



INTERNAL AUDIT DIVISION

REPORT 2020/045

Audit of medical insurance claims at the United Nations Office at Geneva

**Some aspects of the operational and internal
control framework need to be strengthened to
enhance the efficiency and effectiveness of
medical insurance claims processing**

1 December 2020

Assignment No. AE2020-310-01

Audit of medical insurance claims at the United Nations Office at Geneva

EXECUTIVE SUMMARY

The Office of Internal Oversight Services (OIOS) conducted an audit of medical insurance claims at the United Nations Office at Geneva (UNOG). The objective of the audit was to assess the adequacy, efficiency and effectiveness of the arrangements for processing medical insurance claims at UNOG. The audit covered the period from 1 January 2018 to 31 December 2019 and included a review of risk areas relating to: (a) timeliness and efficiency in processing claims; (b) legitimacy and accuracy of claims; and (c) support and feedback mechanisms.

There were adequate mechanisms to measure and monitor performance and processing timelines of medical insurance claims, and the timelines were generally achieved. However, some aspects of the operational and internal control framework needed to be strengthened to enhance the efficiency and effectiveness of medical insurance claims processing.

OIOS made nine recommendations. To address issues identified in the audit, the Medical Insurance Section at UNOG needed to:

- Assess the case for establishing a dedicated medical advisor post by taking into consideration the workload statistics and other relevant factors;
- Prepare an overarching planning document that captures its plan, vision and strategy over a 3 to 5-year horizon;
- Prepare standard operating procedures for all key processes including processing payments to members and service providers;
- Strengthen the ex post facto review policy and the arrangements for identifying and addressing overlaps and potential duplicate claims;
- Establish a system for dealing with exceptions to the requirement for prescriptions and ex post facto approvals to enhance consistency and compliance with established requirements;
- Ensure that the Internal Rules and website are updated to accurately and clearly reflect the approved benefits relating to home care in lieu of hospitalization, expensive medicine, psychiatry bills and funeral expenses;
- Assess fraud risks in accordance with the anti-fraud and anti-corruption framework and update the fraud mitigation strategies;
- Update and redesign the website to better communicate all important elements relating to the medical insurance plan; and
- Establish a system for filing queries and feedback received and ensure that lessons learned are identified and addressed.

UNOG accepted the recommendations and has initiated action to implement them.

CONTENTS

I. BACKGROUND	1
II. AUDIT OBJECTIVE, SCOPE AND METHODOLOGY	1-2
III. AUDIT RESULTS	2-10
A. Timeliness and efficiency	2-4
B. Legitimacy and accuracy of claims	4-9
C. Support and feedback mechanisms	9-10
IV. ACKNOWLEDGEMENT	10
ANNEX I	Status of audit recommendations
APPENDIX I	Management response

Audit of medical insurance claims at the United Nations Office at Geneva

I. BACKGROUND

1. The Office of Internal Oversight Services (OIOS) conducted an audit of medical insurance claims at the United Nations Office at Geneva (UNOG).
2. The United Nations Staff Mutual Insurance Society against Sickness and Accident (UNSMIS) was established in 1949 pursuant to Article 6.2 of the United Nations Staff Regulations which requires the Secretary-General to establish a scheme of social security for staff including reasonable compensation in the event of illness or accident. UNSMIS is a self-funded scheme regulated by its Statute and a set of Internal Rules. Its main objective is to reimburse, within limits laid down in its Internal Rules, medical expenses incurred by its members arising from sickness, accident and maternity. Claims are financed through premiums collected from staff, retirees and participating organizations in accordance with cost-sharing ratios approved by the General Assembly.
3. According to UNSMIS' Statute, decisions relating to its operations, amendments to the Internal Rules, and contribution levels are made by the Director-General of UNOG within the framework of the Internal Rules. An Executive Committee comprising of seven members provides advice to the Director-General. The UNOG Medical Insurance Section (MIS) provides secretariat services to UNSMIS. MIS is headed by a P-5 (Senior Benefits Officer) who reports to the Chief of the Financial Resources Management Service. In 2020, MIS had a total of 34 regular staff (1 P-5, 1 P-4, 1 P-3, 1 P-1 and 30 General-Service).
4. UNSMIS serves over 31,000 staff, retirees and eligible dependents across 27 United Nations organizations, funds, programmes and offices of the United Nations Secretariat, with the United Nations High Commissioner for Refugees (UNHCR) being its largest client. The total number of claims processed in 2018 and 2019 was 122,000 and 136,000, respectively, while the total amount reimbursed for the claims submitted in both years was approximately CHF 209 million (approximately \$227 million). MIS' operational budget for the 2018-2019 biennium was \$9.8 million and actual expenditure was \$9.5 million.
5. Comments provided by UNOG are incorporated in italics.

II. AUDIT OBJECTIVE, SCOPE AND METHODOLOGY

6. The objective of the audit was to assess the adequacy, efficiency and effectiveness of the arrangements for processing medical insurance claims at UNOG.
7. This audit was included in the 2020 risk-based work plan of OIOS due to inherent risks associated with processing large volumes of medical claims.
8. OIOS conducted this audit from March to August 2020. The audit covered the period from 1 January 2018 to 31 December 2019. Based on an activity-level risk assessment, the audit covered risk areas relating to: (a) timeliness and efficiency in processing claims; (b) legitimacy and accuracy of claims; and (c) support and feedback mechanisms.
9. The audit methodology included: (a) interviews with key personnel; (b) review of relevant documentation; (c) analytical review of data; (d) re-performance of calculations; and (e) sample testing. Due to the telecommuting arrangements that were in place at the time of the audit in view of the COVID-19 pandemic, paper claims were not accessible. Therefore, only claims processed through the e-claims portal were sampled for detailed testing.

10. The audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.

III. AUDIT RESULTS

A. Timeliness and efficiency

Processing timelines were monitored, and targets agreed with clients were achieved

11. OIOS' analysis of the 2018-2019 claims data showed that the average claim processing timelines from the claim submission date was approximately 13.4 calendar days. This was within the 4 to 5-week target established in Memorandum of Understanding between MIS and its clients. In total, approximately 97 per cent of the claims were processed within five weeks. Performance targets of number of invoices that staff were required to process per day were established and used in the evaluation of staff performance. The "UNSMIS Dashboard Operations" application was used to monitor the workload and timeliness indicators. In addition, the ageing of outstanding claims was monitored and reported in the end of year assessment report and in presentations to the Executive Committee. MIS indicated that it will start reporting the average processing timelines in the end of year assessment reports. OIOS therefore concluded that there were adequate mechanisms to measure and monitor performance and processing timelines.

Need to review the arrangements for the medical advisor role

12. Having an appropriate staffing level and structure is essential for optimizing the efficiency and cost effectiveness of processing medical claims. MIS regularly reviewed and adjusted its structure and had prepared staffing and workload analysis that were used to justify new posts, including the five new posts established during 2018-2019. The increase in staff and workload during this period was mostly due to the integration of an additional 3,000 insured members of the International Telecommunications Union into UNSMIS.

13. The role of medical advisor, which entails the pre-authorization of certain medical treatments as defined in the UNSMIS Internal Rules, is integral to the overall efficiency and effectiveness of claim processing. Therefore, the arrangements for performing the role should be regularly reviewed, as part of the review of staffing and structure, to ensure that they continue to be optimal. Prior to 2020, MIS did not maintain statistics on number of cases submitted to the medical advisors for approval but it is reasonable to assume that the workload has increased at a proportion similar to the increase in number of members and claims. MIS stated that it considered changing the arrangements for the medical advisor's role in the context of discussions regarding the establishment of a Walk-in Clinic, but the assessment had not been done and ultimately the Walk-in-Clinic project did not go ahead.

14. OIOS' review of claims and interviews with medical advisors and staff showed that there is a need to assess whether it would be more beneficial for UNSMIS to have its own dedicated medical advisor instead of the current arrangements where the role is performed by the medical doctors of UNOG and UNHCR. The fact that the medical advisors performed the role in addition to their core functions as medical doctors impacted their ability to regularly follow up and implement case management, which could help to reduce costs and better support members. There were also other shortcomings with the current arrangements that needed to be considered including: (a) the risk of inconsistencies in decision-making by the two medical advisors; (b) potential conflict of interest between the medical doctors' role as medical advisors for UNSMIS and their role as occupational doctors for the Organization; and (c) delays associated with the approval process which was still manual, and historical information of prior cases was not readily available.

15. OIOS was informed that medical insurance programmes of other organizations in Geneva have dedicated medical advisors and therefore, opportunities exist for MIS to benchmark with them. MIS had also started maintaining workload and timeliness statistics of the cases submitted to the medical advisors in 2020 which could provide insights on the resources needed for this function. Further, since MIS had several other planned and ongoing initiatives as discussed later in the present report, it is essential that the case for a dedicated medical advisor is assessed in conjunction with other planned initiatives to ensure that overall operational costs are taken into account in the assessment.

(1) The UNOG Medical Insurance Section should assess the case for establishing a dedicated medical advisor post by taking into consideration the workload statistics and other relevant factors.

UNOG accepted recommendation 1. Recommendation 1 remains open pending receipt of evidence that a business case for establishing a dedicated medical advisor post has been prepared and submitted to UNOG senior management.

Need to prepare an overarching document showing the strategy and planned initiatives over 3 to 5 years

16. MIS rolled out the e-claims portal (system for online submission of claims) in 2018 and has over the last couple of years implemented various changes and improvements on this portal as well as the claim processing system. In addition, MIS plans to implement a Robotic Process Automation solution for administrative and claim processes and to outsource the development of data mining and trending analysis tools for fraud detection.

17. MIS prepared work plans that outlined the ongoing and new initiatives planned for the year and had documented its information technology roadmap. The website and the statutes summarized the ultimate objectives of UNSMIS. Interviews and discussions with staff showed that MIS had a vision of various other initiatives to its operational arrangements in the medium to long term aimed at further strengthening the efficiency and effectiveness of claim processing. It would be useful for MIS to prepare an overarching planning document to better present its strategy and planned initiatives over a 3 to 5-year horizon. This would facilitate a more comprehensive assessment of the planned initiatives and help ensure that overall long-term benefits and costs and any impact on staffing levels and structure are adequately considered. It would also assist in determining the most appropriate phasing and timing of the initiatives and facilitate support and oversight by UNOG management and the Executive Committee. Some of the gaps and recommendations raised in this audit report may also need to be implemented beyond a one-year horizon and could be incorporated in such a long-term plan.

(2) The UNOG Medical Insurance Section should prepare an overarching planning document that captures its plan, vision and strategy over a 3 to 5-year horizon.

UNOG accepted recommendation 2 and stated that MIS will prepare a document capturing its vision and strategy. Recommendation 2 remains open pending receipt of evidence that MIS has documented its vision and strategy over a 3 to 5-year horizon.

Need to document standard operating procedures for all key processes

18. To guide the claim processors, MIS had developed standard operating procedures for standard claims, hospitalization and direct payments in the United States of America. MIS also maintains a compendium of practices where it records frequently asked questions and clarification to the rules to enhance consistency and efficiency in processing of claims. However, the procedures and workflow for processing payments were not documented. The procedures for processing members' bank details and

direct payments to service providers were also not documented. Documenting procedures is vital in ensuring clarity and consistency and for training of new employees. It could also help in identifying gaps and potential opportunities for efficiency gains. For instance, with regard to direct payments to service providers, OIOS' review of a sample of hospital claims showed that due to some limitations of the claim processing system, the procedures were convoluted and sometimes inconsistent. The procedures would benefit from being streamlined, documented and clearly communicated to all concerned.

(3) The UNOG Medical Insurance Section should prepare standard operating procedures for all key processes including processing payments to members and service providers.

UNOG accepted recommendation 3. Recommendation 3 remains open pending receipt of evidence that standard operating procedures for processing payments to members and service providers and related banking details have been established and implemented.

B. Legitimacy and accuracy of claims

Need to improve the arrangements for conducting ex post facto reviews of claims

19. MIS must continuously manage the inherent risk of errors and inconsistencies associated with processing a large number of medical claims from different parts of the world under a complex set of Internal Rules. As part of its quality control framework, MIS performs independent reviews of all claims with reimbursements above CHF 5,000. This figure used to be CHF 10,000 and was lowered to CHF 5,000 in 2018. OIOS' detailed testing of a random sample of 112 claims did not identify any financial errors in claims with reimbursements above CHF 5,000 while for claims below CHF 5,000, financial errors totaling CHF 7,081 were identified in five of the claims. OIOS also reviewed a separate sample of 22 large hospital e-claims above CHF 40,000 and did not identify any processing errors. This showed that the independent review of claims was effective in reducing the risk of errors, and that controls for processing claims above CHF 5,000 were satisfactory.

20. For claims below CHF 5,000, MIS did not carry out independent reviews of each claim, similar to the reviews carried out for claims above CHF 5,000. Management considered that such reviews would not be cost effective and would slow down claim processing given the large volume of low value claims involved. In the last quarter of 2018 MIS opted to invest in ex post facto internal reviews of a sample of all claims which enhanced the control framework. Since the ex post facto reviews are the only quality control mechanism for the claims below CHF 5,000 and such claims constitute almost 50 per cent of the total value of claims processed, it is essential that they are properly designed and consistently done to optimize their effectiveness.

21. However, MIS had not established timelines for the ex post facto reviews and there were inconsistencies. The review for the three-month period ending February and May 2019 were done after two months and four months respectively, and as at July 2020 no reviews had been done for the period since June 2019. The sampling methodology was also not consistent and needed to be refined based on experience to date. OIOS is of the view that the risk-based approach used in the last internal review done in June 2019 that focused on claims below CHF 5,000 was a good approach since claims above CHF 5,000 are already subject to detailed review at the time of processing. OIOS' detailed testing of claims also showed that claims relating to psychology seemed to have a relatively higher risk of errors than standard physician, dental or optical claims where no errors were noted. MIS could consider giving such higher risk categories of claims a greater weight in the sampling criteria.

22. Further, of the five claims that had errors with financial impact, two appeared to be one-off errors but the other three were more systemic in nature. They related to duplicate invoices that were not flagged by the claim processing system and ended up being reimbursed twice. These included: (a) three invoices relating to one member that were submitted and reimbursed twice resulting in overpayment of CHF 1,556; and (b) one invoice for CHF 4,786 that was paid twice, first as a direct payment to the service provider and subsequently to the member. MIS subsequently identified and recovered the overpayment of CHF 917 relating to one of the claims. However, the fact that the claim processing system did not flag such obvious duplicates shows that the system cannot be fully relied on to identify duplicates and overlaps in the course of claim processing. There is need to either upgrade the system or supplement it with ex post facto checks to reduce the risk of duplicate errors going undetected. This is because such duplicate errors can potentially tip the financial error rate to go beyond the established tolerance limit of two per cent, as was the case in the random sample of 112 claims reviewed during the audit.

(4) The UNOG Medical Insurance Section should: (a) update the ex post facto review policy to include clear timelines for conducting the reviews and clearly defined risk-based sampling criteria; and (b) strengthen the arrangements for identifying and addressing overlaps and potential duplicate claims.

UNOG accepted recommendation 4. Recommendation 4 remains open pending receipt of evidence that the ex post facto review policy has been updated and arrangements for identifying and addressing overlaps and potential duplicate claims strengthened.

Need to improve the enforcement of prescription and ex post facto approval requirements

23. Prescriptions are part of the evidence members are required to provide to support the validity of claims for medication and some medical treatments. The Frequently Asked Questions section of the UNSMIS website outlines the prescription requirements. It states that in the absence of a prescription from a medical doctor, no reimbursement for treatment or medication is payable, and that the number of sessions needs to be defined for repeat prescriptions and prescriptions over six months. OIOS' review of a sample of claims showed that these requirements were not consistently and fully enforced as discussed below:

(a) For one of the members sampled, out of 14 psychology claims totaling CHF 17,226, four claims were processed without prescriptions while two claims were rejected for not having a prescription.

(b) Another five claims by the same member had the same prescription used in all the five claims but the prescription did not state the number of sessions as required. In another claim, this requirement was correctly enforced and the claim was rejected because the number of sessions was not stated in the prescription.

(c) One claim for a psychology session was allowed without a valid prescription while the next claim by the same member was rightfully rejected, and the member was asked to obtain a new subscription.

(d) Osteopath treatment in one claim was allowed without a prescription.

(e) In another claim, the prescription provided was from a physiotherapist and not a medical doctor as required.

(f) In yet another case, the prescription was ex post facto by four months; the prescription was dated 25 April 2018 and the bill from the pharmacy was dated 29 December 2017. MIS explained that since the claim was for a recurring medication, the claim processor judged that there was no reason to reject the

claim. Allowing such a claim without questioning, informing or alerting the member could create a perception of laxity in enforcing the established requirements.

24. While it is understandable that there would be situations where exceptions may be necessary given the sensitive nature of medical claims, this must be balanced with the need to ensure that insured members are treated consistently in accordance to established requirements as well as the need to ensure claims are adequately supported. MIS needs to establish an approach/mechanism for dealing with exceptions which could include a combination of a reminder and warning system in cases where there is rationale to justify exceptions; and internal review of exceptions granted.

25. Similarly, the requirement for prior approval by the medical advisors was not consistently complied with and enforced. In the sample reviewed, there were ex post facto approvals in seven of the claims where prior approval was needed. Interviews with the Medical Advisors also confirmed that there are normally many cases of ex post facto approvals. Ex post facto approvals negate the rationale and purpose of requiring pre-approvals and there is a potential risk that they could affect the decisions on whether to authorize a treatment or not since costs have already been incurred. Similar to the prescriptions issue, there is need to establish a mechanism for dealing with exceptions to minimize inconsistencies and to avoid creating a perception of laxity in enforcing the established requirements.

(5) The UNOG Medical Insurance Section should establish a system for dealing with exceptions to the requirement for prescriptions and ex post facto approvals to enhance consistency and compliance with established requirements.

UNOG accepted recommendation 5 and stated that MIS will implement a simple system, considering the limited resources available. Recommendation 5 remains open pending receipt of details of the system established for dealing with exceptions to the requirements for prescriptions and ex post facto approvals.

Need to clarify and update some aspects of the rules to ensure alignment with existing practices

26. The detailed review of claims showed four areas where the practices for reimbursements were not fully aligned to the UNSMIS Internal Rules as explained below.

(a) Home care in lieu of hospitalization

27. MIS applied supplementary benefits to home care in lieu of hospitalization claims. However, according to the Internal Rules the home care claims should be reimbursed under the same conditions as long term hospitalization which does not have supplementary benefits. MIS stated that this was a typing error in the Internal Rules. The Internal Rules need to be updated to ensure alignment with existing practices.

(b) Expensive medicine

28. Although the Internal Rules state that supplementary benefits are not applicable to pharmaceutical expenses, MIS applied supplementary benefits to what it categorized as “expensive medicine”; which it defined as medicine for chronic illnesses that costs over CHF 500 per month. MIS stated that this was approved by the Executive Committee several years back. However, there was no documentation showing the approval and the Internal Rules had not been updated to reflect the expensive medicine provision. The section of the website dealing with pharmaceutical expenses did not also explain this benefit and therefore members were not well informed of it. The MIS internal compendium of practices stated that supplementary benefit would be applicable to expensive medicine, but that prior approval should be

obtained. No such approvals were attached to the “expensive medicine” claims in the sample OIOS reviewed. The benefit as well as the related requirements needs to be clarified and the Internal Rules updated accordingly.

(c) Linkage between psychiatrist and psychology bills

29. According to the Internal Rules, outpatient psychiatrist bills are limited to six times a year. In practice, MIS reclassifies psychiatrist bills above the authorized limits (six claims) as psychology bills and reimburses them if a member still has credit in their psychology benefits. This is not explicitly stated in the Internal Rules or website and may therefore not be known to all members.

(d) Funeral expenses

30. MIS indicated that it applies an 80 per cent cap and reimburses the lower of CHF 1,000 and 80 per cent of the amount claimed. However, the Internal Rules only indicate a lump sum of CHF 1,000 and do not state the 80 per cent limit. This is a relatively minor benefit but nonetheless it is essential that its determination is accurately reflected in the Internal Rules.

31. The above gaps need to be addressed to ensure that the benefits are appropriately approved and clearly communicated to members. The home care and expensive medicines in particular are important since they affect the computation of supplementary benefits which is an important element in the design of the UNSMIS medical plan aimed at limiting members’ financial liability.

(6) The UNOG Medical Insurance Section should ensure that the Internal Rules and website are updated to accurately and clearly reflect the approved benefits relating to home care in lieu of hospitalization, expensive medicine, psychiatry bills and funeral expenses.

UNOG accepted recommendation 6. Recommendation 6 remains open pending receipt of evidence that the Internal Rules and website have been updated to accurately and clearly reflect the approved benefits relating to home care in lieu of hospitalization, expensive medicine, psychiatry bills and funeral expenses.

Need to strengthen fraud risk assessment and strategy

32. MIS had established a fraud mitigating strategy and quality control process that outlined its approach to fraud mitigation, various fraud scenarios, procedures for dealing with suspected fraud and the various controls designed to mitigate the risk of fraud. MIS had also broadly assessed fraud risks in its general risk register and rated overall risks of fraud being committed by claim administrators; insured members; and collusion between members and service providers as “low”. The probability of fraud occurring was rated as “likely” but management considered that the overall financial impact of the risks and the impact to operations would be marginal.

33. Although the fraud strategy and the UNSMIS website had a comprehensive list of fraud scenarios, no assessment of each fraud scenario was done as recommended in the anti-fraud and anti-corruption framework of the United Nations secretariat (ST/IC/2016/25). An assessment of the likelihood and impact of each fraud scenario needs to be done and used as the basis for determining the level of overall fraud risk that should be reflected in the main risk register. The assessment should also include a review of the adequacy of measures currently in place to mitigate the risks and whether more could be done to address the individual risk scenarios beyond the general controls. Based on insights from the detailed review of claims, OIOS is of the view that there was potential to do more to mitigate the fraud scenarios relating to

alteration of documents, bogus health providers and members submitting claims for ineligible family members, as discussed below:

(a) The verification of payments which is a key control defined in the fraud strategy was not systematically done. This control helps to mitigate risks related to alteration of documents. Such risks have a relatively higher likelihood of occurrence given that all the five fraud cases investigated in the last five years related to alteration of documents. It would be useful to improve how the payment control is implemented since it can be both a preventive and detective mitigating control for such fraud risks.

(b) OIOS' review of the sample of claims identified some anomalies which could be innocent mistakes but could also be red flags that the invoices were altered. These included no dates on the invoice; invoice without a currency, and inconsistencies in dates. MIS stated that it ignored such anomalies on the ground that they were not material. In the view of OIOS, in designing the payment control as noted in point "a" above, consideration could be given to including claims with such anomalies in the sample of claims where proof of payment would be requested from members.

(c) With regard to the risk of bogus health providers, while there were established mechanisms for checking whether service providers in Switzerland were registered, no specific checks had been established for providers outside of Switzerland. The fact that the details of service providers outside Switzerland are not entered in the claim processing system also means that the data generated from the system may not be satisfactory for performing trend analysis on such providers. The exposure to this risk would reduce if members use the recently established medical network access platform for Africa, Asia, South America and Central America. However, the risk still needs to be assessed since the use of the network is not obligatory, and also with the network access platform now available, the risk scenarios will change and need to be re-assessed.

(d) There were no specific measures established to mitigate the risk of claims submitted on behalf of ineligible dependents or family members which is one of the risk scenarios identified in the fraud strategy. One of the claims OIOS sampled for testing had an invoice that had only the family name but no additional checks were done to ensure that the treatment was for a bona fide member. MIS stated that such invoices that had only one name were common. The level of risk needs to be assessed and considerations given on the extent to which such claims should be validated with the service provider before they are processed.

34. With regard to fraud risks that could be committed internally, MIS had outlined in its fraud strategy the various measures it had put in place to mitigate the risks such as access controls and other controls on how work is allocated to claim administrators. OIOS reviewed the access rights and reports generated from the system and identified the following additional measures that need to be considered: (a) exception reports on changes made to banking details of members; (b) clearer documentation of changes made to the claims payment report generated from the system; and (c) a clearer list of access controls that each individual has and exception reporting of any changes made to access rights. Further, MIS had not undertaken the exercise to seek tools for improving data mining and trending analysis and had also not reviewed the quality of data analysis in the claim processing system for such trend analysis as it envisioned in its 2019 work plan. The extent to which MIS plans to use data analytics as a fraud detection tool had therefore not been clearly determined.

35. Based on the above, OIOS concluded that MIS needs to strengthen its approach to fraud risk assessment to ensure that adequate measures are in place to mitigate specific risks.

(7) The UNOG Medical Insurance Section should assess fraud risks in accordance with the anti-fraud and anti-corruption framework and update the fraud mitigation strategies as appropriate.

UNOG accepted recommendation 7 and stated that MIS will update the assessment of its fraud risks and fraud mitigation strategies. Recommendation 7 remains open pending the receipt of the updated fraud risk assessment and mitigation strategies.

C. Support and feedback mechanisms

Need to update and improve the design of the website

36. The UNSMIS website was the main communication tool to members and had useful information relating to the benefits, how to submit a claim, premiums, contact details and a frequently asked questions page. There were however some aspects that need to be improved to help ensure that the members are well informed which in turn could help reduce the level of queries and questions from members and the overall efficiency of claim processing. Important elements such as prescription requirements and direct payments and supplementary benefits were included in frequently asked questions and not clearly and visibly communicated in dedicated sections or sub-sections of the website. Similarly, the information on supplementary benefits was not presented in a clear and visible manner and improvements could be made on the substantive information. For instance, it would be useful to include in the website a summary of the categories of claims where supplementary benefits are applicable/not applicable. More scenarios and related out of pocket expenses that members would incur in each scenario may also be useful.

37. The list of agreements that MIS had negotiated with a range of health care providers in conjunction with other Geneva-based organizations was appropriately posted in the website under a separate section of the website. A review of a sample of 38 claims showed that the agreed rates and discounts were accurately applied. However, the agreed discounts with a major group of pharmacies was utilized in only two out of the seven invoices that were in the sample of claims reviewed. OIOS attributed the low utilization to the fact that members may not be aware of the discounts since it was a relatively new agreement and the list of agreements in the website had not been updated to include this service provider. In addition, for one of the service providers, the fact that the five per cent agreed discount was applicable only in cases where MIS made the payments directly to the service provider was not reflected in the list of agreements posted in the website. This could affect members' awareness and utilization of the discount.

38. Also, since March 2002, the tax for the patient for pharmaceutical bills is not reimbursed and it would be useful to communicate this information in the website. It would also be useful to highlight opportunities for members with diplomatic status to ask for Value Added Tax reimbursements. Further, OIOS noted that the frequently asked questions in the e-claims portal addresses important information on editing of claims and submission of additional information to already submitted claims and it would be useful to replicate this information in the main website. There was also no direct link to the website from the UNOG Intranet (i-Seek) which is the place secretariat staff are likely to go to first when seeking information on the medical plan. Since there were constantly new members at UNSMIS and given the broad range of benefits, it is essential that the gaps noted above are addressed so that the website can be an effective source of information; and to help ensure that members are well informed of their entitlements and claim submission processes and requirements.

(8) The UNOG Medical Insurance Section should: (a) update and redesign its website to better communicate all important elements relating to the medical insurance plan; and (b) ensure that the list of agreements with service providers is updated and accurate.

UNOG accepted recommendation 8 and stated that MIS will update the website by making certain points clearer and updating the provider list. Recommendation 8 remains open pending receipt of evidence that: (a) the website has been updated and redesigned; and (b) the list of agreements with service providers posted in the website is up to date and accurate.

Feedback mechanisms need to be improved

39. Various ways of contacting MIS were included in the website and the e-claims portal. These included a generic email address; an email address for submitting requests for prior authorization through the medical advisor; request for service through the iNeed system; in person visit to the Client Support Centre, telephone and fax contact and a contact form in the e-claims portal. Targeted response timelines for queries received through the iNeed system and the Client Support Centre were set in the work plan and monitored through the year end assessment. However, the queries received, and answers given were not filed and organized in a systematic manner which is necessary for ease of reference and analysis and to facilitate the identification of lessons learned. Recurring queries could for instance be incorporated in the frequently asked questions in the website. MIS also conducted various surveys to solicit feedback from members including surveys done in the iNeed system after every issue is resolved; e-claims portal (2018) and the general survey done by the Division of Administration. It is essential that lessons learned from all these feedback mechanisms are identified so that good practices can be reinforced and opportunities for improvement addressed.

(9) The UNOG Medical Insurance Section should: (a) establish a system for filing queries and feedback received; and (b) ensure that lessons learned from the queries and client satisfaction surveys are identified and addressed.

UNOG accepted recommendation 9. Recommendation 9 remains open pending receipt of evidence that MIS has established a system for filing queries and feedback received and for identifying and addressing lessons learned from the queries, and client satisfaction surveys.

IV. ACKNOWLEDGEMENT

40. OIOS wishes to express its appreciation to the management and staff of UNOG for the assistance and cooperation extended to the auditors during this assignment.

(Signed) Eleanor T. Burns
Director, Internal Audit Division
Office of Internal Oversight Services

STATUS OF AUDIT RECOMMENDATIONS

Audit of medical insurance claims at the United Nations Office at Geneva

Rec. no.	Recommendation	Critical ¹ / Important ²	C/ O ³	Actions needed to close recommendation	Implementation date ⁴
1	The UNOG Medical Insurance Section should assess the case for establishing a dedicated medical advisor post by taking into consideration the workload statistics and other relevant factors.	Important	O	Receipt of evidence that a business case for establishing a dedicated medical advisor post has been prepared and submitted to UNOG senior management.	31 December 2021
2	The UNOG Medical Insurance Section should prepare an overarching planning document that captures its plan, vision and strategy over a 3 to 5-year horizon.	Important	O	Receipt of evidence that MIS has documented its vision and strategy over a 3 to 5-year horizon.	31 March 2021
3	The UNOG Medical Insurance Section should prepare standard operating procedures for all key processes including processing payments to members and service providers.	Important	O	Receipt of evidence that standard operating procedures for processing payments to members and service providers and related banking details have been established and implemented.	31 March 2021
4	The UNOG Medical Insurance Section should: (a) update the ex post facto review policy to include clear timelines for conducting the reviews and clearly defined risk-based sampling criteria; and (b) strengthen the arrangements for identifying and addressing overlaps and potential duplicate claims.	Important	O	Receipt of evidence that the ex post facto review policy has been updated and arrangements for identifying and addressing overlaps and potential duplicate claims strengthened.	31 December 2021
5	The UNOG Medical Insurance Section should establish a system for dealing with exceptions to the requirement for prescriptions and ex post facto approvals to enhance consistency and compliance with established requirements.	Important	O	Receipt of details of the system established for dealing with exceptions to the requirements for prescriptions and ex post facto approvals.	31 December 2021
6	The UNOG Medical Insurance Section should ensure that the Internal Rules and website are updated to accurately and clearly reflect the approved benefits relating to home care in lieu of hospitalization,	Important	O	Receipt of evidence that the Internal Rules and website have been updated to accurately and clearly reflect the approved benefits relating to	31 March 2021

¹ Critical recommendations address those risk issues that require immediate management attention. Failure to take action could have a critical or significant adverse impact on the Organization.

² Important recommendations address those risk issues that require timely management attention. Failure to take action could have a high or moderate adverse impact on the Organization.

³ Please note the value C denotes closed recommendations whereas O refers to open recommendations.

⁴ Date provided by UNOG in response to recommendations.

STATUS OF AUDIT RECOMMENDATIONS

Audit of medical insurance claims at the United Nations Office at Geneva

	expensive medicine, psychiatry bills and funeral expenses.			home care in lieu of hospitalization, expensive medicine, psychiatry bills and funeral expenses.	
7	The UNOG Medical Insurance Section should assess fraud risks in accordance with the anti-fraud and anti-corruption framework and update the fraud mitigation strategies as appropriate.	Important	O	Receipt of the updated fraud risk assessment and mitigation strategies.	31 December 2021
8	The UNOG Medical Insurance Section should: (a) update and redesign its website to better communicate all important elements relating to the medical insurance plan; and (b) ensure that the list of agreements with service providers is updated and accurate.	Important	O	Receipt of evidence that (a) the website has been updated and redesigned and (b) the list of agreements with service providers posted in the website is up to date and accurate.	31 March 2021
9	The UNOG Medical Insurance Section should: (a) establish a system for filing queries and feedback received; and (b) ensure that lessons learned from the queries and client satisfaction surveys are identified and addressed.	Important	O	Receipt of evidence that MIS has established a system for filing queries and feedback received and for identifying and addressing lessons learned from the queries, and client satisfaction surveys.	30 June 2021

APPENDIX I

Management Response



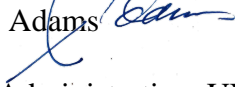
MEMORANDUM INTERIEUR

INTEROFFICE MEMORANDUM

TO: Ms. Eleanor T. Burns
A: Director
Internal Audit Division, OIOS

DATE: 24 November 2020

REF.: UNOGDOA-2020-00235

FROM: Clemens M. Adams 
DE: Director
Division of Administration, UNOG

SUBJECT: **Draft report of an audit of medical insurance claims at the United Nations**
OBJET: **Office at Geneva (Assignment No. AE2020-310-01)**

1. UNOG acknowledges receipt of the draft report of an audit of medical insurance claims at the United Nations Office at Geneva (Assignment No. AE2020/310/01).
2. UNOG agrees with the recommendations issued in this report and has completed the annex I attached. Please note that some implementation dates have been revised, in comparison with the dates provided at the earlier stage of the issuance of the detailed result report.
3. UNOG would like to thank OIOS for having considered its request, with the inclusion of an overall summary in the report. It enables the readers of the report to conclude on the overall assessment of the adequacy, efficiency and effectiveness of the arrangements for processing medical insurance claims at UNOG.
4. I take this opportunity also to thank you and the Geneva OIOS team for their work and the value-added recommendations for UNSMIS.

cc: Tatiana Valovaya
Sophie Veaudour
Giovanni Pizzini
Celine Noel
Anna Nyaoro
Maya Fridman

Management Response

Audit of medical insurance claims at the United Nations Office at Geneva

Rec. no.	Recommendation	Critical ¹ / Important ²	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
1	The UNOG Medical Insurance Section should assess the case for establishing a dedicated medical advisor post by taking into consideration the workload statistics and other relevant factors.	Important	Yes	Chief UNSMIS	31 December 2021	UNSMIS will implement this recommendation by the end of 2021.
2	The UNOG Medical Insurance Section should prepare an overarching planning document that captures its plan, vision and strategy over a 3 to 5-year horizon.	Important	Yes	Chief UNSMIS	31 March 2021	UNSMIS will prepare a document capturing its vision and strategy before the end of March 2021.
3	The UNOG Medical Insurance Section should prepare standard operating procedures for all key processes including processing payments to members and service providers.	Important	Yes	Chief UNSMIS	31 March 2021	UNSMIS will implement this recommendation before the end of March 2021.
4	The UNOG Medical Insurance Section should: (a) update the ex post facto review policy to include clear timelines for conducting the reviews and clearly defined risk-based sampling criteria; and (b) strengthen the arrangements for identifying and addressing overlaps and potential duplicate claims.	Important	Yes	Chief UNSMIS	31 December 2021	UNSMIS will implement this recommendation by the end of 2021.
5	The UNOG Medical Insurance Section should establish a system for dealing with exceptions to the requirement for prescriptions and ex post facto approvals to	Important	Yes	Chief UNSMIS	31 December 2021	UNSMIS will implement a simple system, considering the limited resources available by the end of 2021.

¹ Critical recommendations address those risk issues that require immediate management attention. Failure to take action could have a critical or significant adverse impact on the Organization.

² Important recommendations address those risk issues that require timely management attention. Failure to take action could have a high or moderate adverse impact on the Organization.

Management Response

Audit of medical insurance claims at the United Nations Office at Geneva

Rec. no.	Recommendation	Critical ¹ / Important ²	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
	enhance consistency and compliance with established requirements.					
6	The UNOG Medical Insurance Section should ensure that the Internal Rules and website are updated to accurately and clearly reflect the approved benefits relating to home care in lieu of hospitalization, expensive medicine, psychiatry bills and funeral expenses.	Important	Yes	Chief UNSMIS	31 March 2021	UNSMIS will update the Internal Rules and website by the end of March 2021.
7	The UNOG Medical Insurance Section should assess fraud risks in accordance with the anti-fraud and anti-corruption framework and update the fraud mitigation strategies as appropriate.	Important	Yes	Chief UNSMIS	31 December 2021	UNSMIS will update the assessment of its fraud risks and update its fraud mitigation strategies by the end of December 2021
8	The UNOG Medical Insurance Section should: (a) update and redesign its website to better communicate all important elements relating to the medical insurance plan; and (b) ensure that the list of agreements with service providers is updated and accurate.	Important	Yes	Chief UNSMIS	31 March 2021	UNSMIS will update the website by making certain points clearer and updating the provider list. This will be done by the end of March 2021.
9	The UNOG Medical Insurance Section should: (a) establish a system for filing queries and feedback received; and (b) ensure that lessons learned from the queries and client satisfaction surveys are identified and addressed.	Important	Yes	Chief UNSMIS	30 June 2021	UNSMIS will implement this recommendation by June 2021.