and description of persons covered by the policy and the extent of the cover, or is such other amount as is determined in writing by the Minister. The Table provides by item that:

Item 1: for a policy covering three or more people the incentive amount is $350 for hospital cover, $100 for ancillary cover and $450 if the policy covers both hospital and ancillary cover.

Item 2: for a policy covering two people, being one dependent child and one other person, the incentive amount is $350 for hospital cover, $100 for ancillary cover and $450 if the policy covers both hospital and ancillary cover.

Item 3: for a policy covering two people who are not dependent children, the incentive amount is $200 for hospital cover, $50 for ancillary cover and $250 if the policy covers both hospital and ancillary cover.

Item 4: for a policy covering one person only, the incentive amount is $100 for hospital cover, $25 for ancillary cover and $125 if the policy covers both hospital and ancillary cover.

(2) This subclause provides that a determination of an alternative amount under paragraph (1)(b) is a disallowable instrument.

Clause 5-4 - Policies that cease to be dependent child policies

For the purposes of paragraph 5-1(2)(a) if a dependent child covered by a policy that covers only dependent children, ceases to be a dependent child during the financial year and remains covered by the policy, then that policy ceases to be a dependent child policy from that day.

Clause 5-5 - Persons who are not eligible persons for part of a financial year

This clause provides that if on one or more days during a financial year a person is not an eligible person within the meaning of section 3 of the *Health Insurance Act* 1973, or is not treated as an eligible person under section 6 of that Act, any premium that has been paid under a private health insurance policy is, for the purposes of clause 5-1, taken not to have been paid in respect of those days.

Clause 5-6 - Premiums paid in respect of certain periods around 1 July 1997

(1) This subclause provides that if a person has applied before 1 July 1997 for registration in respect of a policy for the financial year commencing on that day and has paid an amount of premium in respect of a period starting before 1 July 1997 and ending on a date after 31 July 1997, the health fund must, on or before 31 August 1997, either pay the person an amount equal to the amount that is payable to the health fund in respect of the policy during the current policy period, or offset that amount against the amounts of premium that the person would be liable to pay to the health fund after the day the policy expired if the policy were to continue in force after that day.

(2) This subclause defines "current policy Period" to mean the period starting on 1 July 1997 and ending on the expiry day.

Part 3 - Reimbursement of health funds

Division 6 - Introduction

Clause 6-1 - What this part is about

This part of the Bill is about how health funds become involved in the incentives scheme and how the Government reimburses them for the reductions in premiums they make under the scheme.

Division 7 - How do health funds become participating funds?

This Division of the Bill deals with applications by health funds to become participating funds in the incentives scheme.

Clause 7-1 - Becoming a participating fund

(1) This subclause provides that a fund may apply to the Minister under clause 7-2 to become a participating fund for a financial year.

(2) This subclause provides that if the Minister approves the application the fund is a participating fund for that financial year.

Clause 7-2 - Requirements for applications

(1) This subclause provides that an application must be in a form determined by the Minister, include information determined in writing by the Minister, be signed by the public officer of the applicant fund, and include an undertaking from the public officer of the fund that the fund will participate until the end of the financial year in question.

(2) This subclause provides that the application must be made no later than 2 months or such shorter period as is determined by the Minister before the start of the financial year in question, but that if the fund becomes registered under Part VI of the *National Health Act 1953* during a financial year, the application must be made as soon as practicable after registration.

(3) This subclause defines "public officer" for the purposes of clause 7-2 to mean a person who is appointed the public officer of a health fund for the purposes of the *National Health Act 1953.*

Clause 7-3 - Consideration of applications

(1) This subclause requires the Minister to approve applications to participate unless the fund is subject to Part VIA of the *National Health Act* 1953, although the Minister may approve a fund subject to that Part if the Minister is satisfied that it is in the public interest to do so.

(2) This subclause defines a health fund as being subject to part VIA of the *National Health Act* if:

- the Minister has served notice on a fund that they must show grounds why an inspector should not be appointed and the Minister has not yet decided whether or not to appoint an inspector; or
- the Minister has appointed an inspector; or
- the Minister is considering the report of an inspector; or
- the Minister has made an application for judicial management or winding up of the fund; or
- the fund has made an application for a judicial winding-up; or
- an order for judicial management is currently in force; or
- an order of winding up as a result of either the Minister's or the fund's application has been made.

Clause 7-4 - Notice of Minister's decision

(1) This subclause requires the Minister to notify the applicant in writing of a decision on an application to participate in the incentives scheme within 28 days of receiving the application.

(2) This subclause provides that if the application is rejected, the notice must set out the reasons for the rejection.

Division 8 - How are participating funds reimbursed?

This division of the Bill provides for reimbursement of participating funds in respect of premium reductions for persons registered in the incentives scheme.

Clause 8-1 - Health funds may claim reimbursement

(1) This subclause provides that a health fund may claim reimbursement from the Commission for each month that it is a participating fund.

(2) This subclause requires the Commission to pay to the participating health fund the amount payable for that month under clause 8-3.

Clause 8-2 - Requirements for claims

(1) This subclause provides that a claim by a health fund for a month must be made to the Commission on the first business day of the month or on the day of the month (not being later than the seventh day of the month) determined by the Managing Director or, if the day determined is not a business day, then the first business day after that day.

(2) This subclause requires that a claim by a health fund must contain such information as the Managing Director of the Commission determines.

(3) This subclause provides that the details may include, but are not limited to, details about any or all of the policies issued by the fund that were, on the first day of the month, policies in respect of which persons were participants in the scheme and/or policies that had been, at any time before that day, policies in respect of persons who were participants in the scheme.

(4) This subclause prohibits the Managing Director from determining that funds must provide the tax file number of any person, any information about the income of any person other than that each participant has made a declaration under clause 4-3 and has not given a notice under 4-7, or information about the physical, psychological or emotional health of any person.

(5) This subclause provides that determinations made under subclause (1) or (2) are disallowable instruments.

(6) This subclause provides that claims by funds for reimbursement must be in a form approved by the Managing Director.

Clause 8-3 - Amounts payable to the health fund

(1) This subclause provides that the amount payable to a fund for the month is one twelfth of the sum of the annual incentive amounts for each of that fund's policies that cover a person who is participating in the scheme on the first day of that month.

(2) This subclause provides that, subject to subclause (3), for the purposes of subclause (1), the annual incentive amount for a private health insurance policy in respect of which a person is participating is taken to be the amount that would be the annual incentive amount if the number of people covered and the number of these people who are dependent children were as stated in the most recent application made under clause 4-3 by the person in respect of the policy.

(3) This clause provides that subclause (2) only applies if the amount worked out under that subsection is less than the annual incentive amount under clause 5-3.

(4) This subclause requires that the amount be paid to the fund on or before the 15th day of the month, or if the 15th day is not a business day, then on the first business day after the 15th day.

(5) This subclause requires the amount to be paid in the way determined by the Managing Director.

Clause 8-4 - Notifying health funds if amount is not payable

This clause sets out the requirements for the Commission to notify a health fund if it decides not to pay an incentive amount in respect of one of that fund's members.

(1) This subclause provides that if the Commission decides that an amount is not payable in respect of a policy included in a claim by a fund it must notify the fund.

(2) This subclause provides that the notice must include the reason for the decision.

(3) This subclause provides that if the Commission does not give notice of its decision that the amount is not payable by the 15th day of the month, the Commission is taken to have decided that the amount is payable.

Clause 8-5 - Reconsideration of decisions

(1) This subclause provides that a fund that has been given a notice under subclause 8-4(1) may request the Commission to reconsider the decision.

(2) This subclause provides that a request under subclause (1) above must be in writing, must set out the reasons for the request, and must be made on or before the first day of the month following the month during which the Commission gave the notice (or if that day is not a business day then the first business day after that day.)

(3) This clause requires the Commissioner to reconsider the decision and affirm, vary or revoke the decision as soon as practicable after receiving the request.

(4) This clause provides that revocation of a decision has the effect that the amount in question is payable.

(5) This clause provides that if a decision is varied then the decision has effect, and is taken to have always had effect, in accordance with the variation.

(6) This clause requires the Commission to notify the health fund stating its decision on the reconsideration together with a statement of its reasons for its decision.

(7) This clause provides that the Commission is taken to have revoked the decision if it does not notify the health fund of its decision on the reconsideration within 28 days after receiving the request.

Clause 8-6 - Appropriation

This clause provides that the Consolidated Revenue Fund is appropriated for the purposes of making payments under Division 8.

Part 4 - Administering the incentive scheme

Division 9 - Introduction

Clause 9-1 - What this part is about

This part of the Bill deals with administration of the incentives scheme. In particular, it deals with auditing and recovery of payments.

Division 10 - How is the scheme administered?

Clause 10-1 - General administration of the Act

This clause provides that the Commission has the responsibility for general administration of the Act.

Clause 10-2 - Audits by the Commission

(1) This subclause provides that the Commission may, at any time, audit the accounts and records of health funds that are or have been participating in the incentives scheme.

(2) This subclause provides that an audit must relate only to the fund's accounts and records to the extent that they deal with participation by persons in the incentives scheme, reduction of premiums under the scheme, and receipt of money from the Commission under the incentives scheme.

(3) This subclause provides that the Commission must notify a fund in writing that it is to conduct an audit.

(4) This subclause requires health funds to ensure that the Commission has access to all accounts, papers, records and documents that are relevant to the audit.

(5) This subclause provides that the person carrying out the audit may make copies of, or take extracts from, any such relevant documents.

(6) This subclause provides that the Commission may take into account a report under section 82PA of the *National Health Act* 1953 in considering whether or not to conduct an audit.

Clause 10-3 - Commission may require production of applications

(1) This subclause provides that the Commission may, by written notice to a health fund, require the health fund to produce to the Commission within the period and in the manner specified in the notice applications retained under clause 4-10, and to make copies of these applications and give them to the Commission within the period and in the manner specified in the notice.

(2) This subclause provides that the period specified under (1) above must not be less than one month.

(3) This subclause provides that a health fund is entitled to be paid by the Commission reasonable compensation for complying with a request for information under paragraph (1)(b).

Clause 10-4 - Information to be provided to the Commissioner of Taxation

This clause requires that within 60 days of the end of each financial year the Commission must provide the Commissioner of Taxation with the following information:

- the name, date of birth and address of each person who participated in the incentive scheme for that financial year;
- the name of the fund that issued the policy in respect of the participating person;
- the type of cover provided by the policy;
- the total amount of payments made to the health fund in respect of the policy that the person was covered by;
- the number of months for which incentive payments were made;
- the name and date of birth of all other persons covered by the policy for which payments were made;
- whether, at any time during that financial year, any person covered by the policy was a dependent child;
- the name and date of birth of all people whose income was taken into account when determining eligibility for that policy for that year.

Division 11 - When and how does the Government recover payments?

Clause 11-1 - Recovery of payments

This clause deals with recovery of payments by the Commonwealth.

(1) This subclause identifies amounts recoverable as debts due to the Commonwealth to be:

(a) so much of a payment under clause 8-1 as related to a policy that covers a person who was not eligible to participate in the incentives scheme for the financial year in question; and.

(b) (i) 150% of the part of an incentive payment made to a fund that the fund does not pass on to an eligible person in the form of reduced premiums payable for policies; or

(ii) 150% of the amount paid in relation to a financial year in respect of a person whose application in respect of the financial year has not been retained by the fund; or

(iii) 150% of the amount paid in relation to a financial year and in respect of a person whose application has been retained but has not been produced as required by the Commission under clause 10-3; or

(c) so much of a payment purportedly made under clause 8-1 as was not payable under that clause.

(2) This subclause identifies the parties from whom the amounts may be recovered.

(a) If the amount was paid in respect of a person referred to in paragraph (1)(a), the funds may be recovered from that person or the estate of that person; and

(b) If the amount was paid to a health insurance fund in circumstances set out in paragraph (1)(b) or (1)(c), the amounts are recoverable from the fund.

(3) This subclause provides that the amounts recoverable under subclause (1) are recoverable whether or not any person has been convicted of an offence relating to the payment.

Clause 11-2 - Interest on amounts recoverable

(1) This subclause provides that if the Managing Director has served a notice on a person, or a person's estate, from whom moneys are recoverable under 11-1(2)(a) or (b), claiming an amount as a debt due to the Commonwealth, and:

- within the period in subclause (4) the Managing Director has entered into an arrangement for repayment with the person or the estate and there has been a default in repaying the amount; or

- at the end of the period in subclause (4) no arrangement has been entered into and all or part of the amount remains unpaid;

interest is payable from the day after that period on so much of the amount as from time to time remains unpaid.

(2) This subclause provides that interest is payable at the rate of 15% per annum unless otherwise specified in regulations.

(3) This subclause provides that interest payable by a person is recoverable as a debt due to the Commonwealth from the person or the person's estate.

(4) This subclause provides that the period for entering into an arrangement for repayment is a period of three months following the service of the notice under subclause (1) or such longer period as the Managing Director allows.

(5) This subclause provides that the Court may order that interest payable on unpaid amounts under subclause (3) is payable from a day later than the day that would otherwise be applicable.

Clause 11-3 - Write off and waiver

(1) This subclause provides that the Managing Director may, on behalf of the Commonwealth, by instrument in writing, write off an amount recoverable under clause 11-1, waive the Commonwealth's right to recover the whole or part of an amount a person is required to pay under that clause, or allow a person to repay an amount by such instalments as are specified in the instrument.

(2) This subclause provides that a decision under subclause (1) takes effect on either the day specified in the notice or, if no day is specified, on the day on which the decision is made.

Division 12 - How is information protected?

This division states how information is protected.

Clause 12-1 - Principles relating to personal information

(1) This subclause provides that the Minister may make in writing, principles relating to the acquisition of, storage of, security of, access to, correction of, use of and disclosure of personal information in relation to this Bill.

(2) This subclause provides that health funds must comply with such principles.

(3) This subclause provides that principles made under subclause (1) are disallowable instruments.

Clause 12-2 - Disclosure of information relating to another person

This clause deals with the use and disclosure of information relating to another person

(1) This subclause provides that a person who uses, makes a record of or discloses or communicates to any person any information that relates to the affairs of another person and was acquired under the Bill is guilty of an offence, the penalty for which is five penalty units.

(2) This subclause provides that this clause does not apply to conduct carried out in the performance of an obligation imposed by the Bill or the exercise of a power conferred by the Bill.

Part 5 - Miscellaneous

Division 13 - Miscellaneous

Clause 13-1 - Review by Administrative Appeals Tribunal

This clause lists the clauses of the Bill that are subject to Administrative Appeals Tribunal review.

Clause 13-3 - Exclusion of certain State insurance

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

Clause 13-3 - Application of the *Criminal Code*

This clause provides that Chapter 2 of the *Criminal Code* applies to all offences against the Bill.

Clause 13-4 - Regulations

This clause provides that the Governor General may make regulations, not inconsistent with the Bill, prescribing matters required or permitted by the Bill to be prescribed or necessary or convenient to be prescribed for carrying out or giving effect to the Bill.

Schedule 1 - Dictionary

Part 1 - Definitions

This Part of the Schedule defines words and phrases for the purposes of the Bill.