Office of Internal Oversight Services

# INTERNAL AUDIT DIVISION

# REPORT 2015/051

## Audit of the administration and management of the health insurance scheme at United Nations Headquarters

Overall results relating to effective administration and management of the health insurance scheme at United Nations Headquarters were initially assessed as unsatisfactory. Implementation of three critical and three important recommendations remains in progress.

FINAL OVERALL RATING: UNSATISFACTORY

16 June 2015
Assignment No. AH2014/511/01

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# AUDIT REPORT

## Audit of the administration and management of the health insurance scheme at United Nations Headquarters

## I. BACKGROUND

1. The Office of Internal Oversight Services (OIOS) conducted an audit of the administration and management of the health insurance scheme at United Nations Headquarters.

2. In accordance with its mandate, OIOS provides assurance and advice on the adequacy and effectiveness of the United Nations internal control system, the primary objectives of which are to ensure: (a) efficient and effective operations; (b) accurate financial and operational reporting; (c) safeguarding of assets; and (d) compliance with mandates, regulations and rules.

3. The United Nations health insurance scheme was established under United Nations Staff Regulations to provide medical and dental benefits to staff members and retirees worldwide and their eligible dependents. Five major customized insurance plans for eligible staff and retirees were administered and managed at United Nations Headquarters by the Health and Life Insurance Section (HLIS) under the Insurance and Disbursement Service (IDS), Accounts Division, Office of Programme Planning, Budget and Accounts (OPPBA) in the Department of Management. Table 1 provides basic facts on the five insurance plans.

**Table 1: Basic facts on the five major insurance plans as of 31 December 2014**

| Third party administrator | Type of plan | Covered staff/retirees and location | Year engaged | Primary subscribers | | Covered family members |
|---|---|---|---|---|---|---|
| | | | | Active | Retiree | |
| Empire Blue Cross | Medical | United States-based staff | 1986 | 7,731 | 2,167 | 13,097 |
| Aetna | Medical | United States-based staff | 1997 | 1,824 | 3,195 | 4,137 |
| Cigna | Dental | United States-based staff | 1998 | 9,241 | 5,484 | 14,725 |
| Vanbreda International | Medical/ dental | International and some local staff outside of the United States[1] | 1970/2000[2] | 15,804 | 4,593 | 33,306 |
| Henner/GMC | Medical/ dental | Locally recruited staff at field mission and offices away from Headquarters | 2010 | 17,879 | 1,049 | 49,846 |
| **Total[3]** | | | | **43,238** | **11,126** | **100,386** |

Source: Health and Life Insurance Section.
[1] Except those covered by local plans at Geneva and Vienna.
[2] Initially contracted in 1970; an administrative-service-only agreement under a self-insured policy was signed in 2000.
[3] Total excludes duplicates if enrolled in both medical and dental plans.

4. Combined financial data of the five major plans for the last two biennia are provided in Table 2.

**Table 2: Income and expenditure for the five insurance plans** (in thousands of United States dollars)

| | *Biennium* | |
|---|---|---|
| | ***2010-2011*** | ***2012-2013*** |
| **Income** | | |
| Contributions from staff and the Organization | 602,358 | 702,006 |
| Rebates, interest and other miscellaneous income | 12,428 | 10,490 |
| **Total income** | **614,786** | **712,496** |
| **Expenditure** | | |
| Subsidies to retirees enrolled in United States Medicare programme | 3,064 | 9,568 |
| Service fees paid to TPAs | 39,339 | 39,778 |
| Operating expenses | 337 | 840 |
| Claim reimbursements | 550,825 | 639,656 |
| **Total expenditure** | **593,565** | **689,842** |
| **Excess(shortfall) of income over expenditure** | **21,221** | **22,654** |
| Adjustments | (2,303) | (1,945) |
| **Operational reserves and fund balances, beginning of period** | **230,136** | **249,054** |
| **Accumulated operational reserves and fund balances, end of period** | **249,054** | **269,763** |

Source: Financial report and audited financial statements A/67/5(Vol.I) and A/69/5(Vol.I)

5. Third-party administrators (TPAs) process claims and payments to healthcare providers (professionals and facilities), while the cost of healthcare services is borne by the premium contributions made by the Organization and the staff and retirees participating in the plans. The cost-sharing ratios between the Organization and staff were as follows: 67:33 for three United States-based plans, 50:50 for the Vanbreda plan, and 75:25 to 80:20 for the Medical Insurance Plan (MIP) for local staff. The insurance plans are renewed annually when premiums and benefits coverage are reviewed and adjusted, in consultation with the Health and Life Insurance Committee (HLIC) at Headquarters, a standing body of the staff-management Joint Negotiation Committee at Headquarters. Ultimate decisions on health insurance matters rest with the Department of Management.

6. HLIS comprised 2 Professional and 13 General Service staff members headed by a Chief of Section at the P-5 level. The Section had a broad range of responsibilities including monitoring and reviewing financial and clinical experiences, managing the annual plan renewal processes and relationship with TPAs, and managing actuarial and diagnostic studies and contractual audits. Each of the 13 General Service staff members was responsible for processing health insurance enrolment and termination applications from approximately 4,000 members and responding to their inquiries. The staffing cost of HLIS constituted less than 0.5 per cent of total healthcare expenditure.

7. Comments provided by Department of Management are incorporated in *italics*.

## II. OBJECTIVE AND SCOPE

8. The audit was conducted to assess the adequacy and effectiveness of OPPBA governance, risk management and control processes in providing reasonable assurance regarding **effective administration and management of the health insurance scheme at United Nations Headquarters.**

9. The audit was included in the 2014 OIOS risk-based work plan due to the risk that inadequate administration and management of the health insurance scheme may result in inability to provide cost-effective insurance coverage for staff members.

10. The key control tested for the audit was regulatory framework. For the purpose of this audit, OIOS defined regulatory framework as controls that provide reasonable assurance that adequate policies and procedures: (i) exist to guide the administration and management of the health insurance scheme at United Nations Headquarters; (ii) are implemented consistently; and (iii) ensure reliability and integrity of financial and operational information.

11. The key control was assessed for the control objectives shown in Table 3.

12. OIOS conducted the audit from July to December 2014. The audit covered administration and management activities in relation to the three United States-based insurance plans and the Vanbreda plan for the period from 1 July 2011 to 30 October 2014. The audit reviewed the policy and governance framework of the health insurance scheme, human resources capacity to manage the scheme and operational controls in managing the TPAs and the insurance plans. A separate audit of the MIP for local staff was planned for 2015 due to differences in its governance and administration arrangements and the fact that the related TPA contract was being finalized during the audit. The liability for after-service health insurance (ASHI) was not included in the scope of this audit as it was audited by the Board of Auditors, and management had made proposals to the General Assembly to fund for the liability.

13. OIOS conducted an activity-level risk assessment to identify and assess specific risk exposures, and to confirm the relevance of the selected key control in mitigating associated risks. Through interviews, analytical reviews and tests of controls, OIOS assessed the existence and adequacy of internal controls and conducted necessary tests to determine their effectiveness.

# III. AUDIT RESULTS

14. The OPPBA governance, risk management and control processes examined were initially assessed as **unsatisfactory**[1] in providing reasonable assurance regarding **effective administration and management of the health insurance scheme at United Nations Headquarters.** OIOS made three critical and three important recommendations to address issues identified in the audit. The policy framework of the health insurance scheme at Headquarters needed to be established through promulgation of appropriate administrative issuances. OPPBA also needed to establish contracts with the TPAs and ensure that the service fees paid to them are reasonable. Additionally, OPPBA needed to conduct ongoing analytical monitoring of the claims data in order to optimize the design of the insurance plans, contain healthcare costs and help prevent fraud, abuse and waste. Furthermore, OPPBA needed to follow industry practices in reimbursing out-of-network services and ensure that actual reimbursement of out-of-network claims were in compliance with authorized rates.

15. The initial overall rating was based on the assessment of key controls presented in Table 3 below. The final overall rating is **unsatisfactory** as implementation of three critical and three important recommendations remains in progress**.**

[1] A rating of "unsatisfactory" means that one or more critical and/or pervasive important deficiencies exist in governance, risk management or control processes, such that reasonable assurance cannot be provided with regard to the achievement of control and/or business objectives under review.

**Table 3: Assessment of key control**

| Business objective | Key control | Control objectives | | | |
|---|---|---|---|---|---|
| | | Efficient and effective operations | Accurate financial and operational reporting | Safeguarding of assets | Compliance with mandates, regulations and rules |
| **Effective administration and management of the health insurance scheme at United Nations Headquarters** | Regulatory framework | Unsatisfactory | Partially satisfactory | Partially satisfactory | Unsatisfactory |
| **FINAL OVERALL RATING: UNSATISFACTORY** | | | | | |

# Regulatory framework

## (a) Policy framework

Inadequate administrative issuances for the health insurance scheme

16. The Secretary-General's 2009 bulletin on the procedures for the promulgation of administrative issuances required administrative instructions to be issued by the Under-Secretary-General for Management or other designated official to prescribe instructions and procedures to implement *inter alia*, the Staff Regulations and Rules. The bulletin also required officials responsible for promulgating and/or implementing administrative issuances to ensure that issuances were reviewed periodically so that the rules, instructions and procedures that they prescribe are up to date

17. The Staff Regulations and Rules required the Secretary-General to establish a health protection scheme and stipulated that staff members may be required to participate in the established medical insurance scheme. However, apart from the 1994 Secretary-General's bulletin on HLIC, the 1987 administrative instructions on MIP and the 2007 administrative instructions on ASHI, there was no administrative issuance prescribing the procedures covering important aspects of the health insurance scheme for staff. The Controller issued an annual information circular on the renewal of the United Nations Headquarters health insurance plans outlining eligibility criteria and administrative procedures. However, this was insufficient as, according to the 1997 Secretary-General's bulletin on information circulars, they may not be used to promulgate new rules, policies or procedures.

18. Furthermore, except for the processing of ASHI, there were no formal operating procedures to provide guidance on processes such as procuring and renewing the insurance plans, reviewing the plan design and offering, enrolling participants, and monitoring health insurance claims including preventing, detecting and investigating fraud and abuse.

19. The 1994 Secretary-General's bulletin on HLIC described the composition and reporting lines of the Committee; however, the bulletin did not describe its specific responsibilities. In practice, the Committee reviewed the utilization of healthcare benefits and changes to premiums, administrative service fees to TPAs and benefits coverage proposed by OPPBA.

20. Major groups of participants in the insurance scheme, namely staff members of the United Nations Development Programme and the United Nations Children's Fund as well as retirees only had observer status with no voting rights in the Committee. The Joint Negotiation Committee, to which HLIC reported, was a consultative body between management and staff members at New York only, even

though health insurance matters for international staff members outside New York, i.e., those covered under the Vanbreda plan, were also reviewed and decided by HLIC. There was therefore a mismatch in the representation of staff members at the Committee. Furthermore, there was no term limit for the members of the Committee. OIOS noted that new terms of reference for HLIC were drafted in 2013 by OPPBA but were yet to be promulgated; however, the draft terms of reference did not address the voting mechanism.

21. According to OPPBA, the three strategic objectives in administering and managing the health insurance scheme were to: (i) ensure that healthcare benefits continue to be competitive and in line with those offered by other large organizations and government entities; (ii) ensure that the various insurance plans are financially viable in the long run; and (iii) provide high-quality and timely services to staff members and retirees as well as organizations participating in the health insurance plans. However, OPPBA did not perform formal risk assessment exercises to identify the risks that may threaten the achievement of these objectives or define the methods for measuring performance against the objectives. Since 2011, no benchmarking exercise was conducted by OPPBA to evaluate the relative competitiveness and appropriateness of the United Nations plan offerings and design against peer organizations.

22. In the absence of an administrative instruction on the health insurance scheme, the policies and procedures governing the scheme were not appropriately promulgated and key information on the management of the scheme, including performance measurement, were not articulated. The outdated Secretary-General's bulletin on HLIC did not provide any assurance that the existing staff-management consultative mechanism on health insurance matters was efficient and effective. These weaknesses partly resulted in non-performance of some critical functions, as described in the present report.

**(1) The Department of Management should review and promulgate administrative issuances on the administration and management of the health insurance scheme and the related staff-management consultative mechanism.**

*OPPBA accepted recommendation 1 and stated that the new administrative instruction and information circular on MIP were issued in April 2015. The ASHI administrative instruction is expected to be published by December 2015 after the required consultations with stakeholders. The agreement reached with the Staff-Management Committee on the mandatory participation in the health insurance scheme will be elaborated on in the relevant administrative instruction. Regarding the administrative instruction on the staff-management consultative mechanism, the Department of Management needed to review and approve a revised framework for the Headquarters and field committees that could potentially provide for voting rights to staff members of the United Nations Development Programme and United Nations Children's Fund and a retiree group.* Recommendation 1 remains open pending notification that relevant administrative issuances on the administration and management of the health insurance scheme and the related staff-management consultative mechanism have been promulgated.

### (b) Operational control processes

Need to address the lack of formal agreements with TPAs

23. The Procurement Manual required that written procurement contracts be used to formalize every procurement action with a monetary value exceeding specific thresholds, currently $4,000.

24. The administrative service relationships with four of the five insurance companies reviewed by OIOS were entered into several years ago. The insurance companies were paid service fees ranging from

$520,000 to $7 million and processed total claims exceeding $300 million per year. However, OPPBA had no written agreements on file at the time of the audit that specified the terms and conditions of the relationship and the respective rights and obligations of the United Nations and the insurance companies. No re-solicitation exercise was conducted after the initial contracts were awarded.

25. In the absence of written contracts, OPPBA relied on the standard performance guarantees provided by the TPAs upon the annual renewal of the insurance plans to define the performance targets for different aspects of the routine services provided by them, including accuracy of processing and paying claims, efficiency of claims processing, client services and member satisfaction. All the targets were quantified and linked to a scale of penalty. However, some important services were not covered in the standard performance guarantees such as regular reporting and provision of claims data, monitoring of claims patterns, and detection and investigation of abuse and fraud. Furthermore, the performance guarantees were not always signed by OPPBA and the administrators. For the last three performance cycles, OPPBA was only able to provide two performance guarantees signed by one of the administrators.

26. OPPBA planned to conduct a solicitation exercise in 2013 for the insurance plans but so far HLIS was only able to do so for MIP due to insufficient capacity in the section. Previous attempts to obtain more resources by HLIS did not succeed due to the prevailing zero-growth budget environment and other priorities of the Organization. Implementation of the Umoja project and the additional workload caused by implementation of cost containment initiatives such as the enrollment of eligible retirees in Medicare, further strained the existing resources within HLIS.

27. A few technical factors also contributed to the solicitation not being conducted. First, the exercise was expected to be technically complex due to the fact that the award of the contract would be determined not only by the contract price, i.e., the administrative service fees, but also by the scale of the insurance network and level of discounts the carriers obtained. Second, the three United States-based carriers currently engaged by the Organization were already among the most competitive ones available, and hence re-bidding may not lead to significant savings. Third, a change of the carriers would cause disruption to both the participating entities and members. Additional studies would have to be performed to assess the level of disruption, and actions needed to manage the transition to any new TPAs. In the absence of formal agreements signed with the TPAs, there could be insufficient legal basis for the scope and level of services to be delivered, and hence the Organization may not be able to hold the administrators accountable in the case of unsatisfactory or non-delivery of expected services.

**(2) OPPBA should allocate resources to enable contracts to be established with the third-party administrators of the health insurance plans through effective solicitation processes.**

*OPPBA accepted recommendation 2 and stated that OPPBA would explore alternative means by which the resources needed to implement it can be established given the current tight budgetary environment. The efforts required in connection with a change in third party administrator of any of the plans cannot be underestimated. The Organization would not have the capacity to make worldwide changes in administrators in short succession since any transition required will impose a burden on HLIS to manage issues and educate the staff and retirees. In addition, the implementation of Umoja and the required changes in the way HLIS functions, as well as the adjustments made by the staff at large, will also affect the speed at which the solicitation process for all the remaining plans could be completed.* Recommendation 2 remains open pending notification that contracts with the third-party administrators of the health insurance plans have been established.

Need to ensure reasonableness of administrative fees paid to TPAs

28. The Procurement Manual stated that before extending a contract a comparative cost estimate (benchmarking) should be undertaken to determine if the prices under the contract are still competitive and less than the cost would be if the United Nations were to engage in formal competitive bidding.

29. No benchmarking or solicitation exercise was carried out by OPPBA to determine the administrative fees paid to the TPAs. Instead, the fees, expressed as a dollar amount per month per subscriber (staff and retirees), were periodically reset by applying a negotiated percentage increase or decrease to the existing fees. Upon endorsement by the HLIC, OPPBA submitted a case to renew the plans at re-negotiated administrative fees to the Headquarters Committee on Contracts on an annual basis. The Committee always approved the new fees and renewal of the plans. For the 2014-2015 plan year, total administrative fees for the four insurance plans were projected to be approximately $17 million, while current fees per subscriber were lower than five years ago for three of the four plans.

30. OPPBA explained that the administrative fees had not been benchmarked, mainly due to insufficient capacity of HLIS. Without benchmarking, there was no assurance that the fees paid to the administrators were reasonable.

**(3) OPPBA should allocate resources to the conduct of effective solicitation or benchmarking exercises to ensure the reasonableness of service fees paid to the third-party administrators of the health insurance plans.**

*OPPBA accepted recommendation 3 and stated that it would be implemented in conjunction with recommendation 2. For two of the health insurance plans, the "per subscriber per month" administrative fee amounts for the upcoming 2015-2016 plan years will be lower than those paid during the 2009-2010 plan years.* Recommendation 3 remains open pending notification of the measures taken to ensure the reasonableness of service fees paid to the TPAs.

Need to strengthen analytical monitoring and follow-up of action points

31. Management is expected to obtain or generate and use relevant, quality information to support the operation of the internal control function. Management should also perform periodic reviews to assess whether components of internal control are functioning as intended.

32. OPPBA did not request and analyze detailed claims data on an ongoing basis to identify claims trends by healthcare provider, type of service and subscriber/member. Instead, reliance was placed on the TPAs for such monitoring and analysis. However, advices and alerts from the administrators were not always timely or complete. For instance, one administrator alerted OPPBA in May 2012 that total claims processed by it for physical, occupational and speech therapies during 2011 were 700 per cent more than its book of business. The same administrator reported in March 2014 that the plan had seen unusually high claims at plan, provider and individual member levels for acupuncture in 2013. OPPBA met with one of the top providers to advise him to join the insurance network and to collect the co-share portion of fees that should be borne by participants. An annual reimbursement cap per member was also set for acupuncture in June 2014 by OPPBA. However, no further action was taken by either OPPBA or the administrator to determine if the paid acupuncture claims were legitimate and reasonable, i.e., whether fraud or abuse had occurred; therefore no provider or member was held accountable. OIOS analysis of detailed claims data also noted similar unusual patterns with physical therapy claims reimbursed by the same administrator in 2014, which was not raised by the administrator and addressed by OPPBA.

33. In order to encourage health insurance participants to use services supplied by in-network providers with whom the insurance companies had obtained deep discounts through contracts, OPPBA established annual deductibles, coinsurance and out-of-pocket maximum amounts for reimbursing out-of-network healthcare claims. According to the report of one of the TPAs for the period September 2012 to August 2013, use of in-network providers by active staff and their dependents accounted for 80 per cent of claim payments, while that for retirees was at 86.6 per cent, in comparison to 94.2 per cent for its book of business for both groups. A second TPA reported for the period July 2012 to June 2013 an in-network utilization ratio of 79.2 per cent, against 87.7 per cent of its book of business. The statistics of the dental plan for United Nations participants were slightly higher than those of its book of the business, but also indicated significant room to increase use of in-network providers and save cost. The lost discounts arising from such high levels of services obtained from out-of-network providers were significant. The audit team estimated that the Empire plan alone had incurred approximately $7.7 million more, or 6.5 per cent of the total payments, due to lower in-network utilization during the period September 2012 to August 2013.

34. While noting that a small proportion of healthcare services was obtained from non-domestic suppliers at the United Nations, which were out of the networks of the US-based plans, OPPBA and HLIC members interviewed during the audit concurred that the higher levels of out-of-network healthcare services used by the plan members was a major contributor to the cost of the insurance plans, particularly the two medical plans. The TPAs had also consistently recommended that actions be taken to increase in-network utilization by increasing co-insurance percentage and deductibles to industry levels and by educating members on how to find in-network providers. The deductible, coinsurance and annual out-of-pocket maximums were not raised to higher levels partly due to the difficulty to reach consensus at HLIC, although Management's authority on health insurance matters was not invoked.

35. According to OPPBA, insufficient capacity of HLIS was the main reason not conducting adequate monitoring and analysis of the claims and undertaking follow-up actions. Lack of written contracts with TPAs also resulted in gaps in understanding and fulfilling responsibilities in preventing, detecting and investigating fraud and abuse between OPPBA and the administrators. Plan participants were also not aware of the distinction between in-network and out-of-network services and their cost implications.

36. Without effective analytical monitoring and follow-up action, the health insurance plans would likely continue to experience unusual claims patters and higher utilization of out-of-network services and incur associated high costs.

**(4) OPPBA should allocate resources to the monitoring and analysis of health insurance data in order to proactively manage risks and take advantage of opportunities to optimize plan designs, contain costs and prevent waste due to fraud and abuse.**

*OPPBA accepted recommendation 4 and stated that a dedicated staff member with statistical or actuarial background would be ideally devoted to this work, subject to the identification of resources to fund the position. OPPBA would also work on developing communication materials that could be used to educate staff and retirees on the need to use in-network providers in order to control costs.* Recommendation 4 remains open pending notification that resources to monitor and analyze health insurance data and take necessary follow-up actions have been allocated.

Need to review payment of charges for out-of-network services

37. Industry practice suggests that out-of-network healthcare services should be reimbursed at usual, customary and reasonable (UCR) rates. A national not-for-profit corporation published two sets of such

rates for medical and dental procedures by geographical area in the United States that were widely used in the healthcare industry as the basis for reimbursing out-of-network services: UCR-based and Medicare-based. Additionally, the TPAs were required to process claims accurately according to the performance guarantees agreed between them and OPPBA.

38. One United Stated-based medical plan TPA used UCR-based rates while the other used 395 per cent of Medicare rates as allowable charges for reimbursing out-of-network claims, per OPPBA authorization. The latter rate was authorized, based on a suggestion by the TPA that it would put the United Nations on par with "good employers". OPPBA did not perform further research to determine the continued reasonableness of the rates against industry practices/trend or the rates adopted by peer organizations.

39. The audit team analyzed claims related to the top 20 medical procedures both by unit cost and by total payments processed by one of the TPAs during the period January to September 2014 and identified several cases where the actual payment for a specific procedure significantly exceeded the 395 per cent of Medicare rates. The administrator was yet to explain or acknowledge these observations.

40. OPPBA relied on contractual audits of the TPAs conducted every three to four years to ascertain the accuracy of the claims processed and paid by the administrators, including out-of-network claims; however, these audits only identified minor processing errors.

41. Inadequate monitoring and compliance with industry practices may result in higher reimbursement and cost in relation to out-of-network healthcare services. Lack of capacity and inadequate performance of contractual audits led OPPBA not to request and analyze the claims processed and paid.

42. High reimbursable charges for out-of-network service and paying for out-of-network services at rates above the authorized rates will result in higher costs.

**(5) OPPBA should allocate resources to reevaluate the authorized reimbursement rates for out-of-network healthcare services against industry practices and ensure that reimbursements of out-of-network claims do not exceed authorized rates.**

*OPPBA accepted recommendation 5 and stated that OPPBA was committed to completing a solicitation process in 2015 to identify an external firm that will review the work of TPAs in the first half of 2016 and ensure that reimbursements of out-of-network claims are in accordance with authorized rates. OPPBA would also work with the TPAs and other international governmental organizations based in the United States regarding the basis for reimbursing out-of-network expenses to facilitate a review of those set for the United Nations' United States-based plans.* Recommendation 5 remains open pending notification of the results of the review of the reimbursement rates for out-of-network services and the related claims processed by TPAs.

Need to establish an effective vendor performance management process

43. The Procurement Manual specified that vendors' performance should be managed effectively and evaluated formally once a year.

44. OPPBA did not monitor the administrators' performance by using a system to capture performance data and compute performance statistics. Reports on the targets that were included in performance guarantees were expected to be submitted by the administrators themselves; however, no such reports were submitted. Furthermore, the administrators' performance was not evaluated.

45. OPPBA acknowledged that contract management was an area of their responsibilities that was not adequately carried out mainly due to insufficient capacity in HLIS. Without effective management, under-performance by the TPAs may not be detected timely and managed, and remedial action taken.

**(6) OPPBA should allocate resources to institutionalize adequate performance management processes for the third-party administrators of the health insurance plans.**

*OPPBA accepted recommendation 6 and stated that OPPBA would strengthen the conclusion of performance guarantees with all TPAs for the upcoming plan year with the first full cycle of performance management expected to be completed at the end of the 2015-2016 plan year.* Recommendation 6 remains open pending receipt of a copy of the first set of performance evaluation reports on the TPAs.

# IV. ACKNOWLEDGEMENT

46. OIOS wishes to express its appreciation to the Management and staff of the Department of Management for the assistance and cooperation extended to the auditors during this assignment.

(*Signed*) David Kanja
Assistant Secretary-General for Internal Oversight Services

**ANNEX I**

## STATUS OF AUDIT RECOMMENDATIONS

### Audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Recom. no. | Recommendation | Critical[2]/ Important[3] | C/ O[4] | Actions needed to close recommendation | Implementation date[5] |
|---|---|---|---|---|---|
| 1 | The Department of Management should review and promulgate administrative issuances on the administration and management of the health insurance scheme and the related staff-management consultative mechanism. | Critical | O | Promulgation of relevant administrative issuances on the administration and management of the health insurance scheme and the related staff-management consultative mechanism. | 31 December 2016 |
| 2 | OPPBA should allocate resources to enable contracts to be established with the third-party administrators of the health insurance plans through effective solicitation processes. | Critical | O | Establishment of contracts with TPAs. | 31 December 2018 |
| 3 | OPPBA should allocate resources to the conduct of effective solicitation or benchmarking exercises to ensure the reasonableness of service fees paid to the third-party administrators of the health insurance plans. | Important | O | Notification of measures taken to ensure the reasonableness of service fees paid to TPAs. | 31 December 2018 |
| 4 | OPPBA should allocate resources to the monitoring and analysis of health insurance data in order to proactively manage risks and take advantage of opportunities to optimize plan designs, contain cost and prevent waste due to fraud and abuse. | Critical | O | Notification that resources to monitor and analyze health insurance data and take necessary follow-up actions have been allocated. | 31 December 2016 |
| 5 | OPPBA should allocate resources to reevaluate the authorized reimbursement rates for out-of-network healthcare services against industry practices and ensure that reimbursements of out-of-network claims do not exceed authorized rates. | Important | O | Notification of the results of the review of the reimbursement rates for out-of-network services and the related claims processed by TPAs. | 30 June 2016 |
| 6 | OPPBA should allocate resources to institutionalize adequate performance management processes for | Important | O | Receipt of a copy of the first set of performance evaluation reports on the TPAs. | 30 June 2016 |

[2] Critical recommendations address significant and/or pervasive deficiencies or weaknesses in governance, risk management or internal control processes, such that reasonable assurance cannot be provided regarding the achievement of control and/or business objectives under review.
[3] Important recommendations address important deficiencies or weaknesses in governance, risk management or internal control processes, such that reasonable assurance may be at risk regarding the achievement of control and/or business objectives under review.
[4] C = closed, O = open
[5] Date provided by the Department of Management in response to recommendations.

**ANNEX I**

## STATUS OF AUDIT RECOMMENDATIONS

### Audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Recom. no. | Recommendation | Critical[2]/ Important[3] | C/ O[4] | Actions needed to close recommendation | Implementation date[5] |
|---|---|---|---|---|---|
| | the third-party administrators of the health insurance plans. | | | | |

# APPENDIX I

# Management Response

United Nations Nations Unies

INTEROFFICE MEMORANDUM MEMORANDUM INTERIEUR

TO: Ms. Muriette Lawrence-Hume, Officer-in-Charge DATE: 19 May 2015
A: New York Audit Service, Internal Audit Division
Office of Internal Oversight Services

THROUGH: Christian Saunders, Director
S/C DE: Office of the Under-Secretary-General for Management

FROM: Mario Baez, Chief, Policy and Oversight Coordination Service
DE: Office of the Under-Secretary-General for Management

SUBJECT: **Draft report on an audit of the administration and management of the health**
OBJET: **insurance scheme at United Nations Headquarters (Assignment No. AH2014/511/01)**

1. With reference to your memorandum dated 1 May 2015, please find attached Management comments on the above subject draft report.

2. Thank you for giving us the opportunity to provide comments on the draft report.

15-01327
20 May 2015

**Appendix I**

## Management Response

## Draft report on an audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Rec. no. | Recommendation | Critical[1]/ Important[2] | Accepted? (Yes/No) | Title of responsible individual | Implementation date | Client comments |
|---|---|---|---|---|---|---|
| 1 | The Department of Management should review and promulgate administrative issuances on the administration and management of the health insurance scheme and the related staff-management consultative mechanism. | Critical | Yes | Chief, Insurance and Disbursement Service (IDS) and Chief, Health and Life Insurance Section (HLIS) for the administrative instructions<br><br>USG/DM and USG/DFS for the staff-management consultative mechanism | 31 December 2016 | The new administrative instruction and information circular on the MIP were issued in April 2015. These are available on the United Nations Health and Life Insurance Section website, http://www.un.org/insurance/plans/medical-insurance-plan-mip).<br><br>OPPBA has recently received comments on the draft revisions to the ASHI administrative instruction following the required consultations with stakeholders, and these are being reviewed. Revisions to the draft are expected by the end of June 2015 at which time the final draft will be submitted to OHRM for further review and submission to OLA. It is expected that the revised administrative instruction for ASHI will be published by December 2015.<br><br>On paragraph 25, OIOS indicated that the administrative instruction on health insurance was put on hold pending a decision by the Management Committee to make |

[1] Critical recommendations address significant and/or pervasive deficiencies or weaknesses in governance, risk management or internal control processes, such that reasonable assurance cannot be provided regarding the achievement of control and/or business objectives under review.

[2] Important recommendations address important deficiencies or weaknesses in governance, risk management or internal control processes, such that reasonable assurance may be at risk regarding the achievement of control and/or business objectives under review.

**Appendix I**

## Management Response

## Draft report on an audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Rec. no. | Recommendation | Critical[1]/ Important[2] | Accepted? (Yes/No) | Title of responsible individual | Implementation date | Client comments |
|---|---|---|---|---|---|---|
| | | | | | | health insurance participation mandatory. On 18 April 2015, a session was held by OPPBA at the Staff-Management Committee session in Bonn in order to discuss and agree on the modalities of the proposal. The agreements reached will be elaborated in the administrative instruction on the health insurance scheme.<br><br>Regarding the administrative instruction on the staff-management consultative mechanism, considerable work will first need to be undertaken by DM to review and approve a revised framework for the Headquarters and field committees that could potentially provide for voting rights by UNDP, UNICEF and a retiree group. |

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## Management Response

## Draft report on an audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Rec. no. | Recommendation | Critical[1]/ Important[2] | Accepted? (Yes/No) | Title of responsible individual | Implementation date | Client comments |
|---|---|---|---|---|---|---|
| 2 | OPPBA should allocate resources to enable contracts to be established with the third-party administrators of the health insurance plans through effective solicitation processes. | Critical | Yes | Chief, IDS and Chief, HLIS | Completion of solicitation for US plans:<br>30 June 2017*<br><br>Completion of solicitation for United Nations Worldwide Plan:<br>31 December 2018*<br><br>* Assumes that the required additional resources are provided by 2016 | OPPBA will explore alternative means by which the resources needed to implement this recommendation can be established given the current tight budgetary environment.<br><br>It should also be highlighted that the efforts required in connection with a change in third party administrator of any of the plans cannot be underestimated. The Organization will not have the capacity to make worldwide changes in administrators in short succession since any transition required will impose a burden on HLIS to manage issues and educate the staff and retirees. In addition, the implementation of Umoja and the required changes in the way the HLIS functions, as well as the adjustments made by the staff at large, will also affect the speed by which this solicitation process for all the remaining plans can be completed. |

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## Management Response

## Draft report on an audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Rec. no. | Recommendation | Critical[1]/ Important[2] | Accepted? (Yes/No) | Title of responsible individual | Implementation date | Client comments |
|---|---|---|---|---|---|---|
| 3 | OPPBA should allocate resources to the conduct of effective solicitation or benchmarking exercises to ensure the reasonableness of service fees paid to the third-party administrators of the health insurance plans. | Important | Yes, but please see comments | Chief, IDS and Chief, HLIS | Completion of solicitation for US plans:<br>30 June 2017*<br><br>Completion of solicitation for United Nations Worldwide Plan:<br>31 December 2018*<br><br>* Assumes that the required additional resources are provided by 2016 | This recommendation will be implemented when recommendation #2 above is implemented. OPPBA requests the two recommendations to be combined into one.<br><br>It is also worth mentioning that, for the Aetna and Empire Blue Cross plans, the "per subscriber per month" administrative fee amounts for the upcoming 2015-2016 plan year are lower than the those paid during the 2009-2010 plan years. |
| 4 | OPPBA should allocate resources to the monitoring and analysis of health insurance data in order to proactively manage risks and take advantage of opportunities to optimize plan designs, contain cost and prevent waste due to fraud and abuse. | Critical | Yes | Chief, IDS and Chief, HLIS | 31 December 2016 | As previously indicated, a dedicated staff member with statistical or actuarial background would be ideally devoted to this work and will be subject to identification of resources to fund the position. |
| 5 | OPPBA should strengthen its capacity to monitor and analyze claims data and use the results to enhance controls to encourage members to use in-network healthcare service providers and control the costs of the insurance plans. | Important | Yes | Chief, IDS and Chief, HLIS | 31 December 2016 | This recommendation is related to recommendation #4 as far as data analysis is concerned. Nevertheless, OPPBA will work on developing communication materials in the interim that can be used to educate staff and retirees on the need to use in-network providers in order to control costs. |

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## Management Response

## Draft report on an audit of the administration and management of the health insurance scheme at United Nations Headquarters

| Rec. no. | Recommendation | Critical[1]/ Important[2] | Accepted? (Yes/No) | Title of responsible individual | Implementation date | Client comments |
|---|---|---|---|---|---|---|
| 6 | OPPBA should allocate resources to reevaluate the authorized reimbursement rates for out-of-network healthcare services against industry practices and ensure that reimbursements of out-of-network claims do not exceed authorized rates. | Important | Yes | Chief, IDS and Chief, HLIS | 30 June 2016 | OPPBA is committed to completing a solicitation process in 2015 to identify an external firm that will review the work of the third party administrators in the first half of 2016 and ensure that reimbursements of out-of-network claims are in accordance with authorized rates.<br><br>OPPBA will also work with third party administrators as well as other international governmental organizations based in the US regarding basis for reimbursing out-of-network expenses to facilitate a review of those set for the United Nations' US-based plans. |
| 7 | OPPBA should allocate resources to institutionalize adequate performance management processes for the third-party administrators of the health insurance plans. | Important | Yes | Chief, IDS and Chief, HLIS | 30 June 2016 | OPPBA will strengthen the conclusion of performance guarantees with all the third party administrators for the upcoming plan year with the first full cycle of performance management expected to be completed at the end of the 2015-2016 plan year. |