Audit program guidance for PHIAC 1 Returns

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Section 1

Guidelines and template audit programs for PHIAC 1 Returns

Section 1 Guidelines and template audit programs for PHIAC 1 Returns

Section 1.1 Exclusion clause

"*Audit Program Guidance for PHIAC 1 Returns*" is a publication produced by the Australian Prudential Regulation Authority (APRA) to assist Registered Private Health Insurers (the Insurers) with their auditing processes and to help encourage uniform procedures for reporting and auditing. Insurers and auditors should be aware that these guidelines are generic and are not binding rules. As systems found in Insurers vary, the programs should be tailored to each Insurer's circumstances. Insurers are responsible for engaging competent auditors. Auditors of Insurers are responsible for executing their audits of the PHIAC 1 Return (the Return) in accordance with applicable Auditing Standards. Under no circumstances should an Insurer, or an auditor, rely solely upon the guidelines to the exclusion of their duties to produce accurate audited accounts. INSURERS AND AUDITORS ARE RESPONSIBLE FOR THEIR OWN AUDIT PROGRAMS AND PROCESSES.

Section 1.2 Introduction

The following guidelines and template audit programs have been designed to assist the external and internal auditors of Insurers in Australia in their audit of the Returns for the quarter commencing 1 July 2014. The programs are necessarily generic as the systems found in Insurers vary and where appropriate, the programs should be tailored to each Insurer's circumstances.

Audit certification for the four quarters to 30 June each year must be provided within 3 months of the end of the financial year or such time as approved by APRA . Please ensure that the certificate for the 2014-15 year reaches APRA by 30 September 2015.

1.2.1 Purpose of PHIAC 1 Return

Insurers are required to submit data on a quarterly basis for each state or Territory in the approved PHIAC 1 Form to APRA, which then becomes a Return. The information contained in the Return is used by APRA to calculate the quarterly payments due by or to each Insurer to/from the Risk Equalisation Special Account for each state and Territory[1]. In addition, the Returns form the basis for several health insurance statistical summaries provided to a wide range of users including the health insurance industry and the Government.

APRA reminds officers that in submitting the Return they are not only stating that the information is true and correct but that they are aware that giving false or misleading information, documents or statements to APRA is an offence under the *Criminal Code Act 1995*. The *Criminal Code Act 1995* (see section 6.1) imposes substantial penalties including imprisonment, for committing offences which includes failure to lodge required Returns to APRA.

1.2.2 Scope of audit

The auditor of an Insurer is required to determine, in respect of each state, whether the information contained in the Returns for the four quarters to 30 June or such other period as is specified by the

[1] NSW and ACT are regarded as one state for the risk equalisation calculation. Insurers must provide separate returns for NSW and ACT. APRA amalgamates the data for NSW and ACT when calculating risk equalisation.

APRA, accurately reflects, in all material respects, the data contained in the books and records of the health benefits fund (the Fund) administered by the Insurer and has been compiled in accordance with the provisions of the *Private Health Insurance Act 2007* (the Act), the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* (Policy Rules) approved by the Minister for Health and Ageing, and the *Private Health Insurance (Risk Equalisation Administration) Rules 2007* (Administration Rules) made by APRA, so as to give a true and fair view of:

a the policies and insured persons covered by the Fund

b the benefits paid during the periods.

In undertaking the audit it is expected that external auditors will have reviewed the systems and procedures used by the Insurer to process and maintain policy records and benefits eligible for risk equalisation, and are satisfied that there is sufficient appropriate audit evidence that:

a the Insurer's classification of single, family, single parent, couple 2+ persons no adults and 3+ adults policies between hospital treatment, hospital and general treatment combined and general treatment is correct

b the system for determining the age of insured persons is adequate

c the Insurer's method of determining who are high cost claimants is correct

d the benefits paid are in accordance with the Insurer's fund rules

e the benefits paid by the Insurer have been correctly allocated between the applicable age groups of the insured persons apportioned correctly to the different classifications of:

i hospital treatment

ii hospital-substitute treatment

iii Chronic Disease Management Program (CDMP)

iv general treatment (ancillary) excluding hospital-substitute and CDMP

f the benefits allocated to the High Cost Claimants Pool (HCCP) are correctly calculated

g only eligible benefits stated under Rule 5 of Part 1 of the Policy Rules, see link at Appendix B, have been debited to the risk equalisation account.

In cases where the auditor is unable to provide an unqualified opinion that the Return for a particular quarter or quarters accurately reflects the provisions of the legislation or the Policy Rules, a report should be provided by the auditor which outlines the nature and magnitude of the errors detected. This report will form the basis for APRA to make adjustments to amounts paid to or from the risk equalisation account.

Section 1.3 Audit approach

1.3.1 Review of systems and procedures

The approach adopted in the accompanying template audit programs is a systems-based approach and requires the auditor to undertake the following procedures:

a identify and evaluate the systems and control procedures, whether computer or manual, put in place by management to control the processing of policies/insured persons information and benefits paid

   i in the case of computerised systems, making a preliminary assessment of Information Technology controls by completing the template audit program titled "Preliminary Assessment of Information Technology Controls" (PAIT). If following the completion of the PAIT, the auditor determines that it would not be efficient to conduct a more detailed assessment of controls, the auditor should conduct a substantive testing audit approach

   ii in the case of computerised systems, when the auditor has completed the PAIT and has decided that it may be efficient to carry out an extended assessment of the Information Technology controls, the auditor should complete the "Detailed Assessment of Information Technology Controls" (DAIT) (using the guidance notes provided on selecting samples for testing, if appropriate)

   iii if, in the case of computerised systems, the auditor concluded from his overall review of the systems environment using the DAIT program that detailed testing of file and transaction controls (application" controls) was warranted the auditors should complete the template audit programs titled "Record of Application Controls" (RAC) for each significant transaction type and file for both benefits paid and policies/insured persons records

   iv in the case of non-computerised systems the auditor should just complete the programs titled RAC for each significant transaction type and file for both benefits paid and policies/insured persons records.

b reviewing key performance indicators using the "Key performance indicators" guidelines provided

c assessing the results of the controls testing and analytical review and determining sample sizes for detailed substantive testing of risk equalisation benefit transactions and policyholder records (using the guidance notes provided on sampling)

d carrying out detailed tests on risk equalisation benefit transactions and policies/insured persons records using the substantive testing programs provided

e reconciling the Insurers records for the Fund to the Return and ensuring the Returns are internally consistent using the cross referencing testing program provided. (Note that it is suggested that the cross referencing checklist be completed by the Insurer and evidenced as having been reviewed by a suitably senior official of the Insurer).

Section 1.4 Major inherent risk areas

Prior to commencing the audit of the Returns, the auditor should gain an understanding of the major inherent risks associated with the information contained in the Returns. Some general guidance on the inherent risks in auditing the Returns is given below but the auditor must obviously assess the specific risks for each of the Insurers for which they are responsible.

In order to appreciate the impact of any errors in the Return, the auditor must understand the basis of the calculation carried out by APRA each quarter to determine the average number of policies of each fund, calculated as average single equivalent units (SEUs). The method of calculation is provided in

the Policy Rules, which is linked in Appendix B to this document. The mean State policies for a particular fund is used to determine what proportion of the risk equalisation benefits paid by all funds in that state should be borne by that fund. High cost claims are included in a pool for high cost claimants (the HCCP), which is calculated after considerations for age based pooling (the ABP) have been taken into account. Therefore, an error in the Return that impacts on either the calculation of the mean number of policies or misstates the risk equalisation benefits paid in the quarter will result in an error in the amount receivable or payable by the Fund.

1.4.1 Policy records

Completeness, accuracy and cut-off control

The nature of the calculation to determine the risk equalisation contributions to the ABP and the HCCP encourages misstatement of the number of policies. Insurers that pay risk equalisation contributions may be encouraged to understate the number of policies in order to pay less or receive more from the pool.

In addition, the Policy Rules are reasonably complex. Therefore, the risk of error for the completeness, accuracy and cut-off control audit objectives is considered high. Any of the misstatements will result in a financial gain or loss to the Insurer being audited.

Of particular note for completeness is accounting for single, family, single parent, couple, 2+ persons no adults and 3+ adult policies. To overcome any uncertainty as to when a policy should be counted, the Policy Rules clarify the situation in respect of unpaid premiums. The template substantive audit program provided incorporates these Policy Rules but the auditor should ensure that they have access to a complete set of these guidelines.

Retrospective coverage of Policy

Some Insurers offer products that cover new policies retrospectively. Any policies that are covered retrospectively must be reported to APRA so that appropriate adjustments to risk equalisation can be undertaken. Insurers that cover persons retrospectively are expected to submit revised policies/insured persons statistics for all quarters affected. This requires the resubmission of the Return with updated information in part 1. The template substantive audit program provided covers retrospective coverage in section 109. If amended Returns are required, the auditor should ensure that the program is followed for the amended Returns.

Presentation and disclosure control objective

The Policy Rules are complex and the Return requires a significant amount of detail. Therefore, the risk of presentation and disclosure errors in the Return is high.

1.4.2 Benefits transactions

Accuracy and existence control objectives

The nature of the calculation to determine the risk equalisation contributions to the ABP and HCCP encourages overstatement of benefits paid from the risk equalisation account (e.g. age incorrect, inclusion of ineligible benefits, etc).

Various adjustments are made each quarter to account for write backs, stale date or dishonoured cheques etc. These adjustments to benefits paid must be reflected in the Return.

For the purpose of quarterly returns, a benefit is regarded as being paid during the quarter in which the benefit is recorded and liability for it is accepted (Admin Rules 6 (4A))

Presentation and disclosure control objective

The Policy Rules are not necessarily well understood and the Return requires a significant amount of detail. Therefore, the risk of presentation and disclosure errors in the Return is high.

Section 2

Guidance notes

Section 2 Guidance notes

Section 2.1 Factors to be considered in the preparation of the PHIAC 1 Return

Section of Return	Factors to be considered by auditors/Insurers
Part 1 - Policies and Insured Persons **Total Hospital and General Treatment**	
Hospital treatment and general treatment by policy category, is split into: i. Total Hospital Treatment (includes Hospital Treatment Only and Hospital Treatment and General Treatment Combined) ii. Hospital Treatment Only iii. Hospital Treatment and General Treatment Combined iv. General Treatment Ambulance Only v. Total General Treatment Only vi. General Treatment excluding Hospital-Substitute,CDMP and Hospital-linked Ambulance Treatment vii. Total General Treatment Within categories i to iii above, hospital and general treatment is further split between: i. Hospital and general cover that excludes certain treatments (exclusionary) and those that do not (non exclusionary) ii. Hospital and general cover that deducts an initial amount from the benefit otherwise payable and where there is more than one policyholder contributing (excess and co-payments) versus those that do not (no excess and no co-payments) Information is required for both the number of policies and the number of insured persons in the categories described above.	Insurers will need to ensure that their systems are capable of analysing and grouping together these types of policies into these categories. Insurers will need to ensure that their systems classify hospital treatment policies that also cover ambulance transport as Hospital Treatment and General Treatment Combined. Prior to 1 April 2007 those policies that covered hospital treatment and included a component for ambulance transport but no other general treatment were classified as hospital treatment only, but the ambulance component is defined under the Act as general treatment. Insurers will need to ensure that their systems can report the policies and persons that are covered for General Treatment (ancillary) and exclude from that count those who are classified as general treatment because they have hospital-substitute, CDMP or hospital-linked ambulance but do not have any ancillary cover. Ambulance only policies and persons should be included in the category General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment.

Section of Return	Factors to be considered by auditors/Insurers
There are six categories of policyholders. Determining a policyholder's category is based on the status of the contributor, not the type of product the contributor may have purchased. For example, a couple without dependants may have a family product; however they are to be recorded as a couple. The six categories are: i. Single policy - this covers all single policies. Insurers are not expected to match single policy details to identify their actual marital/relationship status. ii. Family policies - this category includes all policies with an adult couple and a dependant, or dependants. iii. Single parent policies - this category includes all policies with only one adult and a dependant or dependants. iv. Couples policies - this category includes all policies that are for two adults and no dependants. v. 2+ persons no adults – this category includes all policies with no adults and two or more dependants. vi. 3+ adults – this category includes all policies with three or more people, at least three of whom are adults.	Insurers will need to ensure that their systems are capable of analysing and grouping together their policies into these categories. Insurers will need to ensure that policies are not reported in the wrong category, for example 3+ adults. 3+ adult policies are counted as two SEUs. If they should have been reported in another category and counted as one SEU there will be an affect on the risk equalisation calculation. Refer to PHIAC Circular 09/17 for more information.
Changes during the quarter This table shows changes during the quarter in policies and insured persons classified under hospital treatment only, hospital treatment and general treatment, and general treatment only. The end of quarter Hospital Treatment Only policies/insured persons will agree with Hospital Treatment Only policies/insured persons on page 1. The end of quarter Hospital Treatment and General Treatment policies/insured persons will agree with Hospital	Insurers will need to be able to record the number of policies/insured persons at the start of the quarter (the end of the previous quarter); the number of new policies/ insured persons policies/ insured persons transferring from/to another state or territory; policies/ insured persons transferring from another fund; policies/ insured persons transferring from/to another policy; and end of quarter policies/ insured persons. Discontinued policies/ insured persons are a balancing item.

Section of Return	Factors to be considered by auditors/Insurers
Treatment and General Treatment Combined policies/insured persons on page 2. The end of quarter General Treatment Only policies/insured persons will agree with Total General Treatment Only policies/insured persons on page 2.	

Parts 2 to 9 and Part 11 – All sections reporting benefits paid

Business as usual activities such as claims reversals can affect benefits previously included in the Risk Equalisation calculation in either the Age Based Pool or the High Cost Claimants Pool	Insurers will need to ensure that they have processes in place to adjust benefits on their PHIAC1 Return as a result of reversal of claims. These process should include adjustment of benefits in both the Age Based Pool and the High Cost Claimants Pool This adjustment should be included in a PHIAC1 Return as soon as possible after the insurer processes the reversal.
Part 2 – Total benefits paid for Hospital Treatment and General treatment	
Total benefits for Hospital Treatment and Hospital-Substitute Treatment	
This table analyses hospital and hospital-substitute patients benefits paid showing the following for each type of facility: i. Episodes ii. Days iii. Benefits paid An episode should only be reported when there is a separation from hospital and hospital-substitute, not when an interim invoice is received, whereas days and benefits should be reported when benefits are paid. It is recognised that this will result in some mismatching of data within quarters.	Insurers will need to ensure that they have benefits systems in place that can accurately record details of benefits paid for Hospital Treatment and Hospital-Substitute Treatment.
Nursing home type patients	
This section includes the number of episodes, days and benefits paid for nursing home type patients.	Insurers will need to ensure that they have benefits systems in place that can accurately record details of benefits paid for nursing home type patients.
Medical services	
This section includes the number of medical services and the benefits paid	Insurers will need to ensure that they have benefits systems in place that can accurately record details of benefits paid for medical.

Section of Return	Factors to be considered by auditors/Insurers
for medical. The medical benefits number will agree with total number of services in part 11. Benefits paid for medical, will agree with total fund benefits in part 11 as well as with the sum of medical benefits in part 3 and part 4.	
Prostheses	
This section includes the number of prosthetics and the benefits paid for prosthetics. Benefits paid for prosthetic will agree with the sum of prostheses benefits in part 3 and part 4.	Insurers will need to ensure that they have benefits systems in place that can accurately record details of benefits paid for prosthetics.
Chronic Disease Management Programs	
This section includes the number of CDMPs and the benefits paid for CDMPs.	Insurers will need to ensure that they have benefits systems in place that can accurately record details of benefits paid for CDMP. Insurers will need to ensure that only those benefits that are consistent with the definition of a CDMP in Section 12 of the *Private Health Insurance (Health Insurance Business) Rules 2009* and Part 1 of the Policy Rules are reported as CDMPs. The Rules specify that, for an eligible CDMP, there must be (at least): • A written plan • Coordination of the program • An allied health service.
High Cost Claimants Pool	
This section includes the number of HCCP claimants in the current quarter, the gross benefits paid for current and preceding three quarters (for HCCP claimants related to current quarter), the net benefits paid for current and the preceding three quarters for HCCP claimant after age based pooling (related to current quarter claimants), the net benefits above threshold for current and preceding three quarters	Insurers will need to ensure that they have a benefits system and policyholder records system in place that can accurately record details of HCCP claimants and benefits included in the HCCP.

Section of Return	Factors to be considered by auditors/Insurers
(for HCCP claimants related to current quarter) and total benefits to be included in HCCP for the current quarter. PHIAC Circular No 08/04 provides examples of the calculation of benefits to be included in the HCCP.	

Part 3 - Hospital treatment by age category

This section of the Return is to be completed for all persons covered by hospital insurance. The persons covered should be as at the end of the quarter and will agree with the insured persons in section 1 of the Return. Benefits should agree with total hospital benefits, excluding ineligible benefits, at part 2 of the Return. Total episodes and days should agree with the total episodes and days at part 2 of the Return. Fees charged include all fees charged by the provider, including medical fees but excluding the 75% Medicare medical fee benefit.	• Insurers will need to ensure that they have a benefits system and policy records system in place that can accurately record hospital benefits paid by age and by date of commencement. Insurers will need to ensure that their system can derive fees charged, excluding the Medicare medical fee benefit. • Insurers will need to ensure that they have a benefits system that can record benefits paid by the age of the claimant at the date the service was provided and not the date the claim was made or paid.

Part 4 – Hospital-Substitute Treatment by age category

This section of the Return is to be completed for all persons insured for hospital-substitute treatment. The persons covered should be as at the end of the quarter. Benefits should agree with total hospital–substitute benefits at part 2 of the Return. Total episodes and days should agree with the total episodes and days at part 2 of the Return.	Insurers will need to ensure that they have a benefits system and policy records system in place that can accurately record hospital-substitute benefits paid by age.

Part 5 – Chronic Disease Management Program by age category

This section of the Return is to be completed for all persons insured for CDMP. Benefits should agree with total CDMP benefits paid at part 2 of the Return. Programs should agree with the number of programs at part 8 of the Return.	Insurers will need to ensure that they have a benefits system and policy records system in place that can accurately record CDMP benefits paid by age.

Section of Return	Factors to be considered by auditors/Insurers
Part 6 – General Treatment by age category	
This section of the Return is to be completed for all persons insured for general (ancillary) treatment, including ambulance only cover and excluding persons covered for hospital-substitute treatment, CDMP and hospital-linked ambulance treatment. The persons covered should be as at the end of the quarter and will agree with the insured persons in part 1 of the Return for the category "General Treatment excluding Hospital Substitute, CDMP and Hospital-linked Ambulance. Services, benefits and fees charged should agree with services, benefits and fees charged in part 9 of the Return, including benefits paid for ambulance transport for persons with hospital-linked ambulance cover. Note that persons with hospital-linked ambulance cover, and no other ancillary cover, are not regarded as having ancillary cover, but any benefits paid, services and fees for ambulance transport for these persons should be reported as ancillary benefits, services and fees. This provides consistent mapping with historical data.	Insurers will need to ensure that they have a benefits system and policy records system in place that can accurately record general treatment (ancillary) benefits paid by age.
Part 7 – Total Hospital Treatment Policies by type of cover	
This table analyses hospital treatment policies by type of exclusionary as well as excess and co-payments cover.	Insurers will need to ensure that they have policy records systems in place that can accurately record policies by the level of excess and co-payments as well as exclusionary cover.
General Treatment (ancillary) claims processing for the state (excluding Hospital-Substitute Treatment and CDMP)	
Percent of claims processed within five working days. This data item is designed to show, of all the general treatment (ancillary) claims processed in the current quarter, how many were processed within five working days of the Fund receiving the claims. Note, date of receipt of a claim	Insurers will need to ensure that they have general treatment claims systems in place that can accurately record time to process claims.

Section of Return	Factors to be considered by auditors/Insurers
refers to receipt of a valid claim, not claims that have to be returned to the contributor due to incomplete or incorrect information. A claim is classified as processed when the payment is drawn/made. Claim adjustments/reversals should be ignored for this calculation. The percent of claims processed within five working days is calculated based on risk equalisation jurisdictions not on national data.	
National retention index - Hospital Treatment policy holders The national retention index is designed to provide a performance indicator by showing the percent of policies that have remained hospital policies of the same fund for two years or more, over all states/territories. If a contributor changes their coverage from hospital only, or hospital and general combined, to general only then they would not be regarded as having retained their hospital cover. A policy which is suspended at the quarter end date is not included in the policy totals in the Return. They should not be included in the retention index. If they are re-instated they would then be included as if there had been no lapse in their policy. The retention index is calculated based on national policies as: [Policies at end of reporting/current quarter less policies joining over previous eight quarters including the reporting quarter] divided by [Number of policies at the end of quarter nine quarters previously]. The retention index should be reported	Insurers will need to ensure that they have systems to identify the number of policies at the end of each quarter and nine quarters prior.

Section of Return	Factors to be considered by auditors/Insurers
correct to two decimal points.	
Part 8 – Benefits paid for Chronic Disease Management Programs	
This table analyses CDMP benefits paid and fees charged by the Insurer in the quarter by individual service and programs. "Programs" refers to the number of people participating in each program, not the number of programs offered by the Insurer.	Insurers will need to ensure that they have benefits systems in place that can accurately record CDMP benefits paid by service and programs. Insurers will need to ensure their systems can capture fees charged by service and programs.
Part 9 - Benefits paid for General Treatment (excluding Hospital-Substitute Treatment and CDMP)	
This table analyses non-contractual and contractual general treatment benefits paid and fees charged by the Insurer in the quarter by individual service type.	Insurers will need to ensure that they have benefits systems in place that can accurately record general treatment benefits paid by service type. Insurers will need to ensure their systems can capture fees charged by service type.
Part 10 – Lifetime Health Cover	
This table analyses the number of adults with hospital cover, split between male and female, by certified age of entry and shows the loading for late entry.	Insurers will need to be able to record the number of adults with hospital cover, split between male and female, by certified age of entry. Insurers will need to be able to record the number of adults with hospital cover, split between male and female, by certified age of entry who have their Lifetime Health Cover loading removed. See PHIAC Circulars No 10/04 and 10/05 and Department of Health and Ageing Circular PHI 13/10 for further details.
Part 11 – Total Hospital Treatment Medical Service Statistics	
This table analyses medical benefits paid by type of contract or agreement, and by amount charged in relation to the MBS fee.	Insurers will need to ensure that they have benefits systems in place that can accurately record medical benefits and medical fees charged by contract or agreement category.

Section 3

Overview of controls testing

Section 3 Overview of controls testing

Section 3.1 Introduction

Information technology controls (IT controls) in computerised systems and file and transaction processing controls (application controls) form the internal accounting controls established by management. They should ensure, together with an effective control environment that an entity's transactions are completely and accurately processed and recorded in accordance with management's authorisation.

Section 3.2 Information technology controls

3.2.1 Preliminary assessment of information technology controls

The attached programs direct the auditor towards making a "Preliminary Assessment of IT controls (PAIT) at Insurers where there is a significant computer installation i.e. one within which applications are run that process accounting, financial or other data relevant to the data contained in the Returns.

The PAIT will assist the auditor in obtaining a general understanding of the client's IT controls, as a basis for assessing, on a preliminary basis, whether reliance on those controls might be feasible. However, only limited credit may be taken from the assessment for the purpose of reducing the level of substantive tests unless an extended assessment of the IT control risk is made.

The importance of the PAIT is that if, having completed the initial assessment, the auditor decides that no reliance can be placed upon the IT controls; the auditor may plan to carry out no detailed testing of application controls and decide to only carry out substantive testing.

3.2.2 Detailed assessment of information technology controls

If having completed the PAIT the auditor decides that a detailed assessment of the IT controls appears warranted, the "Detailed Assessment of Information Technology Controls" program should be completed. The program directs the auditor towards determining the controls and techniques used by the client to achieve certain specified objectives in connection with the IT environment. The functions include, for example, maintenance of computer programs, data file security and file conversion. If the auditor makes the overall conclusion having tested these controls and techniques that credit can be taken for the IT controls, then the next appropriate step is to consider testing of the application controls.

Section 3.3 Application controls

3.3.1 File controls

The file level controls program assists the auditor in understanding and recording the principal controls over key files or data. The program steps are broken down under the following headings:

a file continuity

b division of duties

c data file security.

If having completed the testing, the auditor considers the file controls to be inadequate, it will generally be inefficient to test the adequacy of the transaction processing controls.

3.3.2 Transaction processing controls

The transaction level controls program assists the auditor in identifying the principal transactions that update key files and the controls over recording them on files. Ultimately, the auditor is required to make an assessment of the effectiveness of the controls and the extent to which further evidence from detailed substantive testing of transactions can be restricted.

Where testing is to be conducted, the guidance notes provided on test samples should be regarded.

Application control programs have been completed for the following transaction cycles:

Benefits cycle

- File level controls
- Transaction level controls

Policyholder records

- File level controls
- Transaction level controls

Section 4

Controls testing program

Section 4 Controls testing program

Section 4.1 Preliminary assessment of information technology controls

Control objective	What control activities address the control objective?	*WP Ref
Introduction		
The preliminary assessment of information technology controls assists the auditor in obtaining a general understanding of the client's information technology controls as a basis for assessing, on a preliminary basis, whether reliance on those controls might be feasible.		
A. Insurer of computer processing		
In the context of the client's operations, is the number of people employed to perform data processing sufficient to enable a proper division of duties to exist?		
B. Implementation		
Where systems are developed internally, does the client have adequate controls governing the review and approval of the design, testing and implementation of new systems by responsible user and data processing personnel? Where systems are purchased from outside vendors, does the client have controls governing the selection, testing and implementation of new systems by processing personnel? Are there controls for transferring all new programs into production? Are instructions for the following prepared and issued as part of the systems documentation:		
(a) Operation procedures? (b) Back-up requirements? (c) User clerical procedures? Do the answers to questions B above indicate that the implementation is likely to be adequately controlled?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
C. Maintenance		
Are there controls for making amendments to systems and programs and data, including modifications to purchased application packages that govern the review and approval of the design, testing and implementation of amendments by responsible user and data processing personnel? Are there controls for transferring all modified programs into production? Are there procedures to ensure that the users of modified systems are instructed in their duties? Where purchased software is used, is the source code secure from access by client's staff? Where vendor maintained software is used, are there adequate controls to prevent the vendor making unauthorised or erroneous changes to the client's production software and data? Do the answers to the above questions indicate that the maintenance of applications is likely to be adequately controlled?		
D. Computer operations		
Are there properly specified instructions setting out the procedures to be followed in operating the IT environment? Are there procedures to ensure that all variations from normal computer processing are reviewed and approved by responsible personnel? Are there controls to ensure that the correct data files are used and that all batch processes are complete and accurate? In the event of processing failures, does the client have adequate back-up and recovery routines? Do the answers to the above questions indicate that computer operations are likely to be adequately controlled?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
E. Data file security		
Are any data files held on-line subject to protection by software? For example, the use of passwords or security software. If passwords are used to identify authorised users, are there controls over the issue, selection, changing and security of passwords? Are reports resulting from the security software reviewed and followed up as appropriate? If software controls alone do not provide control over data, are there appropriate physical controls to protect files? For example, library procedures, controls over access to the computer, to terminals or to communications equipment. Are there controls over the use of utilities and user programming facilities that can update or change data files? Do the answers to the above questions indicate that data file security is likely to be adequate?		
F. Program security		
Are there controls in force to protect program libraries from unauthorised insertions, deletions or modifications when they are: (a) on-line (b) off-line. If passwords are used to control access, are there controls over the issue, selection, changing and security of passwords? Are reports resulting from security software reviewed and followed up as appropriate? Is there a system of controls in effect to protect all options, parameters, job control statements, etc. stored on the system from unauthorised		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
changes (this question may not be appropriate in the case of smaller computer systems)?		
Are there procedures to prevent operations personnel from gaining access to source statements listings, flowcharts, file layouts and other systems documentations?		
Are there controls over the use of utilities and user programming facilities that can update or change programs? Do the answers to the above questions indicate that program security is likely to be adequate?		
G. System software		
Is all the system software in use vendor supplied and maintained? Are the following reviewed and approved by a responsible official: (a) The decision to utilise new system software? (b) The selection of options to be incorporated? Are new software and amendments appropriately tested and approved before implementation? Do the answers to the above questions indicate that system software is likely to be adequately controlled?		
Overall conclusion		
Based on the preliminary assessment of the IT controls, are the IT controls, taken as a whole, likely to be adequate and therefore warrant a detailed assessment using the "Detailed assessment of Information Technology Controls" program? IT audit manager		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
Audit manager review		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.2 Detailed assessment of information technology controls

4.2.1 Purpose

The attached program should be used to record the client's IT control procedures and should be cross-referenced to the detailed compliance tests the auditor decides to perform. The program is divided into the following sections:

a Implementation

b Maintenance

c Computer operations

d Data file and program security

e System software

f File conversion.

In completing the program it will be appropriate to complete certain sections such as operations or system software only once for each computer installation. Other sections such as implementation or data file security may need to be completed for each application if the control procedures vary by application.

4.2.2 Recording controls

Each section of the program contains questions relevant to the procedures and techniques used by the client to achieve the control objective addressed by that section. The auditor should record specific controls in a brief narrative. There may be instances in which the client has designed more than one control procedure applicable to a particular question. In those instances, only the control procedure that the auditor intends to assess should be documented.

4.2.3 Recording tests

Evidence of tests performed should be recorded in work papers that should be cross-referenced to the program.

Tests should be described in sufficient detail to support the auditor's conclusion as to whether the control procedures are operating as prescribed. The auditor should consider the effect of any significant control weaknesses encountered during the recording and testing of controls. Weaknesses in certain aspects of the client's procedures would not necessarily preclude the auditor from concluding that the procedures, taken as a whole, are adequate to achieve the control objective.

Control objective	What control activities address the control objective?	*WP Ref
Implementation		
If a new system or interface has been implemented appropriate procedures should be included in production programs when the new system becomes operational. Consider, for example, the following points of focus: • Are the following people involved to an adequate extent in the implementation of the system, including final approval where appropriate: (a) relevant users (b) relevant IT subject matter experts (c) relevant management/business sponsors (d) other (e.g. quality assurance, internal audit, external audit – to ensure that application controls are adequately built in to the design of the new system) • Are programs and systems adequately tested having regards to the following: (a) methods of testing used (unit testing, integration testing, performance testing, user acceptance testing) (b) scope of testing? (c) test data used for testing (d) business and IT sign off and accountabilities • Are new systems subject to an adequate live test period (e.g. parallel or pilot running)? • Are the following prepared and issued as part of systems documentation: (a) operating procedures (b) back-up requirements (c) user clerical procedures? • Are there controls to ensure that only programs that have been properly approved and tested are transferred to production status?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
Maintenance		
Changes to programs should be controlled to ensure that: **(a) new procedures are appropriate and timely (valid and authorised);** **(b) errors are not introduced as a result of the change.** Consider, for example, the following points of focus: • Are there controls to ensure that: (a) the modifications are appropriate to the user's requirements (b) the amended system, and interfaces are adequately tested (c) systems, operations, back-up and user documentation is appropriately updated? • Are there controls to ensure that: (a) all requests for system amendment are considered for action (b) all approved requests are implemented on a timely basis (e.g. entry in a register and investigation of outstanding changes)? • If modifications are made to existing systems and interfaces, during the year, are there controls to ensure that modifications are properly tested?		
• Are the testing procedures performed or checked by persons other than those involved in writing the programs? • Are the testing procedures adequate to prevent any unauthorised coding from being inserted into programs during their modification?		
• Are there controls to ensure that program libraries are recovered properly after a failure and that no errors are introduced by the recovery process		
• If immediate modifications are made to programs or interfaces during emergencies, are		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
there controls to ensure that the changes are correctly made and approved?		
Computer operations		
Controls in computer operations should be adequate to ensure that: **(a) authorised programmed procedures are consistently applied** **(b) the correct data files are used and that batch processes complete successfully** **(c) processing can be properly resumed in the event of failures and that systems performance is monitored and managed**		
Consider, for example, the following points of focus: If on-line application systems are in operation, scheduling will be relevant only to regular batch jobs, end of day or period routines, back-up and housekeeping where the control considerations are whether the jobs are run at the appropriate point in time and in the correct sequence. • Are there controls to ensure that: (a) proper schedules of jobs/programs are prepared (b) jobs/programs are run in accordance with the schedules (c) any departures from the schedules are documented and approved? • Are there adequate procedures for: (a) setting up batch jobs (b) loading on-line application systems (c) loading system software? • Are there controls to prevent, or detect and investigate, unauthorised changes to approved job set-up instructions? • Is there appropriate written approval, including user involvement where appropriate, for: (a) variations in parameters and control statements that may affect the way a batch job or an on-line system runs (e.g. dates, period-end routines)		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
(b) departures from authorised set-up and execution procedures (e.g. use of programs from a test library for production)?		
• Are there controls to ensure that the correct data files are used (e.g. software label checking, generation data sets, use of a tape management system, user check of volume/serial numbers, controlling manual overrides that bypass label checking)? • Is there adequate identification and reporting of: (a) system failures (b) restart and recovery (c) emergency situations (d) other unusual situations? • Are operator actions in the event of the above incidents reviewed for appropriateness and to ensure that the results of processing were not adversely affected (e.g. review of logs and incident reports, daily problem meetings)? • Is there appropriate supervision of operators at all times, including shifts outside the usual working period? • Are there adequate controls to either prevent or report and investigate the use of utilities to change data or programs during processing? • Are there adequate controls to: (a) back-up and store independently copies of all data at appropriate intervals (b) log or save activity so that the status of data files at the time of failure is known? • Are there controls to ensure that data files are recovered properly after a processing failure and that no errors are introduced by the recovery process? • If modifications are made to data after failures or during emergencies, are there adequate procedures to ensure that the changes are made correctly and approved?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
• Is there adequate user involvement to ensure that proper recovery from failures takes place? • Are the above procedures subject to adequate supervision by a responsible official?		
Data File and Program Security **Controls are needed to prevent unauthorised changes to data and programs.** **Consider the following points of focus:** • Is there an adequate combination of software procedures and manual action to: (a) prevent unauthorised accesses to the system, programs, program libraries, data files and data elements and report and investigate persistent attempts to bypass the access controls or (b) report and investigate unauthorised accesses? • Are there adequate controls over: (a) assigning and reviewing access rights to appropriate individuals in the Insurer (b) granting and revoking authorised access on the system (e.g. user IDs or passwords) (c) allocating and withdrawing special facilities from users (e.g. ability to use certain utilities, higher levels of clearance in a hierarchy). • Where passwords (or other codes) are used to identify individuals to the system as authorised users, are there controls to ensure that the passwords are: (a) regularly changed (b) kept secret (e.g. not written down or displayed on screen) and are not easily guessable (c) promptly cancelled for terminated or transferred employees? • Are there controls to prevent unauthorised public access via dial-up (e.g. use of dial back, dial-up access restricted to non-sensitive functions)? • Are the procedures above subject to adequate		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
supervision by a responsible official? If software access control is present, consider the following: • Is a responsible official independent of computer operations, systems development and systems software in charge of security? • Is a record kept of all modifications and fixes to the security software? • Are there adequate controls to ensure that: (a) all modifications are appropriate to the installation's requirements (b) operating and other documentation is properly updated (c) the modifications function as expected (e.g. review of subsequent operations or other testing)? • Are there controls to ensure that: (a) the security software protection can only be removed by appropriately authorised personnel (b) when the software protection has been removed, is the unauthorised modification of programs and data files prevented (e.g. software protection removed only when all on-line services are down and physical access procedures can be relied on)? • Are there adequate controls over: (a) granting and revoking of the means of permitting physical access (e.g. key, security badge, combination number) (b) where applicable, physical access to unissued permits, badges or keys? • Is there adequate supervision by a responsible official? ***Custody of data stored off-line*** • Where data, including back-up copies, is physically controlled: (a) are there records to identify data files		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
uniquely (e.g. external labels) (b) are there controls over the issue and return of data files to and from the: (i) physical library (ii) store to be used for recovery in the event of a disaster (iii) installation (c) do the storage methods prevent the unauthorised removal of data files? • Is the file librarian function performed by a person independent of both computer operation and programming responsibilities? • Where it is necessary to bypass normal security and access controls (e.g. emergencies or maintenance of program libraries by outside software support, such as vendors, through dial-up): (a) is there appropriate authorisation before or after the event (b) are there controls to: (i) ensure that security is subsequently reinstated (ii) prevent or report and investigate unauthorised changes to data? • Where users are permitted to use utilities or high level programming languages that can change data: (a) are there controls either to prevent the unauthorised use of this facility or to report and investigate unauthorised use, or attempts to use it (b) are there adequate procedures to report or prevent unauthorised use of programs written by an authorised user? • Are there adequate controls to prevent: (a) computer operators, schedulers, data input staff and other operations personnel from gaining access to program documentation and development libraries (b) development personnel from gaining access to the computer operations area (c) systems implementation personnel responsible for the cataloguing function		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
from gaining access to program documentation and development libraries, and from entering the operations area or performing computer operations functions? • If confidential or sensitive output is not spooled directly to a printer but is held on-line or transmitted to a remote location for subsequent batch printing, are there controls to prevent or detect and investigate modifications to output prior to printing? • Are there controls to ensure that output is sent to the proper destination? ***Custody of programs stored off-line*** • If programs, including back-up copies, are physically controlled: (a) are there adequate records to identify files containing programs uniquely (e.g. external labels) (b) are there controls over the issue and return of program files.		
System Software		
Controls are needed over system software to ensure that: **(a) system software is properly checked and approved before implementation** **(b) all modifications are appropriate and properly implemented** **(c) system software is adequately secured.** Consider, for example, the following points of focus: • Are staff employed in the technical support function only on the basis of either: (a) thorough inquiry into the validity of references or (b) assessment of the integrity of the individual in the course of earlier duties in the Insurer? • Are there controls to ensure that system software packages, options, and fixes selected		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
are appropriate to the Insurer's requirements? • Are there controls to ensure that the tailoring of system software by the technical support group is: (a) designed to meet the Insurer's requirements (b) reviewed or otherwise tested prior to implementation (c) documented to a sufficient standard to provide a basis for subsequent maintenance? • Is new system software, including any tailoring, subjected to an adequate live test to ensure that it does not adversely affect existing applications or system software functions? • Are there controls to ensure that system software libraries are recovered properly after a processing failure, and that no errors have been introduced by the recovery process? If the operating system is maintained by vendors: • Are there controls to ensure that the modifications: (a) are appropriate to the installation's requirements (b) function as expected (e.g. testing, review of software update log)? If modifications or enhancements are made to the operating system by the Insurer's staff: • Are there controls to ensure that modifications or enhancements: (a) are appropriate to the installation's requirements (b) are subjected to adequate testing, either before or after going live? • Is the database periodically reviewed: (a) to identify redundant (duplicate) information (b) to ensure that information duplicated on other systems is consistent?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
File conversion		
When data is created or substantially modified during system conversion, controls are necessary to ensure that data set-up on file is complete, accurate and valid. Consider, for example, the following points of focus: • Are there adequate controls to ensure that both transaction and standing data transferred from the old system to the new file was: (a) completely transferred (b) accurately transferred (c) if applicable, kept secure (no unauthorised changes)? • Are there controls to ensure that new data, not present on the previous system, has been calculated or otherwise obtained and: (a) completely set up (b) accurately set up (specify key data of accounting significance) (c) authorised? • Were the final results of the conversion process approved (e.g. review and sign-off of above procedures)?		
Overall conclusion		
Based on the control procedures described and the results of tests performed, are the control procedures, taken as a whole, appropriately designed to achieve the control objectives and are they operating as prescribed? Set out the principal reasons for arriving at the overall conclusion. IT audit manager ..... Audit manager review		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.3 Record of application controls – File level controls

4.3.1 Policy system

The following program is designed to assist the auditor in understanding and recording the internal accounting controls instigated by an Insurer in respect of the specific audit objectives identified in the program. Having identified the controls, the auditor must consider the extent to which a particular control procedure should be tested.

The nature and extent of the tests that may be undertaken have not been specified, but the auditor must ensure that the techniques are sufficiently comprehensive to support their assessment of the effectiveness of the control procedures. The auditor should record the program of tests and the results and conclusions from the tests on work papers that should be cross-referenced to the attached programs.

The following program should be completed for each of the key files identified.

Key files are identified by determining those which, if not correctly processed, could result in a material misstatement of policy information in the Returns.

The number of policies is used in calculating the net contribution per SEU to the risk equalisation pool hence the completeness and accuracy of the number of policies will affect a fund's overall contribution to or refund from the risk equalisation pool.

4.3.2 Key files/data elements:

Control objective	What control activities address the control objective?	*WP Ref
Completeness and Accuracy of Accumulated Data: ***The integrity of the data in the policy master file after related transactions and adjustments have been accumulated in them is preserved.*** Consider, for example, the following points of focus: • What are the processes for comparison of data from the master file and subsidiary ledgers with data from the policy? • What are the processes for resolution of conflicts generated by the above processes with the policies? • What ensures appropriate adjustments made are recorded? File continuity controls can be exercised at a detail level or a total level. At the detail file level, continuity controls may assist in ensuring the completeness/accuracy and/or existence of the details on the file and may include reviews of management information such as the comparison of policy numbers analysed between table types (applicable benefit arrangements, exclusionary, non exclusionary, general excess and co-payment and no excess and no co-payments) or age groups File continuity controls at a total level are designed to ensure that the file carried forward from one update process is the file brought forward to the next update process and in the event of a processing failure the file is promptly recovered to its proper state. **Division of Duties:** ***In order that control be effective it is essential that there should be an adequate division of duties between those who input data, process data, supervise, write programs and control output.***		

Control objective	What control activities address the control objective?	*WP Ref
Relevant divisions of duties would typically be: • Segregation of users from computer operations. • Segregation of authorising supervisors from clerical duties. • Separation of programs from computer operators. • Separation of functions within the systems, for example ledger keepers separated from cashiers. **Restricted Access to Records (data file security): *Only authorised personnel have the access to alter information in the policy master file*.** Security controls over stored data must be sufficient to prevent manipulation of financial and non-financial data through unauthorised access to the data files. Stored data must be physically secure and amendments to the data should only take place when properly approved and recorded. Consider, for example, the following points of focus: • What ensures policy and transaction data are not modified or lost? • How is access to policy master file records restricted (i.e. password or other controls which limit the extent of access to master file records based on area of responsibility)? • Is there adequate segregation of duties between cash receipts processing and posting to the master file and subsidiary ledgers?		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.4 Record of application controls - Transaction level controls

4.4.1 Policy system

The following program is designed to assist the auditor in understanding and recording the internal accounting controls instigated by an Insurer in respect of the specific audit objectives identified in the program. Having identified the controls, the auditor must consider the extent to which a particular control procedure should be tested.

The nature and extent of the tests that may be undertaken have not been specified, but the auditor must ensure that the techniques are sufficiently comprehensive to support their assessment of the effectiveness of the control procedures. The auditor should record the program of tests, the results and conclusions from the tests on work papers that should be cross-referenced to the attached programs.

Ultimately, the auditor is required to make an assessment of the effectiveness of the controls and the extent to which further evidence required from detailed substantive testing of transactions can be restricted.

The following program should be completed for **each** of the key transaction types that may include the following:

- new policy
- policy amendments

The approximate volumes per month of each type of transaction should be recorded on your working paper and used as a guide to determine which the more significant transaction types are.

4.4.2 Transaction type:

4.4.3 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Completeness of Input: ***All authorised transactions are input and accepted for processing, and transactions are processed once and once only.*** Consider, for example, the following points of focus: • What ensures that all valid policy applications/amendments are input and accepted for processing? • What prevents or detects duplicate input of transactions? • What ensures suspense account balances are analysed, cleared and reviewed by appropriate personnel for large, old or unusual items? Examples of control techniques which could be used include: (a) Matching - usually a system initiated function which for example may indicate when information from mandatory field is missing - for example date of birth, policyholder table etc. (b) Batching - comparison of system generated batch totals with manually calculated batch totals over key fields. (c) One-for-one checking of data input against source documents. (d) Sequence checking - investigating missing numbers from batch number sequences or policyholder number sequences.		

4.4.4 Transaction type:

4.4.5 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Accuracy of Input: ***Transactions are accurately recorded and are reflected in the proper period.*** Consider, for example, the following points of focus: • Are all required policy details, in particular age/date of birth of all the insured persons under that policy recorded on the application form? • What ensures policy information is correctly input? • What ensures premium rates are correctly calculated/applied (including, but not limited to the correct loading rate for persons aged over 30 years in accordance with Lifetime Health Cover)? Is the correct classification made in recording new policies of: Total hospital treatment for policies and insured persons between exclusionary and non-exclusionary excess and co-payments and no excess and no co-payments . Other policies classified as general treatment (ambulance only & total general treatment only and general treatment excluding hospital-substitute, CDMP and hospital-linked ambulance treatment). • What ensures that transactions are recorded in the proper period? (NB. particularly retrospectively covered policies)		
Examples of control techniques which could be used include: (a) Batching - however it should be remembered that this will only provide an		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
accuracy control for the particular field that is batched. (b) One-for-one checking - which once again will only confirm the accuracy of the fields that are checked. (c) Edit checks - which may include: - checks that a data field being input, such as the policy table/type of cover exists on the master file - dependency checks to ensure that the contents of a data field are logically possible in relation to other data fields input or on the master file - for example whether the policy table number is for the same state as the postcode or where more than one person is covered under the same policy number that the policy is categorized as policy covering more than one person as described in Part 1.4 of the Policy Rules.		

* Cross-reference to the working paper where the tests of controls have been performed

4.4.6 Transaction type:

4.4.7 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Authorisation: ***Recorded transactions are based on actual applications/amendment advices received hence maintaining the integrity of policy numbers.*** Consider, for example, the following points of focus: • What ensures that applications/amendments are not received from fictitious people? • What source proof documentation is provided with the initial application/amendment - such as birth certificate etc? • What prevents policies being duplicated on the system? • What prevents input of information by unauthorised persons? The timing of authorisation should be identified to ensure that additional transactions cannot be introduced nor authorised transactions removed between authorisation and input. Authorisation controls for computerised systems could include limiting access by password protection to certain functions and the review and follow up of override or exception reports by a responsible person (although this is usually a retrospective authorisation procedure since it usually occurs after the update of information to the system).		

* Cross-reference to the working paper where the tests of controls have been performed

4.4.8 Transaction type:

4.4.9 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Completeness and Accuracy of Updating: *Transactions input are completely and accurately updated to the corresponding database(s).* Consider, for example, the following points of focus: • What ensures all policy transaction and application data input is reconciled with information and data updated to the master file? • What prevents or detects incorrect entries (i.e. inconsistent with existing or anticipated data)? • Depending on the timing of performance, many of the controls over the completeness and accuracy of input will also be controls over the completeness and accuracy of update. Examples include: • Batching - where reports of batch numbers used in updating are obtained and missing batches are investigated (completeness and to a lesser extent accuracy of update). • Review of exception or override reports that may identify inconsistencies in the data input or fields for which no data has been input (accuracy of update). • Reconciliation with information contained in other files - for example the matching of contributions received with individual policy on the system.		

* Cross-reference to the working paper where the tests of controls have been performed

4.4.10 Transaction type:

4.4.11 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Division of Duties: ***In order for controls to be effective, it is essential that there is adequate segregation of duties between those who initiate, input, authorise and process transactions.*** These divisions must be sufficient to limit the activities of individuals so that the opportunity for misappropriation of assets or concealment of fraud is minimised. For example the persons responsible for the maintenance of policy master file information should be independent of those responsible for inputting contributions received so as to prevent cash being misappropriated where policy details are not input to the master file.		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.5 Record of Application controls - File level controls

Section 4.6 Benefits cycle

The following program is designed to assist the auditor in understanding and recording the application controls at the file level instigated by an Insurer in respect of the specific audit objectives identified in the program. Having identified the controls, the auditor must consider the extent to which a particular control procedure should be tested.

The nature and extent of the tests that may be undertaken have not been specified, but the auditor must ensure that the techniques are sufficiently comprehensive to support their assessment of the effectiveness of the control procedures. The auditor should record the program of tests and the results and conclusions from the tests on work papers that should be cross-referenced to the attached programs.

The following program should be completed for each of the key files from which the benefits paid information in the Returns are derived.

Key files are identified by determining those that, if not correctly processed, could result in a material misstatement of benefits information in the Return.

4.6.1 Key files/data elements:

Control objective	What control activities address the control objective?	*WP Ref
Completeness and Accuracy of Accumulated Data (file continuity): ***The integrity of [policy master file data] claims/benefits paid in the subsidiary ledgers and the general ledger, after related transactions and adjustments have been accumulated in them, is preserved.*** File continuity controls can be at a detail level or a total level. At the detail level file continuity controls may assist in ensuring the completeness, accuracy and/or existence of the details on the file and may include the following: • Reviews of management information (although it should be noted that management information is generally not sufficiently detailed to enable detection of errors). • Open items cleared by matching with information from other systems or external documents. File continuity controls at the total level are designed to ensure that the file carried forward from one update process is the file brought forward to the next update process and in the event of a processing failure the file is promptly recovered to its proper state. Consider, for example, the following points of focus: • What ensures all benefits/claims transactions are accurately updated to the necessary databases e.g. the claims database and the subsidiary creditors ledger and the general ledger? • How are bank statements reconciled to the general ledger cash accounts? **Division of Duties:** ***In order that control be effective it is essential that there should be an adequate division of duties between those who input data, process data, supervise, write programs and control output.***		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
Relevant divisions of duties would typically be: • Segregation of users from computer operations. • Segregation of authorising supervisors from clerical duties. • Separation of programs from computer operators. • Separation of functions within the systems, for example ledger keepers separated from cashiers. **Restricted Access to Records (data file security):** ***Only authorised personnel have access to claims records, including standing data, cash accounts, and unissued cheques***. Security controls over stored data must be sufficient to prevent misappropriation of assets or manipulation of financial and non-financial data through unauthorised access to the data files. Consider, for example, the following points of focus: • How is access to the claims records restricted? • Is there adequate segregation of duties between those maintaining the claims payable records and those responsible for cash disbursements processing? • How is access to unissued cheques and cheque signing machines restricted? • How are electronic funds transfers controlled?		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.7 Record of Application controls -Transaction level controls

4.7.1 Benefits cycle

The following program is designed to assist the auditor to obtain and record an understanding of the application controls at the transaction level instigated by an Insurer in respect of the specific audit objectives identified in the program. Having identified the controls, the auditor must consider the extent to which a particular control procedure should be tested.

The nature and extent of the tests that may be undertaken have not been specified, but the auditor must ensure that the techniques are sufficiently comprehensive to support their assessment of the effectiveness of the control procedures. The auditor should record the program of tests, and the results and conclusions from the tests on work papers that should be cross-referenced to the attached programs.

Ultimately, the auditor is required to make an assessment of the effectiveness of the controls and the extent to which further evidence required from detailed substantive testing of transactions can be restricted.

The following program should be completed for each of the key transaction types that may include the following:

- claims entry
- adjustments
- cheque production
- master file maintenance
- cash

The approximate volumes per month of each type of transaction should be recorded on your working paper and used as a guide to determine which are the more significant transaction types.

4.7.2 Transaction type:

4.7.3 Volume per month:

Control Objective	What control activities address the control objective?	*WP Ref
Completeness of Input: ***All authorised benefits/claims transactions are input and accepted for processing and transactions are processed once and once only.*** Consider, for example, the following points of focus: • What ensures that all valid benefits/claims transactions received are input and accepted for processing? • What ensures that all eligible benefits/claims recoverable through risk equalisation are recorded? • What ensures the Insurer has kept a record by claimant of how much has gone into the ABP so that once the threshold has been reached, the residual can be assessed to determine if it fits the criteria for a high cost claim. • What ensures suspense account balances are analysed, cleared and reviewed by appropriate personnel for large, old or unusual items? Examples of control techniques which could be used include: (a) Matching - usually a system initiated function which for example may include when information from mandatory fields has been omitted. (b) Batching – comparison of system generated batch totals with manually calculated batch totals over key fields. (c) One for one checking - of data input to source documents (d) Sequence checking - investigating missing numbers from batch number sequences.		

* Cross-reference to the working paper where the tests of controls have been performed

4.7.4 Transaction type:

4.7.5 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Accuracy of Input: ***Are all data fields required to determine risk equalisation eligibility and benefit amount accurately input and the claim benefit accurately generated and reflected in the proper period as to:*** • **Amount of benefit payment or settlement** • **Service type** • **Service provider** • **Date of processing** • **Date of claim event (e.g. period and dates of hospitalisation, illness, etc)** • **Date of payment** • **Claim number** • **Policy number** • **Policy coverage (amount and type)** • **Policy effective date** Consider, for example, the following points of focus: • Are all risk equalisation benefit and eligibility details (set out above) recorded on claim form? • What ensures claims payable and disbursements are applied to the correct policy and paid to the correct claimant? • What prevents or detects incorrect entry of the above key data? • Has the appropriate plan and table benefit(s) rate(s) associated with the service item been used in calculating the benefit amount? • How are appropriate excesses identified and deducted in calculating benefit amounts? • How are appropriate limits identified and applied in calculating benefits amounts? • What ensures that disputed claims are properly investigated and that corrections to claims or coverage data, if necessary, are made on a timely basis?		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
• What ensures transactions are recorded in the proper period? • What ensures that benefits attributed to the Aged Based Pool have been calculated in the correct age bands? Examples of control techniques which could be used include: (a) Batching - however it should be remembered that this will only provide an accuracy control for the field that is batched. (b) One-for-one checking - which once again will only confirm the accuracy of the fields that are checked. (c) Edit checks - which may include: • checks that a data field being input, such as a policy number, exists on the master file • screen checks, such as the name of a policyholder of a policy, address and policy appearing on the screen when the policy number is entered. • dependency checks, to check whether the contents of a data field are logically possible in relation to other data fields on the transaction or master file - for example whether the claim being processed is allowable under the level of cover taken out by that policy Consideration may also be given as to whether: • Instructions are provided to policyholders on how a claim form should be completed and details required? • Are staff trained in the review of completed claim forms, the processing of claims documentation and use of the system? • Are systems documentation/user manuals available that include details of the manual		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
and/or computer system procedures to be followed by staff in the processing of claims documentation?		

4.7.6 Transaction type:

4.7.7 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Authorisation of input: ***Benefits/claims paid or incurred represent valid obligations incurred by the entity under policies that are current.*** Consider, for example, the following points of focus: • What prevents the payment of benefits for claims that are not covered under the policies? • What ensures that the proper documentation in support of claims has been obtained, reviewed and approved i.e. was the service for which the claim is made actually provided? • What prevents payment of claims by unauthorised persons? • How are individual benefits/claims obligations/payments approved? • What procedures exist for identifying and investigating suspicious or contestable claims? • Was the service provided by an authorised service provider? • What prevents duplicate payments? The timing of authorisation should be identified to ensure that additional transactions cannot be introduced nor authorised transactions removed between authorisation and input. Authorisation controls in the case of computerised systems could include limiting access by password protection to certain functions and the review of override or exception reports by a responsible person (although this is a retrospective authorisation procedure since it usually occurs after update of information input to the system).		

* Cross-reference to the working paper where the tests of controls have been performed

4.7.8 Transaction type:

4.7.9 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Completeness and accuracy of updating: *Claims/benefits transactions input are completely and accurately updated to the general ledger and any relevant subsidiary ledgers and/or the relevant master file*. Consider, for example, the following points of focus: • What ensures that claims for policy benefits reported are properly updated to claims registers, subsidiary ledgers, and the general ledger? • What ensures claims/benefits payments input are equal to the amounts updated to the cash accounts, relevant databases and general ledger? • Depending on the timing of performance many of the controls over the completeness and accuracy of input will also be controls over the completeness and accuracy of update. Examples include: • Batching - where reports of batch numbers updated are obtained and missing batches followed up (completeness). • Review of exception or override reports generated after update (accuracy). • Reconciliations between subsidiary and general ledger bank accounts and reconciliations between subsidiary ledger and related general ledger accounts.		

* Cross-reference to the working paper where the tests of controls have been performed

Section 4.8 Transaction type:

Section 4.9 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Generation of benefits transactions details **Completeness:** ***Are the ABP and HCCP accounts debited in respect of all eligible benefits paid?*** **Accuracy:** ***Are benefits correctly recorded at the age the person received the service?*** Consider, for example: • Are benefits paid calculated according to the correct age bands? • Are all high cost claims paid, irrespective of age included when calculating the HCCP benefit? • Are high cost claims only included in the high cost claims pool, once the Age based pooling has been taken into account, after the threshold has been deducted and after all the benefits already included in the HCCP in the preceding three quarters have been deducted? **Authorisation:** ***Do the generated benefits debited to the ABP and HCCP accounts represent valid risk equalisation benefits?*** Consider, for example, the following points of focus: • Are the ABP and HCCP accounts debited only in respect of paid benefits? • If applicable, is prescribed information, included in calculating the risk equalisation benefit, in line with the Policy Rules? Does it pass the ABP and HCCP eligibility criteria: • What procedures are in place to ensure risk equalisation benefits generated only in respect of persons aged 55 or over, or for high cost claims of persons of all ages.		

* Cross-reference to the working paper where the tests of controls have been performed

Control objective	What control activities address the control objective?	*WP Ref
• Do the dates used in the determination of eligibility correspond with the date the service was provided and not the date the claim was made or paid? • Are the details used in determining eligibility verified to external supporting evidence? • Is the age of claimant 55 or over verified? • Are the claims included in the high cost claimants pool verified?		

* Cross-reference to the working paper where the tests of controls have been performed

4.9.1 Transaction type:

4.9.2 Volume per month:

Control objective	What control activities address the control objective?	*WP Ref
Division of Duties: In order for controls to be effective, it is essential that there is an adequate segregation of duties between those who initiate, input, authorise and process transactions. These divisions must be sufficient to limit the activities of individuals so that the opportunity for misappropriation of assets or concealment of fraud is minimised.		

* Cross-reference to the working paper where the tests of controls have been performed

Section 5

Key performance indicators

Section 5 Key performance indicators

Section 5.1 General

The following key performance indicators should be calculated for each Insurer for each quarter and the results recorded on a work paper.

The indicators calculated should then be compared with the results for that Insurer in prior quarters and, where available, industry statistics.

All variances greater than plus or minus 10% should then be further investigated and the results, including management's comments, should also be recorded on a work paper.

Key performance Indicator	Significance
Policies	
1. Change in the average contribution income per SEU per quarter. Calculate the average contribution for single, family, single parent, couples, 2+ persons no adults and 3+ adults SEUs (or for total SEUs if contribution income cannot be split between policy type). The average calculated should be compared to prior quarters and industry statistics where available.	• Contributions should increase or decrease in line with increase or decrease in number of policies by category and any change in rates. • Decrease in number of policies coupled with increase in contributions for that category may indicate incorrect recording in policy records, contributions records or both.
2. Change in the number of policies in arrears per quarter. Need to ensure that the two-month limit has been applied for the purposes of determining valid contributions in the Return. If the Insurer's policy for bringing to account policies in arrears is different, this should be agreed to the Insurer's fund rules.	• An increase or decrease may indicate: - a difference in the way policies are being classified by an Insurer - misinterpretation of the Policy Rules leading to potential errors in the risk equalisation account.
3. Ratio of insured persons aged 55 or over to total number of insured persons compared to industry average or to similar Insurers by quarter.	• If this ratio is higher than the industry average, the ratio of risk equalisation benefits to total benefits could also be expected to be higher than the industry average.
4. Hospital Treatment changes in quarter	• The movement in policies/insured persons joining and policies/insured persons leaving the Fund should be consistent with trends found on the statutory audit.

Key performance Indicator	Significance
Benefits/Aged based pool	
1. Ratio of benefits paid to persons 55 and over to total benefits compared by quarter.	• A change in this ratio may indicate errors in debiting benefits to the ABP account.
2. Ratio of benefits paid to persons 55 and over to total benefits compared to industry average or to similar Insurers.	• For Insurers with a high proportion of aged insured persons, this ratio should be higher than for Insurers with a low proportion of aged insured persons. • A higher than average ratio may also indicate: – errors in debiting the ABP account – misinterpretation of the Policy Rules.
3. Ratio of benefits paid to persons 55 and over to benefits per SEU compared to industry average or to similar Insurers.	• See number 2 above.
Benefits/High cost claims pool	
1. Ratio of benefits paid relating to high cost claims to total benefits compared by quarter.	• A change in this ratio may indicate errors in debiting benefits to the HCCP account.
2. Ratio of benefits paid relating to high cost claims to total benefits compared to industry average or to similar Insurers.	• For Insurers with a high proportion of high cost claimants, this ratio should be higher than for Insurers with a low proportion of high cost claimants. • A higher than average ratio may also indicate: – errors in debiting the HCCP account – misinterpretation of the Policy Rules.
3. Ratio of benefits paid relating to high cost claims to benefits per SEU compared to industry average or to similar Insurers.	• See number 2 above.

Section 6

Sampling guidelines

6.1.1 Introduction

The auditor must establish and gain sufficient appropriate evidence from a combination of tests of control and substantive testing to enable reasonable conclusions to be drawn on which to base the audit opinion.

Guidance on sampling is available in Auditing Standard ASA 530: Audit Sampling and Other Means of Testing.

Section 7

Substantive testing program

7.1.1 Policy records

	Work paper reference	Exception Yes/No	Signature and date
Policy records 100 This section of the template substantive audit program deals with the audit of policy records.			
Control risk assessment 101 Has a control evaluation been completed in respect of policy records?			
Analytical review procedures 102 Have analytical review procedures been completed and discussed with management?			
Determining degree of assurance 103 The results of the control risk assessment and the analytical review procedures should be assessed by the in-charge accountant and manager to determine the level of substantive test of details required to obtain the necessary level of assurance.			
Cut-off procedures 104 Cut-off of policy processing is a high-risk area. From discussions with client personnel, is there a significant delay in processing of policy applications. ***Notes:*** Policy records must be closed off as soon as practicable after the end of a quarter and the policy reported must reflect the information available to the Insurer at the end of the period e.g. Insurers must not re-assess their end of period policy with the benefit of information on financial status obtained after the end of the quarter.			

	Work paper reference	Exception Yes/No	Signature and date
Cut-off procedures 105 If you have answered "YES" to the previous program step, the processing delay should be discussed with the audit manager and the effect on the policy count quantified.			
Accounting for policies in arrears 106 The Minister has outlined policy rules relating to the inclusion or exclusion of policies where contributions are in arrears. The application of these policy rules are most important for group policyholders where there is the possibility of greater errors in policy numbers. Policy numbers are to exclude persons who normally make individual payments to the Insurer or to an agent of the Insurer whose contribution payments are more than two months in arrears or if the fund rules allow a longer period than two months and the Insurer has provided written notice to the policyholders in whose names the policy is held that the policy is no longer in operation. Policy numbers are to include all group policies even where the group is more than two months in arrears. However, policy numbers are to exclude any person who pays through a group arrangement and whose "paid-to" date is more than two months in arrears of the paid-to date for the group generally. In addition, for group policies to be excluded they must be notified in writing that they are no longer policyholders. Un-financial policyholders who retain continuity of entitlements on payment of arrears will be regarded as valid policyholders.			

		Work paper reference	Exception Yes/No	Signature and date
Suspended policies				
107	Some Insurers have rules that provide for suspension of policies for various reasons e.g. temporarily overseas or unemployed.			
108	Suspended policies are defined as policies who have temporarily ceased payment of contributions for a period agreed with the Insurer, and are not entitled to any fund benefits for services performed during the period of suspension.			
	For risk equalisation purposes suspended policies should not be counted during the period of the suspension. That is, if a policy is under suspension at the end of a quarter, that policy should not be counted when completing the Return.			
	When the policy resumes payment of contributions, that policy should continue to be classified on the same basis that applied before contributions were suspended, i.e. would be an existing policy for risk equalisation purposes.			
109	Some Insurers offer products that cover new policies retrospectively. These policies must be reported to APRA so that appropriate adjustments to risk equalisation can be undertaken. As such amendments to pages 1 and 2 of the Return must be submitted to APRA, for all quarters affected during the financial year, by September following the end of the financial year.			
110	Where there is evidence (either from a review of performance indicators or from discussion with management) that the Insurer may have misstated its policies by inappropriately accounting for policies in arrears, or of suspended policies or			

	Work paper reference	Exception Yes/No	Signature and date
retrospectively covered policies consider whether the nature and extent of substantive audit testing is adequate to detect any material error.			
111 If there is an exception to question 110 determine any required amendments to the audit plan.			
Sample selection 112 Select the appropriate size for detailed testing of policy records using the guidance notes provided on statistical sampling.			
Detailed substantive testing			
113 Select a sample of policy records for detailed testing (using audit software if considered appropriate). For each policy record selected, obtain the policy application form, perform the following tests and then record your conclusions.			
Age of persons covered 114 Is the age or date of birth of the applicant (each applicant for policy covering more than one person) recorded on the application form?			
Age of persons covered 115 Has the age or date of birth of each applicant been verified against a suitable form of identification or supporting evidence?			
Classification as single, family, single parent, couples, 2+ persons no adults, or 3+ adults policy 116 Have all applications been accurately recorded as a single, family single parent, couple , 2+ persons no adults or 3+ adults policy in accordance with the details on the application form?			

	Work paper reference	Exception Yes/No	Signature and date
Family, single parent, couples, 2+ persons no adults and 3+ adults policies – insured persons covered 117 For each family, single parent, couples, 2+ persons no adults and 3+ adults policy tested, does the total number of insured persons per the policy records of the Insurer agree to the number of persons listed on the application form?			
Classification as excess and co-payments or no excess and no co-payments 118 Have the application's been accurately recorded on the policy system as either excess and co-payments or no excess and no co-payments, in accordance with the details on the application form?			
Classification as exclusionary or non exclusionary policy 119 Have the applications been accurately recorded on the policy system as either exclusionary hospital treatment policies or as non-exclusionary hospital treatment policies in accordance with the details on the application form and the Insurer's hospital tables.			
Classification as hospital or general policy 120 Have the applications been accurately recorded on the policy system as either hospital (hospital only or hospital and general combined) or general (general ambulance only, general only or general excluding hospital-substitute, CDMP and hospital-linked ambulance) policy in accordance with the details on the application form and the Insurer hospital tables.			

Evaluating results of tests 121 If there are any exceptions to the above questions, it will be necessary to consider whether further detailed testing of policy records is required or whether it is necessary to qualify the audit opinion.			
Conclusion 122 State whether any exceptions were noted in the above steps and confirm that: (a) any exceptions have been recorded on the working papers; (b) the nature and extent of the substantive tests have been amended as appropriate; (c) where un-cleared exceptions have been noted these have been drawn to the attention of the in-charge auditor or manager. In charge accountant ..... Manager			

7.1.2 Benefits paid

	Work paper reference	Exception Yes/No	Signature and date
Benefits transactions 200 This template substantive audit program deals with the audit of benefits paid transactions. 201 Questions 202 to 207 should be completed in respect of the audit of all benefits transactions.			
Control Risk Assessment 202 Has a control evaluation been completed in respect of benefits transactions?			
Analytical Review Procedures 203 Have analytical review procedures been completed and discussed with management?			
Determining degree of assurance 204 The results of the control risk assessment and the analytical review procedures should be assessed by the in-charge accountant and manager to determine the remaining degree of assurance for benefits transactions required from substantive testing.			
Classification of benefits 205 Have all details of benefits paid per the claim form and/or hospital form been correctly classified in the benefits records of the Insurer as hospital treatment, hospital-substitute treatment, CDMP or other general treatment. 206 Have all details of benefits paid in accordance with a CDMP been correctly classified.			

	Work paper reference	Exception Yes/No	Signature and date
207 Have all benefit transactions been classified in the correct age bands.			

	Work paper reference	Exception Yes/No	Signature and date
Mathematical accuracy of benefits transactions 208 Using audit software test the mathematical accuracy of all benefit transactions by age band as well as those included in the HCCP. Based on this test, are the totals in the benefits records of the Insurer accurate?			
Adjustments to benefits transactions 209 If there are any adjustments to the benefits transactions recorded in the quarter resulting from write-backs, stale-dated cheques etc, they should be reviewed for reasonableness. Do all adjustments appear reasonable?			
Notes There should not be an *unreasonable delay** between the date of processing a claim and the date of release of the physical payment. Benefits that have been recorded, and liability accepted, during a quarter are to be regarded as paid during that quarter. The physical payment may occur in a later quarter. *A "*reasonable delay*" would be regarded as: • No more than a few days for payments directly to policy holders, or • Agreed / negotiated payment terms in regard to payments directly to providers.			
Debits to benefits transactions Questions 210 to 211 should be completed for all benefits paid by the Insurer.			
Sample selection 210 Select the appropriate sample size for detailed testing of benefits paid by the Insurer using the guidelines on statistical sampling.			

	Work paper reference	Exception Yes/No	Signature and date
211 Select a sample of benefits transactions for detailed testing (using audit software if considered appropriate). For each benefit transaction selected, obtain the claim form, the hospital form and/or the claimant records, perform the following tests and record your conclusions.			
Debits to benefits transactions			
212 Have all details of benefits paid per the claim form and/or hospital form been accurately recorded in the benefits records of the Insurer?			
213 Have all details of benefits paid per the claim form and/or hospital form been correctly classified in the benefits records of the Insurer as hospital treatment, general treatment that was not hospital-substitute treatment or hospital-substitute treatment.			
214 Is the benefit paid in relation to a valid financial policy? Refer to the policy program for the definition of a policy.			
215 Was the claim paid on or before the relevant quarters end?			
216 If you have answered "No" to any of the above questions 212-215 it will be necessary to consider whether further detailed testing of policy records is required or whether it is necessary to qualify the audit opinion.			
Debits to ABP account 300 Questions 305 to 317 should be completed for benefits paid from the ABP and HCCP accounts.			

Sample selection 301 Select the appropriate sample size for detailed testing of benefits paid from the ABP and HCCP accounts using the guidelines provided on sampling.			
302 Select a sample of benefits transactions for detailed testing (using audit software if considered appropriate). For each benefit transaction selected, obtain the claim form and/or the hospital form and/or the policy records, perform the following tests and record your conclusions.			
303 For each transaction selected, determine in which age band the claimant was at the date the hospital service was provided.			
Debits to ABP account - claimant aged 55 and older 304 Questions 305 to 308 should be completed in respect of those claims for which the claimant was aged 55 or older at the date the service was provided.			
305 Was the age or date of birth of the claimant recorded on the hospital/claim forms?			
306 If the answer to question 305 is "Yes", does the age or date of birth recorded on the hospital/claim forms agree to the age or date of birth recorded in the policy records?			
307 If the answer to question 305 is "No", obtain the relevant policy application form. Does the age or date of birth recorded on the application form agree to the age or date of birth recorded in the policy records?			

308 If a claimant changed the age band during a hospital stay, ensure that benefits are reported correctly in each age band. Is this the case?			
Debits to risk equalisation account - HCCP 309 Questions 310 to 312 should be completed in respect of those high cost claims.			
310 Where net benefits after age pooling exceed the threshold, a maximum of 82% of net benefits, paid in current and preceding three quarters, in excess of the threshold are to be pooled. Is this the case? A claimant should only be included in the count of claimants if benefits are included in the HCCP in the current quarter, regardless of being included in the previous quarter. Is this the case?			
311 When assessing HCCP in each quarter, the current cumulative residual after Aged Based Pooling is compared with the threshold level that applies at that time. Any benefits included in the HCCP in one of the preceding three quarters are to be deducted from the cumulative residual. Has that been done?			
Debits to risk equalisation account - all claims 312 Question 314 should be answered for all risk equalisation benefit transactions selected for testing			
313 Do the details recorded on the hospital form match the details recorded on the claim form if applicable?			
314 Have all details of benefits paid per the claim form and/or hospital form been accurately recorded in the benefits records of the Insurer?			

315 Is the risk equalisation benefit paid in relation to a valid, financial policy?			
316 Is prescribed information included in respect of the risk equalisation benefit transaction in line with the Policy Rules?			
317 Was the claim paid on or before the relevant quarters end?			
Evaluating results of tests 318 If you have answered "No" to any of the above questions 304 - 317 it will be necessary to consider whether further detailed testing of policy records is required or whether it is necessary to qualify the audit opinion.			
Conclusion 320 State whether any exceptions were noted in the above steps and confirm that: (a) any exceptions have been recorded on the working papers; (b) the nature and extent of the substantive tests have been amended as appropriate; (c) where unclear exceptions have been noted these have been drawn to the attention of the in-charge auditor or manager. In-charge accountant ..... Manager			

Section 8

Cross reference checklist

Section 8 Cross reference checklist

		Work paper Reference	Exception Yes/No	Signature and date
PHIAC 1 Return – General				
100	Obtain copies of the Returns (for each State) for each quarter during the year and complete the steps outlined below. In completing this program, it will be necessary to refer to the referenced copy of the Return which is attached.			
101	Have the Returns been signed by an officer of the Insurer, on the current cover sheet including reference to the *Criminal Code Act 1995*?			
102	Re-perform additions and extensions of the Returns. Are all additions and extensions correct?			
103	Are all amounts appearing in the Return transposed directly from computer reports generated from systems/databases which have been subject to audit procedures? If the answer to this question is Yes, go to question 106. if the answer to this question is no, answer questions 104 and 105.			
104	Are reconciliations performed between the systems generated numbers and the amounts appearing in the Return?			
105	If reconciliations are performed, review all material reconciling items to ensure that it is appropriate to adjust the systems generated numbers for the purposes of the Return. Are all reconciling items valid?			
Exceptions				
106	Obtain explanations for any exceptions noted in questions 100 to 105 and document the discrepancy			

		Work paper Reference	Exception Yes/No	Signature and date
	and the explanation for consideration by engagement manager/partner.			
Part 1 - Policies and Insured Persons				
200	This part deals with policy records and the type of policy and the coverage obtained by each insured person. Hospital treatment and general treatment by policy category, is split into: i. Total Hospital Treatment (includes Hospital Treatment Only and Hospital Treatment and General Treatment Combined) ii. Hospital Treatment Only iii. Hospital Treatment and General Treatment Combined iv. General Treatment Ambulance Only v. Total General Treatment Only (includes General Treatment Ambulance Only) vi. General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment (includes Ambulance Only) vii. Total General Treatment (includes Hospital Treatment and General Treatment Combined and Total General Treatment Only) Within categories i to iii above, hospital and general treatment is further split between: iii. Hospital and general cover that excludes certain treatments (exclusionary) and those that do not (non exclusionary) iv. Hospital and general cover that deducts an initial amount from the benefit otherwise payable and where there is more than one policyholder contributing (excess			

		Work paper Reference	Exception Yes/No	Signature and date
	and co-payments) versus those that do not (no excess and no co-payments) Information is required for both the number of policies and the number of insured persons in the categories described above.			
201	Do the total columns for Total policies and Total insured persons in the Total Hospital Treatment table agree to the combined total of the Total policies and Total insured persons under the Hospital Treatment only table and the Hospital Treatment and General Treatment Combined table? Do the policies and persons reported as Hospital Treatment Only exclude policies that have a component covering ambulance transport? Those policies should be reported as Hospital Treatment and General Treatment Combined.			
202	Agree the totals for Single, Family, Single Parent, Couple, 2+ persons no adults and 3+ adults to the relevant Hospital policyholder records maintained by the Insurer which have been audited. Do these totals agree?			
203	Do the total columns for "General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment" agree to all persons and polices with ancillary coverage including those with "General Treatment Ambulance Only", and excluding those classed as General Treatment because they have cover for hospital substitute, CDMP or hospital-linked ambulance cover but do not have any other ancillary cover. Do the total columns for Total policies and Total insured persons under Total General Treatment agree			

		Work paper Reference	Exception Yes/No	Signature and date
	to the combined total of the Total policies and Total insured persons under Hospital Treatment and General Treatment Combined and Total General Treatment Only.			
204	Agree the totals for Single, Family, Single Parent, Couple, 2+ persons no adults and 3+ adults to the relevant general treatment policyholder records maintained by the Insurer which have been audited. Do these totals agree?			
Changes during the quarter				
205	This Sections records policy fluctuation during the quarter.			
206	Agree the number of policies and insured persons at the start of the quarter to the end of quarter policies and persons from the previous quarter. Agree the number of new policies and insured persons joining to the policyholder records maintained by the Insurer. Agree the policies and insured persons transfers within the Fund from/to another state/territory to the policyholder records maintained by the Insurer. Agree the policies and insured persons transfers from other funds to the policyholder records maintained by the Insurer. Agree the policies and insured persons transfers within the Fund from/to another policy to the policyholder records maintained by the Insurer. Agree the policies and insured persons at the end of the quarter to the totals under the Hospital Treatment Only, Hospital Treatment and General Treatment Combined and General Treatment Only tables. Do the totals agree?			

		Work paper Reference	Exception Yes/No	Signature and date
207	Agree the net movement in policies and insured persons as the difference between the total policies and insured persons at the end of the quarter and at the beginning of the quarter under Hospital Treatment Only, Hospital Treatment and General Treatment and General Treatment Only. Do the policies/insured persons agree?			
Check total				
208	The check total is an internal cross referencing tool used by APRA to ensure that the signed hard copy matches the soft copy. Comparing the check totals between the soft and the hard copy is considered necessary.			
Part 1 - Exceptions				
209	Obtain explanations for any exceptions noted in questions 200 to 209 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 2 - Hospital and General Treatment benefits paid				
300	This section of the Return is to record episodes, days and benefits paid by hospital category, total benefits paid for hospital treatment and general treatment and details in relation to the High Cost Claims Pool.			
Total benefits for Hospital Treatment and Hospital-Substitute Treatment				
301	The tables provide details of benefits paid on account of persons covered that received hospital and hospital-substitute treatment according to the length of stay in hospital or hospital substitute treatment.			
302	Add the columns and agree the total number of episodes, days and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree?			

		Work paper Reference	Exception Yes/No	Signature and date
Nursing home Type Patients				
303	This table classifies benefits paid to nursing home type patients according to the type of facility providing the services.			
304	Agree the total number of episodes, days and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree?			
Medical benefits				
305	This table shows the medical benefits paid.			
306	Agree amount for number of services and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree?			
Prostheses benefits				
307	This table shows the prostheses benefits paid.			
308	Agree the total number of prosthetic items and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree?			
Total Chronic Disease Management Programs				
309	This table shows the benefits paid to policyholders on Chronic Disease Management Programs			
310	Agree the total number of programs and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree?			
Total Benefits paid for General Treatment from page 10				
311	This table shows the total benefits paid for General Treatment.			
312	Agree the total benefits paid for General Treatment to the total benefits on page 10.			

		Work paper Reference	Exception Yes/No	Signature and date
Ineligible benefits paid				
313	This section shows the total benefits paid that are not eligible benefits			
Total benefits paid for Hospital Treatment and General Treatment				
314	This section shows the total of all benefits paid for both Hospital Treatment and General Treatment combined and includes ineligible benefits.			
High Cost Claimants Pool				
315	This section shows the number of HCCP claimants in the current quarter, the gross and net benefits paid for the current and preceding 3 quarters for HCCP claimants related to current quarter claimants, the net benefits above threshold for the current and preceding 3 quarters for HCCP claimants related to current quarter claimants and the total benefits to be included in the HCCP for the current quarter.			
316	Agree the total number of claimants and benefits paid to the benefits records of the Insurer which have been audited. Do the amounts agree? See PHIAC Circular No 08/04 for examples of benefits to be included in the HCCP.			
Part 2 - Exceptions				
317	Obtain explanations for any exceptions in questions 300 to 316 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 3 - Hospital Treatment by Age Category				
401	This part deals with benefits, from all persons covered by hospital insurance by gender.			
402	Agree the number of insured persons, episodes, days, other HT, medical and prostheses benefits paid and fees charged (excluding the Medicare			

		Work paper Reference	Exception Yes/No	Signature and date
	benefit) by age group to the benefits records of the Insurer which have been audited.			
403	The total of the hospital (the sum of other HT, medical and prostheses) benefits paid to males in addition to the hospital benefits paid to females should equal the total hospital treatment benefits in Part 2 of the Return. The total of the medical benefits paid to males in addition to the medical benefits paid to females should be combined with the total medical benefits paid to males and females in Part 4 of the Return to equal the totals under the Total Medical benefits in Part 2 of the Return. The total of the prostheses benefits paid to males in addition to the prostheses benefits paid to females should be combined with the total prostheses benefits paid to males and females in Part 4 of the Return to equal the totals under the Total Prostheses benefits in Part 2 of the Return. The total fees charged should include all fees charged by the providers, including medical fees but excluding the 75% Medicare medical benefit.			
Part 3 - Exceptions				
404	Obtain explanation for any exceptions in questions 400 to 403 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 4 – Hospital-Substitute Treatment by Age Category				
405	This part deals with benefits, from all persons covered by hospital-substitute insurance by gender.			

		Work paper Reference	Exception Yes/No	Signature and date
406	Agree the number of insured persons, episodes, days, other H-ST , medical and prostheses benefits paid and fees charged (excluding the Medicare benefit) by age group to the benefits records of the Insurer which have been audited.			
407	The total of the hospital-substitute (the sum of other H-ST, medical and prostheses benefits) benefits paid to males in addition to the hospital-substitute benefits paid to females should equal the totals hospital-substitute treatment benefits in Part 2 of the Return. The total of the medical benefits paid to males in addition to the medical benefits paid to females should be combined with the total medical benefits paid to males and females in Part 3 of the Return to equal the totals under the Total Medical benefits in Part 2 of the Return. The total of the prostheses benefits paid to males in addition to the prostheses benefits paid to females should be combined with the total prostheses benefits paid to males and females in Part 3 of the Return to equal the totals under the Total Prostheses benefits in Part 2 of the Return. The total fees charged should include all fees charged by the providers, including medical fees but excluding the 75% Medicare medical benefit.			
Part 5 – Chronic Disease Management Program by Age Category				
500	This part deals with benefits, from all persons covered by CDMP insurance by gender.			

501	Agree the number of insured persons, programs, eligible benefits, ineligible benefits and fees charged (excluding the Medicare benefit) by age group to the benefits records of the Insurer which have been audited.			
502	Agree total male plus female programs/benefits to total CDMPs at Part 2 of the Return. Agree total benefits for male plus female to Part 8 of the Return. Agree total fees charged for male plus female to Part 8 of the Return.			
Part 4 - Exceptions				
503	Obtain explanations for any exceptions noted in questions 500 to 503 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 6 – General Treatment by Age Category				
600	This part deals with benefits from all persons covered by general treatment (ancillary) excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance treatment.			
601	Agree total male plus female persons to general treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance treatment persons at Part 1 of the Return. Agree total services for male plus female to Part 9 of the Return, including ambulance services. Agree total benefits for male plus female to Part 9 of the Return, including benefits for ambulance even if the person is not included in Part 6 because they have hospital-linked ambulance cover and no other ancillary cover. Note: persons with hospital-linked ambulance cover, and no other ancillary			

	cover, are not regarded as having ancillary cover, but any benefits paid, services and fees for ambulance transport for these persons should be reported as ancillary benefits, services and fees. This provides consistent mapping with historical data. Agree total fees charged for male plus female to Part 9 of the Return.			
Part 6 - Exceptions				
602	Obtain explanations for any exceptions in questions 600 to 601 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 7 – Total Hospital Treatment Policies by type of cover				
700	This table shows total policies by level of excess and exclusionary cover			
701	Agree individual categories to the policy records of the organization which have been audited Agree total policies in the category ">$500/$1000" with policies of the organization that are subject to the Medicare Levy Surcharge. Agree the total policies to policies at Part 1 of the Return.			
Part 7B – General Treatment claims Processing for the state				
702	This table shows the percent of general treatment (ancillary) claims processed for the state (excluding hospital substitute and CDMP) within five working days by risk equalisation jurisdiction (state)			
703	Agree percent shown to claims processing records			
Section 1.15 – National retention Index				
704	Agree the percent shown to the calculation [Policies at end of reporting quarter less policies joining over previous eight quarters			

	including the reporting quarter divided by policies at end of quarter nine quarters previously]. This is a national calculation, not by risk equalisation jurisdiction and it refers to Hospital Treatment policy holders.			
Part 7 – Exceptions				
705	Obtain explanations for any exceptions in questions 700 to 705 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 8 – Benefits paid for Chronic Disease Management Programs				
800	This section deals with the benefits paid for CDMPs.			
801	This amount should sum to the total CDMP benefits paid from the benefits records of the Insurer which have been audited. The CDMP benefits by program type, for example Cardiovascular, should agree with the benefits records of the Insurer			
802	The total benefits for CDMP's should agree to the total CDMPs on Part 2 of the Return.			
Part 8 - Exceptions				
803	Obtain explanations for any exceptions noted in questions 800 to 702 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 9 - Benefits paid for General Treatment (excluding Hospital-Substitute treatment and CDMP)				
900	This section is the total contractual and non-contractual benefits paid for General Treatment.			
901	This amount should sum to the total general benefits paid from the benefits records of the insurer which have been audited. Categories of general treatment			

	(ancillary) benefits, for example dental, should agree with the benefits records of the Insurer. Care should be taken to ensure benefits are not reported in the wrong category, for example reporting dental under dietetics. Other general treatment (ancillary) benefits should be assigned a meaningful description, not just "Other1", or "Other2".			
902	The total benefits for general treatment should agree to the total general treatment on Part 2 of the Return.			
Part 9 - Exceptions				
903	Obtain explanations for any exceptions noted in questions 900 to 902 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 10 – Lifetime Health Cover				
1000	This part deals with the collection of information on Lifetime Health Cover.			
1001	This section is the total number of adults with hospital treatment cover and Lifetime Health Cover loading by gender.			
1002	Add the columns and agree the individual and total number of adults by certified age of entry to the relevant policy records maintained by the Insurer. Do the numbers agree?			
1003	Agree the total Lifetime Health Cover persons, as an approximation, to the sum of hospital policies (from page 1 of the Return) as follows: Single + Single parent + 2 * (Family + Couple) + 3 * (3+adults).			

1004	Agree the total males, as an approximation, to the sum of males covered aged 30 and above at Part 3 of the Return.			
1005	Agree the total females, as an approximation, to the sum of females covered aged 30 and above at Part 3 of the Return.			
1006	Agree the number of males with a Lifetime Health Cover loading removed in each 'certified age at entry' match the insurer's records.			
1007	Agree the number of females with Lifetime Health Cover loading removed in each 'certified age at entry' match the insurer's records.			
1008	Check the number of males and females with 'certified age at entry' of 30 is '0' for loading removed.			
1009	Agree that the number of males with a Lifetime Health Cover loading removed, in each 'certified age at entry', is less than the number with a loading in the previous quarter.			
1010	Agree that the number of females with a Lifetime Health Cover loading removed, in each 'certified age at entry', is less than the number with a loading in the previous quarter.			
Part 10 – Exceptions				
1011	Obtain explanations for any exceptions noted in questions 1000 to 1005 and document the discrepancy and the explanation for the engagement manager/partner.			
Part 11 – Medical Services Statistics				
1100	Agree the individual entries to the records of the Insurer.			
Part 11 – Exceptions				
1100	Obtain explanations for any exceptions noted in questions 1100			

	and document the discrepancy and the explanation for the engagement manager/partner.			
Conclusion				
1200	This section contains the conclusions reached as a result of audit testing. In-charge accountant ……. Manager …….			

Appendix A

Private Health Insurance (Risk Equalisation Administration) Rules 2007

Private Health Insurance (Risk Equalisation Administration) Rules 2007

as amended

made under section 333-25 of the

Private Health Insurance Act 2007

This compilation was prepared on 30 March 2011
taking into account amendments up to *Private Health Insurance (Risk Equalisation Administration) Amendment Rules 2011 (No. 1)*

Prepared by the Office of Legislative Drafting and Publishing,
Attorney-General's Department, Canberra

The *Private Health Insurance (Risk Equalisation Administration) Rules 2007* can be obtained from the following link on the Comlaw site.

http://www.comlaw.gov.au/Details/F2011C00173

Appendix B

Private Health Insurance (Risk Equalisation Policy) Rules 2007

Private Health Insurance (Risk Equalisation Policy) Rules 2007

I, ANTHONY JOHN ABBOTT, Minister for Health and Ageing, make these Rules under item 15 of the table in section 333-20 of the *Private Health Insurance Act 2007*.
Dated 30 March 2007

TONY ABBOTT

_____

Minister for Health and Ageing

The *Private Health Insurance (Risk Equalisation Policy) Rules 2007* can be obtained from the following link on the Comlaw site.

http://www.comlaw.gov.au/Details/F2007L00912

Appendix C

Referenced PHIAC 1 template

Australian Government

Private Health Insurance Administration Council

PHIAC 1 Quarterly Return

For Council use only

Fund Id			*Date Exported*
Errors	*Initials*	*Resubmission*	*Date Check Total*

Form PHIAC 1 Return
This form is issued under Part 310-1 of the *Private Health Insurance Act 2007*

This collection is a census of all private health insurers in Australia. It provides essential data for the calculation of the Risk Equalisation Trust Fund, complaints levy and Council administration levy. It also provides data for monitoring trends in the private health insurance industry.

Related Legislation
Private Health Insurance (Risk Equalisation Administration) Rules 2007

Lodgement details

Name of private health insurer

Name of health benefits fund

Quarter ended

Re-submission (yes/no)*

If this is a re-submission, list what states are affected

* All re-submissions must have a detailed explanatory statement attached

Who should PHIAC contact should we wish to discuss this return

Officer Name

Phone

Position of Officer

Fax

Email address

Signature

This return to be signed by an officer of the private health insurer:
officer, of a private health insurer, means:
(a) a *director of the insurer; or
(b) a *chief executive officer of the insurer; or
(c) a person who makes, or participates in making, decisions that affect the whole, or a substantial part, of the business of the insurer.
(Private Health Insurance Act 2007)

Declaration and signature of officer

The information I have provided in this return is true and correct. I am aware that the giving of false or misleading information, documents or statements to the Private Health Insurance Administration Council is an offence under the *Criminal Code Act 1995*. I am also aware that failure to lodge this census to the Private Health Insurance Administration Council is a strict liability offence under the *Criminal Code Act 1995 (see section 6.1 of the Criminal Code)*, and that the Criminal Code Act imposes substantial penalties, including imprisonment, for committing these offences.

Officer name (please print)

Date

Signature

101

Lodgement

Due date no later than four weeks (28 days) after the end of the quarter to which it relates

Please complete and submit

A signed hardcopy to Private Health Insurance Administration Council
Suite 16,
71 Leichhardt Street
KINGSTON ACT 2604

and

A soft copy to returns@phiac.gov.au

Assistance If you have difficulty in completing this return or if you are not able to complete it by the due date, please contact PHIAC as soon as possible on
02 6215 7900 or fax 02 6215 7977.

Components of this return will be distributed to other funds to support the risk equalisation audit program, otherwise individual fund data remains confidential to the Private Health Insurance Administration Council.

PHIAC 1 Template (version 2009.05)

Page 1

Quarter		FundID		State	
Name of health benefits fund					
Contact name				Contact phone	
Contact email				Fax	

Part 1 Policies and Insured Persons (200)

Total Hospital Treatment (includes Hospital Treatment Only and Hospital Treatment and General Treatment Combined)

	Single	Family	Single parent	Couple	2+ persons no adults	3+ adults	Total (201)
Policies	**Exclusionary policies**						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total policies	0	0	0	0	0	0	0
Insured persons	**Exclusionary policies**		(202)				
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total insured persons	0	0	0	(202) 0	0	0	0

Hospital Treatment Only

	Single	Family	Single parent	Couple	2+ persons no adults	3+ adults	Total
Policies	**Exclusionary policies**						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total policies	0	0	0	0	0	0	0
Insured persons	**Exclusionary policies**						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total insured persons	0	0	0	0	0	0	0

The following Check Total must be Printed ——> 0.00

Part 1 (Cont.) Policies and Insured Persons

Page 2

Hospital Treatment and General Treatment Combined

	Single	Family	Single parent	Couple	2+ persons no adults	3+ adults	Total
Policies	**Exclusionary policies**						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total policies	0	0	0	0	0	0	0
Insured persons	**Exclusionary policies**						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total exclusionary policies	0	0	0	0	0	0	0
	Non-exclusionary policies						
Excess & co-payments	0	0	0	0	0	0	0
No excess & no co-payments	0	0	0	0	0	0	0
Total non-exclusionary policies	0	0	0	0	0	0	0
Total insured persons	0	0	0	0	0	0	0

	Single	Family	Single parent	Couple	2+ persons no adults	3+ adults	Total
General Treatment Ambulance Only							
Policies	0	0	0	0	0	0	0
Insured persons	0	0	0	0	0	0	0
Total General Treatment Only							
Policies	0	0	0	0	0	0	0
Insured persons	0	0	0	0	0	0	0
General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment							
Policies	0	0	0	0	0	0	0
Insured persons	0	0	0	0	0	0	0
Total General Treatment							
Policies	0	0	0	0	0	0	0
Insured persons	0	0	204 0	0	0	0	203 0

Changes During the Quarter

205	Hospital Treatment Only		Hospital Treatment and General Treatment		General Treatment Only	
206	Policies	Insured persons	Policies	Insured persons	Policies	Insured persons
Start of quarter	0	0	0	0	0	0
New policies/persons	0	0	0	0	0	0
Transferring from another state	0	0	0	0	0	0
Transferring to another state	0	0	0	0	0	0
Transferring from another fund	0	0	0	0	0	0
Transferring from another policy	0	0	0	0	0	0
Transferring to another policy	0	0	0	0	0	0
Discontinued	0	0	0	0	0	0
207 End of quarter	0	0	0	0	0	0

Net b

The following Check Total must be Printed ——> 0.00

Part 2 Total Benefits Paid for Hospital Treatment and General Treatment

300

Page 3

Total Benefits for Hospital Treatment and Hospital-Substitute Treatment

301

		Episodes	Days	Benefits paid
Day hospital		0	0	0
Public hospitals	Day only	0	0	0
	Overnight	0	0	0
Private hospitals	Day only	0	0	0
	Overnight	0	0	0
Hospital-Substitute	Day only	0	0	0
Treatment greater than one day		0	0	0
302 **Total**		0	0	0

Nursing Home Type Patients 303

	Episodes	Days	Benefits paid
Public hospitals	0	0	0
Private hospitals	0	0	0
Total Nursing Home Type Patients	0	0	0

304

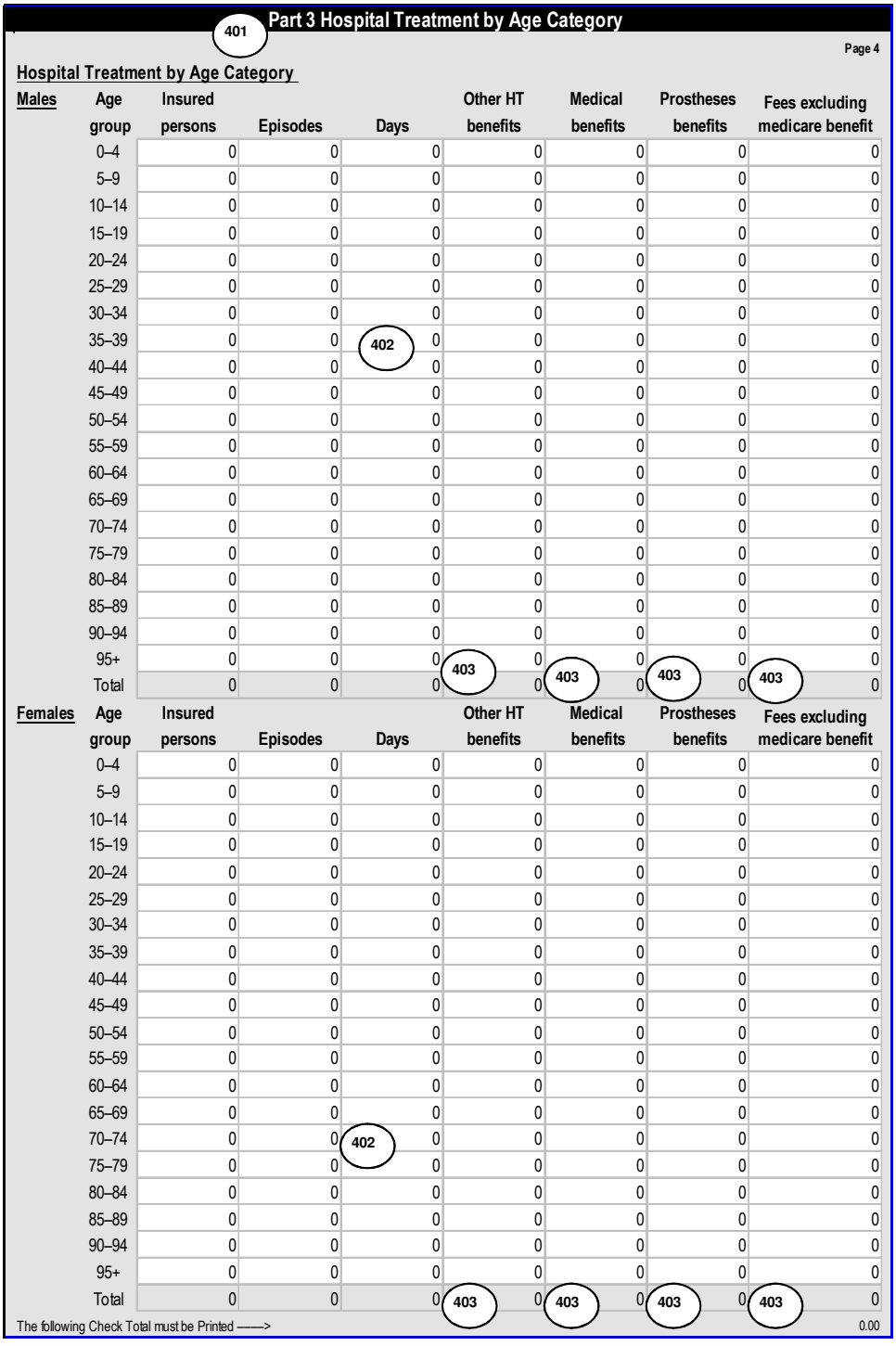
	306 Number	Benefits paid
305 **Medical benefits**	0	$0
307 **Prostheses benefits** 308	0	$0
Total Chronic Disease Management Programs 309 310	0	0

		Benefits paid
Total benefits paid for General Treatment from page 10 311	312	0
Ineligible hospital benefits 313		0
Total benefits paid for Hospital Treatment and General Treatment 314		0

High Cost Claimants Pool 315

	316
Number of HCCP Claimants (current quarter)	0
Gross Benefits for current and preceding 3 quarters (for current quarter HCCP claimants)	0
Net Benefits for current and preceding 3 quarters for current quarter HCCP claimants - after ABP	0
enefits above threshold for current and preceding 3 quarters (for current quarter HCCP claimants)	0
Total benefits to be included in HCCP (current quarter)	0

The following Check Total must be Printed ——> 0.00



Part 3 Hospital Treatment by Age Category

401

Page 4

Hospital Treatment by Age Category

Males	Age group	Insured persons	Episodes	Days	Other HT benefits	Medical benefits	Prostheses benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0	0
	5–9	0	0	0	0	0	0	0
	10–14	0	0	0	0	0	0	0
	15–19	0	0	0	0	0	0	0
	20–24	0	0	0	0	0	0	0
	25–29	0	0	0	0	0	0	0
	30–34	0	0	0	0	0	0	0
	35–39	0	0	402 0	0	0	0	0
	40–44	0	0	0	0	0	0	0
	45–49	0	0	0	0	0	0	0
	50–54	0	0	0	0	0	0	0
	55–59	0	0	0	0	0	0	0
	60–64	0	0	0	0	0	0	0
	65–69	0	0	0	0	0	0	0
	70–74	0	0	0	0	0	0	0
	75–79	0	0	0	0	0	0	0
	80–84	0	0	0	0	0	0	0
	85–89	0	0	0	0	0	0	0
	90–94	0	0	0	0	0	0	0
	95+	0	0	0	403 0	403 0	403 0	403 0
	Total	0	0	0	0	0	0	0

Females	Age group	Insured persons	Episodes	Days	Other HT benefits	Medical benefits	Prostheses benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0	0
	5–9	0	0	0	0	0	0	0
	10–14	0	0	0	0	0	0	0
	15–19	0	0	0	0	0	0	0
	20–24	0	0	0	0	0	0	0
	25–29	0	0	0	0	0	0	0
	30–34	0	0	0	0	0	0	0
	35–39	0	0	0	0	0	0	0
	40–44	0	0	0	0	0	0	0
	45–49	0	0	0	0	0	0	0
	50–54	0	0	0	0	0	0	0
	55–59	0	0	0	0	0	0	0
	60–64	0	0	0	0	0	0	0
	65–69	0	0	0	0	0	0	0
	70–74	0	0	402 0	0	0	0	0
	75–79	0	0	0	0	0	0	0
	80–84	0	0	0	0	0	0	0
	85–89	0	0	0	0	0	0	0
	90–94	0	0	0	0	0	0	0
	95+	0	0	0	0	0	0	0
	Total	0	0	0	403 0	403 0	403 0	403 0

The following Check Total must be Printed ——> 0.00

Part 4 Hospital-Substitute Treatment by Age Category

405

Page 5

Hospital-Substitute Treatment by Age Category

Males	Age group	Insured persons	Episodes	Days	Other H-ST benefits	Medical benefits	Prostheses benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0	0
	5–9	0	0	0	0	0	0	0
	10–14	0	0	0	0	0	0	0
	15–19	0	0	0	0	0	0	0
	20–24	0	0	0	0	0	0	0
	25–29	0	0	0	0	0	0	0
	30–34	0	0	0	0	0	0	0
	35–39	0	0	0	0	0	0	0
	40–44	0	0	0	0	0	0	0
	45–49	0	0	0	0	0	0	0
	50–54	0	0	406 0	0	0	0	0
	55–59	0	0	0	0	0	0	0
	60–64	0	0	0	0	0	0	0
	65–69	0	0	0	0	0	0	0
	70–74	0	0	0	0	0	0	0
	75–79	0	0	0	0	0	0	0
	80–84	0	0	0	0	0	0	0
	85–89	0	0	0	0	0	0	0
	90–94	0	0	0	0	0	0	0
	95+	0	0	0	0	0	0	0
	Total	0	0	0	407 0	407 0	407 0	407 0

Females	Age group	Insured persons	Episodes	Days	Other H-ST benefits	Medical benefits	Prostheses benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0	0
	5–9	0	0	0	0	0	0	0
	10–14	0	0	0	0	0	0	0
	15–19	0	0	0	0	0	0	0
	20–24	0	0	0	0	0	0	0
	25–29	0	0	0	0	0	0	0
	30–34	0	0	0	0	0	0	0
	35–39	0	0	0	0	0	0	0
	40–44	0	0	406 0	0	0	0	0
	45–49	0	0	0	0	0	0	0
	50–54	0	0	0	0	0	0	0
	55–59	0	0	0	0	0	0	0
	60–64	0	0	0	0	0	0	0
	65–69	0	0	0	0	0	0	0
	70–74	0	0	0	0	0	0	0
	75–79	0	0	0	0	0	0	0
	80–84	0	0	0	0	0	0	0
	85–89	0	0	0	0	0	0	0
	90–94	0	0	0	0	0	0	0
	95+	0	0	0	0	0	0	0
	Total	0	0	0	407 0	407 0	407 0	407 0

The following Check Total must be Printed ——> 0.00

Part 5 Chronic Disease Management Program by Age Category

500

Page 6

Chronic Disease Management Program by Age Category

Males	Age group	Insured persons	Programs	Eligible benefits	Ineligible benefits	Total benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0
	5–9	0	0	0	0	0	0
	10–14	0	0	0	0	0	0
	15–19	0	0	0	0	0	0
	20–24	0	0	0	0	0	0
	25–29	0	0	0	0	0	0
	30–34	0	0	0	0	0	0
	35–39	0	0	0	0	0	0
	40–44	0	501	0	0	0	0
	45–49	0	0	0	0	0	0
	50–54	0	0	0	0	0	0
	55–59	0	0	0	0	0	0
	60–64	0	0	0	0	0	0
	65–69	0	0	0	0	0	0
	70–74	0	0	0	0	0	0
	75–79	0	0	0	0	0	0
	80–84	0	0	0	0	0	0
	85–89	0	0	0	0	0	0
	90–94	0	0	0	0	0	0
	95+	0	0	502 0	502 0	502 0	502 0
	Total	0	0	0	0	0	0

Females	Age group	Insured persons	Programs	Eligible benefits	Ineligible benefits	Total benefits	Fees excluding medicare benefit
	0–4	0	0	0	0	0	0
	5–9	0	0	0	0	0	0
	10–14	0	0	0	0	0	0
	15–19	0	0	0	0	0	0
	20–24	0	0	0	0	0	0
	25–29	0	0	0	0	0	0
	30–34	0	0	0	0	0	0
	35–39	0	0	0	0	0	0
	40–44	0	501	0	0	0	0
	45–49	0	0	0	0	0	0
	50–54	0	0	0	0	0	0
	55–59	0	0	0	0	0	0
	60–64	0	0	0	0	0	0
	65–69	0	0	0	0	0	0
	70–74	0	0	0	0	0	0
	75–79	0	0	0	0	0	0
	80–84	0	0	0	0	0	0
	85–89	0	0	0	0	0	0
	90–94	0	0	0	0	0	0
	95+	0	0	502 0	502 0	502 0	502 0
	Total	0	0	0	0	0	0

The following Check Total must be Printed ——> 0.00

rt 6 General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatm

600

General Treatment by Age Category

Males	Age group	Insured persons	Services	Benefits	Fees charged
	0–4	0	0	0	0
	5–9	0	0	0	0
	10–14	0	0	0	0
	15–19	0	0	0	0
	20–24	0	0	0	0
	25–29	0	0	0	0
	30–34	0	0	0	0
	35–39	0	0	0	0
	40–44	0	0	0	0
	45–49	0	0	0	0
	50–54	0	0	0	0
	55–59	0	0	0	0
	60–64	0	0	0	0
	65–69	0	0	0	0
	70–74	0	0	0	0
	75–79	0	0	0	0
	80–84	0	0	0	0
	85–89	0	0	0	0
	90–94	0	0	0	0
	95+	601 0	601 0	601 0	601 0
	Total	0	0	0	0

Female	Age group	Insured persons	Services	Benefits	Fees charged
	0–4	0	0	0	0
	5–9	0	0	0	0
	10–14	0	0	0	0
	15–19	0	0	0	0
	20–24	0	0	0	0
	25–29	0	0	0	0
	30–34	0	0	0	0
	35–39	0	0	0	0
	40–44	0	0	0	0
	45–49	0	0	0	0
	50–54	0	0	0	0
	55–59	0	0	0	0
	60–64	0	0	0	0
	65–69	0	0	0	0
	70–74	0	0	0	0
	75–79	0	0	0	0
	80–84	0	0	0	0
	85–89	0	0	0	0
	90–94	0	0	0	0
	95+	601 0	601 0	601 0	601 0
	Total	0	0	0	0

The following Check Total must be Printed ——> 0.00

Part 7 Total Hospital Treatment Policies by Type of Cover

700

Page 8

Total Hospital Treatment Policies

	Number of policies				
701 **Excess & co-payments**	Full cover	Reduced cover but no lifetime exclusions	Reduced cover and some lifetime exclusions	Some lifetime exclusions but no reduced cover	Total
NIL	0	0	0	0	0
<= $500/$1,000 (*)	0	0	0	0	0
> $500/$1,000 (**)	0	0	0	0	0
701 Total	0	0	0	0	701 0

(*) Excess <= $500 per policy covering only one person and excess <=$1,000 for all other policies
(**) Excess > $500 per policy covering only one person and excess > $1,000 for all other policies

General Treatment claims processing for the state (excluding Hospital-Substitute Treatment and CDMP)

702

Percent of claims processed within five working days

0% 703

National retention index - Hospital Treatment policy holde 704

Percent of policies existing two years or more that are still in force

0% 704

[Policies at end of reporting quarter less policies joining over previous eight quarters including the reporting quarter] divided by [policies at end of quarter nine quarters previously]

The following Check Total must be Printed ——> 0.00

Part 8 Benefits Paid for Chronic Disease Management Programs

800

Page 9

Benefits Paid for CDMPs

	801		
	Services	Benefits	Fees charged
Planning	0	0	0
Coordination	0	0	0
Allied Health Services	0	0	0
Other	0	0	0
	802		
Total CDMPs	0	0	0

Benefits Paid by Program Type

	801		
Type of CDMP	Programs	Benefits	Fees charged
Risk factors for chronic disease	0	0	0
Cardiovascular	0	0	0
Diabetes	0	0	0
Mental Health	0	0	0
Other	0	0	0
	802		
Total by program type	0	0	0

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Part 9 Benefits Paid for General Treatment (excluding Hospital-Substitute Treatment and CDMP)

900

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Benefits paid for General Treatment (excluding Hospital-Substitute Treatment and CDMP)

Type of Treatment By Service Type	Services	Benefits	Fees charged
Accidental Death / Funeral Expenses	0	0	0
Acupuncture / Acupressure	0	0	0
Ambulance	0	0	0
Chiropractic	0	0	0
Community, Home, District Nursing	0	0	0
Dental	0	0	0
Dietetics	0	0	0
Domestic Assistance	0	0	0
Ex gratia Payments	0	0	0
Preventative Health Products/Health Management Program	0	0	0
Hearing Aids and Audiology	0	0	0
Hypnotherapy	0	0	0
Maternity Services	0	0	0
Natural Therapies	0	0	0
Occupational Therapy	0	0	0
Optical	0	0	0
Orthoptics (Eye Therapy)	0	0	0
Osteopathic Services	0	0	0
Overseas	0	0	0
Pharmacy	0	0	0
Physiotherapy	0	0	0
Podiatry (Chiropody)	0	0	0
Prostheses, Aids and Appliances	0	0	0
Psych/Group Therapy	0	0	0
School	0	0	0
Sickness and Accident	0	0	0
Speech Therapy	0	0	0
Theatre Fees	0	0	0
Travel and Accommodation	0	0	0
Other (Please specify)			
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0

901

902

Total General Treatment (*)	0	0	0

(*excluding Hospital-Substitute Treatment and CDMP)

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Part 10 Lifetime Health Cover

1000

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Lifetime Health Cover

Number of Adults with Hospital Cover

Certified age at entry	Male	1001 Female	1006 Male LHC loading removed	1007 Female LHC loading removed	LHC loading%
30	0	0	1008	0	0%
31	0	0	0	0	2%
32	0	0	0	0	4%
33	0	0	0	0	6%
34	0	0	0	0	8%
35	0	0	0	0	10%
36	0	0	0	0	12%
37	0	0	0	0	14%
38	0	0	0	0	16%
39	0	0	0	0	18%
40	0	0	0	0	20%
41	0	0	0	0	22%
42	0	0	1009 0	1010 0	24%
43	0	0	0	0	26%
44	0	0	0	0	28%
45	0	0	0	0	30%
46	0	0	1003 0	0	32%
47	0	0	0	0	34%
48	0	0	0	0	36%
49	0	0	0	0	38%
50	0	0	0	0	40%
51	0	0	0	0	42%
52	0	0	0	0	44%
53	0	1002 0	0	0	46%
54	0	0	0	0	48%
55	0	0	0	0	50%
56	0	0	0	0	52%
57	0	0	0	0	54%
58	0	0	0	0	56%
59	0	0	0	0	58%
60	0	0	0	0	60%
61	0	0	1003 0	0	62%
62	0	0	0	0	64%
63	0	0	0	0	66%
64	0	0	0	0	68%
65	1004 0	1005 0	0	0	70%
Total	0	0	0	0	

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Part 11 Total Hospital Treatment Medical Services Statistics

1100

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Agreements	1 Amount charged*	2 Medicare benefit	3 Fund benefit	4 Gap(d)	5 Number of services	6 % of services	7 Amount charged % of MBS
No-gap(a) agreement							
<= MBS Fee	0	0	0	0	0	0%	0%
>MBS to 125% MBS Fee	0	0	0	0	0	0%	0%
1100 >125% to 150% MBS Fee	0	0	0	0	0	0%	0%
>150% to 200% MBS Fee	0	0	0	0	0	0%	0%
>200% MBS Fee	0	0	0	0	0	0%	0%
Total No-gap agreement	0	0	0	0	0	0%	0%
Known gap(b) agreement							
>MBS to 125% MBS Fee	0	0	0	0	0	0%	0%
1100 >125% to 150% MBS Fee	0	0	0	0	0	0%	0%
>150% to 200% MBS Fee	0	0	0	0	0	0%	0%
>200% MBS Fee	0	0	0	0	0	0%	0%
Total Known gap agreement	0	0	0	0	0	0%	0%
Total Agreement	0	0	0	0	0	0%	0%
No agreement(c)							
<= MBS Fee	0	0	0	0	0	0%	0%
>MBS to 125% MBS Fee	0	0	0	0	0	0%	0%
1100 >125% to 150% MBS Fee	0	0	0	0	0	0%	0%
>150% to 200% MBS Fee	0	0	0	0	0	0%	0%
>200% MBS Fee	0	0	0	0	0	0%	0%
Total No agreement	0	0	0	0	0	0%	0%
Grand total	0	0	0	0	0	0%	0%
Total services with no gap	0	0	0	0	0	0%	0%
Total services with no or known gap	0	0	0	0	0	0%	0%

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The following Total of all Check Total must be Printed ——> 0.00

Required audit certification

[TO BE PREPARED ON AUDIT FIRM LETTERHEAD]

INDEPENDENT AUDITOR'S REPORT

[Insurer Name and Address]

cc: Australian Prudential Regulation Authority (APRA)

Report pursuant to PHIAC Circular No 14/06

We have audited the quarterly schedules of the PHIAC 1 Form (the Form) of [enter name of Insurer], which is used by APRA for the purpose of collecting information about an Insurer's policies and benefits for risk equalisation and statistical purposes.

The Director's Responsibility

The directors of [enter name of Insurer] are responsible for ensuring compliance with the accounting and financial reporting matters contained in the PHIAC Circular No 14/06. This responsibility includes the preparation of the Form and the information contained therein and ensuring that the report is prepared in accordance with the requirements of the *Private Health Insurance Act 2007* (the Act) and the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* (Policy Rules).

Auditor's Responsibility

Our responsibility is to express an opinion to APRA on whether the report is prepared in accordance with the requirements of the Act and the Policy Rules.

The Form has been prepared to fulfil the requirements of Circular No 14/06 We disclaim any assumption of responsibility for any reliance on this report or on the Form to which our report relates, to any person other than APRA or for any purpose other than that for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the PHIAC 1 Returns including the systems and procedures used by the Insurer to process and maintain policy records and benefits paid. These procedures have been undertaken to form an opinion as to whether, in all material respects, the PHIAC 1 Returns are presented fairly in accordance with the provisions of the Act and the Policy Rules.

Auditor's Opinions

In our opinion:

1 the information contained in the HRF 601.0PHIAC 1 Returns accurately reflect the data contained in the books and records of the Insurer, and

2 in accordance with the provisions of Division 318 of the Act, the books and records of the Insurer have been accurately compiled so as to fairly state:

a the number of single, family, single parent, couples, 2+ persons no adults and 3+ adults policies to the tables of the Insurer,

b the number of insured persons covered by policies to the tables of the Insurer, and

c the Insurer's risk equalisation benefits and total benefits paid during the quarterly periods.

Where the Insurer received a qualified audit report in relation to the previous financial year we have examined the issues identified and are satisfied that the Insurer has taken the appropriate steps to rectify the matters raised in that report.

[Name of Audit Firm]

Chartered Accountants

by *[Name of Partner]* *[Location]*

Partner *[Date]*

[Note - It is the responsibility of the auditor to ensure that their opinion is in compliance with any additional internal risk management policies and procedures.]