The Auditor-General
Audit Report No.47 2001–02
Performance Audit

Administration of the 30 Per Cent Private Health Insurance Rebate

Health Insurance Commission
Department of Health and Ageing
Australian Taxation Office
Department of Finance and Administration
Department of the Treasury

Australian National Audit Office

ISSN 1036–7632

ISBN 0 642 80633 0

Australian National
Audit Office

Canberra ACT
7 May 2002

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in selected agencies in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Administration of the 30 Per Cent Private Health Insurance Rebate.*

Following its tabling in Parliament, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

P. J. Barrett
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Audit Team

Dr Paul Nicoll

Contents

Abbreviations/Glossary

ABS	Australian Bureau of Statistics
ANAO	Australian National Audit Office
ANTS	A New Tax System
ATO	Australian Taxation Office
FAO	Family Assistance Office
Finance	Department of Finance and Administration
HAC PBS	Health and Ageing Portfolio Budget Statements
Health	Department of Health and Ageing
HIC	Health Insurance Commission
HLA	*Health Legislation Amendment Bill (No. 3) 1999*
IPS	Incentive Payments Scheme
ITAA	*Income Tax Assessment Act 1997*
LHC	Lifetime Health Cover
MLS	Medicare Levy Surcharge
MOU	Memorandum of Understanding on Estimates Management
MYEFO	Mid-Year Economic and Fiscal Outlook
ORIMA	ORIMA Research Pty Ltd
PHI	private health insurance
PHIAC	Private Health Insurance Administration Council
PHIIA	*Private Health Insurance Incentives Act 1998*
PHIIS	Private Health Insurance Incentives Scheme
PHIR	30 per cent Private Health Insurance Rebate
PRD	Professional Review Division
PRS	Premium Reduction Scheme
SBA	Source Based Audit
SLA	Service Level Agreement for the PHIR between Health and ATO
SPA	Strategic Partnership Agreement between Health and HIC
SSPA	Schedule for the PHIR under the SPA
Tax Offset	30 per cent Private Health Insurance Tax Offset
Treasury	Department of the Treasury

Summary and Recommendations

Summary

Background

The 30 per cent Private Health Insurance Rebate (PHIR)

1. The 30 per cent Private Health Insurance Rebate (PHIR) is a financial incentive for individuals to purchase private health insurance cover. The PHIR provides for a reimbursement or discount of 30 per cent of the cost of private health insurance cover, and it is available to all Australians who are eligible for Medicare and have private health insurance. An eligible person can access the PHIR in three ways:

- as a reduction in his or her private health insurance premium—the Premium Reduction Scheme (PRS);
- as a direct cash payment at Medicare offices—the Incentive Payments Scheme (IPS); or
- as a tax offset in his or her annual income tax return—the 30 per cent Private Health Insurance Tax Offset (Tax Offset).

2. For a given period of cover, individuals are only entitled to claim via one PHIR payment option (i.e. PRS, IPS or Tax Offset). The PRS has proved to be by far the most popular PHIR payment option, accounting for over 85 per cent of PHIR payments. The IPS has accounted for less than one per cent of PHIR payments.

3. Table 1 below sets out the total cost of the PHIR to the Commonwealth budget and the initial estimates prepared when the scheme was announced in August 1998.

Table 1

Total Gross Cost of the PHIR to the Commonwealth Budget ($m)

	Jan–Jun 1999	1999–2000	2000–2001	2001–2002
Budget Outcome/ 2001–2002 Budget Estimate*	784	1533	2127	2180
Initial Estimate when PHIR Announced (August 1998)	549	1420	1536	1613

*The 1998–1999, 1999–2000, 2000–2001 figures are budget outcomes. The 2001–2002 figure is the 2001–2002 Budget estimate.

Source: Department of Health and Ageing, Department of the Treasury

Operational environment

4. The PHIR was announced in the *Tax Reform: not a new tax, a new tax system* package in August 1998 for introduction on 1 January 1999. It was to replace the Private Health Insurance Incentives Scheme (PHIIS) that had operated since 1 July 1997. Unlike the PHIR, the PHIIS was income-tested and the amount of PHIIS benefit to which a person was entitled depended on the type of policy and the number of persons covered by the policy rather than on the cost of the policy. When announced, the Department of the Treasury (Treasury) had policy responsibility for the PHIR and it was envisaged that the PHIR would be delivered through a tax offset or direct cash payments administered by the Family Assistance Office, which was to be set up within the Australian Taxation Office (ATO).

5. In early November 1998, the Government decided to allow fund members to receive the PHIR as a premium reduction from their health fund, with health funds to be reimbursed by the Commonwealth. Policy responsibility for the PHIR was then transferred from Treasury to the then Department of Health and Aged Care1 (Health). The Health Insurance Commission (HIC) was given responsibility for administering the PRS and IPS, while ATO was to administer the Tax Offset. The PHIR legislation was introduced in Parliament on 12 November 1998.

6. In order for the PHIR to be operational by 1 January 1999, Commonwealth agencies had to work to very tight timeframes: for instance, HIC effectively had six weeks to implement systems to support the PRS and IPS. The PHIR legislation was passed on 10 December 1998 and the PHIR commenced on 1 January 1999 as planned.

7. The administrative arrangements for the PHIR are complex. As previously indicated, the PHIR can be paid in three different ways, through two different Commonwealth agencies and to two different sets of clients (health funds and individual private health insurance members). Funding for the administration of the PHIR and the payment of the PHIR under the PRS and IPS is appropriated to Health, which has formal agreements with HIC and ATO in relation to the PHIR. Administration of the PHIR is governed by two separate pieces of legislation: the Private Health Insurance Incentives Act 1998 (PHIIA) specifies HIC's responsibilities in administering the PRS and IPS, while the Income Tax Assessment Act 1997 specifies ATO's responsibilities in administering the Tax Offset.

8. The PHIR is part of a package of measures aimed at improving the attractiveness of private health insurance to consumers. The other measures include, inter alia, Lifetime Health Cover, the Medicare Levy Surcharge, simplified billing for private health services and no-gap or known-gap health insurance.

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[1] The Department's name was changed to the Department of Health and Ageing in November 2001.

9. The PHIR and these other measures have contributed to increased membership of private health insurance funds, consistent with the Government's policy objective. At 30 June 2001, 8.7 million Australians were covered by private health insurance for hospital services, compared with 5.7 million at 31 December 1998.

Audit objective and approach

10. The objective of the audit was to determine the effectiveness of Commonwealth Government agencies' administration of the PHIR. The primary issues examined were whether:

- Health (with quality assurance by the Department of Finance and Administration (Finance)), Treasury and ATO had employed sound approaches to estimating the impact of the rebate on the Commonwealth budget;
- HIC and ATO had adequate financial controls in relation to PHIR payments;
- Health, HIC and ATO had clearly defined roles and worked together to fulfil the Government's objectives for the PHIR; and
- Health generated adequate performance information for internal management purposes and to report to the Government, the Parliament and the public.

11. To achieve the audit objective, the ANAO's approach included:

- interviewing relevant staff and examining relevant files and documents within ATO, Finance, Health, HIC and Treasury; and
- interviewing representatives of the Private Health Insurance Administration Council and a selection of health insurance funds.

Overall conclusion

12. Health, HIC and ATO worked together effectively in the implementation phase of the PHIR to meet the Government's tight timeframe for implementation. HIC had only six weeks to implement systems to support the PHIR, while ATO had only a few days to draft legislative amendments required to support the premium reduction option. Notwithstanding the complexity and significant scale of this task, the agencies implemented the scheme in time to allow eligible persons to receive the rebate from the Government's announced commencement date of 1 January 1999.

Budget Estimates

13. While the total cost of the PHIR to the Commonwealth budget significantly exceeded the initial budget estimates prepared by Treasury and ATO, the agencies adopted a reasonable approach to produce these estimates. The difference between the initial estimates and budget outcomes reflected the impact of Lifetime Health Cover, which was not Government policy at the time the estimates were prepared, and a range of uncertainties associated with estimating the initial budgetary impact of the PHIR. Health also adopted a reasonable approach in the preparation of subsequent PHIR budget estimates.

Financial Controls

14. HIC did not comply with s19–15 of the PHIIA, which required it to provide ATO with the data necessary for the ATO to conduct adequate data matching checks for persons who may already have claimed the rebate through HIC. Initially, this was because the legislation did not permit HIC to obtain relevant data from health funds in order for HIC to comply with s19–15. After December 1999, the legislation was amended to require health funds to provide this data. However, HIC decided not to implement the systems necessary to provide to ATO the data prescribed in s19–15. An effect was that for the PHIR's first 2.5 years, arrangements were not adequate to detect persons inappropriately claiming the rebate through more than one delivery channel.

15. To ensure the implementation of the PRS in the six week timeframe specified by the Government and after analysing and advising Health and ATO of the potential risks, HIC initially decided not to impose robust controls to confirm the accuracy and validity of payments to private health funds under the PRS. While this approach was reasonable in the initial implementation stage of the PHIR, HIC did not strengthen its controls until mid□2001.

16. Due to an administrative oversight, HIC's administration of the PRS did not comply with the provisions of the PHIIA relating to registration notifications and registration variations. This resulted in HIC being unable to enforce the PHIR eligibility criteria set down in the PHIIA. However, given the breadth of the eligibility criteria, the total payment to ineligible persons is not likely to have been material, in financial statements terms, given the total reimbursement to health funds in 2000–01 of $1.9 billion. HIC informed ANAO that subsequent analyses had confirmed this assessment.

Roles and Responsibilities

17. Health, HIC and ATO developed a clear and common understanding of their respective roles and responsibilities. However, this understanding was not

formalised in a timely manner, as agreements between the agencies were not finalised until 2.5 years after the commencement of the PHIR. The delay in finalising the Health-ATO agreement partly reflected a disagreement between the agencies about funding. The absence of formal agreements, together with shortcomings in consultative arrangements, contributed to Health obtaining only limited performance information on HIC's and ATO's administration of the PHIR for the first 2.5 years of the scheme.

18. Health's overall policy responsibility for the PHIR encompassed ensuring that, on a broad level, the administration of the PHIR was meeting the Government's objectives. It was not Health's role to closely monitor, scrutinise or take responsibility for the day-to-day administration of the PHIR. However, the ANAO concluded that Health would have been better placed to provide informed policy advice on the implementation of this new measure had it monitored and evaluated implementation issues at a high level.

19. The formal Health-HIC and Health-ATO agreements in relation to the administration of the PHIR, signed in April and June 2001 respectively now provide for adequate performance information to be supplied to Health for its monitoring and evaluation of PHIR administration.

Performance Information

20. As discussed in paragraphs 18–20 above, Health did not obtain adequate performance information on HIC's and ATO's administration of the PHIR for the first 2.5 years of the scheme. However, with the finalisation of formal agreements with HIC and ATO in mid 2001, Health developed a sound basis for assessing HIC's and ATO's overall administrative performance for both internal management and external reporting purposes.

21. Health developed adequate outcome indicators for the PHIR for inclusion in the Portfolio Budget Statement. Health used reliable data to obtain performance information against these indicators and reported this information appropriately.

Key Findings

Have agencies employed a sound approach to estimating the impact of the PHIR on the Commonwealth budget?

Initial Treasury/ATO Estimates

22. The initial estimates of the total cost of the PHIR to the Commonwealth budget were significantly lower than final budget outcomes, with the estimates for 1998–99 and 2000–01 being 30 and 28 per cent lower than the budget outcome respectively. These estimates were prepared by Treasury and ATO before the PHIR was introduced, and were subsequently adopted by Health for the 1999–2000 Budget.

23. Around half of the 1998–99 underestimate was accounted for by an incorrect assumption about the proportion of claims that would be processed through the tax system. This assumption was based on historical claiming patterns under the Private Health Insurance Incentives Scheme, which, at the time, appeared reasonable. The remainder of the underestimate reflected a range of other uncertainties associated with the introduction of the scheme, including the impact of the scheme on private health insurance participation, premiums and the timing of rebate claims in the first six months of the scheme.

24. The 2000–01 underestimate primarily reflected the impact of Lifetime Health Cover (LHC) in raising private health insurance participation. The impact of LHC was, properly, not taken into account in the preparation of the initial estimates because it was not Government policy at the time.

Health Estimates

25. From the 1999–2000 Mid-Year Economic and Fiscal Outlook (MYEFO), Health prepared the PHIR budget estimates in consultation with Finance and Treasury. Health's estimates of the total budgetary cost of the PHIR were within 12 per cent of the final budget outcome.

26. Health's approach was based on a well documented estimates construction model. Further, Health's assumptions were reasonable and based on an adequate level of analysis. For example, Health used both actuarial modelling and market research to help inform its assessment of the likely impact of LHC.

27. With the accumulation of data on the impact of LHC, Health was in a position, at the end of the audit fieldwork, to enhance its estimates model through

the analysis of the factors underlying PHI premium growth (including private health insurance funds' income and costs and Medicare hospital statistics), trends in PHI participation among different demographic groups post-LHC, and the relationship between PHI premium growth and PHI participation.

28. Health responded positively to preliminary advice from ANAO about the scope for utilising available data to improve its budget estimates approach, including commencing a comprehensive review of its estimates model.

Did HIC and ATO have adequate financial controls?

Premium Reduction Scheme

29. To ensure the implementation of the PRS in the six week timeframe specified by the Government, and after analysing and advising Health and ATO of the potential risks, HIC decided to allow funds to submit only summary data with their monthly claims for payment. This data consisted of figures for the total amount claimed and the number of policies underlying the claim. Consequently, HIC did not have sufficient data to conduct robust pre-payment checks for the validity and accuracy of these payments.

30. Until July 2001, HIC's strategy to control the risk that health fund claims were not correct consisted of two main elements. First, HIC sought to obtain from health funds, on an annual basis, detailed line-by-line data on policies for which a PRS claim had been made and to use this data to conduct post-payment reconciliation checks against the monthly summary claims data provided by the funds. Second, HIC required each participating health fund annually to provide an audit certificate by a registered company auditor as to the correctness of the fund's accounts and records to the extent that they related to participation in the PRS. Audit certificates were obtained by HIC for the first time in July–August 2000 in relation to the 1999–2000 financial year.

31. HIC received line-by-line data from all health funds relating to the first half of 1999 in November 2000. HIC did not commence its first post-payment reconciliation checks until March 2001, more than two years after the commencement of the PHIR. Further, this process was not carried out effectively because health funds did not provide complete data in the required format, inaccuracies in HIC's PRS registration database reduced the reliability of HIC's checks, and only a limited range of tests was applied.

32. Due to an administrative oversight, HIC did not comply with the provisions of the PHIIA relating to registration notifications and registration variations. HIC's non-compliance with the registration notification provisions of the PHIIA had the legal effect that all persons who had applied for registration

were deemed to be registered, notwithstanding HIC's refusal to register certain applicants on eligibility grounds. For this reason, HIC's non-compliance resulted in it being unable to enforce the PHIR eligibility criteria set down in the PHIIA. However, given the breadth of the eligibility criteria, the total payment to ineligible persons is not likely to have been material.

33. In July 2001, HIC advised the ANAO that it would strengthen its controls in relation to PRS payments to health funds via two measures. First, HIC planned to conduct audits of the PRS claims of all 43 health funds in 2001–02. Second, HIC intended to implement, during 2001–02, a new PRS payments procedure. Under this procedure, health funds would be required to support their monthly claims with detailed line-by-line data on individual insurance policies. As well, HIC would only pay funds in respect of policies registered on the HIC PRS registration database. HIC also advised the ANAO that it had devoted considerable resources to addressing issues raised by the ANAO, including:

- adding two auditors, one IT specialist and one business analyst to the 30 per cent Rebate Team;
- engaging a consultant to conduct a Scoping Audit in order to better understand the weaknesses of the PRS and formulate an initial audit strategy; and
- conducting a two-day workshop with 30 per cent Rebate stakeholders (both Commonwealth agencies and private health funds) to examine options for strengthening controls.

34. In March 2002, HIC advised the ANAO that 26 funds had been audited and that the remainder would be audited by June 2002. HIC also advised that it had implemented its new PRS claiming procedure in February 2002. Under this procedure, funds supply a summary claim and line-by-line data to support claims. HIC processes and pays the claims, processes the line-by-line data and extracts any policies which are not registered with HIC.

35. HIC advised the ANAO in March 2002 that analyses conducted as part of the strengthened financial controls implemented since the audit had not identified any materially incorrect payments to any party.

Incentive Payments Scheme

36. Over the life of the PHIR, HIC conducted a number of risk assessments and reviews of the direct cash payment option under the PHIR, the Incentive Payments Scheme (IPS). A risk assessment conducted by HIC in December 1998 concluded that there was a high to very high risk of forged receipts, multiple payments and payments for ineligible policies under the IPS. In September 2000,

HIC's Internal Audit found that HIC's financial controls did not adequately address these risks. Subsequently, in November 2000, a HIC review of the IPS identified various process deficiencies which weakened HIC's ability to control the risks associated with the IPS.

37. As at the end of the ANAO audit fieldwork, HIC had not taken action to address these issues due to the relatively low value of PHIR payments made through IPS and ongoing discussions with Health concerning the possibility of Health recommending to the Government that the IPS be abolished on cost-benefit grounds. Total cash payments under the IPS accounted for $4.3 million, or 0.2 per cent of the PHIR payments administered by HIC, in 2000–01.

38. In March 2002, HIC advised the ANAO that it had strengthened financial controls over the IPS, including implementing enhanced procedures to check for duplicate payments. HIC also advised that it would consider further enhancements if the scheme were retained.

Tax Offset

39. The main risks associated with Tax Offset claims are: taxpayers inappropriately claiming both the Tax Offset and a premium reduction and/or a direct cash payment; and incorrectly calculating the amount claimable for the Tax Offset.

40. To address the risk of inappropriate multiple claiming, ATO planned to conduct data matching reconciliations between its data on Tax Offset claims, health fund data on individual health insurance policies and premium reductions under the PRS, and HIC data on PRS and IPS claims. Health funds and HIC are required to provide this data to ATO under legislation. While ATO was able to data match with health funds, it was unable to do so with HIC. It was not until September 2001 that HIC provided accurate and complete sets of line-by-line data to ATO for the 1998–99 and 1999–2000 financial years. The delay in providing this information to the ATO was inconsistent with s19–15 of the PHIIA which requires HIC to provide this data to ATO within 90 days after the end of the financial year.

41. HIC's non-compliance with s19–15 of the PHIIA initially reflected the fact that the legislation did not permit HIC to obtain the required data from health funds. Legislative amendments to overcome this barrier received Royal Assent in December 1999. After December 1999, HIC's non-compliance reflected its decision not to implement the required systems.

42. ATO's data matching with health fund data for the first six months of the PHIR indicated that 95 585 Tax Offset claimants (14.8 per cent of matched Tax

Offset claimants) had inappropriately claimed both the Tax Offset and a premium reduction under the PRS. The total value of over-claiming associated with this 'double dipping' amounted to $8.0 million (6.4 per cent of the total Tax Offset claimed).

43. To address the risk of taxpayers incorrectly calculating the amount of Tax Offset claimable, ATO conducted some outlier analysis to check for unrealistically high claims. However, ATO did not check whether Tax Offset claims were consistent with premium data provided by health funds. ANAO requested that ATO conduct this analysis during the course of the audit fieldwork. ATO found that, in the first six months of the PHIR, 17 775 Tax Offset claimants (3.1 per cent of Tax Offset claimants) appeared to have over-claimed their Tax Offset by at least $100, with an average apparent over-claim of $257 per taxpayer. The total value of these over-claims was $4.6 million (3.7 per cent of the total Tax Offset claimed).

Have Health, HIC and ATO had clearly defined roles and worked together to fulfil the Government's objectives for the PHIR?

44. The ANAO found that Health, HIC and ATO developed a clear and common understanding of their respective roles and responsibilities.

45. The Government set a tight timeframe for the implementation of the PHIR. Health, HIC and ATO implemented the PHIR within this timeframe, enabling eligible persons to receive the rebate from the announced commencement date of 1 January 1999.

46. The original provisions of the PHIIA in respect of the Premium Reduction Scheme were drafted by ATO under considerable time pressure because the Premium Reduction Scheme was approved by the Government only a week before the Private Health Insurance Incentives Bill was to be introduced in Parliament. These provisions did not accord with HIC's preferred model for administering the Premium Reduction Scheme. In particular, the original provisions of the PHIIA did not support the payment of reimbursements to health funds on the basis of monthly summary data (the system implemented by HIC). The provisions also presented a range of impediments including, inter alia: not allowing HIC to back-pay valid health fund claims that had been rejected; requiring annual re-registration of members; and not permitting HIC to obtain line-by-line data (data on each policy for which a premium reduction was claimed) outside of the claim process (such data was required for planned financial controls—annual reconciliations by HIC and checks by ATO for multiple claiming).

47. The agencies worked together to resolve these legislative framework issues, resulting in two sets of amendments to the PHIIA.

48. Agreements between Health, HIC and ATO were not finalised until 2.5 years after the commencement of the PHIR. The delay in finalising the SLA and SSPA, together with shortcomings in the consultative arrangements between Health, HIC and ATO, contributed to Health obtaining only limited performance information on PHIR administration for the first 2.5 years of the operation of the PHIR.

49. Health was not aware of the shortcomings in HIC's financial controls, HIC's non-compliance with the PHIIA, nor of the lack of effective data exchange between HIC and ATO for the detection of 'double dipping' by PHIR claimants.

50. In the light of these audit findings, Health, HIC and ATO informed the ANAO that they would improve formal consultative arrangements for the PHIR, with a significant increase in the frequency of consultation and the introduction of a new high-level committee, the Interagency Committee, to oversee co-ordination among the agencies on the PHIR.

Has Health generated adequate performance information on the PHIR for internal management purposes and to report to the Government, the Parliament and the public?

51. Health's two outcome indicators are linked to the achievement of the objectives/planned outcomes of the PHIR. Health used reliable data to obtain performance information against these indicators and reported this information in its annual report and in its Portfolio Budget Statements.

52. The SLA and SSPA contain an appropriate range of performance indicators on HIC's and ATO's overall administrative performance for both internal management and external reporting purposes. Most of these indicators are clear and based on valid and reliable performance information. However, the claim processing accuracy indicator for HIC does not appropriately address accuracy.

53. The SLA and SSPA contain adequate mechanisms for reporting performance and for resolving disputes relating to performance.

Auditee responses

54. Significant improvements in the administration of the PHIR have been implemented as a result of this audit. In particular, the HIC has stated that it has devoted considerable resources to improving financial controls over the program.

55. Each agency's comments on the audit findings are presented below.

Department of Health and Ageing

56. The Department welcomes the contribution that the ANAO has made to improving the administration of the PHIR and found a number of the recommendations useful in clarifying areas for further focus.

57. The Department agrees with the findings of the report that the agencies involved in the administration of the PHIR were required to work to a very tight timeframe and successfully implemented the program within a six-week period.

Health Insurance Commission

58. As the report notes, HIC worked to a very tight timeframe in successfully implementing this program in a six-week period. HIC considers that, given the timeframe, the agencies involved were very effective in implementing a program which made a substantial contribution to the Government's objective of increasing private health insurance participation levels. This is evidenced by a new level of around 46 per cent of Australians holding private health insurance after a ten year decline where private health participation was reduced to under 30 per cent of the population.

59. Notwithstanding this, HIC generally accepts the ANAO's assessment of the administration of the Federal Government 30 per cent Rebate on Private Health Insurance. HIC also agrees with ANAO's assessment that HIC's non-compliance with the provisions of the Private Health Insurance Incentives Act 1998 relating to registration notifications and registration variations was inadvertent.

60. The delay in implementing legislative and system improvements was in recognition of the impact of successive initiatives introduced by the Department of Health and Ageing on health funds, including Simplified Billing, No or Known Gap requirement and Lifetime Health Cover. These all required health funds to implement substantial operational and system changes. While HIC planned to implement changes from May 2000, Lifetime Health Cover created an historic rise in planned memberships which resulted in funds being under extreme pressure to cope with an avalanche of processing work. As a result, HIC delayed its improvement program until December 2000. Since then, HIC has made significant inroads into addressing the issues and has implemented a range of improvements as at February 2002. Further enhancements are envisioned that will bring the 30 per cent Rebate into line with HIC's Business Improvement Strategy and streamline the operation of the Scheme.

61. The registration difficulties experienced by HIC and health funds are largely data entry problems associated with differences between personal details

supplied by applicants and those recorded on Medicare cards. These difficulties are compounded by privacy legislation that prevents HIC divulging Medicare details to funds for comparison with details provided in registration applications.

62. In summary, while the report raises concerns on some aspects of financial control and legislative compliance, it correctly concludes that the resulting total payments to ineligible persons is not likely to be a material amount. It also acknowledges that, since implementation, HIC has devoted considerable resources to improving financial control over this program. HIC is continuing in its efforts to improve administration of the program, including pursuing necessary legislative changes.

Australian Taxation Office

63. The Commissioner agrees with Recommendation No.5 of the report, which relates directly to the ATO.

Department of Finance and Administration

64. Finance supports Recommendation No.1 of the report. On the remaining recommendations, Finance has no comment.

Department of the Treasury

65. Treasury has no comment on the report.

Recommendations

Set out below are the ANAO's recommendations with abbreviated responses from relevant auditees. More detailed responses are shown in the body of report. The ANAO recommends that priority be given to recommendations 2, 3, 4 and 5. These recommendations address financial control issues.

Recommendation No. 1 Para. 2.30

To ensure that Health's budget estimates in relation to the PHIR continue to be soundly based, the ANAO recommends that Health review its budget estimates approach with a view to effectively utilising available data relating to private health insurance premium growth and participation.

Health response: Agreed.
***Finance response*:** Agreed.

Recommendation No. 2 Para. 3.94

The ANAO recommends that HIC review its Premium Reduction Scheme (PRS) registration procedures to ensure that:

(a) they comply with the *Private Health Insurance Incentives Act 1998*;
(b) all eligible PRS applicants are registered; and
(c) health funds are fully informed of their responsibilities in respect of the registration process.

HIC response: Agreed.

Recommendation No. 3 Para. 3.96

The ANAO recommends that HIC ensure arrangements for Premium Reduction Scheme (PRS) reimbursements have adequate financial controls, including:

(a) requiring health funds to support their claims with data on the policy details of each health fund member for whom a PRS reimbursement is claimed (line-by-line data);

(b) implementing pre- and post- payment checks and a systematic audit program to help ensure the validity and accuracy of claims, with post-payment checks conducted on a timely basis; and

(c) undertaking reconciliations of PRS payments made in 1998–1999, 1999–2000 and 2000–2001 against line-by-line data to provide assurance that health funds have correctly calculated their PRS reimbursement claims, identify claiming irregularities that require further investigation, and assist HIC in targeting future audit activity.

HIC response: Agreed.

Recommendation No. 4 Para. 3.98

Pending any change in policy and related legislation for the Incentive Payments Scheme, the ANAO recommends that HIC strengthen financial controls surrounding the Scheme.

HIC response: Agreed.

Recommendation No. 5 Para. 3.100

The ANAO recommends that HIC and ATO review their data exchange arrangements to ensure that ATO obtains timely access to the data it requires to undertake adequate data matching checks for inappropriate multiple claiming under the PHIR.

HIC response: Agreed.
***ATO response*:** Agreed.

Recommendation No. 6 Para. 5.21

The ANAO recommends that Health and HIC develop clear performance indicators and standards in relation to PHIR payment accuracy by HIC (i.e. the extent to which eligible people receive a rebate of the correct amount).

HIC response: Agreed.
Health response: Agreed with qualification.

Audit Findings and Conclusions

1. Introduction

This chapter provides background to the audit, and it introduces the audit objectives and approach, as well as environmental factors that the ANAO took into account.

Background

The 30 per cent Private Health Insurance Rebate (PHIR)

1.1 The 30 per cent Private Health Insurance Rebate (PHIR) is a financial incentive for individuals to purchase private health insurance cover. The PHIR provides for a reimbursement or discount of 30 per cent of the cost of private health insurance cover and is available to all Australians who are eligible for Medicare[2] and who have private health insurance[3] with a registered fund.[4] An eligible person can access the PHIR in three ways:

- as a reduction in his or her private health insurance premium—the Premium Reduction Scheme (PRS);
- as a direct cash payment at Medicare offices—the Incentive Payments Scheme (IPS); or
- as a tax offset in his or her annual income tax return—the 30 per cent Private Health Insurance Tax Offset (Tax Offset).

1.2 For a given period of cover, individuals are only entitled to claim via one PHIR payment option (i.e. PRS, IPS or Tax Offset).

1.3 The PRS has proved to be by far the most popular PHIR payment option, accounting for over 85 per cent of PHIR payments. The IPS accounted for less than one per cent of PHIR payments.

1.4 Table 2 sets out the total cost of the PHIR to the Commonwealth budget and the initial estimates prepared when the scheme was announced in August 1998.

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2 Medicare eligibility criteria are specified in sections 3, 6 and 7 of the *Health Insurance Act 1973*.

3 The health insurance policy must provide hospital, ancillary or combined cover and each of the persons covered by the policy must be eligible to claim Medicare benefits.

4 All Australian funds, with the exception of two, are registered under the *National Health Act 1953*.

Table 2

Total Gross Cost of the PHIR to the Commonwealth Budget ($m)

	Jan–Jun 1999	1999–2000	2000–2001	2001–2002
Budget Outcome/ 2001–2002 Budget Estimate*	784	1533	2127	2180
Initial Estimate when PHIR Announced (August 1998)	549	1420	1536	1613

*The 1998–1999, 1999–2000, 2000–2001 figures are budget outcomes. The 2001–2002 figure is the 2001–2002 Budget estimate.

Source: Department of Health and Ageing, Department of the Treasury

Operational environment

1.5 The PHIR was announced in the *Tax Reform: not a new tax, a new tax system* (ANTS) package in August 1998 for introduction on 1 January 1999. It replaced the Private Health Insurance Incentives Scheme (PHIIS) that had operated from 1 July 1997. Unlike the PHIR, the PHIIS was income-tested[5] and the amount of PHIIS benefit to which a person was entitled depended on the number and kind of persons covered by the policy and whether the policy provided hospital cover, ancillary cover or combined cover.[6] When announced in the ANTS package, the Department of the Treasury (Treasury) had policy responsibility for the PHIR. It was envisaged that the PHIR would be delivered through a tax offset or direct cash payments to be administered by the Family Assistance Office (FAO), which was to be set up within the Australian Taxation Office (ATO).

1.6 In early November 1998, the Government decided to allow fund members to receive the PHIR as a premium reduction from health funds, with health funds to be reimbursed by the Commonwealth. Policy responsibility for the PHIR was then transferred from Treasury to the then Department of Health and Aged Care[7] (Health). HIC was given responsibility for administering the PRS and IPS, while ATO was to administer the Tax Offset.

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5 The PHIIS was available to single individuals with taxable income up to $35 000 and to couples or families with a combined taxable income of up to $70 000. The income test threshold for families was increased by $3000 for each dependent child after the first.

6 For example, under the PHIIS, a single person whose taxable income was less than $35 000 and who had paid premiums for a full year of hospital and ancillary cover was entitled to a benefit of $125 regardless of the cost of the cover. 1.3 million PHIIS participants were automatically entitled to the PHIR. For most PHIIS participants, the PHIR was more generous. There was an 18-month overlap between the introduction of the PHIR and the closure of PHIIS in June 2000, in which PHIIS participants could continue to collect the PHIIS benefit if it exceeded their entitlement under the PHIR.

7 The Department's name was changed to the Department of Health and Ageing in November 2001.

1.7 In order for the PHIR to be operational by 1 January 1999, Commonwealth agencies had to work to very tight timeframes. HIC effectively had six weeks to implement systems to support the PRS and IPS, while ATO had only a few days to draft the necessary legislative amendments.[8]

1.8 The PHIR legislation was introduced in Parliament on 12 November 1998 and passed on 10 December 1998. The PHIR commenced on 1 January 1999 as planned.

1.9 The administrative arrangements for the PHIR are complex. As previously indicated, the PHIR can be paid in three different ways, through two different Commonwealth agencies and to two different sets of clients (health funds and individual private health insurance members). Funding for the administration of the PHIR and the payment of the PHIR under the PRS and IPS is appropriated to Health[9], which has formal agreements with the Health Insurance Commission (HIC) and ATO in relation to the PHIR. Administration of the PHIR is governed by two separate pieces of legislation: the *Private Health Insurance Incentives Act 1998* (PHIIA) specifies HIC's responsibilities in administering the PRS and IPS, while the *Income Tax Assessment Act 1997* (ITAA)[10] specifies ATO's responsibilities in administering the Tax Offset.

1.10 The PHIR is part of a package of measures aimed at improving the attractiveness of private health insurance to consumers. The other measures include, *inter alia*, Lifetime Health Cover, the Medicare Levy Surcharge, simplified billing for private health services and no-gap or known-gap health insurance.

1.11 The PHIR and these other measures have contributed to increased membership of private health insurance funds, consistent with the Government's objectives At 30 June 2001, 8.7 million Australians were covered by private health insurance for hospital services, compared with 5.7 million at 31 December 1998.

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[8] The Government approved the PRS option a matter of days before the PHIR legislation was to be tabled in the Parliament. Given that ATO had had previous carriage of the legislative drafting process, it was given responsibility for amending the *Private Health Insurance Incentives Bill 1998*, notwithstanding that HIC would be administering the PRS.

[9] The administration of the PHIR is funded as a departmental output under departmental appropriations. The rebate payments are funded as an administered item under a special appropriation.

[10] Amendments to the ITAA 1997 to provide for the Tax Offset were contained in the *Taxation Laws Amendment (Private Health Insurance) Bill 1998*.

Audit objective and approach

1.12 The objective of the audit was to determine the effectiveness of Commonwealth Government agencies' administration of the PHIR. The primary issues examined were whether:

- Health (with quality assurance by the Department of Finance and Administration (Finance)), Treasury and ATO had employed sound approaches to estimating the impact of the rebate on the Commonwealth budget;
- HIC and ATO had adequate financial controls to ensure that PHIR payments met the requirements of the relevant legislation;
- Health, HIC and ATO had clearly defined roles and worked together to fulfil the Government's objectives for the PHIR; and
- Health generated adequate performance information on the PHIR for internal management purposes and to report to the Government, the Parliament and the public.

1.13 To achieve the audit objective, the ANAO's approach included:

- interviewing relevant staff and examining relevant files and documents within ATO, Finance, Health, HIC and Treasury; and
- interviewing representatives of the Private Health Insurance Administration Council and a selection of health insurance funds.

1.14 The audit was conducted in conformance with the ANAO Auditing Standards at a cost to the ANAO of $322 000.

Consultants to the audit

1.15 The ANAO engaged ORIMA Research Pty Ltd to assist with the conduct of the audit and obtained legal advice from Minter Ellison.

Structure of the report

1.16 The following chapters cover the four primary issues addressed by the audit:

- Chapter 2 assesses the approaches adopted to estimate the impact of the PHIR on the Commonwealth budget;
- Chapter 3 assesses the adequacy of the financial controls in relation to the PHIR within HIC and ATO;
- Chapter 4 reviews the roles and responsibilities of Health, HIC and ATO; and
- Chapter 5 assesses the adequacy of performance information on the PHIR.

2. Budget Estimates

This chapter discusses the accuracy of the budget estimates prepared for the Private Health Insurance Rebate (PHIR) and assesses whether agencies have employed sound approaches in preparing these estimates. Part A outlines the background to the issue. Part B discusses Treasury/ATO's estimates processes. Part C discusses Health's estimates processes. Part D presents the ANAO's conclusions and recommendation.

Introduction

2.1 The three delivery mechanisms of the PHIR give rise to impacts on both Commonwealth expenses and taxation revenue. Expense impacts arise via the Health Insurance Commission (HIC) administered direct cash payments to policy holders and reimbursements to health insurance funds for upfront premium reductions. Revenue impacts arise via policy holders electing to claim the PHIR as a taxation offset on their income taxation returns.

2.2 Treasury had responsibility for the preparation of the budget estimates (expenses and revenue) for the PHIR and overall policy responsibility for the scheme until November 1998, when this policy responsibility and responsibility for PHIR expenses estimates were transferred to Health. Treasury retained responsibility for PHIR revenue estimates.

2.3 The first budget estimates for the PHIR were prepared by Treasury, with substantial input from the Australian Taxation Office (ATO), for inclusion in the A New Tax System (ANTS) announcement. Treasury (again with ATO input) also prepared the second set of estimates—for the December 1998 Mid-Year Economic and Fiscal Outlook (MYEFO). Health adopted the December 1998 MYEFO estimates for the 1999–2000 Budget. Subsequent budget estimates for the PHIR (from the 1999–2000 MYEFO) were prepared by Health, in consultation with Finance and Treasury.

2.4 The ANAO assessed whether agencies employed sound approaches in estimating the impact of the rebate on the Commonwealth budget.

Treasury/ATO estimates processes

Initial Treasury/ATO Estimates—ANTS

2.5 The first budget estimates prepared for the PHIR were finalised on 4 August 1998 for inclusion in the ANTS policy release. The estimates were largely put together by ATO, although ultimate responsibility for the estimates rested with Treasury. Moreover, Treasury shaped the final estimates significantly via

the imposition of key assumptions and a 'top down' adjustment of the estimates originally produced by ATO.

2.6 Under ATO's methodology[11], the key drivers of the estimates of the total budgetary cost of the PHIR were assumptions about private health insurance (PHI) participation/take-up and average PHI premiums. To derive estimates of the outlays cost of the PHIR and the revenue forgone as a result of the PHIR, Treasury/ATO divided their total PHIR cost estimates between outlays and revenue forgone on the basis of an assumed breakdown (or split) between claims for the PHIR via direct cash payments (outlays) and claims through tax returns via the Tax Offset (revenue forgone).[12]

2.7 For the 1998–99 financial year, the Treasury/ATO estimate of the total cost of the PHIR was 30 per cent lower than the final budget outcome.[13] Analysis conducted by ATO during the course of the audit indicates that around half of this underestimate was accounted for by an assumption, which turned out to be incorrect, in relation to the outlays/tax revenue forgone split. The remainder of the estimate-outcome variation reflected a range of other factors, including PHI participation and premium assumptions and uncertainties associated with the timing of rebate claims in the first six months of the operation of the scheme.

2.8 Treasury imposed the following outlays/tax revenue forgone split assumptions (on a tax income year basis) on the estimates:

- 1998–1999—70 per cent outlays, 30 per cent revenue; and
- 1999–2000 and subsequent years—80 per cent outlays, 20 per cent revenue.

2.9 These assumptions were based on the observed claiming trend in relation to the Private Health Insurance Incentives Scheme (PHIIS)—the income-tested scheme that was replaced by the PHIR—whereby an increasing proportion of participants were opting for upfront premium reductions over the alternative income tax return delivery option. At the time, these assumptions appeared reasonable.

2.10 The actual outlays/revenue splits that have occurred since the introduction of the PHIR are as follows and reflect a strong preference among PHIR claimants for the upfront premium reduction delivery option:

- 1998–99—86.6 per cent outlays, 13.4 per cent revenue; and
- 1999–2000—88.1 per cent outlays, 11.9 per cent revenue.

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[11] The methodology employed by ATO to produce the estimates is outlined in detail in Appendix 1.

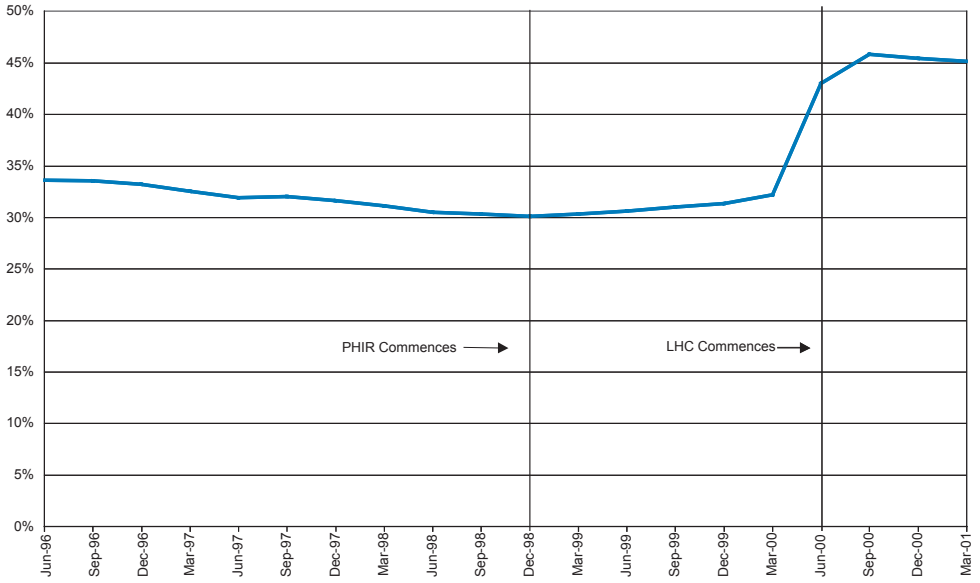
[12] When these estimates were put together, it was envisaged that the rebate would only be delivered as a cash refund or via tax returns. The upfront premium reduction option was announced in November 1998.

[13] In 1998–99, which covered the first six months of the operation of the scheme, the PHIR only involved expense/outlays impacts on the budget and hence there was also a 30 per cent underestimate of the expenses associated with the PHIR.

2.11 For the 1999–2000 financial year, the Treasury/ATO estimate of the total budgetary cost of the PHIR was seven per cent lower than the final budget outcome. Analysis undertaken by ATO during the audit indicates that, in the absence of the impact of Lifetime Health Cover (LHC)[14], the ANTS total cost estimate for the PHIR would have been around 3.5 per cent below the actual outcome. LHC was not Government policy at the time the ANTS PHIR budget estimates were prepared. It was therefore not taken into account by Treasury/ATO in the preparation of the estimates. Figure 1 highlights the impact of LHC, with the PHI participation rate increasing considerably in the three months prior to the originally announced commencement date of 1 July 2000 and also significantly in the next three months (reflecting an extension of the commencement deadline[15]).

Figure 1

Private Health Insurance Participation Rate
(Percentage of Population with Hospital Insurance—quarterly)



Source: Private Health Insurance Administration Council, Quarterly Report A

2.12 The estimate-outcome variations for the 1999–2000 Treasury/ATO PHIR revenue forgone estimates and outlays/expenses estimates were significantly higher than the total PHIR cost estimate variations discussed above. The PHIR revenue forgone estimate was 70 per cent higher, while the PHIR expense

[14] ATO performed this adjustment by attributing all of the increase in PHI participation in the last three months of 1999–2000 to LHC.

[15] The initially announced commencement date was extended by two weeks to ensure that any person who could not join a fund before 1 July 2000 due to delays resulting from the high level of membership demand on funds was not disadvantaged under the LHC rules.

estimate was 14 per cent lower than the budget outcome. This reflected a higher take-up of the upfront premium reduction delivery mechanism for the PHIR than anticipated by Treasury/ATO.

2.13 For 2000–01, the Treasury/ATO PHIR total cost estimates were 28 per cent lower than the final budget outcome. This largely reflected the impact of LHC on PHI participation. As discussed above, LHC was not Government policy at the time the ANTS PHIR estimates were prepared and hence its potential impact was not taken into account by Treasury/ATO.

Second Treasury/ATO estimates—December 1998 Mid-Year Economic and Fiscal Outlook (MYEFO)

2.14 Treasury and ATO undertook a minor revision to their ANTS estimates for the December 1998 MYEFO. The MYEFO *gross* PHIR cost estimates were the same as the ANTS estimates. The only significant change was a revision upwards of the *net* PHIR cost in 1999–2000 as a result of a downward revision of savings associated with the abolition of the PHIIS. The estimate of the total cost of the PHIR for 1999–2000 was revised upwards by $64 million.

2.15 The ANAO considers that the lack of a comprehensive re-evaluation of the original ANTS estimates was understandable given the short time period between the ANTS estimates (finalised in August 1998) and MYEFO estimates (finalised in September 1998).

Health estimates processes

First Health estimates—1999–2000 Budget

2.16 Health assumed responsibility for preparing outlays/expenses estimates in relation to the PHIR after the December 1998 MYEFO. Health's first budget estimates process in this respect was in the lead up to the 1999–2000 Budget.

2.17 In the 1999–2000 Budget, expense estimates were prepared for the first time on a full accrual basis (in previous budgets, estimates had been constructed on a cash basis). As part of the change to the accrual budgeting framework, responsibility for estimates production was largely decentralised to line agencies. Prior to the 1999–2000 Budget process, Finance was extensively involved in constructing, approving and/or entering expense estimates in a whole of government management information system. From the 1999–2000 Budget, line agencies responsible for particular outcomes were also given responsibility for estimates preparation, with Finance taking on a quality assurance role.

2.18 Relevant Health files examined by the ANAO indicated that Health had taken the decision on 10 March 1999, the deadline set by Finance for the production of final 1999–2000 Budget estimates, to adopt, unchanged, the Treasury / ATO 1998–99 MYEFO estimates for the PHIR. The stated reason for this decision was that the PHIR was in its initial stages (the estimates were prepared two months after the commencement of the scheme), and that it would be better to revise the Treasury / ATO estimates after there was further evidence on the impact of the scheme.

Health estimates—1999–2000 MYEFO to 2001–02 Budget

2.19 The ANAO found sound documentation of the preparation of Health's budget estimates for the 1999–2000 MYEFO, the 2000–01 Budget, the 2000–01 MYEFO and the 2001–02 Budget. In each case, Health employed an estimates construction model.[16] The model used was essentially the same for each of these budget processes. Like the Treasury / ATO model, critical factors driving the total PHIR cost estimates produced using the model were the assumptions about increases in average premiums and PHI participation.

2.20 Health's assumptions about average premium growth and PHI participation growth were reasonable and were made on the basis of adequate analysis. In each budget estimates process, Finance, Treasury and Health engaged in active discussions about these assumptions. The final estimates (expenses, revenue and total PHIR cost) were agreed by the three departments.

2.21 The variations between the total PHIR cost estimates made in the 1999–2000 MYEFO, the 2000–01 Budget, the 2000–01 MYEFO and the baseline of budget outcome / latest (2001–02 Budget) estimate were all within 12 per cent of the original estimates. Variations associated with PHIR expenses and revenue forgone estimates were generally higher.[17]

2.22 PHIR expenses estimates for 2000–01 to 2003–04 in the 1999–2000 MYEFO and the 2000–01 Budget were between 9 and 21 per cent lower than the budget outcome / latest estimate baseline. This primarily reflected underestimation of the impact of LHC on PHI participation. Both of these estimates processes were finalised before the commencement of LHC and hence were framed against the background of a lack of data on the impact of the measure. The introduction of LHC represented a major once-off structural change to the PHI market. The impacts of such changes are highly uncertain and difficult to forecast. Health used both actuarial modelling and market research to help inform its assessment of the likely impact of LHC. Both of these sources forecast an increase in the PHI

[16] The model is outlined in Appendix 1.

[17] See Appendix 1.

participation rate of around five percentage points as a result of the introduction of LHC. However, as Figure 1 highlights, the actual increase in the PHI participation rate was over 10 percentage points.

2.23 In the first budget estimates process after the commencement of LHC, the 2000–01 MYEFO, the PHIR expenses estimates for 2000–01 to 2003–04 were between two and six per cent greater than the budget outcome/latest budget estimate baseline.

2.24 Revenue forgone estimates in the 1999–2000 MYEFO, 2000–01 Budget and 2000–01 MYEFO for 1999–2000 to 2003–04 were between eight and 103 per cent greater than budget outcome/2001–02 Budget estimates. This overestimation of revenue forgone was driven by a lower than assumed take-up of the Tax Offset delivery option. Health's assumption in this regard was reasonably based on the historical pattern of PHIR claims.

2.25 With the accumulation of data on the impact of LHC, Health was in a position, at the end of the audit fieldwork, to enhance its estimates model through the analysis of the factors underlying PHI premium growth (including private health insurance funds' income and costs and Medicare hospital statistics), trends in PHI participation among different demographic groups post-LHC, and the relationship between PHI premium growth and PHI participation.

Conclusions

2.26 While the total cost of the PHIR to the Commonwealth budget significantly exceeded the initial budget estimates prepared by Treasury and ATO, the agencies adopted a reasonable approach to produce these estimates. The difference between the initial estimates and budget outcomes reflected the impact of Lifetime Health Cover, which was not Government policy at the time estimates were prepared, and a range of uncertainties associated with estimating the initial budgetary impact of the PHIR.

2.27 Health's approach of adopting, unchanged, the initial Treasury/ATO estimates in its first estimates process (the 1999–2000 Budget process) was reasonable in the circumstances. The deadline for the finalisation of estimates was only two months after the commencement of the PHIR and hence there was little new data on the impact of the scheme on which to base a thorough estimates revision.

2.28 Health also adopted a reasonable approach in the preparation of subsequent PHIR budget estimates. Health's assumptions were reasonable and based on an adequate level of analysis.

2.29 Health responded positively to preliminary advice from ANAO about the scope for utilising available data to improve its budget estimates approach, including commencing a comprehensive review of its estimates model.

Recommendation No.1

2.30 To ensure that Health's budget estimates in relation to the PHIR continue to be soundly based, the ANAO recommends that Health review its budget estimates approach with a view to effectively utilising available data relating to private health insurance premium growth and participation.

Health Response

2.31 Agreed. The Department has undertaken a review of the estimate model for the 30 per cent Rebate now that sufficient time has elapsed since the introduction of LHC and adequate post LHC data is available. A revised model, incorporating a capitation-based approach to private health services and benefits paid and projecting these factors into the future has been developed and will be introduced. A preliminary examination of the estimates from this model shows little difference from the existing model's estimates.

Finance Response

2.32 Finance supports this recommendation.

3. Financial Controls

This chapter assesses the adequacy of the financial controls in relation to the PHIR within HIC and ATO. Parts A and B assess HIC's controls in relation to payments made under Premium Reduction Scheme and Incentive Payments Scheme, respectively. Part C assesses ATO's controls in relation to payments made under the Tax Offset. Part D draws conclusions and recommendations from these findings.

The Premium Reduction Scheme (PRS)

3.1 Under the PRS, health funds reduce the health insurance premiums of members by 30 per cent, i.e. members pay 70 per cent of the amount that would have otherwise been due. The funds then submit a monthly claim to HIC for reimbursement of the reductions for the preceding month.

3.2 As noted in Chapter 1, the PRS has proved to be by far the most popular PHIR payment option, accounting for over 85 per cent of PHIR payments and over 99 per cent of the PHIR payments administered by HIC. In 2000–01, PRS reimbursements to health funds amounted to $1.9 billion.[18]

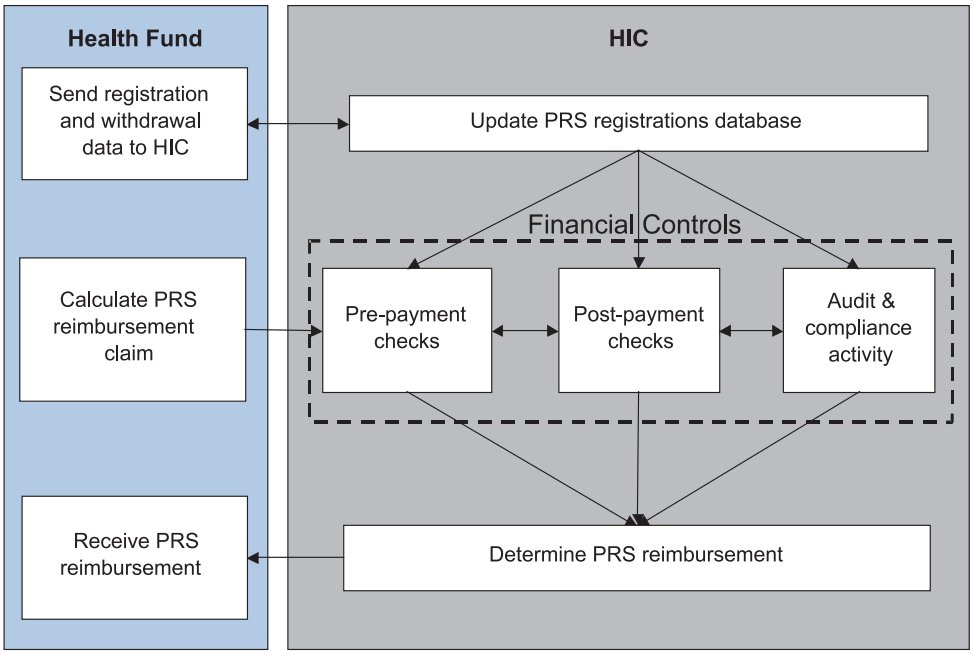
3.3 The objective of HIC financial controls in relation to the PRS is to ensure that PRS reimbursement claims are correctly calculated by health funds and only paid in relation to eligible persons. The ANAO's assessment of the adequacy of these controls was informed by relevant HIC reviews, risk assessments and audits.

3.4 Figure 2 illustrates HIC's financial control framework in relation to PRS reimbursements to health funds. The components of this control framework are addressed in the following sections.

[18] This represented 99.8 per cent of the PHIR payments administered by HIC in 2000–01, as IPS cash payments amounted to only $4.3 million in 2000–01.

Figure 2

HIC Premium Reduction Scheme Financial Control Framework



Source: ANAO and HIC

The PRS Registration Process

3.5 In order to receive a premium reduction from his or her health fund, a health fund member must apply to be registered as an eligible PRS participant with HIC. As indicated in Figure 2, health funds send data on PRS registration applications to HIC. HIC then uses these data to update the PRS registration database, which underpins HIC's financial controls (i.e. pre- and post-payment checks and audit and compliance activity).

3.6 HIC's registration system was developed under considerable time pressure in the lead up to the introduction of the PHIR. As mentioned in Chapter 1, HIC effectively had six weeks to implement this system. HIC was able to implement a workable system within this timeframe.

3.7 The ANAO found three main shortcomings with HIC's administration of the PRS registration process, as follows:

- first, HIC was not complying with some of the registration provisions in the *Private Health Insurance Incentives Act 1998* (PHIIA);
- second, HIC did not adequately monitor the registration processes to ensure that health funds understood and fulfilled their responsibilities in relation to these processes; and

- third, there were deficiencies with some aspects of the registration process conducted by HIC that contributed to inaccuracies in the PRS registration database.

Non-compliance with PHIIA registration provisions

3.8 The PHIIA provides that, if HIC does not register an applicant for the PRS, it must notify the applicant and his or her health fund. The ANAO found that HIC had not been notifying applicants whom it did not register. Instead, its practice had been to return the details of rejected applicants to health funds and expect health funds to undertake necessary follow-up activity. This process is not consistent with the PHIIA, which gives HIC the responsibility to contact individual applicants whom it refuses to register.

3.9 An important consequence of HIC not notifying individual applicants whom it had not registered is that all such persons were deemed by the PHIIA to be registered and entitled to a premium reduction.[19] Preliminary reconciliation data for the first half of 1999 showed that around five per cent of the PRS reimbursements to health funds were paid in relation to persons who had not been registered with HIC.[20] The ANAO has obtained legal advice that, as a result of HIC's non-compliance with its obligation to notify applicants whom it has not registered, HIC cannot recover any amount paid to such persons or their health funds.[21] However, given that the PHIR is a non-means tested benefit available to all Medicare-eligible persons, the ANAO considers it reasonable to expect that the majority of these persons were actually eligible and follow-up activity would reveal that the total payment to ineligible persons to be immaterial. Nevertheless, HIC's non-compliance with the PHIIA has resulted in it being unable to enforce the eligibility criteria legislated by Parliament.

3.10 The ANAO also found that HIC had not been complying with its obligation under the PHIIA to notify health funds of the details of those applicants whom it had registered and that HIC neither enforced nor adhered to those provisions of the PHIIA relating to the procedures for PRS participants to inform HIC of variations to their policy details. The provisions of the PHIIA that HIC did not comply with are shown as broken lines in Figure 3.

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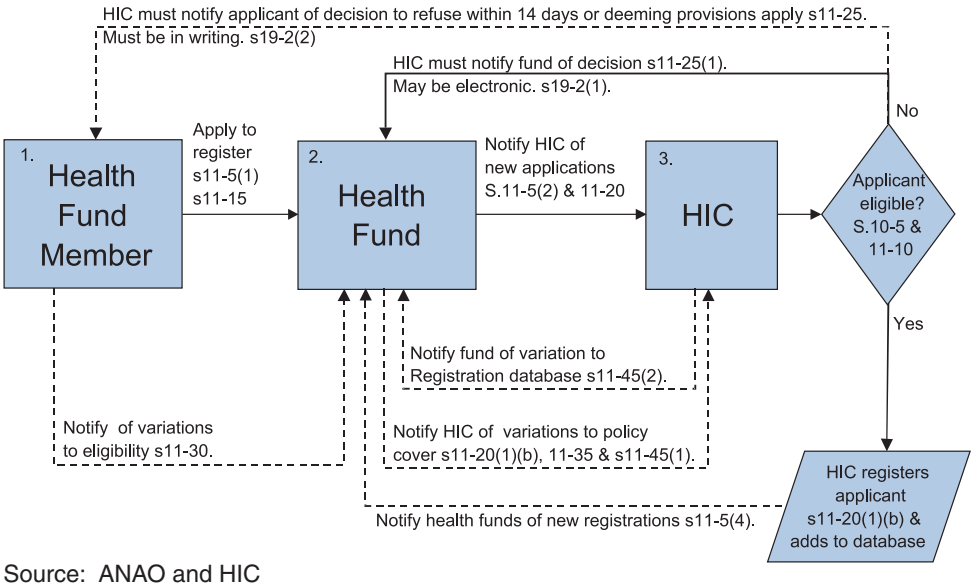
[19] Section 11–25(2) of the PHIIA provides that if HIC does not give notice of non-registration to the applicant within 14 days of receiving his or her application, then the applicant is deemed to be registered. Section 12-10(1)(c) of the PHIIA states that a person is a participant in the PRS if 'the person has applied to be registered under Division 11 in respect of the policy and the registration has not been refused.'

[20] These preliminary reconciliation results are detailed at Appendix 3 and pertain to the 40 health funds that had provided correctly formatted line-be-line data for that period. There are four health funds (together accounting for nine per cent of PRS reimbursements over this period) for which HIC did not have sufficiently reliable data at the time of the ANAO's audit.

[21] HIC can, however, recover overpayments to health funds or persons due to other reasons (such as fraud or incorrect reimbursement calculation).

Figure 3

The Registration and Registration Variations Processes in the PHIIA



Source: ANAO and HIC

Inadequate monitoring of the registration processes performed by health funds

3.11 In addition to the problems of legislative compliance, the ANAO found a number of shortcomings with the administration of the registration process.[22] These resulted in, first, health funds claiming for members whom HIC had not explicitly registered and, second, the HIC PRS registration database not being accurate and up-to-date.

3.12 A number of problems reflected the fact that some health funds did not adequately perform tasks that were their responsibility. For example:

- some health funds did not, consistently, comply with the requirement to notify HIC within 28 days of receiving PRS registration applications. Indeed, one health fund did not provide registration data for around 18 months. Despite this, HIC continued to pay claims lodged by this fund;
- some funds did not correct formatting problems in the registration data they submitted to HIC[23]; and
- many funds did not follow-up all registration refusal notices from HIC and continued to make claims in relation to members whose applications

[22] Appendix 2 describes the PRS registration and withdrawal processes in detail.

[23] Health funds compile individual PRS registration applications into batches of data. In order for HIC to process this data, the batches must be in a particular format. Otherwise, HIC sends a batch rejection message. The fund must then correct and resubmit the whole batch.

were rejected by HIC. In the worst cases, claims for rejected members went back over 2.5 years and represented a significant proportion of the fund's total claims.

3.13 In part, these administrative problems within health funds reflected the tight timeframe for the implementation of the PHIR, given funds' need to implement significant operational and system changes as part of the scheme. Moreover, funds were required to continue to implement significant system changes after the introduction of the PHIR as a result of the impact of subsequent Government initiatives, particularly Lifetime Health Cover.

3.14 HIC has overall responsibility for the administration of the PRS. his includes a responsibility to monitor the registration process and ensure that health funds understand and fulfil their responsibilities in relation to these processes.

3.15 HIC did not check whether health funds had followed up registration refusal notices and it did not monitor the outcomes of follow-up. Consequently, HIC did not know whether or not applicants it did not register were actually ineligible to participate in the PRS. Indeed, the extent of registration anomalies within some health funds only became evident once HIC attempted in March 2001 to reconcile the health fund summary claims with annual line-by-line data provided by the funds. As an indication of registration anomalies, at the conclusion of the first six months of the PHIR, out of 40 health funds[24]: 25 per cent of funds had between two per cent and 16 per cent of PRS participants unregistered while 10 per cent of funds had over 16 per cent of PRS participants unregistered.

Deficiencies with some registration processes conducted by HIC

3.16 There were also some deficiencies with the aspects of the registration processes that were conducted by HIC. HIC commissioned a consultant to conduct a scoping audit of six health funds in May 2001 as part of a first step towards formulating an audit strategy.[25] The findings of the scoping audit suggest that HIC did not always revise the PRS registrations database for registrations it processed, and it may not have always been timely in advising health funds of the status of PRS registration applications. Moreover, not all PHIIS participants were transferred to the PHIR PRS registration database.[26]

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[24] These 40 health funds provided correctly formatted line-by-line data for that period. There were four health funds (together accounting for 9 per cent of the reimbursements paid in the first six months of the PRS) for which HIC did not have sufficiently reliable data during the ANAO audit fieldwork. See further Appendix 3.

[25] Paras. 3.45–3.47 present further findings of the scoping audit.

[26] 1.3 million health fund members receiving a premium reduction under the PHIIS scheme were automatically entitled to be registered under the PHIR premium reduction scheme. HIC noted that many of the registration discrepancies in relation to PHIIS participants could be due to the 18-month overlap between the introduction of the PHIR and the closure of PHIIS in June 2000.

Consequences of registration process deficiencies

3.17 As a result of administrative deficiencies on the part of health funds and HIC, the PRS registration database was neither accurate nor complete during the audit fieldwork. This weakened HIC's pre- and post-payment checks that were based on this database.[27] It also weakened ATO's checks for premium reduction/tax rebate 'double dipping'.[28]

3.18 HIC advised the ANAO that to address the weaknesses with the registration processes, it would:

- reduce the number of registration validation checks, including removing the postcode check. The new claiming process will require funds to provide line-by-line data in support of their PRS reimbursement claims;
- develop new reports on registration rejections and improved reason codes to assist health funds in following up of registration refusals;
- distribute a new plain English processing manual to health funds in September 2001 to assist them comply with current requirements;
- develop a processing manual to support the new registration and claiming processes being developed by HIC; and
- assist health funds to gain registration for previously rejected policies.

Pre-payment checks

3.19 'Pre-payment checks' refer to those checks of the validity of health fund claims made by HIC prior to approving payment.

3.20 Under the PHIIS scheme, health funds were required to provide data on the policy details of each health fund member for whom they were making a PRS claim in any given month. These data are referred to in this report as 'line-by-line data'.

3.21 Section 15–10(3) of the PHIIA similarly allows HIC to require health funds to provide line-by-line data with claims made under the PHIR scheme. However, HIC has determined that claims only need to be supported by five figures—the total number of policies claimed for the current and previous months, the total amount of PRS reimbursement claimed for the current and previous months

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[27] This finding is consistent with an HIC compliance report that concluded that 'the accuracy of data currently held on the Premium Reduction tables is extremely doubtful' and that 'the consequence of this is that any reconciliation run will not be accurate, and the results of the run may be open to dispute'.

[28] ATO financial controls are discussed in the section '30 per cent Private Health Insurance Tax Offset Administered by ATO' below.

and the total number of registered policies at the health fund.[29] This information is referred to in this report as 'summary data'.

3.22 The decision to only require summary data reflected the fact that HIC had less than two months to get the PRS component of the new PHIR scheme operational. Accordingly, the most feasible option in the short term was to pay health funds based on summary data. Consequently, HIC did not have sufficient data to conduct robust pre-payment checks for the validity and accuracy of payments to health funds. HIC assessed the potential risks of this approach before adopting it and advised Health and ATO of this assessment.

3.23 The only pre-payment check conducted by HIC was to check that the total number of policies included in a fund's monthly claim was less than the total number of policies that the fund had registered on the HIC PRS registrations database. There are a number of weaknesses with this 'reasonableness check'. For example:

- in some funds, the maximum frequency at which members can pay premiums is quarterly. If all members are paying on a quarterly basis, then on average only one third of members will pay their premiums in any given month. Consequently, such a fund could report that it was claiming for far fewer people than it had registered with HIC and yet still be over-claiming. Even if one half of such a fund's members were not registered, it would not breach this pre-payment check in a typical month;
- due to the problems with the processing of withdrawal notices from health funds, the PRS registration database may overstate the number of registered members of some health funds, making it even less likely that the pre-payment test will detect over-claiming; and
- the pre-payment check does not evaluate the reasonableness of the average amount claimed per member.

3.24 In practice, instances where funds have claimed for more policies than they have registered with HIC have primarily served to alert HIC to registration problems. HIC's response has typically been to request the funds to update their registrations data and to seek assurances that future registration data will be sent in a more timely fashion.

3.25 HIC's use of this relatively weak pre-payment control was reasonable in the early stages of the PHIR given the tight implementation timeframe. However, it was a weakness that the ANAO expected would have been addressed as early

[29] According to HIC, health funds did not comply with (and HIC did not enforce) the requirement to provide data on the number of registered policies at the fund. This information could have assisted HIC to monitor the registration process by checking that fund registration numbers were consistent with HIC PRS registration database.

as practicable after the full implementation of the program. The ANAO advised HIC about the weakness of the pre-payment checks in March 2000, as part of its annual audit of HIC's financial statements. The ANAO noted that section 15-10 of the PHIIA empowered HIC to obtain the line-by-line data required to reconcile claims prior to making payments.

3.26 In a report on the PHIR in September 2000, HIC's Internal Audit recommended that 'funds be required to forward sufficient information to adequately determine the validity of their monthly payments on a timely basis'. An internal HIC performance improvement workshop conducted in February 2001 also identified as issues that HIC needed to address, the importance of obtaining monthly line-by-line data and improving the pre-payment reasonableness checks.

3.27 In July 2001, HIC advised the ANAO that it intended to implement, during 2001–02, a new PRS payments procedure. Under this procedure, health funds would be required to support their monthly claims with detailed line-by-line data on individual insurance policies, and HIC would only pay funds in respect of policies registered on the HIC PRS registration database.

Possible analytical checks based on line-by-line data

3.28 A key operational imperative for HIC is the tight payment timeframes specified in the PHIIA for reimbursing health funds. Under section 15–10(1), health funds must lodge claims for a given month within the first week of the following month. Under section 15–15(2), HIC must reimburse the health fund on or before the 15th day of the month in which the claim is made[30]—that is, a little over a week after receiving the claim.

3.29 There is limited scope to conduct pre-payment checks within a week, especially once allowance is made for the time required to organise the transfer of funds from Health to HIC and then to health funds. However, obtaining line-by-line data on a monthly basis will enable HIC to test the internal consistency[31] of health fund PRS reimbursement claims. Such tests include checking that:

- the claim equals the sum of the individual premium reductions listed in the line-by-line data;
- health funds only claim for registered members;
- health funds are not claiming for terminated policies;

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[30] Or, if that day is not a business day, the first business day after that day.

[31] This is not a complete check on the validity of the claim. It would not be feasible for HIC to verify the accuracy of claims via audit/compliance activity prior to payment (for example, that the health fund data corresponds to actual policies held by members).

- health funds do not claim for the same policy more than once (i.e. check for duplicates);
- individual premiums appear reasonable and are broadly consistent with the type of cover being provided (i.e. outlier analysis);
- the period of cover is consistent with the frequency of claims (e.g.. payment history checks may be used to ensure that quarterly premiums are only claimed four times per year);
- there are no overlapping periods of cover;
- there are no unexplained instances where the amount claimed in relation to a member was neither 30 per cent nor 0 per cent of the full premium; and
- only appropriate private health insurance policies are included in the claim (i.e. the policies relate to hospital and/or ancillary cover).

3.30 The above list is not intended to be either exhaustive or prescriptive, but illustrates the kind of checks that could be conducted. The checks ultimately adopted by HIC should be refined in light of the findings of future ongoing audit and compliance activity.

3.31 Ideally, basic validity checks (such as ensuring that the total claim corresponds to the sum of the individual premium reductions) would be conducted prior to payment. However, HIC has the power to set-off debts of health funds to the Commonwealth against future PRS reimbursements and health funds have an ongoing relationship with HIC whereby they make relatively large claims each month. Therefore, an overpayment in a particular month to a fund can be recovered readily by HIC reducing subsequent payments. The ANAO therefore considers that, in the course of normal business arrangements, HIC can manage the risk of debt to the Commonwealth by ensuring that post-payment checks are rigorous and timely. This will facilitate targeted audit and compliance activity and, if necessary, timely debt recovery.

Post-payment/reconciliation checks

3.32 'Post-payment' or 'reconciliation' checks refer to those checks of the validity of health fund claims made by HIC after approving payment.

Collecting the data necessary for post-payment reconciliation checks

3.33 Since the inception of the PRS, HIC and Health have recognised that it would not be possible to verify the accuracy of payments to health funds only with summary data and that post-payment checks based on line-by-line data would be required. In a January 1999 briefing to its Minister, Health advised that:

> accountability mechanisms for the payment of the Rebate will also be introduced. These mechanisms will include a requirement for an audit certificate and line-by-line data to be transmitted during the financial year, with those intervals to be determined by the Managing Director of HIC.

3.34 The original PHIIA legislation did not provide for HIC to obtain line-by-line data outside of the claiming process. Consequently, having determined that health funds need only provide summary data in support of their claims, HIC did not have the power to require health funds to provide the line-by-line data necessary to support post-payment checks of the validity of fund claims. The December 1999 PHIIA amendments remedied this by inserting a new section 19–1 which empowers HIC to require health funds to provide line-by-line data and to impose penalties on funds for non-compliance.[32]

3.35 In September 2000, HIC Internal Audit found that, although HIC had requested health funds to provide annual line-by-line data, it had not used the section 19–1 procedure. This was despite the fact that a few health funds were extremely tardy in providing line-by-line data to HIC. It was not until November 2000 that HIC had received line-by-line data from all funds for the first half of 1999.

3.36 In March 2001, HIC commenced its first post-payment reconciliation check of payments made in the first half of 1999. Preliminary results were not provided to the ANAO until June 2001. The ANAO found that HIC did not ensure that health funds provided complete data in the correct format. This reduced the effectiveness of HIC's reconciliation checks.

Deficiencies with HIC post-payment reconciliation checks and reports

3.37 When conducting its reconciliation checks, HIC only checked whether the persons identified as receiving a premium reduction in the annual line-by-line data provided by funds were identified in HIC PRS registration database as registered in that period. HIC did not test the validity of the monthly claims by applying any of the checks listed in paragraph 3.29 (i.e. checking for outliers, duplicates, terminated policies etc.). Consequently, the results of HIC's reconciliation checks provided little assurance that funds had correctly calculated their PRS reimbursement claims.

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[32] This amendment was also required so that HIC could fulfil its legislative obligation to provide line-by-line data to ATO.

3.38 In addition to not rigorously testing the validity of fund claims, HIC reconciliation reports did not identify the amounts paid in respect of persons not registered with HIC until revised as requested by the ANAO in June 2001. The revised reports showed that, out of $701.1 million paid to 40 funds[33], a total of $35.5 million (5.1 per cent) had been paid to persons not on HIC's PRS registration database. However, around 85 per cent of this amount related to unregistered members amongst three health funds. The majority of these persons are likely to have been eligible for the PRS—the fact that they were unregistered largely reflects deficiencies with the registration processes. Accordingly, payment to ineligible persons is unlikely to have been material.

3.39 Nevertheless, given that reconciliation checks are used to identify potential debts/set-offs, they should quantify the extent to which PRS payments have been made in relation to unregistered persons. For example, HIC's scoping audit[34] quantified the PRS payments to persons not registered with HIC. It found that 1.6 per cent of one fund's April 2001 PRS reimbursement claim related to persons who were not registered with HIC. In response to this finding, the fund elected to refund HIC $2.5 million. The fund anticipated that most of this amount would be recovered from HIC in future claims once the members' eligibility had been confirmed.[35]

3.40 Finally, the ANAO notes that HIC has taken around two years to undertake reconciliation checks for the first half of 1999. This delay will hamper efforts to investigate any claiming irregularities or to recover incorrect payments. Many unregistered health fund members would have changed funds and addresses and so it may be difficult to confirm their eligibility.

Ongoing audit/compliance activity

3.41 Pre- and post-payment analytical checks can verify the accuracy and consistency of claim processing, but they cannot verify the accuracy of the underlying fund data. HIC's December 1998 risk assessment judged the risk of error or fraud by funds or fund employees as high. Other potential causes of inaccuracy of health fund data include member fraud and error.

3.42 Source Based Audit (SBA) activity verifies the accuracy of health fund data, for example, by contacting fund members to verify the policy details reported by health funds. SBA activity is routinely conducted for Medicare and

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[33] A meaningful reconciliation could not be conducted for four registered health funds (together accounting for nine per cent of the PRS reimbursements) due to data problems. These preliminary reconciliation results are described more fully in Appendix 3.

[34] This HIC Scoping Audit is discussed at paragraphs 3.45 through 3.47 below.

[35] As noted in paragraphs 3.8 and 3.9, such amounts do not represent legally recoverable debts to the Commonwealth because of HIC's non-compliance with its obligation to notify persons whom it does not register.

PBS payments. The ANAO considers that SBA activity should be a necessary part of HIC's financial control framework for the PHIR.

3.43 The need for ongoing audit of claims was acknowledged by Health in its submission to the Senate Community Affairs Legislation Committee on the *Health Legislation Amendment* (HLA) *Bill (No. 3) 1999*. From at least February 1999 there were discussions between HIC's 30 per cent Rebate Team and the Professional Review Division (PRD) as to what area would conduct the audits and what data would be required. Audits were also identified as a priority by HIC Internal Audit in September 2000[36]. It noted that the then draft 30 per cent Rebate Schedule to the Strategic Partnership Agreement between Health and HIC required HIC to 'undertake audit programs to target fraud and compliance'.

3.44 In March 2000, as part of its annual audit of HIC's financial statements, the ANAO advised HIC that there was a need for a systematic approach to auditing claims, especially given the absence of rigorous pre-payment controls. It noted that 'there is no audit trail for the ANAO to review the payments to health funds and form an opinion on the validity of the amount paid under this arrangement'. It strongly recommended that HIC formalise its compliance program immediately.

3.45 The ANAO acknowledges that HIC has undertaken a number of reviews of high risk elements of the PRS. However, these were one-off investigations that were limited in coverage and based on very small samples. While these reviews have shed light on problem areas within the PHIR, by themselves they provide limited assurance that payments made to health funds are accurate or that HIC systems are adequate.

3.46 It was not until May 2001 that HIC commissioned a scoping audit as part of a first step towards formulating an audit strategy. The scoping audit highlighted a number of compliance and administrative issues. For example, it found that one fund had deficient IT controls and had not been correctly adjusting its claims for terminated policies. In another fund, 30 per cent of members for whom claims were made were not registered with HIC.

3.47 The scoping audit concluded that, notwithstanding these issues, it was unlikely that there were material claiming errors in the six funds audited. However, this does not provide assurance that payments made to health funds generally are accurate given the considerable variance in administrative performance found by both the scoping audit and HIC's reconciliations. Moreover, the scoping audit did not seek to validate the accuracy of underlying fund data or consider the full range of factors that could bear upon the accuracy of claims.

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[36] In September 2000, HIC Internal Audit noted that only two HIC staff members undertook compliance activities. It concluded: 'sound management practices and controls were not in place to validate program payments'.

3.48 In July 2001, HIC advised the ANAO that it had developed an Audit Strategy for 2001–02 that provided for ongoing audits of health fund PRS reimbursement claims. This Audit Strategy built on the methodology employed in the scoping audit and added SBA activity to its focus. Under this Strategy, HIC planned to audit all 43 health funds in 2001–02.

PHIR Audit Certificates

3.49 In the absence of rigorous pre- and post-payment checks and an ongoing audit program, HIC has relied heavily on audit certificates provided by health funds themselves.

3.50 Pursuant to section 16–5(7) of the PHIIA[37], HIC requires health funds to provide a written audit certificate by a registered company auditor as to the correctness of the fund's accounts and records for that year to the extent that they relate to participation in the PRS. HIC guidelines on this section require the auditor to confirm that:

> Claims were only made in relation to premiums reduction for members of the health fund who were registered for participation in the premiums reduction scheme, as provided for in section 11–5 of the Act.

3.51 However, without access to HIC's database, fund auditors are unable to verify that fund members are actually registered with HIC.[38] Accordingly, in practice, fund auditors have restricted their inquiries to the processes adopted by health funds to ensure that claims are calculated in accordance with the PHIIA. Fund auditors have also relied on the deeming provisions discussed at paragraphs 3.8 and 3.9 above to limit their opinion to whether HIC has been notified of applications. For example, one auditor's certificate noted that:

> The Fund has made claims in relation to premium reductions for members of the Fund who have applied for participation in the premiums reduction scheme but for which registration under the Scheme was rejected for documentation discrepancies, such as incorrect post codes and Medicare numbers.[39]

3.52 HIC recognises the limitations of the audit certificate process. A HIC Internal Audit Report (September 2000) noted that the PHIIA does not impose penalties on funds that do not provide audit certificates or provide qualified audit certificates. The interim progress report for the internal performance

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[37] This section was introduced by the *Health Legislation Amendment* (HLA) *Bill (No. 3) 1999*, which was not passed until December 1999. Accordingly, no audit certificates were provided for the first six months of the PRS.

[38] For example, the auditor of one fund noted in its audit certificates for both 1999–2000 and 2000–01 that it was unable to express an opinion on the guideline statement because the 'HIC was unable to provide a detailed list of [the fund's] members which were registered during the year.'

[39] The ANAO's findings indicate that almost all funds have members who were inappropriately rejected.

improvement workshop conducted in February 2001 indicates that HIC will review the adequacy of audit certificates for 2001–2002, including developing new audit guidelines (with reference to the PHIAC audit guidelines).

Provision of line-by-line data by HIC to ATO

3.53 Section 19–15 of the PHIIA requires HIC to provide ATO with line-by-line data on each person who paid a premium for an appropriate private health insurance policy or has received a benefit under either the PRS or the IPS. This data is to be provided within 90 days after the end of the financial year.

3.54 For each person, this line-by-line data includes:

- their personal details (name, date of birth and residential address);
- their health fund details (name, identification code);
- their policy details (policy number, type, period of cover, total premium payments etc.); and
- total PHIR reimbursements made (either via the PRS or IPS).

3.55 HIC has not complied with section 19–15. It was not until September 2001 that HIC provided accurate and complete sets of line-by-line data to ATO for the 1998–99 and 1999–2000 financial years. HIC's non-compliance with s19–15 initially reflected the fact that the legislation did not permit HIC to obtain the required data from health funds. Legislative amendments to overcome this barrier received Royal Assent in December 1999. After December 1999, HIC's non-compliance reflected its decision not to implement the required systems.

3.56 Due to HIC not providing timely and complete line-by-line data to ATO, the latter was not able to run a full set of reconciliations for the Tax Offset. As a consequence, ATO was not able to check for Tax Offset/IPS 'double dipping' and the effectiveness of its Tax Offset/PRS 'double dipping' tests was reduced.

Scope to streamline health fund reporting requirements

3.57 There is scope to streamline the reporting requirements being placed on health funds. Except for some slight formatting differences, the line-by-line data that health funds are required to provide to HIC is essentially the same as the data they are required to provide to ATO. There is no sound administrative reason for health funds to be required to provide essentially the same data to two different government agencies at different times and in different formats. Health funds have raised this issue with HIC, Health and ATO.

3.58 A more streamlined approach that would reduce the administrative burden on health funds would be for health funds to provide data to HIC and

for HIC to provide data to ATO. The following factors are relevant to considering the best way of transmitting data between health funds, HIC and ATO:

- currently only HIC is able to check that persons claiming PRS, IPS or Tax Offset meet the Medicare eligibility requirement. Accordingly, for this requirement to be checked, the data must pass through HIC at some stage in the reconciliation process;
- removing health funds' obligation to provide data directly to ATO would require HIC to consult with ATO as to their data requirements and to assure ATO that accurate data would be provided in a timely manner; and
- the extent to which the 90 day timeframe can be relaxed, taking into account ATO's operational requirements.[40]

The Incentive Payments Scheme (IPS)—Cash Payment[41]

3.59 The Incentive Payments Scheme (IPS) allows eligible fund members to obtain a cash payment equivalent to 30 per cent of the cost of their policy from Medicare offices by showing a receipt from their health fund certifying that their premiums have not already been reduced. Total cash payments have fallen in absolute terms over the life of the PHIR and accounted for only $4.3 million of payments (or 0.2 per cent of the PHIR payments administered by HIC[42]) in 2000–01.

3.60 In November 1998, HIC identified numerous scenarios that could result in cash payments being inappropriately made, either due to fraud or mistake. A risk assessment conducted by HIC in December 1998 judged there to be a high/very high risk of forged receipts;[43] multiple payments; and payments for ineligible policies. There is also a risk that persons 'double dip' by claiming the cash payment as well as either the premium reduction or the Tax Offset.

3.61 In December 1998, immediately prior to the introduction of the PHIR, HIC identified a number of controls required to address these risks. However, many required additional data from funds and/or legislative amendments. An Internal Audit memorandum concluded that without these changes there seemed

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[40] The PHIIA currently requires HIC to provide annual line-by-line by 28 September. ATO only require health funds to provide the equivalent data by 30 November.

[41] HIC deliver IPS payments in the form of cash and/or cheque (depending on the amount claimed). The term 'direct cash payment' is taken to refer to both cash and cheque IPS payments at Medicare offices.

[42] This does not include the Tax Offset, which is administered by ATO.

[43] For example, fund employees who gained access to health fund and Medicare details could easily produce forged receipts that would not be detected by HIC (some fund receipts are hand written and easy to alter or reproduce).

to be 'few controls to detect fraud through cash claiming'. However, health funds were reluctant to incur the costs necessary to provide the additional information and the December 1999 amendments to the PHIIA did not provide for improved IPS controls.

3.62 Over the life of the PHIR, HIC has investigated a number of the high risk areas identified in its risk assessments.

3.63 A review of the IPS in November 2000 found approximately 1800 policies that appeared more than once in the record of cash payments. These were checked to see whether there were any overlapping periods of cover or duplicate payments. As a result, 201 recovery letters were sent out to persons who may have been reimbursed more than once. As of December 2000, $32 431.84 (an average of $284 per person) had been repaid.

3.64 An investigation of 103 cash payments[44] of over $600 made in the six months to October 2000 found that 18 (18.5 per cent) involved errors in either the period of cover or premium paid amount.

3.65 In light of these compliance activities, an HIC compliance report on the IPS concluded that:

- there were numerous deficiencies with the IPS IT system and improvements were required to facilitate adequate preventative and detective controls;
- health funds made errors when providing receipts (e.g. providing different membership number formats or incorrect period of cover dates) that hampered detective controls and/or could lead to incorrect cash payments; and
- Medicare staff did not always accurately enter policy details and this made it difficult to detect multiple claims.

3.66 The IPS Review in November 2000 concluded:

> The integrity of the data for cash claiming is very poor due to the numerous processing errors made by Medicare Staff and health funds. Health funds seem to have a very casual approach when issuing 30 per cent Rebate receipts/statements. To improve the data held in the system an adjustment system is required and previous registrations and claims amended.

3.67 HIC Internal Audit Report (September 2000) found that:

- apart from a compliant receipt, there was no control to ensure that direct cash payments are for an eligible health insurance policy;

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[44] The investigation did not consider payments made by cheque.

- there is no post-payment validation of a direct cash payment; and
- a receipt created to look like a real receipt but which does not relate to a valid health insurance policy will not be detected.

3.68 Internal Audit recommended that HIC conduct a post-payment[45] check for IPS/PRS 'double dipping' utilising annual line-by-line data.

3.69 As at the conclusion of the ANAO audit fieldwork, HIC had not taken action to address the above issues. HIC advised the ANAO that this was due to the relatively low value of PHIR payments made through IPS and ongoing discussions with Health concerning the possibility of Health recommending to the Government that the IPS be abolished on cost-benefit grounds.[46]

The PHIR Tax Offset

3.70 The PHIR Tax Offset is provided for by subdivision 61–H of the *Income Tax Assessment Act 1997*. In 1999–2000 Tax Offset claims amounted to $188.9 million (or 11.8 per cent of PHIR payments).

3.71 ATO administers the Tax Offset as part of the annual income tax return process for individuals.[47] Accordingly, it relies on taxpayer self-assessment to determine the amount of Tax Offset payable. To assist taxpayers to accurately complete their return, the Tax Pack sets out the eligibility requirements and the procedure for calculating the amount that can be claimed as a Tax Offset.

3.72 In addition, health funds are required to issue each member with a statement at the end of each financial year that sets out: (1) the annual premium; (2) the annual PHIR entitlement; (3) the total reduction in premiums under the PRS; and (4) the remaining PHIR claimable as a Tax Offset or IPS payment (i.e. (2) less (3)). To derive his or her Tax Offset claim, the taxpayer must also subtract any IPS payments he or she has received from amount (4).

3.73 The four main risks associated with Tax Offset claims are:

- taxpayers inappropriately claiming a Tax Offset as well as receiving a premium reduction—Tax Offset/PRS 'double dipping';[48]

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[45] HIC has a pre-payment check whereby it matches cash claimants with the PRS registration database. However, due to problems with the accuracy and timeliness of this database, it is unclear how effective this check would be in detecting IPS/PRS 'double dipping'.

[46] For example, one of the recommendations of HIC's performance improvement workshop was to employ an extra staff member to monitor the IPS. However, this was put on hold pending the outcome of discussions with Health of the possibility that the IPS may be abolished.

[47] Question R5 of the 2000 tax return for individuals asks taxpayers to specify the amount of 30 per cent rebate refundable as a Tax Offset. The 2000 Tax Pack component related to question R5 informs the taxpayer in relation to eligibility to, and calculation of, the amount of the 30 per cent Private Health Insurance Rebate (PHIR) that can be claimed as a Tax Offset.

[48] For a given period of cover, individuals are only entitled to claim via one option (PRS, IPS or Tax Offset). However, individuals may use a combination of options for different periods of cover.

- taxpayers inappropriately claiming a Tax Offset as well as a direct cash payment—Tax Offset/IPS 'double dipping';
- taxpayers incorrectly calculating the amount claimable as a Tax Offset; and
- ineligible persons claiming the Tax Offset.

Data available to ATO to conduct reconciliations

3.74 ATO relies on data provided by health funds and HIC to identify incorrect Tax Offset claims.

3.75 ATO requires health funds to provide line-by-line data for each financial year by 30 November. ATO reports that health funds have generally met this deadline. However, there were some data quality issues. For example, one fund had not provided correct data in relation to PRS reimbursements, so it had to be excluded from checks for Tax Offset/PRS 'double dipping'.[49]

3.76 HIC is also required to provide annual line-by-line data to ATO. However, as discussed above, as of August 2001, HIC had not provided accurate and complete sets of line-by-line data to ATO. Accordingly ATO has had to rely solely on the data provided by the funds. The ANAO notes that:

- without information on IPS payments, ATO could not check for Tax Offset/IPS 'double dipping'. This is not satisfactory given the considerable risk that cash recipients may mistakenly claim the Tax Offset as well.[50] Although the total amount of such 'double dipping' would not be material[51], it is important to alert taxpayers to such errors to prevent their recurrence; and
- HIC reconciliation data suggest that some health funds may be providing inaccurate data in relation to their members' participation in the PRS. Such errors would undermine ATO checks for Tax Offset/PRS 'double dipping'. Without HIC data, ATO cannot detect these errors.

Tax Offset/PRS 'double dipping'

3.77 ATO has used health fund data for the first six months of the PHIR to check whether there was any Tax Offset/PRS 'double dipping'. This involved testing for cases where people had claimed both the Tax Offset and a premium

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[49] HIC had encountered similar data problems with this health fund.

[50] It would be easy to envisage such 'double dipping' errors by households where one spouse takes responsibility for preparing tax returns while the other looks after health insurance and Medicare claims.

[51] Cash claims amounted to only $4.3 million in 2000–01.

reduction for the same period of cover. The ATO did not test whether the value of rebate claimed was consistent with premium receipts recorded by health funds.

3.78 ATO found that, in the first six months of the PHIR, 95 585 Tax Offset claimants (14.8 per cent of matched claimants[52]) had already received a PRS benefit. The total value of over-claiming associated with this 'double dipping' amounted to $8.0 million (6.4 per cent of the total Tax Offset claimed). Of these claimants:

- 69 345 (72.5 per cent) had claimed Tax Offsets of less than $100. This amounted to a total over-claim of $1.7 million (or an average of $24 per claimant). ATO elected not to pursue these debts on the basis that it would not be cost effective to do so; and
- the remaining 26 240 (27.5 per cent) had claimed Tax Offsets of at least $100. This amounted to a total over-claim of $6.3 million (or an average of $241 per claimant). ATO decided to recover these debts, which amount to 5.0 per cent of the total Tax Offset claimed over this six month period.

Incorrect Tax Offset claim amounts

3.79 ATO conducted some outlier analysis to check for unrealistically high Tax Offset claims. However, prior to the audit fieldwork, ATO had not checked whether Tax Offset claims were consistent with the premium receipt data provided by health funds. The ANAO requested that ATO conduct such an analysis given the risk of taxpayers incorrectly calculating their claims.

3.80 ATO found that, in the first six months of the PHIR, 17 775 Tax Offset claimants (3.1 per cent of matched claimants[53]) appear to have over-claimed their Tax Offset by at least $100, with an average apparent over-claim of $257 per taxpayer. The total value of these apparent over-claims of $4.6 million (3.7 per cent of the total Tax Offset claimed) is not insignificant and is of the same order of magnitude as the $6.3 million of double-dipping debts (of over $100 per person) identified by ATO. However, ATO has decided not to take any further action in relation to these potential debts.

3.81 ATO also identified 21 999 taxpayers (3.9 per cent of matched claimants) who had claimed a Tax Offset at least $100 less than their PHIR entitlement. However, ATO was not in a position to identify those persons who had actually

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[52] ATO were able to match 645 695 Tax Offset claims with fund data for the purposes of this analysis. Around 25 000 (4 per cent) policyholders could not be matched and so ATO were unable to conduct any checks for these claimants. A manual check of a small sample of these suggested that most were either dependent children or older Australians who were not taxpayers.

[53] ATO were able to match 568 583 Tax Offset claims with health fund data for the purposes of this analysis.

under-claimed the Tax Offset—as opposed to those who had correctly reduced their claim to account for cash payments at Medicare Offices—because it had not received data from HIC in relation to cash payments.[54]

Checking the eligibility of Tax Offset claimants

3.82 The Tax Pack clearly states that to be eligible for the Tax Offset, every person covered by the policy must be eligible to claim Medicare benefits. However, as acknowledged by Health in November 1998[55], ATO cannot check whether Tax Offset claimants satisfy this criterion as it does not have access to the Medicare database[56]. Accordingly, ATO may inadvertently grant the Tax Offset to persons whom HIC has refused to register for the PRS on eligibility grounds. However, the proportion of taxpayers who would not be eligible for Medicare would be very small. Hence, not controlling for this risk is unlikely to have a material impact.

Conclusions

HIC financial controls

Premium Reduction Scheme

3.83 To ensure the implementation of the PRS in the six-week timeframe specified by the Government, and after analysing and advising Health and ATO of the potential risks, HIC initially decided not to impose robust controls to confirm the accuracy and validity of payments to private health funds under the PRS. While this approach was reasonable in the initial implementation stage of the PHIR, HIC did not strengthen its controls to a reasonable level until mid–2001.

3.84 Moreover, due to an administrative oversight, HIC's administration of the PRS did not comply with the provisions of the PHIIA relating to registration notifications and registration variations. This resulted in HIC being unable to enforce the PHIR eligibility criteria set down in the PHIIA. However, given the breadth of the eligibility criteria, the total payment to ineligible persons is not likely to have been material. HIC informed ANAO that subsequent analyses had not identified any materially incorrect payments to any party.

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[54] 24 393 cash claims were paid over the first half of 1999. Hence, this could account for a significant proportion of this apparent under-claim.

[55] In November 1998 meeting of the Legislative Working Group, Health noted that taxpayers claiming the Tax Offset would not be checked for Medicare eligibility, creating an inconsistency between the three PHIR payment options.

[56] However, on a strict interpretation of section 19-15 of the PHIIA, HIC is required to provide ATO with line-by-line data on all persons who are eligible for the PHIR—whether or not they received a PRS or IPS benefit. ATO could verify eligibility of Tax Offset claimants by checking their details were included in these data.

3.85 In July 2001, HIC advised the ANAO that it would strengthen its controls in relation to PRS payments to health funds via two measures. First, HIC planned to conduct audits of the PRS claims of all 43 health funds in 2001–02. Second, HIC intended to implement, during 2001–02, a new PRS payments procedure. Under this procedure, health funds would be required to support their monthly claims with detailed line-by-line data on individual insurance policies. As well, HIC would only pay funds in respect of policies registered on the HIC PRS registration database. HIC also advised the ANAO that it had devoted considerable resources to addressing the ANAO's concerns, including:

- adding two auditors, one IT specialist and one business analyst to the 30 per cent Rebate Team;
- engaging a consultant to conduct a Scoping Audit in order to better understand the weaknesses of the PRS and formulate an initial audit strategy; and
- conducting a two-day workshop with 30 per cent Rebate stakeholders (both Commonwealth agencies and private health funds) to examine options for strengthening controls.

3.86 In March 2002, HIC advised the ANAO that 26 funds had been audited and that the remainder would be audited by June 2002. HIC also advised that it had implemented its new PRS claiming procedure in February 2002. Under this procedure, funds supply a summary claim and line-by-line data to support the claim; HIC processes and pays the claim, processes the line-by-line data and extracts any unregistered policies; a report is generated and sent to funds; funds then take action to register these policies; and, if, at the end of three months, a policy remains unregistered, the responsible fund withdraws that policy and submits a negative claim amount to HIC, thereby refunding HIC the amount of rebate claimed in respect of the unregistered policy.

3.87 HIC also advised the ANAO in March 2002 that analyses conducted as part of the strengthened financial controls implemented since the ANAO audit had not identified any material incorrect payments to any party.

Incentive Payments Scheme

3.88 The IPS accounted for less than 0.2 per cent of the PHIR payments administered by HIC in 2000–01. However, it involves a high risk of inappropriate payment, including the risk of IPS/PRS and IPS/Tax Offset double dipping. This risk is well documented and understood by HIC. Two internal HIC reviews identified a range of weaknesses in HIC's financial controls in relation to the IPS. However, as at the end of the ANAO audit fieldwork, HIC had not taken action to address these weaknesses. This reflects a risk management decision by

HIC based on the relatively low value of PHIR payments made through IPS and ongoing discussions with Health concerning the possibility of Health recommending to the Government that the IPS be abolished on cost-benefit grounds.

3.89 In March 2002, HIC advised the ANAO that it had strengthened financial controls over the IPS, including implementing enhanced procedures to check for duplicate payments. HIC also advised that it would consider further enhancements if the scheme were retained.

Data transfer between HIC and ATO

3.90 HIC did not comply with s19–15 of the PHIIA, which required it to provide ATO with the data necessary for the ATO to conduct adequate data matching checks. Initially, this was because the legislation did not permit HIC to obtain relevant data from health funds in order for HIC to comply with s19–15. After December 1999, the legislation was amended to require health funds to provide this data. However, HIC decided not to implement the systems necessary to provide to ATO the data prescribed in s19–15. An effect was that for the PHIR's first 2.5 years, arrangements were not adequate to detect persons inappropriately claiming the rebate through more than one delivery channel.

3.91 In considering how to resolve this issue, HIC and ATO should also investigate the scope for streamlining the exchange of data between health funds and Commonwealth agencies to reduce the administrative burden on funds.[57]

ATO financial controls

3.92 ATO's planned data matching controls on inappropriate multiple claiming were reasonable. However, as discussed in paragraph 3.91, ATO was not able to implement these controls adequately because HIC did not provide the ATO with the necessary data.

3.93 The ANAO found that, prior to the audit fieldwork, ATO had not checked whether Tax Offset claims were consistent with the data provided by health funds. Subsequent analysis requested by the ANAO revealed that the total value of apparent over-claims was of the same order of magnitude as the Tax Offset/PRS double-dipping debts identified by ATO. The ANAO understands from discussions with ATO that conducting such tests using data provided to ATO by health funds would not involve a significant additional resource cost for ATO. The ANAO therefore considers that ATO should examine the merits of incorporating such tests into its annual data matching process.

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[57] As discussed at paragraph 3.58 above, an alternative approach would be for monthly line-by-line data to be provided to HIC and for HIC to provide annualised data to ATO.

Recommendation No. 2

3.94 The ANAO recommends that HIC review its Premium Reduction Scheme (PRS) registration procedures to ensure that:

a) they comply with the Private Health Insurance Incentives Act 1998; all eligible PRS applicants are registered; and

b) health funds are fully informed of their responsibilities in respect of the registration process.

HIC Response

3.95 Agreed. HIC has initiated action to address deficiencies noted in relation to the Premium Reduction Scheme:

- HIC has identified anomalies in the Private Health Insurance Incentives Act 1998 and a working group has been set up to review the legislation and draft amendments that will accurately reflect policy intent and appropriate procedures for the operation of the program;
- a new claiming procedure requiring line-by-line data was implemented in February 2002 which will facilitate identification and enforcement of the registration requirement; and
- health funds have been informed of their responsibilities at every opportunity. Working groups are conducted at regular intervals by HIC. All funds have been issued with new processing manuals and HIC plans to conduct education seminars to ensure that health funds fully understand their responsibilities and to provide a forum for reviewing new processes and procedures associated with the operation of the Rebate.

Recommendation No. 3

3.96 The ANAO recommends that HIC ensure arrangements for Premium Reduction Scheme (PRS) reimbursements have adequate financial controls, including:

- requiring health funds to support their claims with data on the policy details of each health fund member for whom a PRS reimbursement is claimed (line-by-line data);
- implementing pre and post-payment checks and a systematic audit program to help ensure the validity and accuracy of claims, with post-payment checks conducted on a timely basis; and
- undertaking reconciliations of PRS payments made in 1998–1999, 1999–2000 and 2000–2001 against line-by-line data to provide assurance that health funds have correctly calculated their PRS reimbursement claims, identify claiming irregularities that require further investigation, and assist HIC in targeting future audit activity.

HIC Response

3.97 Agreed. Financial controls over Premium Reduction Scheme reimbursements have been strengthened:

- a new monthly claiming system was introduced in February 2002. Health funds now supply line-by-line data to support their summary claims;
- pre- and post-payment checks have been implemented. An audit program has been initiated, with all funds scheduled for audit by June 2002. At February 2002, the first 26 funds had been audited with audit results confirming the potential risk to which PRS is exposed is low; and
- HIC has conducted reconciliations of payments made in 1998–99, 1999–2000 and 2000–01.

Recommendation No. 4

3.98 Pending any change in policy and related legislation for the Incentive Payments Scheme, the ANAO recommends that HIC strengthen financial controls surrounding the Scheme.

HIC Response

3.99 Agreed. Controls over the Incentive Payments Scheme have been strengthened, including implementation of enhanced procedures to check for duplicate claims against the Premium Reduction System.

Recommendation No. 5

3.100 The ANAO recommends that HIC and ATO review their data exchange arrangements to ensure that ATO obtains timely access to the data it requires to undertake adequate data matching checks for inappropriate multiple claiming under the PHIR.

HIC Response

3.101 Agreed. HIC and ATO are working together to design a new data exchange protocol and have agreed a rationalised approach for data collection involving a single data set that funds will provide to HIC by the legislated date of 30 September. HIC will add required information to the data and forward to ATO by a date determined by ATO.

ATO Response

3.102 Agreed. Ongoing discussions between HIC and ATO, through the Interagency Steering Committee of the 30 per cent PHIR Process Improvement Project, has led to the formation of a working group to address data exchange issues. The ATO has appointed appropriate resources to the working group and will continue to liaise closely with HIC with a view to ensuring the ATO has timely access to data necessary to detect inappropriate PHIR claims.

4. Roles and Responsibilities of Health, HIC and ATO

This chapter discusses the extent to which ATO, Health and HIC had clearly defined roles and responsibilities in relation to the PHIR and the extent to which the agencies had worked together to ensure the effective and efficient administration of the PHIR. Part A discusses the roles and responsibilities of the agencies. Part B addresses the effectiveness of the working relationships among the agencies in the context of their roles and responsibilities. Part C presents the ANAO's conclusions.

Roles and responsibilities of Health, HIC and ATO

Roles and responsibilities of HIC and ATO

4.1 The roles and responsibilities of ATO and HIC in relation to the PHIR are clearly defined in the:

- Private Health Insurance Incentives Act 1998 (PHIIA);
- Income Tax Assessment Act 1997 (ITAA);
- Service Level Agreement for the PHIR between Health and ATO (SLA); and
- Schedule for the PHIR under the Strategic Partnership Agreement between Health and HIC (SSPA).

4.2 The PHIIA and the ITAA provide the legislative basis for the PHIR. As previously indicated, these Acts stipulate the eligibility criteria for the PHIR, confer administrative functions in relation to the PHIR on HIC and ATO and set out some specific administrative requirements. HIC is responsible under the PHIIA for the administration of the premium reduction and the direct payment options of the PHIR. ATO is responsible under the ITAA for the administration of the Tax Offset option of the PHIR.

4.3 The SLA and SSPA provide a detailed specification of the roles and responsibilities of ATO and HIC in relation to the PHIR, building on the legislative framework.[58] These agreements set out specific responsibilities for ATO and HIC consistent with their statutory obligations, including the provision of performance information and other data to Health.

[58] Appendix 4 provides a summary of the relevant provisions of each agreement.

Roles and responsibilities of Health

4.4 The roles and responsibilities of Health in relation to the PHIR were not as well documented as those of ATO and HIC.

4.5 Clause 12 of the Health-HIC SSPA states that Health has 'overall policy and management responsibility for the 30 per cent Rebate'. Clause 13 states that Health 'will provide or arrange funding for HIC to administer the 30 per cent Rebate'.

4.6 Clause 7.1 of the Health-ATO SLA states that Health has 'overall policy responsibility for the 30 per cent Rebate' and that Health 'agrees to provide ATO with funding' for the administration of the PHIR.

4.7 During the course of the audit, the agencies advised the ANAO (in a jointly prepared paper) that they considered that Health's overall policy role encompassed the responsibilities expressly specified in the SLA and SSPA as well as the following:

- providing advice to Government and reporting to Parliament on issues relating to the PHIR in terms of the costs and meeting the objectives of the program;
- proposing changes to the PHIIA, in consultation with HIC;
- ensuring that, on a broad level, the administration of the PHIR is meeting the Government's objectives; and
- assisting ATO and HIC in addressing industry concerns in the context of Health's regulatory function.

4.8 The responsibility to ensure that, overall, the administration of the PHIR is meeting the Government's objectives is consistent with the fact that funding for PHIR administration is appropriated to Health. Under the Government's outcomes and outputs framework, all Commonwealth agencies are responsible for managing funds appropriated to them in a manner that contributes to outcomes consistent with Government policy (including that the funds are efficiently and effectively applied).

4.9 In line with its acknowledged overall accountability in relation to PHIR administration, Health has taken action to monitor the administrative performance of ATO and HIC by including performance information requirements in the SLA and SSPA. The SLA and SSPA contain provisions that set out performance standards for ATO and HIC and provide for relevant performance information to be supplied to Health. The information provided under the agreements also enables Health to monitor the efficiency of administration (via regular output data).

4.10 Reflecting this approach by Health, the Health and Aged Care Portfolio Budget Statements 2001–02 states that Health will 'monitor HIC's service delivery functions in accordance with agreed protocols',[59] while the SLA states that a reason for developing the SLA was to:

> provide a framework to ensure that the provision of cost effective, reliable and appropriate services from ATO. . .

4.11 In terms of the Health-HIC SPA, the following extracts from written advice provided to the Health Audit Committee by its Health Access and Financing Division in May 2000, regarding the Secretary's responsibility for the financial activities of portfolio agencies, present a useful summary of Health's approach to that issue:

> ... it is the Department's responsibility to ensure performance and value for money through management of the SPA. . .
>
> In the absence of the SPA, HIC and its Board would be accountable solely to the Minister and Parliament. The SPA is an additional checkpoint because the Minister has delegated to the Secretary the responsibility for ensuring that certain functions set out in HIC Act and other Acts are carried out in accordance with the SPA. This is how the SPA is intended to operate. . .

Effectiveness of working relationships

4.12 Within the context of the roles and responsibilities discussed above, the ANAO assessed the extent to which the agencies had worked together towards the effective and efficient administration of the PHIR.

Implementation of the PHIR

4.13 The Government set a tight timeframe for the implementation of the PHIR. Health, HIC and ATO implemented the PHIR within this timeframe, enabling eligible persons to receive the rebate from the announced commencement date of 1 January 1999.

Development of a documented relationship framework

4.14 The ANAO found that the agencies had developed a documented relationship framework through the Health-ATO SLA and the Health-HIC SSPA. However, the SLA and SSPA were only finalised during the fieldwork period of the audit—around 2.5 years after the commencement of the PHIR.[60]

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[59] Health and Aged Care Portfolio Budget Statements 2001–02, p. 213.

[60] The SLA was signed on 29 June 2001 and the SSPA was signed on 6 April 2001.

4.15 The development of the Health-ATO SLA was delayed by a protracted disagreement between Health and ATO about funding.

4.16 The Government decided in November 1998 that funding for ATO's role in the administration of the PHIR would be appropriated to Health, which would then enter into a purchaser/provider agreement with ATO.[61] However, no additional funding for this purpose was provided to Health in the 1998–99 Additional Estimates or in the 1999–2000 Budget processes.

4.17 ATO developed a draft service level agreement and provided it to Health for comment in June 1999. The draft agreement made provision for Health to pay ATO for its services for the 1999–2000 and subsequent financial years.

4.18 Negotiations on the draft agreement focused on the issue of funding. Health advised its Minister on 17 September 1999 to write to the Prime Minister seeking additional funding for ATO's administration of the PHIR, but the Minister decided against this approach. Health then advised ATO (29 November 1999) that it could not absorb the cost of funding ATO for the PHIR from within its existing budget allocation and that ATO should seek funding independently. ATO decided to continue to seek funding from Health. On 31 July 2000 the funding issue was resolved, with the Department of Finance and Administration, Health and ATO agreeing that Health would receive an equity injection in the 2000–2001 Additional Estimates process (without offsets) to cover funding for ATO's services (for 1999–2000 and 2000–01).

4.19 Following the resolution of the funding issue, it took ATO and Health a further 11 months to finalise their SLA.

4.20 The first draft of the Health-HIC SSPA was prepared by Health and provided to HIC for comment in December 1999. Protracted negotiations followed, with the agreement being finalised on 6 April 2001. Unlike the Health-ATO negotiations, ANAO did not find evidence of significant areas of disagreement. Instead, the delay in finalising the agreement appeared to reflect a low priority attached to the exercise by both Health and HIC. This may have partly been due to the fact that Health and HIC had in place the broader SPA, which contained a general framework for the relationship between the agencies. However, the SPA did not provide a clear statement of roles and responsibilities in relation to the PHIR.

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[61] The term 'purchaser/provider' was used in the correspondence between Ministers that documented this decision.

Features of the documented relationship framework

4.21 As discussed in Section A of this chapter, the SLA and SSPA clearly specify the respective roles and responsibilities of ATO and HIC and the funding arrangements between the agencies. The agreements also contain performance management frameworks. Issues surrounding these frameworks are discussed in Chapter 5.

Legislative framework

4.22 As discussed in Chapter 1, the original provisions of the PHIIA in respect of the Premium Reduction Scheme were drafted by ATO under considerable time pressure because the Premium Reduction Scheme was approved by the Government only a week before the Private Health Insurance Incentives Bill was to be introduced in Parliament.[62] These provisions did not accord with HIC's preferred model for administering the Premium Reduction Scheme. In particular, the original provisions of the PHIIA did not support the payment of reimbursements to health funds on the basis of monthly summary data (the system implemented by HIC). The provisions also presented a range of impediments including, *inter alia*:

- not allowing HIC to back-pay valid health fund claims that had been rejected;
- requiring annual re-registration of members; and
- not permitting HIC to obtain line-by-line data (data on each policy for which a premium reduction was claimed) outside of the claim process (such data was required for planned financial controls—annual reconciliations by HIC and checks by ATO for multiple claiming).

4.23 To address these issues, Health recommended, and received Ministerial approval to, a set of legislative amendments to the PHIIA in January 1999. These amendments were introduced in Parliament on 11 March 1999 as part of the *Health Legislation Amendment Bill (No.3) 1999.* The Bill was passed in November 1999.

4.24 Further legislative issues were noted in a September 2000 HIC Internal Audit report on the PHIR. HIC Internal Audit found that:

- a number of actions undertaken by HIC and health funds in respect to the PHIR were in breach of the legislation;
- there were a number of deficiencies in the PHIIA; and
- HIC's ability to soundly control the PHIR was constrained by the PHIIA.

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[62] ATO had to meet this tabling date in order for the legislation to be passed in time for the Government-announced commencement date for the scheme of 1 January 1999.

4.25 Some of the issues raised in the HIC Internal Audit report were addressed via a second set of amendments to the PHIIA, contained in Schedule 3 of the *Health Legislation Amendment Bill (No.2) 2001*, passed in June 2001. These amendments:

- allowed for the payment of additional or late claims under the Premium Reduction Scheme (previously a health fund failing to claim the full amount on time had no other recourse except to seek an Act of Grace payment); and
- clarified how the premium reduction should be calculated, rectifying an inconsistency with the calculation of the direct cash payments.

4.26 During its analysis of the PHIR Premium Reduction Scheme registration process, the ANAO found that:

- HIC was not complying with the registration notification provisions of the PHIIA;[63] and
- HIC had neither enforced nor adhered to those provisions of the PHIIA relating to registration variations.[64]

4.27 As discussed in Chapter 3, a consequence of this non-compliance by HIC was that HIC was unable to enforce the PHIR eligibility criteria set down in the PHIIA.

4.28 Despite working together on two sets of amendments to a particular section (s11–25) of the PHIIA, HIC and Health were not aware that HIC did not actually comply with this section in that it did not notify individual applicants whom it refused to register.[65] Moreover, the inconsistencies between HIC's administrative practices and the PHIIA do not appear to have been taken into account by those drafting the Health-HIC SSPA (finalised in April 2001), which reiterates the requirements that HIC notify both individuals and Health funds of registration refusals.

Health's monitoring and evaluation of HIC's and ATO's performance

4.29 In a jointly prepared paper submitted to the ANAO during the course of the audit, the three agencies stated that they considered that it was not Health's

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[63] Sections 11-5(4), 11-25(1), and 11-40(3) of the PHIIA.

[64] Sections 11-20(1)(b), 11-30, 11-35, 11-45(1) of the PHIIA.

[65] The second set of amendments actually reinforced the requirement that HIC notify rejected applicants. They resolved a conflict between the time periods for notifying applicants and for deemed acceptance by opting for the time period most advantageous to applicants. See Explanatory Memorandum to the *Health Legislation Amendment Act (No.2) 2001*.

role to closely monitor, scrutinise or take responsibility for the day-to-day administration of the PHIR. The ANAO shares this view. The ANAO expected that Health would have monitored and evaluated performance at a high level, focusing on key ATO and HIC performance measures/indicators. The ANAO also expected that Health would have assured itself that ATO and HIC had adequate risk management approaches and control environments in place.

4.30 The ANAO found that Health had agreed with HIC and ATO on a set of high-level performance indicators for each agency's administration of the PHIR. These indicators were included in the SLA and the SSPA, along with reporting mechanisms. An assessment of these indicators is presented in Chapter 5. However, the delay in finalising the SLA and SSPA resulted in Health obtaining only limited performance information for the first 2.5 years of the operation PHIR from HIC. ATO did not provide Health with any performance information during this period (apart from price/cost information as part of funding negotiations).

4.31 Until the finalisation of the Health-HIC SSPA in April 2001, Health took little action to assure itself that ATO and HIC had adequate risk management approaches and control environments in place in relation to the PHIR.

4.32 Health was aware that:

- an HIC risk assessment of the PHIR scheme completed in December 1998 noted that 30 major risks had been identified (twice the usual amount for a project of this nature) and that a very high proportion of these risks were rated very likely with a very high impact[66]; and
- in its Financial Statement Audits of HIC for 1998–99 and 1999–2000, the ANAO stated that the controls surrounding payments made under the PHIR were not sufficient to ensure the accuracy and validity of the payments made.

4.33 Health was also aware (in January 1999) that HIC intended to implement ongoing audits of fund claims and annual reconciliation checks of health fund summary claim data against detailed line-by-line data. These measures were to be core financial controls for the Premium Reduction Scheme (which accounted for over 99 per cent of PHIR payments administered by HIC).

4.34 In response to the ANAO Financial Statement Audit findings for 1998–99, Health (in February 2000) requested advice from HIC on whether HIC planned to conduct any audit or compliance activity in relation to PHIR payments made in 1998–99. HIC advised that it would investigate its options in this regard. The ANAO did not find evidence of any action by Health to follow up this matter.

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[66] This risk assessment was discussed at a PHIR Steering Committee meeting on 10 December 1998.

4.35 Through its participation in the PHIR Working Group (a consultative committee including representatives of Health, ATO, HIC and health funds), Health was made aware of some of HIC's financial control plans. Health also obtained (in August 2000) a status report from HIC on audit certificates received from health funds for the 1999–2000 financial year.

4.36 However, interviews conducted with Health staff during the audit fieldwork indicated that Health was not aware of the shortcomings in HIC's financial controls identified by the ANAO (discussed in Chapter 3). In particular, Health was not aware that no rigorous audits of health fund claims under the Premium Reduction Scheme were conducted by HIC until a scoping audit of six funds was conducted in May-July 2001. In addition, Health did not request information from HIC on the outcomes of HIC's annual reconciliation checking control—the first reconciliation results (in respect of the first six months of the PHIR) were only produced by HIC in late June 2001 (2.5 years after the commencement of the PHIR).

4.37 Health was aware that checking by ATO for inappropriate multiple claiming (i.e. people inappropriately claiming the PHIR under both the tax offset and premium reduction/direct cash payment mechanisms) was a key financial control in relation to the PHIR, and that ATO required HIC to provide it with line-by-line data to enable ATO to conduct these checks fully effectively. However, Health did not know that HIC had not complied with its statutory obligation to provide these data to ATO within 90 days of the end of the financial year and that, as a consequence, during the audit fieldwork period ATO had not been able to run a full set of multiple claiming checks (see Chapter 3).

4.38 Health's ability to assure itself that ATO and HIC had adequate risk management approaches and control environments in place in relation to the PHIR improved with the signing of the SSPA and SLA.

4.39 The SSPA (signed in April 2001) specifies that HIC will make copies of internal and external audit reports in relation to the PHIR available to Health within one week of their finalisation. The agreement also states that HIC will develop audit programs in consultation with Health and will inform Health of the progress of audits and action taken to implement audit recommendations. The ANAO found no evidence of the systematic provision of information along these lines before the finalisation of the agreement.

4.40 The SLA (signed in June 2001) specifies that ATO will provide Health with a report on the results of its checks for inappropriate multiple claiming and inappropriate over-claiming in an annual report.

Consultation mechanisms

4.41 The ANAO expected that Health, with the co-operation of HIC and ATO, would have established appropriate consultation mechanisms for the regular exchange of information among the agencies.

4.42 Regular meetings among the three agencies commenced on 20 October 1998, with the inception of the PHIR Working Group (comprising representatives of ATO, Health, HIC and health funds). The Working Group was convened to provide a forum for consultation among the agencies and health funds on the implementation of the PHIR. The Working Group met monthly until April 1999. The Group was reconvened in April 2000, and then met in May 2000, September 2000, February 2001 and March 2001.

4.43 During the initial implementation phase of the PHIR, a PHIR Steering Committee was convened, with its first meeting on 13 November 1998. The Steering Committee comprised Health, ATO, HIC and one health fund representative. The purpose of the Steering Committee was to facilitate information exchange on implementation issues among a small number of key stakeholders (the Working Group contained many health fund representatives). The Steering Committee met fortnightly until 5 February 1999. The Steering Committee established two sub-committees—a Legislative Working Group (to consider legislative issues and report back to the committee) and a Technical Working Group (to consider data interchange issues between the health funds, ATO and HIC).

4.44 In addition to the above mechanisms, HIC and Health have operated a HIC/Health Management Committee since early 1998. This was established under the SPA. It provides a forum at which program managers can consider strategic and major operational issues affecting the relationship that arise in relation to the programs that are operated by the HIC. The Committee has met every two to three months. However, until 2001 the PHIR had not been a major point of discussion within it. In March 2002, Health advised that the PHIR had been adopted as a standing item on the agenda and had been discussed at the last two meetings of the Committee.

4.45 These consultative mechanisms worked effectively during the initial implementation phase of the PHIR (November 1998–April 1999) with useful exchange of information on legislative, technical and general administrative matters. However, in view of the findings outlined above, the ANAO considers that the mechanisms were not fully effective after the initial implementation period.

4.46 In light of the audit findings, Health, HIC and ATO informed the ANAO that they would improve formal consultative arrangements in relation to the PHIR, including:

- establishing the PHIR Interagency Committee (with membership including the First Assistant Secretary, Health Industry and Investment Division, Health; the Deputy Commissioner of Personal Tax, ATO; and HIC's General Manager of Program Management), which would meet every six months and have the following functions:
  - ➢ operate as a high level forum for ATO, HIC and Health to raise issues in relation to the PHIR program and discuss administrative improvements;
  - ➢ clarify roles and responsibilities of each agency in respect of the administration of the PHIR;
  - ➢ co-ordinate activities in relation to the administration of the PHIR; and
  - ➢ report on performance and progress.
- reconvening the PHIR Steering Committee (membership comprising the 30 Per Cent Rebate Team, Health; Government Relations Branch, ATO; 30 Per Cent Rebate Section, HIC; and the CEO of the Private Health Insurance Administrative Council (PHIAC)), which would meet monthly, report to the Interagency Committee and have the following functions:
  - ➢ operate as a forum for ATO, Health, HIC and PHIAC to raise issues in relation to the operational aspects of the PHIR;
  - ➢ a forum to obtain agreement from all parties to proceed with actions relating to program administration that have been identified at PHIR Working Group Meetings and the Performance Improvement Workshop;
  - ➢ a forum to consider implementation issues arising from future policy, legislation and process improvements that have been identified at the Interagency Committee or HIC/Health Management Committee; and
  - ➢ report on performance and progress.
- implementing more regular meetings of the PHIR Working Group (membership comprising the 30 Per Cent Rebate Team, Health; Government Relations Branch, ATO; 30 Per Cent Rebate Section, HIC; and health fund representatives), which would meet every three months, would report to the Steering Committee and would have the following functions:
  - ➢ a consultation forum for ATO, Health, HIC and health funds to ensure smooth administration of the PHIR;

- a forum to discuss policy, legislation and process improvement issues at an operational level; and
- report on performance and progress.

ATO's contribution to inter-agency co-ordination

4.47 ATO adopted a positive approach to the working relationship between the agencies during the pre-commencement implementation phase of the PHIR. ATO facilitated HIC, Health and health fund feedback on the initial PHIR proposal (when it had carriage of drafting enabling legislation) and co-operated effectively with these parties after overall responsibility for the PHIR legislation was transferred to Health.

4.48 While ATO had a legitimate concern in relation to funding its activities in the administration of the PHIR (discussed in more detail above), the delay in finalising the ATO-Health SLA (signed 29 June 2001) reflected the inability of both ATO and Health to work effectively towards resolving funding issues. Moreover, following the resolution of the funding issues, it took ATO and Health a further 11 months to finalise the SLA, with the result that a documented relationship framework was not in place until 2.5 years after the commencement of the PHIR.

4.49 As discussed in Chapter 3, despite the issue being raised with HIC and ATO by health funds on a number of occasions, neither agency has taken steps to ensure that health funds are not required to provide essentially the same data to ATO and HIC at different times and in different formats.

HIC's contribution to inter-agency co-ordination

4.50 HIC contributed positively to inter-agency co-ordination during the pre-commencement and early post-commencement implementation phase of the PHIR. It participated constructively in the consultative mechanisms that were set up and provided legal, technical and administrative input.

4.51 However, since the initial post-commencement period, HIC's contribution to inter-agency co-ordination has not been as effective.

4.52 Despite having no major areas of disagreement, HIC and Health did not finalise an agreement clearly documenting the roles and responsibilities of the agencies until 2.5 years after the commencement of the PHIR. While a broader agreement (the main SPA) was put into place earlier, it did not contain the specific reporting requirements incorporated in the SSPA, which significantly aided Health in the discharge of its performance oversight responsibility.

4.53 As discussed above, HIC did not provide ATO with data it was obliged to provide under the PHIIA in a timely or effective manner. This reduced the integrity of the financial controls surrounding the PHIR.

4.54 Since October 1998, HIC has identified a range of administrative issues that have required consideration to be given (by Health) to recommending changes to the legislative framework for the PHIR. As discussed above, two sets of legislative amendments to the PHIIA have been made with HIC's assistance. However, the fact that HIC's model of administering the PHIR continues to be inconsistent with the PHIIA in a number of important ways indicates that HIC has not been fully effective in rectifying legislative issues associated with its administration of the PHIR.

4.55 As discussed above, HIC had not taken steps to resolve the issue of duplication between HIC and ATO of data requests of health funds.

Conclusions

4.56 Health, HIC and ATO worked together effectively in the implementation phase of the PHIR to meet the Government's tight timeframe for implementation. HIC had only six weeks to implement systems to support the PHIR, while ATO had only a few days to draft legislative amendments required to support the premium reduction option. Notwithstanding the complexity and significant scale of this task, the agencies implemented the scheme in time to allow eligible persons to receive the rebate from the Government's announced commencement date of 1 January 1999.

4.57 After the implementation of the PHIR, working relationships across the agencies were not as effective as during the implementation phase.

4.58 Health, HIC and ATO developed a clear and common understanding of their respective roles and responsibilities. However, this understanding was not formalised in a timely manner, as agreements between the agencies were not finalised until 2.5 years after the commencement of the PHIR. The delay in finalising the Health-ATO agreement partly reflected a disagreement between the agencies about funding. The absence of formal agreements, together with shortcomings in consultative arrangements, contributed to Health obtaining only limited performance information on HIC's and ATO's administration of the PHIR for the first 2.5 years of the scheme.

4.59 Health's overall policy responsibility for the PHIR encompassed ensuring that, on a broad level, the administration of the PHIR was meeting the Government's objectives. It was not Health's role to closely monitor, scrutinise or take responsibility for the day-to-day administration of the PHIR. However, the ANAO considers that Health would have been better placed to provide informed

policy advice on the implementation of this new measure had it monitored and evaluated HIC's and ATO's administrative performance at a high level.

4.60 The formal Health-HIC and Health-ATO agreements in relation to the administration of the PHIR, signed in April and June 2001 respectively, now provide for adequate performance information to be supplied to Health for its monitoring and evaluation of PHIR administration.

4.61 In light of the audit findings, Health, HIC and ATO informed the ANAO that they would improve formal consultative arrangements for the PHIR, with a significant increase in the frequency of consultation and the introduction of a new high-level committee, the Interagency Committee, to oversee co-ordination among the agencies on the PHIR. The ANAO considers that these new arrangements have the potential to significantly improve the effectiveness of the working relationship across the agencies.

5. Performance Information

This chapter discusses the adequacy of performance information on the PHIR generated by Health. Part A sets out the scope of the ANAO's assessment. Part B examines the performance indicators contained in the Health and Ageing Portfolio Budget Statements. Parts C and D discuss performance information in the agreements on the PHIR between Health and HIC, and Health and ATO, respectively. Part E presents the ANAO's conclusions and recommendation.

Introduction

5.1 The ANAO's assessment of Health's performance information was guided by better practice guidelines.[67]

5.2 In terms of performance information relating to HIC's and ATO's administrative performance, this chapter focuses on the arrangements prevailing after the finalisation of the Health-HIC Schedule to the Strategic Partnership Agreement on the PHIR (SSPA) and the Health-ATO Service Level Agreement (SLA).[68] Chapter 4 outlines the ANAO's findings on previous arrangements.

Performance Indicators and Measures in Health and Ageing Portfolio Budget Statements

Objectives/Planned Outcomes of the Scheme

5.3 The PHIR is part of a package of measures aimed at improving the attractiveness of private health insurance to consumers, thereby contributing to Outcome 8 of the Health and Ageing Portfolio: 'A viable private health industry to improve the choice of health services for Australians'. The other measures include (inter alia) Lifetime Health Cover, the Medicare Levy Surcharge, simplified billing for private health services and no-gap or known-gap health insurance.

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[67] Australian National Audit Office and Department of Finance (1996), *Better Practice Principles for Performance Information*, and Department of Finance and Administration (1998), *Specifying Outcomes and Outputs—Implementing the Commonwealth's Accrual-based Outcomes and Outputs Framework*.

[68] The SLA was signed on 29 June 2001 and the SSPA was signed on 6 April 2001.

5.4 While not explicitly stated in the Health and Ageing Portfolio Budget Statements, the PHIR (and related measures) were also clearly intended by the Government to take pressure off the public hospital system. For example, in the second reading speech on the *Private Health Insurance Incentives Bill 1998*, the then Minister for Health and Aged Care stated that:[69]

> This is an important Bill for it proposes a measure that will prove to be of enduring benefit to the Australian health system, namely to cut the cost of private health insurance by 30 per cent through a rebate outlined in this bill.
>
> This is one of the simplest, most effective and most important changes that could be made to restore balance in our health system by arresting the drop-out from private health insurance.
>
> The proposed cut in the cost of private health insurance will help the private sector, take pressure off the public hospitals system and help restore much needed balance to our health system.

Effectiveness Indicators in the Portfolio Budget Statements

5.5 In the 2001–2002 Portfolio Budget Statements for Health and Ageing, the relevant outcome indicators for the PHIR were as follows:

- Stabilisation of private health insurance participation rates. Benchmark at 30 June 2000 = 43.0 per cent.[70]
- Increased proportion of in-hospital episodes delivered to private patients in public and private hospitals. Benchmark at 30 June 2000 = 32.7 per cent[71]

5.6 The first indicator is directly linked to the objective of improving the attractiveness of private health insurance to consumers. The specified stabilisation target is consistent with the formulation of the Government's objective in the second reading speech of arresting the drop-out from private health insurance.

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[69] Private Health Insurance Incentives Bill, Second Reading, Hansard, 12 November 1998, p. 263.

[70] Outcome indicator No.1a—information source: Private Health Insurance Administration Council (PHIAC) Quarterly Report A.

[71] Outcome indicator No. 2b—information source: Australian Hospital Statistics.

5.7 The second of the above indicators relates to the objective of reducing pressure on public hospitals. The measurement basis for the indicator, private patient separations in public and private hospitals divided by the total number of separations in public and private hospitals, was selected by Health after consideration of a number of other separation-based and procedure-based options. The selected indicator was preferred on the basis that it:

- was more likely than other options to yield data that was consistent over time; and
- avoided biases and difficult qualitative judgements about appropriate indicative procedure/diagnosis groupings inherent in the other measurement options.

5.8 Health has used valid and reliable data to obtain performance information against its overall effectiveness indicators and has reported this information in its annual report and in its Portfolio Budget Statements.

Price, Quantity and Quality Measures in the Portfolio Budget Statements

5.9 In the 2001–2002 Portfolio Budget Statements for Health and Ageing, the relevant price, quantity and quality performance measures for the PHIR are as follows:

- Quality
  - ➢ *High level of client satisfaction with services provided by HIC*
  - ➢ *Accurate and prompt processing of claims by HIC*
- Quantity
  - ➢ *3.3–3.8 million policy holders claim the Rebate either as a direct cash payment or as a premium reduction*
- Price
  - ➢ *$1.756 million*[72]

5.10 The quality measures are underpinned by the specific indicators and standards in the Schedule for the PHIR under the Health-HIC Strategic Partnership Agreement (SSPA), discussed in Section C following.

5.11 The measures do not cover performance by ATO. Health indicated to the ANAO that ATO indicators were inadvertently omitted from the 2001–02 PBS and that Health intended to include broad agency performance measures, consistent with measures set out in Health's Service Level Agreement (SLA) with ATO, in the next Health annual report and Portfolio Budget Statements.

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[72] Amount paid by Health to HIC for administration. This is additional to funding provided to HIC to cover PHIR payments.

Performance Indicators in Health-HIC Agreement

5.12 The SSPA contains a performance management framework. The framework specifies performance indicators, performance reporting mechanisms and a dispute resolution mechanism.

5.13 Attachment B to the agreement sets out the following performance indicators, standards and performance information sources:

- Payments made to all eligible claimants (under the Incentive Payments Scheme) promptly, but at least within 14 days.
  - ➢ *Source of performance information: client satisfaction survey & complaints and feedback from claimants.*
- Health funds (under Premium Reduction Scheme) are reimbursed by 15th of each month.
  - ➢ *Source of performance information: Monthly and annual reports from HIC and complaints and feedback from health funds.*
- (Eligibility checking) All eligible claimants are able to receive the 30 per cent rebate either as an incentive payment or as a premium reduction.
  - ➢ *Source of performance information: Annual report from HIC.*
- Audit specifications are met or appropriate action is undertaken.
  - ➢ *Source of performance information: External (ANAO) and internal audit reports.*
- Information and data requested by the Department (in relation to briefings and correspondence) is provided by deadlines requested.
  - ➢ *Source of performance information: Feedback from the Department to HIC.*

5.14 Most of these indicators and standards are clear and based on valid and reliable information. However, the agreement does not provide clear standards in relation to the accuracy of processing by HIC (i.e. paying the correct person/entity the correct amount). The eligibility checking standard, 'All eligible claimants are able to receive the 30 per cent rebate either as an incentive payment or as a premium reduction', does not address accuracy—rather, it is a volume/quantity of processing standard (i.e. it seeks to ensure that all eligible people receive the rebate, but not that the amount received is correct or that ineligible people do not receive the rebate).

Performance Indicators in Health-ATO Agreement

5.15 The SLA between Health and ATO also contains a performance management framework. The framework specifies performance indicators, performance reporting mechanisms and a dispute resolution mechanism.

5.16 Attachment C to the agreement contains performance standards and sources of performance information. There are clear performance standards in relation to the timeliness of taxpayer assistance (responses to telephone, written and counter enquiries), tax return processing, audits and debt recovery.

5.17 Attachment B to the agreement provides that ATO must report on the following issues:

- Level of client satisfaction with services.
  - ➢ *Based on measures reported against the Taxpayers' Charter in ATO Annual Report.*
- Accurate and prompt processing of claims.
  - ➢ *Based on measures reported against the Taxpayers' Charter in ATO Annual Report.*
- Monitoring of inappropriate claiming.
  - ➢ *A report on the results of the cross-check of HIC, ATO and fund data regarding the level of multiple claims and/or incorrect claims made.*

5.18 The ANAO considers that the performance indicators in the Health-ATO agreement are adequate given the respective roles and responsibilities of the agencies.[73]

Conclusions

5.19 Health generated adequate performance information on the overall effectiveness of the PHIR. Health's two overall effectiveness indicators were linked to the achievement of the objectives/planned outcomes of the PHIR. Health used reliable data to obtain performance information against these indicators and reported this information in its annual report and in its Portfolio Budget Statements.

5.20 Following the finalisation of the SLA and SSPA, Health has a sound basis for generating adequate performance information on HIC's and ATO's overall service delivery performance for both internal management purposes and to report externally. The SLA and SSPA contain an appropriate range of performance indicators. Most of these indicators are clear and based on valid and reliable performance information. However, the claim processing accuracy indicator for HIC does not appropriately address accuracy.

[73] Discussed in Chapter 4.

Recommendation No. 6

5.21 The ANAO recommends that Health and HIC develop clear performance indicators and standards in relation to PHIR payment accuracy by HIC (i.e. the extent to which eligible people receive a rebate of the correct amount).

HIC Response

5.22 Agreed. HIC and Health have an agreed Schedule to the Strategic Partnership Agreement that details reports to be provided to Health and timeframes for reporting. HIC will consider the incorporation of appropriate performance indicators into the Schedule to the Strategic Partnership Agreement.

Health Response

5.23 Agreed with qualification. The Department will incorporate into its strategic agreement and regular reporting arrangements with HIC some agreed high level performance indicators on administrative accuracy which are determined and used by the Health Insurance Commission to meet other statutory and internal reporting requirements.

Canberra ACT
7 May 2002

P. J. Barrett
Auditor-General

Appendices

Appendix 1

Budget Estimates

This Appendix presents an analysis of the accuracy of budget estimates for the Private Health Insurance Rebate and details the estimates methodologies employed by agencies.

Accuracy rates

1. Tables 1.1–1.3 present:

- budget estimates for gross outlays/expenses, revenue and the total cost of the PHIR that have been made since its announcement in August 1998; and
- accuracy indicators for these estimates—the percentage variation of each estimate from the final budget outcome or (where the final budget outcome has not been determined) the latest budget estimate (that prepared for the 2001–02 Budget).

2. The estimates presented in Tables 1.1–1.3 are on a gross accruals basis—defined as the estimated accrual accounting cost of the PHIR *without taking into account* flow-on expenses in relation to the Medical Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS)[74] or savings associated with the abolition of the Private Health Insurance Incentives Scheme (PHIIS).[75] The estimates for the PHIR published in ANTS, the 1998–99 MYEFO and Budget Paper No.2 of the 1999–2000 Budget were on a *net* (budget measure) cash accounting basis—defined as the gross cost *plus* flow-on MBS and PBS expenses *less* savings associated with the abolition of PHIIS. Estimates published in the 1999–2000 Health and Aged Care Portfolio Budget Statements were on an unusual basis—gross accruals cost plus flow-on MBS and PBS expenses. Estimates published in all budget and MYEFO documents after the 1999–2000 Budget have been on a gross accruals basis.

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[74] It was expected that as expenditure on the PHIR rose, there would be an associated increase in private patient usage of hospital services attracting MBS and PBS subsidies from the Commonwealth.

[75] The PHIR replaced the PHIIS.

Table 1.1

Estimates of Gross Outlays/Expenses on the PHIR

	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05
Estimates ($m)							
ANTS - 13/8/98 (a) (b)	549	1214	1242	1304	1369	-	-
MYEFO - 13/12/98 (a) (b)	549	1214	1242	1304	1369	-	-
1999-00 Budget - 11/5/99 (c)	545	1214	1242	1303	1369	-	-
1999-00 MYEFO - 8/12/99	-	1394	1516	1623	1735	-	-
2000-01 Budget - 9/5/2000	-	1436	1608	1715	1828	1948	-
2000-01 MYEFO - 28/11/2000	-	-	1996	2049	2118	2199	-
2001-02 Budget - 22/5/2001	-	-	1887	1925	2030	2149	2273
Budget Outcome	784	1412	1930				
Percentage Variation from Outcome/2001-02 Budget Estimate							
ANTS - 13/8/98	-30	-14	-36	-32	-33	-	-
MYEFO - 13/12/98	-30	-14	-36	-32	-33	-	-
1999-00 Budget - 11/5/99	-30	-14	-36	-32	-33	-	-
1999-00 MYEFO - 8/12/99	-	-1	-21	-16	-15	-	-
2000-01 Budget - 9/5/2000	-	2	-17	-11	-10	-9	-
2000-01 MYEFO - 28/11/2000	-	-	3	6	4	2	-

Notes

(a) Gross (accruals) basis outlays estimates underlying the net/budget measure (cash) basis published estimates

(b) Accruals adjustment performed using 1999-2000 Budget estimates of accrual liabilities

(c) In the 1999-00 Health and Aged Care Portfolio Budget Statements, the 1999-00 budget estimate is shown as $1292m. This reflects the inclusion in this published figure of gross PHIR expenses of $1214m plus additional expenses associated with the Medical Benefits Scheme and Pharmaceutical Benefits Scheme induced by the PHIR via higher private patient numbers. Subsequent published budget figures are on the same basis as the figures in the table.

Source: Department of Health and Ageing, Department of the Treasury

Table 1.2

Estimates of Gross Revenue Forgone as a Result of the PHIR

	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05
Estimates ($m)							
ANTS - 13/8/98 (a)	0	206	294	309	325	-	-
MYEFO - 13/12/98 (a)	0	206	294	309	325	-	-
1999-00 Budget - 11/5/99	-	206	294	309	324	-	-
1999-00 MYEFO - 8/12/99	-	223	400	428	458	-	-
2000-01 Budget - 9/5/2000	-	131	274	306	327	348	-
2000-01 MYEFO - 28/11/2000	-	-	218	309	317	328	-
2001-02 Budget - 22/5/2001	-	-	191	256	261	275	291
Budget Outcome	0	121	197				
Percentage Variation from Outcome/2001-02 Budget Estimate							
ANTS - 13/8/98	-	70	49	21	25	-	-
MYEFO - 13/12/98	-	70	49	21	25	-	-
1999-00 Budget - 11/5/99	-	70	49	21	24	-	-
1999-00 MYEFO - 8/12/99	-	84	103	67	75	-	-
2000-01 Budget - 9/5/2000	-	8	39	20	25	27	-
2000-01 MYEFO - 28/11/2000	-	-	11	21	21	19	-

Notes

(a) Gross revenue impact basis estimates underlying the net (budget measure) basis published estimates

Source: Department of Health and Ageing, Department of the Treasury

Table 1.3

Estimates of Total Gross Cost of the PHIR

	1998–99	1999–00	2000–1	2001–02	2002–03	2003–04	2004–05
Estimates ($m)							
ANTS - 13/8/98	549	1420	1536	1613	1694	-	-
MYEFO - 13/12/98	549	1420	1536	1613	1694	-	-
1999-00 Budget - 11/5/99	545	1420	1536	1612	1693	-	-
1999-00 MYEFO - 8/12/99	-	1617	1916	2051	2193	-	-
2000-01 Budget - 9/5/2000	-	1567	1882	2021	2154	2296	-
2000-01 MYEFO - 28/11/2000	-	-	2214	2358	2435	2527	-
2001-02 Budget - 22/5/2001	-	-	2078	2180	2291	2424	2564
Budget Outcome	784	1533	2127				
Percentage Variation from Outcome/2001-02 Budget Estimate							
ANTS - 13/8/98 (a)	-30	-7	-28	-26	-26	-	-
MYEFO - 13/12/98 (a)	-30	-7	-28	-26	-26	-	-
1999-00 Budget - 11/5/99	-	-7	-28	-26	-26	-	-
1999-00 MYEFO - 8/12/99	-	5	-10	-6	-4	-	-
2000-01 Budget - 9/5/2000	-	2	-12	-7	-6	-5	-
2000-01 MYEFO - 28/11/2000	-	-	4	8	6	4	-
Notes							
(a) Gross (accruals) basis fiscal balance impact estimates underlying the net/budget measure (cash) basis published estimates							

Source: Department of Health and Ageing, Department of the Treasury

Estimates methodologies

ATO/Treasury methodology

3. The methodology employed by ATO to produce the initial PHIR estimates involved the following steps:

- the total number of private health insurance (PHI) policies in four categories (singles hospital cover, family hospital cover, singles ancillary cover, and family ancillary cover) as of December 1997 was taken from Private Health Insurance Administration Council (PHIAC) data;
- 1995 Australian Bureau of Statistics National Health Survey data on estimated proportions of the population with PHI in various income ranges was applied to the PHIAC policy numbers to obtain estimates of the number of PHI policies by income range (family and single);
- average premiums (Treasury assumptions) for the four policy categories were multiplied by the estimated number of policies in each income range and then by 30 per cent to obtain an estimate of the baseline cost of the PHIR by income range and in aggregate;
- a number of premium growth and PHI policy number growth assumptions for each income range were applied to the baseline cost figures to obtain total PHIR budgetary cost estimates for 1998–99 through to 2002–03; and

- an assumed revenue/outlays percentage split (Treasury assumption) was applied to the total cost estimates to produce outlays and revenue cost estimates for 1998–99 through to 2002–03.

Health methodology

4. For the 1999–2000 MYEFO, the 2000–01 Budget, the 2000–01 MYEFO and the 2001–02 Budget, Health employed an estimates construction model. The model used was essentially the same for each of these budget processes and involved the following steps:

- average monthly outlays (for the previous financial year) were calculated from HIC data;
- indexation parameters for (a) premium increases and (b) increases in insured population were assumed and combined to yield an indexation factor;
- this indexation factor was applied to the average outlays and the result was multiplied by 12 to yield financial year estimates for outlays; and
- a revenue/outlays split was assumed (i.e. percentage of total PHIR cost claimed through taxation offset and percentage claimed through outlays) and applied to estimated outlays to yield total cost and to calculate the revenue cost estimate.

5. Unlike the Treasury/ATO model, the *level* of average premiums or the number of health insurance policies is not an input to the model—the model is anchored on actual outlays in a base period so that:

$$C(t+1) = C(t)*\text{Indexation Factor}$$

$$\text{Indexation factor} = (1+Gp)*(1+Gn)$$

where C(t) is total expenses/outlays in year 't', C(t+1) is total expenses/outlays in the following year 't+1', Gp is growth in average premiums and Gn is growth in the number of insured between year 't' and year 't+1'.

6. Like the Treasury/ATO model, critical factors driving the expense, revenue and total PHIR cost estimates are assumptions about increases in average premiums and PHI participation.

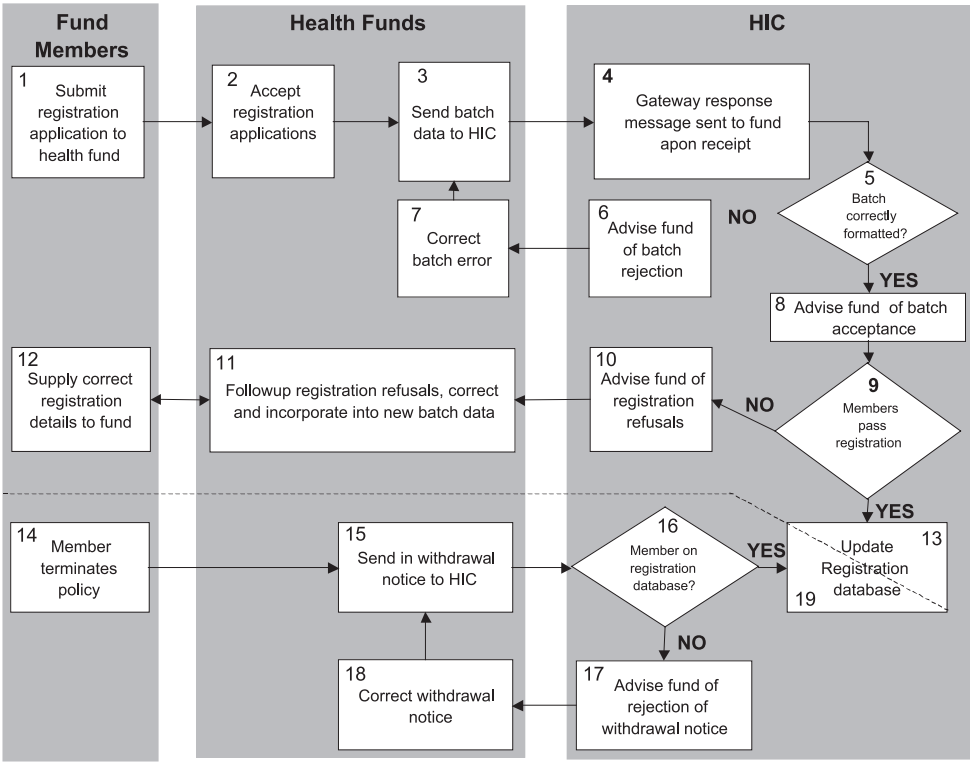
Appendix 2

The PRS Registration and Withdrawal Processes

This Appendix outlines the PRS registration and withdrawal processes as administered by HIC.

1. Figure 2.1 illustrates the PRS registration and withdrawal processes.

Figure 2.1
The PRS Registration and Withdrawal Process



Source: ANAO and HIC

2. A description of the numbered registration and withdrawal processes in Figure 3.1 follows.

1. Applicants apply for the PRS and submit their application to their health fund.
2. Health funds accept and compile these registration applications.
3. Health funds combine the registration data into batches, which they send to HIC.

4. HIC sends an automatic 'Gateway' electronic message to the health fund to indicate that it has received the batch of registration data.

5. HIC checks whether the registration data batch is correctly formatted and ready to be processed.

6. If the batch is not correctly formatted, HIC sends a batch rejection message to the health fund.

7. If the health fund receives a batch rejection message from HIC (each batch is uniquely numbered for identification), it corrects the batch and re-submits it to HIC.

8. If the batch is correctly formatted, HIC sends a batch acceptance message to the health fund.

9. HIC then checks each registration application within the batch to see whether the Medicare number is contained on HIC Medicare database and:

    a. the applicant's name corresponds to the owner of that Medicare card number;

    b. the applicant's date of birth and gender match those of the Medicare cardholder; and

    c. the applicant's suburb and postcode accord with one another.

    In order to pass this Registration Test, the applicant must provide a legitimate Medicare card number and satisfy condition (c)[76] and either of condition (a) or (b).

10. HIC advises health funds of which applicants did not pass the registration test. These electronic registration refusal notices contain the applicant details provided by the fund and a code specifying the reason for rejection.

11. Health funds are expected by HIC to follow-up each registration refusal and resubmit a corrected registration application to HIC.

12. The health fund member may have to provide further information to the health fund in order for the health fund to correct the application. (For example, he or she may have incorrectly transcribed their Medicare number.) If the fund discovers that the applicant is not eligible for the PHIR, it should not resubmit his or her PRS application.

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[76] The Registration Test is discussed in paragraphs 10 through 14 below.

13. HIC registers each applicant who passes the Registration Test (set out in item 9 above) and adds his or her details to the PRS registration database.

14. Policy terminations by health fund members also require the registrations database to be updated.

15. Health funds send HIC electronic batches of withdrawal notices, which specify the details of those members who are withdrawing from the PRS. (Similar batch validation processes apply to withdrawal data as to registration data. These are not separately illustrated in Figure 3 for simplicity.)

16. HIC checks whether the fund member's name and membership number matches the details of a person on the PRS registration database—the Withdrawal Test.

17. HIC returns to health funds the details of those withdrawal notices that have not passed the Withdrawal Test.

18. Health funds are expected to follow-up, correct and resubmit withdrawal messages rejected by HIC.

19. HIC flag each applicant who passes the Withdrawal Test as withdrawn from the PRS on the PRS registration database.

Appendix 3

Preliminary PRS Reconciliation Results

This Appendix discusses preliminary results of HIC's reconciliation checks between annual and monthly data provided to HIC by health funds for the first six months of the Premium Reduction Scheme (PRS)—January through June 1999.

Introduction

1. HIC received annual line-by-line data from health funds with which to validate (or reconcile) the monthly PRS reimbursement claims of funds. When conducting this reconciliation, HIC also used its PRS registration database to check whether funds were only claiming in relation to registered persons. In particular, HIC checked whether the persons identified as receiving a premium reduction in the line-by-line data were identified in HIC PRS registration database as registered in that period. As discussed in Chapter 3, this was not a complete or rigorous test the validity of health fund claims.[77] Consequently, the results of these reconciliation checks did not provide assurance that funds had correctly calculated their PRS reimbursement claims: funds could have lodged incorrect claims and escaped detection.

2. For ease of expression, this Appendix refers to persons who are not included in HIC's PRS registration database as 'unregistered persons'. As noted in Chapter 3, HIC did not comply with its statutory obligation to notify applicants whom it had decided not to register and consequently such persons were deemed by the PHIIA to be registered and entitled to a premium reduction. As a result, payments to unregistered persons did not necessarily represent a debt to the Commonwealth.

Problems with the annual line-by-line data from health funds

3. There were 46 registered health funds operating when the PHIR was introduced in January 1999. As of July 2001:

- HIC had received correctly formatted line-by-line data from 40 of these funds (together accounting for 91 per cent of PRS reimbursements over the first half of 1999) with which it was able to conduct reconciliation checks;
- HIC did not have sufficiently reliable line-by-line data to conduct a meaningful reconciliation for payments made to four funds (which

[77] For example, HIC did not check the reasonableness of individual premiums included in the fund line-by-line data or check that funds had not claimed for the same policy more than once.

together accounted for nine per cent of PRS reimbursements).[78] Consequently, HIC had not conducted any post-payment validation checks in relation to almost $70 million paid to these three funds over this period; and

- HIC had not been provided with separate line-by-line data for two small funds which were acquired by other funds after June 1999. The total PRS reimbursements to these funds were relatively small and have been excluded from the results presented in this Appendix.

4. The preliminary reconciliation results presented in the following section relate to those 40 funds for which HIC had received correctly formatted line-by-line data for the period January through June 1999.

5. However, within this group of 40 funds, three appeared to have very significant PRS registration problems in the first half of 1999: 38 per cent of the 274 094 members of these three funds who received the premium reduction in this period were unregistered. The high proportion of unregistered members in these three funds suggests that they may have not have corrected and resubmitted those registration notifications not accepted by HIC. HIC did not monitor the proportion of registration notices it did not accept from funds, but data requested by the ANAO during the audit showed that HIC had not accepted 31 per cent of registration notices from these three funds over this period.[79] Payments to these three funds accounted for nine per cent of PRS reimbursements over this six-month period. Given the significant impact that these funds had on the overall reconciliation results, they are separately identified in the preliminary reconciliation results presented below.

6. The remaining 37 funds (which together accounted for 82 per cent of PRS reimbursements) had lower proportions of members who were unregistered. 70 per cent of these funds had under two per cent of members unregistered. The remaining 30 per cent had between four per cent and 16 per cent of members unregistered. Overall, only 0.8 per cent of the members of these 37 funds were unregistered. Given that HIC initially did not accept 13.6 per cent of registration notices from these funds, the fact that only 0.8 per cent of members remained unregistered indicates that these funds typically followed up registration refusal messages and resubmitted corrected registration applications to HIC.

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[78] Of these four funds, one had provided incorrectly formatted policy number data; another had not provided premium data; and another had incorrectly flagged all its policies as not receiving the PRS premium reduction. HIC had lost the data sent by the remaining fund.

[79] HIC records indicated that one of these three funds had not lodged registration applications for its unregistered members and one had attempted to register most of its unregistered policies but this had not been accepted by HIC. The reasons for the high proportion of unregistered members at the other fund were not clear to HIC as at July 2001. Closer monitoring of the registration process would have allowed for earlier identification/rectification of these problems.

Preliminary reconciliation results

7. Table 3.1 shows the reconciliation results for the 40 funds for which HIC received reliable line-by-line data for the first six months of the PRS. It shows the:

(1) total PRS reimbursements to funds in this six-month period;

(2) total premium reductions to members flagged as receiving a premium reduction in the fund line-by-line data;

(3) the PRS reimbursements to funds that could not be substantiated by fund line-by-line data (i.e. (1) less (2));

(4) total PRS reimbursements paid in relation to unregistered persons; and

(5) total PRS reimbursements that could not be substantiated or was paid in relation to unregistered persons (i.e. (3) plus (4)).

8. Table 3.1 separately identifies the results for the 37 funds which generally had a low proportion of members unregistered and the three funds which appeared to have significant PRS registration problems.

Table 3.1

Preliminary Reconciliation Results for January—June 1999

$	(1) Total PRS reimbursements to health funds	(2) Total premium reductions to fund members (according to fund line-by-line data)	(3) Unsubstantiated PRS reimbursements to funds	(4) Total premium reductions to unregistered persons	(5) Total unsubstantiated PRS reimbursements plus payments to unregistered persons
Funds 1 - 37	628 301 855	622 349 720	5 952 135	4 796 228	10 748 363
Funds 38 - 40	72 827 666	72 729 996	97 670	30 655 596	30 753 266
Total (funds 1 - 40)	701 129 521	695 079 716	6 049 805	35 451 824	41 501 629

Source: ANAO analysis of data provided by the Health Insurance Commission

9. Table 3.1 shows that these 40 funds were reimbursed $701.1 million for PRS premium reductions to members in the first half of 1999. Of this, funds could not substantiate $6.0 million (0.9 per cent) with their line-by-line data (see column (3)). Only two funds presented line-by-line premium reduction data that corresponded exactly to their total monthly summary claims. One fund provided line-by-line data which suggested that it was reimbursed $2.6 million more than it had reduced premiums for its members—this represented 7.3 per cent of the PRS reimbursements to this fund. Four other health funds provided line-by-line data that indicated they had been reimbursed over two per cent more than the total PRS premium reductions to their members.

10. Table 3.1 shows that a further $35.5 million (5.1 per cent) was paid in relation to unregistered members (see column (4)). Of this, $30.7 million was paid to the three funds that appeared to have significant registration problems (funds 37–40 in Table 3.1). This represents 42 per cent of the PRS reimbursements to these three funds. The remaining $4.8 million paid to unregistered members represented 0.8 per cent of the PRS reimbursements to funds 1– 37.

Appendix 4

Roles and Responsibilities of ATO, Health and HIC

This Appendix presents a summary of the documentation of the roles and responsibilities of ATO, Health and HIC in the Health-ATO Service Level Agreement and the Schedule on the PHIR to the Health-HIC Strategic Partnership Agreement.

Health-ATO Service Level Agreement

1. The Health-ATO Service Level Agreement provides a detailed specification of the roles and responsibilities of Health and ATO in relation to the administration of the PHIR.

2. Health is responsible for:

- overall policy in relation to the PHIR;
- providing ATO with funding to administer the PHIR;
- consulting with ATO on administration, statutory reporting and policy issues; and
- ensuring privacy / confidentiality protection of information relating to the PHIR.

3. ATO is responsible for the administration of the private health insurance tax offset component of the PHIR, including:

- handling taxpayer telephone, counter and written enquiries;
- making changes to relevant tax return forms;
- determining eligibility and processing claims;
- information matching and compliance enforcement (including data matching with HIC);
- debt recovery on behalf of the Commonwealth;
- undertaking legislative amendments to tax legislation related to the PHIR;
- undertaking all activities as required by the ITAA;
- consulting Health on the PHIR section of the Tax Pack and in the preparation of the list of registered health funds to be placed on ATO's website;
- providing certain data and reports to Health (including performance information);

- working with HIC to manage the flow of data to ensure that data matching between the two agencies is as accurate, efficient and as timely as possible;
- consulting with Health on administration, statutory reporting and policy issues; and
- ensuring privacy / confidentiality protection of information relating to the PHIR.

Schedule on the PHIR to the Health-HIC Strategic Partnership Agreement

4. The Schedule on the PHIR to the Health-HIC Strategic Partnership Agreement provides a detailed specification of the roles and responsibilities of Health and HIC.

5. Health is responsible for:

- overall policy and management of the PHIR;
- providing HIC with funding to administer the PHIR;
- consulting with HIC on PHIR administration and policy issues;
- ensuring privacy / confidentiality protection of information relating to the PHIR; and
- dealing with legal actions arising out of policy aspects of the PHIR.

6. **HIC is responsible for:**

- making payments to eligible claimants under the Incentive Payments Scheme (including checking eligibility, providing written notice of claim refusals and maintaining payment records);
- reimbursing health funds under the Premium Reductions Scheme (including checking eligibility of claimants, maintaining a registration system for claimants, notifying health funds of successful registrations, notifying claimants and health funds of registration refusals and maintaining registration records);
- undertaking audit programs to target fraud and compliance;
- recovering amounts on behalf of the Commonwealth;
- providing information to ATO;
- providing Health with information it requires to prepare parliamentary and ministerial briefings;
- consulting with Health on PHIR administration and policy issues;

- ensuring privacy protection of information relating to the PHIR;
- dealing with legal actions relating to its administration of the PHIR;
- undertaking all statutory requirements contained within the PHIIA; and
- providing certain data and reports to Health.

Index

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Audit Report No.46 Performance Audit
Management of an IT Outsourcing Contract
Department of Veterans' Affairs

Audit Report No.45 Assurance and Control Assessment Audit
Recordkeeping

Audit Report No.44 Performance Audit
Australian Defence Force Fuel Management
Department of Defence

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Indigenous Education Strategies
Department of Education, Science and Training

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Australian Electoral Commission

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Senate Order of 20 June 2001 (February 2002)

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Home and Community Care Follow-up Audit
Department of Health and Ageing

Audit Report No.31 Performance Audit
Audit Activity Report: July to December 2001
Summary of Outcomes

Audit Report No. 30 Performance Audit
Test and Evaluation of Major Defence Equipment Acquisitions
Department of Defence

Audit Report No.29 Financial Statement Audit
Audits of the Financial Statements of Commonwealth Entities for the Period Ended 30 June 2001

Audit Report No.28 Information Support Services
An Analysis of the Chief Financial Officer Function in Commonwealth Organisations
Benchmark Study

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Agency Management of Software Licensing

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Management of Fraud and Incorrect Payment in Centrelink

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Accounts Receivable

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Status Reporting of Major Defence Acquisition Projects
Department of Defence

Audit Report No.23 Performance Audit
Broadcasting Planning and Licensing
The Australian Broadcasting Authority

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Personnel Security—Management of Security Clearances

Audit Report No.21 Performance Audit
Developing Policy Advice
Department of Education, Training and Youth Affairs, Department of Employment, Workplace Relations and Small Business, Department of Family and Community Services

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Fraud Control Arrangements in the Department of Agriculture, Fisheries and Forestry—Australia (AFFA)
Department of Agriculture, Fisheries and Forestry—Australia

Audit Report No.19 Assurance and Control Assessment Audit
Payroll Management

Audit Report No.18 Performance Audit
Performance Information in Portfolio Budget Statements

Audit Report No.17 Performance Audit
Administration of Petroleum Excise Collections
Australian Taxation Office

Audit Report No.16 Performance Audit
Defence Reform Program Management and Outcomes
Department of Defence

Audit Report No.15 Performance Audit
Agencies' Oversight of Works Australia Client Advances

Audit Report No.14 Performance Audit
Client Service Initiatives Follow-up Audit
Australian Trade Commission (Austrade)

Audit Report No.13 Performance Audit
Internet Security within Commonwealth Government Agencies

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Selection, Implementation and Management of Financial Management Information Systems in Commonwealth Agencies

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Administration of the Federation Fund Programme

Audit Report No.10 Assurance and Control Assessment Audit
Management of Bank Accounts by Agencies

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Learning for Skills and Knowledge—Customer Service Officers
Centrelink

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Disposal of Infrastructure, Plant and Equipment

Audit Report No.7 Audit Activity Report
Audit Activity Report: January to June 2001
Summary of Outcomes

Audit Report No.6 Performance Audit
Commonwealth Fisheries Management: Follow-up Audit
Australian Fisheries Management Authority

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Department of Finance and Administration

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Australian Taxation Office

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Australian Taxation Office

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Control Structures as part of the Audits of the Financial Statements of Major Commonwealth Entities for the Year Ended 30 June 2001

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