INTERNAL AUDIT DIVISION

REPORT 2018/126

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts in the Department of Management

While the third-party administrator's processing of medical claims was generally effective, there was a need for the Department of Management to improve management of the administrator's contract, and the overall governance and management of the Medical Insurance Plan

11 December 2018
Assignment No. AH2017/511/02

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts in the Department of Management

EXECUTIVE SUMMARY

The Office of Internal Oversight Services (OIOS) conducted an audit of the administration and management of the Medical Insurance Plan (MIP) by the Office of Programme Planning, Budget and Accounts (OPPBA) in the Department of Management (DM). The objective of the audit was to assess the effectiveness of the provision of adequate medical care at reasonable cost and equitably to all plan participants. MIP is the health insurance plan for locally recruited staff at designated duty stations away from Headquarters, including peace operations, regional commissions and United Nations information centres. The audit covered the period from 1 January 2016 to 31 December 2017 and reviewed: (i) governance arrangements; (ii) MIP membership, costs and contribution rates; (iii) settlement of medical claims and recovery of patient shares; (iv) fraud risk management mechanisms; and (v) member satisfaction and performance management of the third-party administrator (TPA) that is responsible for handling and paying medical claims.

OPPBA had integrated membership data for most of the MIP participants into Umoja. The TPA's administration of medical claims was generally effective. Its customer service and network of medical care providers in most geographical areas were regularly being improved. However, there was a need for DM to enhance management of the TPA contract and the overall governance and management of the MIP.

OIOS made 12 recommendations. To address issues identified in the audit, DM needed to:

- Establish a governance mechanism for MIP;
- Deploy adequate resources for efficient and effective management of MIP;
- Follow up on discrepancies in membership records and contributions identified by the audit;
- Initiate migration of relevant retiree records to Umoja;
- Establish monitoring mechanisms over the accuracy of health insurance plan membership records and contributions;
- Review MIP contribution rates to better match revenues with expenses;
- Recover the outstanding patient shares identified by the audit;
- Establish a monitoring mechanism over recovery of outstanding patient shares;
- Establish a log of presumptive health insurance fraud cases and follow up on their resolution;
- Implement an action plan to develop capacity for investigating cases of health insurance fraud;
- Develop guidelines and training on health insurance administration for relevant human resources and finance staff; and
- Periodically evaluate efficiency and effectiveness of the administration and management of health insurance plans.

DM accepted the recommendations and initiated action to implement them.

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Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts in the Department of Management

I. BACKGROUND

1. The Office of Internal Oversight Services (OIOS) conducted an audit of the administration and management of the Medical Insurance Plan (MIP) by the Office of Programme Planning, Budget and Accounts (OPPBA) in the Department of Management (DM).

2. MIP is a health insurance plan established under the Staff Regulations for locally recruited staff at designated duty stations away from Headquarters, including peace operations, regional commissions and United Nations information centres. It is operated in accordance with the Staff Rules, administrative instruction ST/AI/2015/3 and information circular ST/IC/2015/8.

3. MIP is a self-insurance plan, where risks are borne collectively, and contributions are made by the United Nations and plan participants. Participants comprise staff at general service and national officer categories at most field duty stations, except where the coverage through another plan has been approved. Enrolment in MIP is mandatory for staff in these categories and voluntary for eligible retirees and family members. MIP provides protection against the high cost of health care up to the level that is "reasonable and customary" in the country of the duty station or the approved regional area of care.

4. Management of MIP is the responsibility of the Health and Life Insurance Section (HLIS) within the Insurance and Disbursement Service (IDS) in the Accounts Division, OPPBA in DM. HLIS is headed by a chief at P5 level and, as of 30 September 2018, had only one staff at P4 level dedicated to the management of MIP. The administration of MIP, including the handling and payment of medical claims and broader customer service, is entrusted to a third-party administrator (TPA). The contract with the current TPA has been in effect since April 2015. The Medical Services Division (MSD) of the Office of Human Resources Management (OHRM) may advise the TPA on the necessity of medical expenses above the TPA's delegated authority level, and review participants' appeals against TPA's decisions.

5. Human resources offices in field and other duty stations (HR offices) process enrollment and withdrawal of staff and their family members from MIP in Umoja. Payroll offices in relevant duty stations collect monthly contributions for active staff through the payroll, and for retirees through individual payments made by them or deductions from pension. The TPA updates membership data based on "eligibility files" generated from Umoja for active staff or created manually for retirees. Treasury in the Accounts Division settles most of the MIP expenses, including reimbursements to TPA for payment of medical claims, and payment of TPA fees approved by HLIS. Financial Reporting Service in the Accounts Division prepares MIP financial statements.

6. Table 1 provides an overview of MIP financial data for 2015 to 2017, and Table 2 provides data on MIP participants and claim reimbursements during the TPA's two reference periods (July 2015 - June 2017).

Table 1: MIP financial data, 2015-2017 (in United States dollars)

Details	31 December 2015	31 December 2016	31 December 2017
Participant contributions – active staff	27,941,000	5,704,624	6,525,582
UN contributions – active staff		21,831,211	24,424,314
Participant contributions – retirees		285,091	334,878
UN contributions – retirees		893,676	801,971
Investment revenue	294,000	566,961	745,275
Other revenue	27,000	-	(16)
Total revenue	**28,262,000**	**29,281,563**	**32,832,004**
Claim reimbursements	(21,042,000)	(31,699,945)	(36,554,167)
Net adjustments for claim provisions		(7,831,980)	557,926
UN personnel costs	-	(130,060)	(560,465)
TPA fees	(3,352,000)	(2,995,841)	(2,289,795)
Bank fees		(854)	(320)
Foreign exchange gains/losses		(45,237)	54,770
Total expenses	**(24,394,000)**	**(42,703,917)**	**(38,792,051)**
Surplus/Deficit	**3,868,000**	**(13,422,354)**	**(5,960,047)**
Assets	**66,683,000**	**65,001,674**	**55,239,240**
Liabilities	**(3,113,000)**	**(14,853,722)**	**(11,051,335)**
Accumulated surplus	**63,570,000**	**50,147,952**	**44,187,905**

Source: 2015 – A/71/5 (Vol. I); 2016 and 2017 – Umoja

Table 2: MIP participants and claim reimbursements, July 2015 - June 2017

Details	July 2015 - June 2016	July 2016 - June 2017
Primary participants (= families)	17,710	17,890
of which retiree families	1,387	1,429
All participants (including family members)	65,810	66,546[1]
Claimants	32,460	35,295
Number of claims	143,452	167,459
Claim reimbursements (in United States dollars)	25,194,057	32,265,851

Source: TPA data

7. Comments provided by DM are incorporated in italics.

II. AUDIT OBJECTIVE, SCOPE AND METHODOLOGY

8. The objective of the audit was to assess whether the administration and management of the MIP were effective to provide adequate medical care at reasonable cost and equitably to all plan participants.

9. This audit was included in the 2017 risk-based work plan of OIOS due to the risks associated with the administration and management of health insurance plans and their important role in ensuring a healthy workforce.

10. OIOS conducted this audit from February to July 2018. The audit covered the period from 1 January 2016 to 31 December 2017. Based on an activity-level risk assessment, the audit covered

[1] Countries with most participants: Democratic Republic of Congo (14,221); Sudan (8,560); Afghanistan (6,016); South Sudan (5,826); and Liberia (3,538)

higher and medium risk areas in the administration and management of MIP, which included: (i) governance arrangements; (ii) MIP membership, costs and contribution rates; (iii) settlement of medical claims and recovery of patient shares; (iv) fraud risk management mechanisms; and (v) member satisfaction and performance management of the TPA. The audit scope did not include the administration of individual claims.

11. The audit methodology included: (i) interviews of key personnel in OPPBA, OHRM, the Department of Field Support (DFS) and TPA; (ii) review of procedures and analytical reviews of data from OPPBA, OHRM, field missions and offices, and TPA; (iii) reconciliation of TPA data and field missions and offices' data with Umoja; and (iv) survey of all active staff and retirees enrolled in MIP (OIOS survey) to assess their awareness of and satisfaction with the MIP services and benefits. The survey was administered in March 2018 and sent to 14,517 MIP members, of which 1,929 (13 per cent) provided responses

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

III. AUDIT RESULTS

A. Governance arrangements

<u>DM needed to establish adequate governance and resourcing mechanisms for the management of MIP</u>

13. The governance of self-insured health plans commonly requires oversight by an independent committee to ensure that the administration and management are effective and adequately resourced, deficiencies are addressed timely, medical coverage provided is adequate, costs are reasonable, and conditions are fair to all stakeholders. The key stakeholders (the contributing employer and members) should be represented in the governing body.

14. MIP is the only health insurance plan managed at the United Nations Secretariat without a governance committee to oversee the plan and advise on management and resourcing matters. The Health and Life Insurance Committee (HLIC) oversees health insurance plans administered at Headquarters, but not the MIP. Consequently, MIP members were not represented in its governance and did not participate in key issues related to its administration.

15. In addition, the management of MIP by HLIS was not adequate due to insufficient resources. At the time of the audit, only one staff at P4 level (out of the 24 staff in HLIS) was dedicated to its management. As a result, as further detailed in this report, MIP membership records, contributions to MIP, and the overall MIP costs were not adequately monitored; action was not taken on the TPA's investigation reports; member awareness and satisfaction with MIP were not surveyed to assess adequacy; performance and training needs of HR offices were not evaluated; and the TPA's performance was not adequately measured against standards included in the contract. Also, HLIS did not have standard operating procedures for these activities, apart from the procedures included in administrative issuances. During the audit period, the main activities of HLIS in the management of MIP were the cleansing and migration of MIP membership data to Umoja; resolving of ad-hoc issues with MIP members, HR offices and TPA; and overall coordination with TPA.

16. OPPBA had not sufficiently explored options for adequate governance and resourcing of the management of MIP that could bring long-term benefits through improved management practices and new initiatives.

(1) DM should establish an adequate governance mechanism for the Medical Insurance Plan that allows members to participate in strategic issues affecting the administration of the Plan.

DM accepted recommendation 1 and stated that in June 2018, the Staff-Management Committee agreed to increase the membership of HLIC from 6 to 10 members, to include representatives of beneficiaries from outside New York and from the United Nations funds and programmes. The revised membership should allow for active participation of offices away from Headquarters in the review of health and life insurance matters. Recommendation 1 remains open pending receipt of evidence of the increase in HLIC membership, including representation from MIP participants to provide governance and oversight of MIP issues.

(2) OPPBA should review and deploy adequate resources for the efficient and effective management of the Medical Insurance Plan that are commensurate to its size and complexity.

OPPBA accepted recommendation 2 and stated that it was reviewing the resources needed for proper management of MIP, including its monitoring and analytical work. Recommendation 2 remains open pending receipt of evidence that adequate resources have been deployed in the management of the MIP.

B. MIP membership, costs and contribution rates

OPPBA needed to establish monitoring mechanisms to review the accuracy of membership records and contributions to MIP

17. According to the Secretary-General's bulletin on the organization of OPPBA (ST/SGB/2003/16), it has responsibility for coordinating the health insurance programme, as well as monitoring the Organization's expenditures and operations of its information system.

18. The calculation of active staff and employer contribution amounts to MIP was largely accurate. However, there were discrepancies between employment and MIP membership records in Umoja and TPA records, and/or noncompliance with MIP membership rules in administrative instruction ST/AI/2015/3 for about 7 per cent of active staff enrolled in MIP. These included: (i) staff and their family members not removed from TPA records and continuing to receive benefits while no longer contributing to MIP; (ii) contributing staff and their family members not included in TPA records; (iii) differences between eligibility, contribution and enrolment periods; and (iv) no enrolment in MIP where it was mandatory. These discrepancies were due to: (i) HR offices not updating MIP membership records timely; (ii) payroll offices not collecting contributions; (iii) technical errors causing the "eligibility file" to not accurately reflect Umoja records; or (iv) TPA not updating its own records timely.

19. There were similar discrepancies for about 11 per cent of retirees enrolled in MIP. They were due to: (i) HR offices not updating the "retiree files" transmitted to TPA or not transmitting any files at all; or (ii) TPA not updating its own records timely. During the audit period, finance offices also did not collect or correctly post to MIP accounts in Umoja about $19,800 in retiree contributions and about $104,900 in employer contributions. Furthermore, for 7 out of the 21 finance offices contacted, the accuracy of contributions could not be verified because details were not provided for all or part of the retirees. Most of the finance offices also collected contributions from retirees with significant delays contrary to the administrative instruction ST/AI/2015/3.

20. OIOS noted that retiree records were maintained outside Umoja and had to be updated manually, which was not done in many cases. These records varied greatly in quality and accuracy between field missions and offices, which had no guidance on their format, except for the "retiree files" for transmission to TPA.

21. Due to inadequate monitoring of the accuracy of MIP membership records and of contributions to MIP by OPPBA, DFS, or the regional service centres/support offices, 64 active or previously active staff received at least $103,711 in medical benefits from TPA for periods during which they did not contribute to MIP. In addition, six active or previously active staff on leave without pay received at least $2,940 in benefits for periods, in which they paid their own contributions but not the employer contribution and therefore were not eligible to MIP membership. Seventy retirees received at least $343,403 in medical benefits for periods, in which they did not contribute to MIP. In addition, 43 retirees received at least $309,846 in benefits where contributions may have not been posted to MIP as the information provided by field missions/offices to OIOS was incomplete. Without proper monitoring, the causes of identified discrepancies could not be timely addressed.

22. OIOS communicated details of all identified discrepancies to OPPBA, field missions and offices, and TPA. Discrepancies in MIP membership records and in contributions to MIP were exacerbated by the recent transition of MIP membership records to Umoja. OIOS acknowledges the complex environment for the administration of the MIP self-insurance model, with dispersed responsibility between HR and finance offices in field duty stations, payroll offices (and some of the finance offices) located elsewhere, the Financial Information Operations Service in OPPBA (supporting Umoja and configuration of the "eligibility file" template), HLIS, Treasury, Financial Reporting Service, MSD, and an external TPA. The complex administration causes manual and technical errors as well as gaps and delays in data exchange between stakeholders, particularly for the TPA, which does not have access to up-to-date membership and contribution data in Umoja. OPPBA had not conducted an analysis of alternative solutions for improved administration of health insurance plans, for example, administration of all membership and contribution records by a TPA, which could reduce the discrepancies. However, OPPBA commented that such analysis would increase the MIP administration costs.

(3) OPPBA should, in coordination with offices participating in the Medical Insurance Plan and the third-party administrator, follow up on discrepancies identified by the audit and implement corrective actions, including for the technical errors in the "eligibility file" generated by Umoja.

OPPBA accepted recommendation 3 and stated that it was working with the involved parties to rectify the identified discrepancies and was reviewing MIP processes and procedures to identify the gaps that may have contributed to the discrepancies. Recommendation 3 remains open pending receipt of evidence that identified discrepancies and gaps have been addressed.

(4) OPPBA should initiate the migration of health insurance plan membership and contributions records for retirees to Umoja.

OPPBA accepted recommendation 4 and stated that it was reviewing the resources needed for handling the migration of retiree records to Umoja. Recommendation 4 remains open pending receipt of evidence that the migration of retiree records to Umoja has been initiated.

(5) OPPBA should, in coordination with offices participating in the Medical Insurance Plan, establish monitoring mechanisms over the accuracy of health insurance plan membership records and contributions.

OPPBA accepted recommendation 5 and stated that it was reviewing the resources needed to establish monitoring mechanisms over the accuracy of MIP membership records and contributions. Recommendation 5 remains open pending receipt of evidence of the established monitoring mechanisms.

OPPBA needed to monitor the overall MIP costs and contribution rates

23. Periodic reviews of contribution rates are necessary to sustain the financial viability of MIP.

24. In 2016, MIP expenses exceeded revenues for that year by 46 per cent, which was primarily due to processing claim reimbursements from previous years, including those that had not been processed by the previous TPA, and due to downsizing of some field missions, a period during which there were usually higher medical claims. In 2017, MIP expenses exceeded revenues by 18 per cent. In the two years, the MIP reserves decreased from $64 million to $44 million. At the time of the audit, OPPBA did not have any specific proposals to address the increased MIP costs or to increase contribution rates to prevent further depletion of MIP reserves. It had also not established a basis for determining the optimal level of the reserves.

25. The MIP contribution rates in force since 1 September 1987 were revised only once on 1 April 2015. They were increased by 4.58 per cent to reflect increase in medical services benefits. However, the increase did not address the overall increase in MIP costs. By comparison, the contribution rates of the Headquarters-administered health insurance plans are reviewed every year.

26. The current TPA has undertaken an extensive cost analysis of MIP medical claims to potentially differentiate contribution rates. It also maintains a database of "reasonable and customary" medical service costs and has implemented various cost containment measures. OPPBA stated that it was reviewing the existing contribution rates and intended to differentiate them based on the comparative medical costs by location. This had not been completed at the time of the audit to address the continued depletion of MIP reserves.

(6) OPPBA should review the Medical Insurance Plan contribution rates to better match annual contributions with expenses and maintain reserves at a desirable level.

OPPBA accepted recommendation 6 and stated that it was working with the TPA to review the current contribution rates. Recommendation 6 remains open pending receipt of the results of the review and relevant action plan to better match annual contributions with expenses.

C. Settlement of medical claims and recovery of patient shares

TPA procedures for settling medical claims were generally adequate

27. According to its contract, the TPA is required to implement adequate procedures for review and settlement of medical claims, as well as regular quality assurance audits against performance standards for the accuracy of claims.

28. TPA's claims handling service is certified by the International Organization for Standardization and undergoes periodic audits. The external audit of the TPA's overall management system against the Standards in December 2017 did not identify any non-conformities, and the TPA's internal audit of MIP medical claims handling service in March 2017 found that the service exceeded the targets for "financial

accuracy" and "processing accuracy", and nearly met the target for "payment accuracy" (scoring 95.3 per cent against the 96 per cent target).[2]

29. OIOS did not review individual MIP medical claims but analysed the TPA's 2016 and 2017 claim reimbursement data by type of medical service and the applicable rate of reimbursement (for example, hospitalization, vaccinations and chemotherapy should be reimbursed at 100 per cent; and other expenses at 80 per cent). OIOS analysed whether reimbursements and patient shares ("co-pay") were calculated correctly, and ineligible amounts were excluded. OIOS concluded that reimbursement calculations were consistent and generally conformed to the rules stated in the information circular ST/IC/2015/8, with some minor deviations and claims overpayments, which were not material overall.

OPPBA needed to improve the recovery of patient shares from claimants

30. For medical services that are not reimbursable at 100 per cent, claimants either pay their patient share portion directly to the medical provider or, where arrangements exist, TPA pays the full cost of reimbursable medical services to medical providers and sends "recovery files" to relevant payroll offices with the patient shares to be recovered through staff payroll. This procedure is in place to facilitate medical visits and to minimize fraud. OPPBA is responsible for monitoring this procedure by payroll offices in field duty stations.

31. During the audit period, TPA requested recoveries of $2.1 million for patient shares under MIP. OIOS reviewed recoveries for 117 staff amounting to $185,519. Usually it took two to three months or longer, for the payroll offices to make recoveries. Furthermore, for 31 out of 117 staff (26 per cent), $31,512 of patient shares remained unrecovered, partially due to staff separations.

32. Recovery of patient shares under MIP and other health insurance plans is an additional task for payroll offices, which is not automated. OPPBA did not have a monitoring mechanism, such as periodic reviews of whether patient share recovery requests made by the TPA had been recovered from staff. Therefore, the unrecovered patient shares were borne by the MIP.

(7) OPPBA should, in coordination with offices participating in the Medical Insurance Plan, recover the outstanding patient shares identified by the audit.

OPPBA accepted recommendation 7 and stated that it was reviewing the resources needed to implement the recommendation. Recommendation 7 remains open pending receipt of evidence of recovery of outstanding patient shares.

(8) OPPBA should establish a monitoring mechanism for the timely recovery of patient shares through the payroll.

OPPBA accepted recommendation 8 and stated that it was reviewing the process of recovering patient shares in conjunction with TPA in order to streamline it. Recommendation 8 remains open pending receipt of evidence of the established monitoring mechanism for the timely recovery of patient shares.

[2] Financial accuracy = value of correctly paid claims vs. value of all paid claims; processing accuracy = number of correctly processed claims (without procedural or payment errors) vs. number of all processed claims; and payment accuracy = number of correct payments vs. number of all payments

D. Fraud risk management mechanisms

<u>DM needed to log fraud cases communicated by the TPA and improve capacity for investigating health insurance fraud</u>

33. The information circular on the Anti-Fraud and Anti-Corruption Framework of the United Nations Secretariat (ST/IC/2016/25) specifies that every manager is responsible for identifying and mitigating risks that might affect operations under his or her responsibility. According to the administrative instruction on unsatisfactory conduct, investigations, and the disciplinary process (ST/AI/2017/1), investigation reports from external TPAs about suspected or confirmed fraud cases by staff members qualify as "information about unsatisfactory conduct", which shall be forwarded to OIOS. OIOS may decide to handle the case itself or request the "responsible official" (generally the head of department, office or mission of the staff member concerned) to conduct a preliminary assessment followed by an investigation when warranted.

34. The TPA implements fraud control procedures, combining fraud awareness, prevention, detection, and investigation mechanisms. From 2015 to 2017, and in addition to several special reports on suspicious claiming behaviour in certain countries, the TPA submitted to HLIS 41 investigation reports with confirmed fraud cases totalling $321,979. The majority of cases were detected and investigated by TPA prior to payment of claims, which were then denied. However, $82,367 (26 per cent) was paid and remained unrecovered at the time of the audit.

35. The TPA's investigation reports were transmitted to OIOS. However, OPPBA did not maintain any log of identified and reported health insurance fraud cases or follow up on their resolution, despite a recommendation issued in OIOS report 2014/051 to establish a mechanism to collect and reconcile information on presumptive fraud cases. OPPBA relied entirely on the TPA and OIOS Investigation Division in the management of health insurance fraud risks. OIOS Investigation Division primarily handles suspected fraud cases of high value or a serious nature, therefore other cases, following an OIOS assessment, should be handled by the relevant "responsible official". However, heads of offices and, in the case of field missions, special investigation units, may not have the required capacity to investigate health insurance fraud.

36. OIOS survey showed that 40 per cent of staff did not know about their obligation to report suspected cases of health insurance fraud, 75 per cent did not know how to report them, and 65 per cent did not know that unresolved fraud cases could increase their future contribution rate. Recommendation 11 of this report addresses this issue.

37. Without an adequate mechanism to follow up on and investigate health insurance fraud cases, unsatisfactory conduct by staff members remains unaddressed and increased fraudulent claims and MIP expenses.

(9) OPPBA should establish a log of presumptive health insurance fraud cases and follow up on their resolution.

OPPBA accepted recommendation 9 and stated that it was revisiting the log of fraud cases with the TPA. Recommendation 9 remains open pending receipt of the OPPBA log of presumptive health insurance fraud cases and their status.

(10) DM should, in coordination with offices participating in the Medical Insurance Plan and OIOS Investigation Division, implement an action plan to develop capacity for investigating cases of health insurance fraud.

DM accepted recommendation 10 and stated that between 2011 and 2018, HLIS submitted over 140 fraud cases to OIOS Investigation Division and was awaiting response for about 20 cases. Recommendation 10 remains open pending receipt of an action plan to develop capacity for investigating health insurance fraud cases by a "responsible official" upon referral from OIOS.

E. Member satisfaction and performance management of the TPA

OPPBA was considering options for improving access to medical care

38. According to its contract, the TPA has an obligation to develop its medical provider network within or in proximity to United Nations field duty stations and, where possible, negotiate preferential rates and make arrangements for direct billing to the TPA. This is to ensure that the Plan meets the needs of the participants.

39. According to the TPA, its network includes over 12,500 medical providers in 186 countries[3] and continues to improve owing to new or renegotiated agreements with providers. OIOS review of the information on the TPA's website noted a reasonable or good network coverage in most duty station countries. Around 71 per cent of staff enrolled in MIP reside in Africa, where the TPA's network includes about 1,800 providers, of which about 1,000 are hospitals. However, among the largest duty stations, the smallest network coverages were in: Bangui, Central African Republic (six providers, of which one was a hospital); Entebbe, Uganda (five providers, including one hospital); Brindisi, Italy (four providers, including one hospital); Mogadishu, Somalia (three hospitals); El Fasher, Sudan (two hospitals); Bissau, Guinea Bissau (two hospitals); Laayoune, Western Sahara (one hospital); and no providers in Naqoura, Lebanon; Baghdad, Iraq; or Syria. Sometimes, network providers could only be reached by travelling long distances, including to approved regional areas of care in other countries. However, travel expenses are not covered under MIP. While 49 per cent of respondents to the OIOS survey indicated that qualified providers were available in the area, 28 per cent indicated that they or their family members had to travel significant distances (over 100 kilometres) at their own cost to visit a qualified provider in at least one case, while 23 per cent had not looked for medical providers. Also, some of them were not satisfied with the choice of the regional area of care.

40. OIOS survey also showed that 57 per cent of respondents were satisfied with the TPA's network, 9 per cent found the network providers adequate but often needed to look for providers outside the network, 19 per cent were not satisfied, and 15 per cent did not have an opinion. Some respondents could not search for network providers because they did not know how to create their profile on TPA's website, while others were under the wrong impression that they could only get medical services under MIP from the TPA's network providers. In addition, respondents indicated that they experienced particular issues with network providers in at least one instance. For example, 24 per cent indicated that a provider was not operational; 28 per cent that a provider was not able to provide the required services; 20 per cent that a provider did not offer the negotiated rates; and 25 per cent that a provider required full payment and refused to bill the TPA. Respondents also mentioned that: (i) some provider details on the TPA's website were outdated; and (ii) patients were required to make full payment, or were turned away, because the TPA does not pay provider bills on time (it is understood that bills could be disputed by TPA).

41. While availability of medical providers is affected by armed conflicts, MIP members in some locations may not be receiving the necessary medical care even though they were contributing to MIP. Unlike internationally recruited staff who were not required to participate in international health insurance plans, it was mandatory for locally recruited staff to participate in MIP, even though the Plan may not be

[3] Outside the United States with 1.4 million providers and the United Kingdom with 22,800 providers

meeting their needs. OPPBA commented that it planned to review the possibility of ending the mandatory requirement for locally recruited staff to participate in MIP, and to work with the TPA to improve its medical provider network. Therefore, OIOS did not make a recommendation on this issue at this time.

OPPBA needed to develop guidelines and training on health insurance administration for HR and finance offices in field locations

42. Information on MIP is available in relevant administrative issuances, benefits description booklet, and on HLIS and TPA's websites. Newly enrolled staff may be briefed on MIP by their HR office and must receive TPA's membership cards, along with a welcome letter and benefits description booklet. TPA also sends electronic newsletters and targeted messages to members. It has local representatives in three duty stations with a large number of MIP members and, during the audit period, made presentations on MIP in five duty stations, and held tele- or videoconferences with seven of them. According to TPA, member awareness has increased, noting an increased use of its network providers and online claiming.

43. However, according to the OIOS survey, member awareness of MIP varied. Between 40 and 68 per cent of respondents were not well informed on various aspects of MIP policies and procedures. Specifically: 40 per cent did not know requirements for enrolment and withdrawal of family members; 46 per cent did not know what services and medications were covered; 51 per cent did not know the services, for which TPA's prior approval was required; 58 per cent did not know the limits that may apply to medical expenses; and 56 per cent did not know that MIP is a self-insured plan and that TPA is a plan administrator and not an insurer. Respondent comments showed a broad misconception that TPA receives the staff contributions deducted through payroll, and 68 per cent did not know how their contributions to MIP were calculated. In addition, 60 per cent of respondents did not know the conditions for after-service health insurance.

44. Some local staff in field duty stations have limited use of computers and may not be aware of the relevant procedures and information available online. For example, 16 per cent of respondents were not familiar with TPA's website or smartphone application. Overall, 58 per cent of respondents had received no briefing, training or presentation on MIP, and only 29 per cent received a briefing or training by their HR office, and 13 per cent also received training by TPA. Respondents stated that their HR offices were unable to provide briefing on MIP. Others, who identified themselves as HR office staff, stated that they did not know of their obligation to provide such briefing, as they had not received the necessary training themselves.

45. The Field Personnel Division of DFS, in cooperation with OHRM, had trained HR offices on the use of Umoja human resources module, which includes member enrolment and updates in health insurance plans. However, apart from general trainings and job guides on Umoja from OPPBA, most HR offices had not received specialized training in health insurance administration, to assist them with briefing staff on the MIP rules, procedures and benefits, and responding to staff queries.

(11) OPPBA should, in coordination with offices participating in the Medical Insurance Plan, develop guidelines and training on health insurance administration for relevant human resources and finance office staff, and require them to brief newly enrolled staff on the Plan's rules, procedures and benefits, and staff obligation to report suspected cases of fraud.

OPPBA accepted recommendation 11 and stated that it was reviewing the resources needed for the development and implementation of guidelines and training on health insurance administration and was also working with the TPA to review and improve their communications to staff.

Recommendation 11 remains open pending receipt of the issued guidelines and evidence of delivered training on health insurance administration.

<u>OPPBA needed to evaluate the efficiency and effectiveness of the administration and the management of the MIP</u>

46. The Regulations and Rules Governing Programme Planning, the Programme Aspects of the Budget, the Monitoring of Implementation and the Methods of Evaluation (ST/SGB/2018/3) require evaluations of activities to systematically determine their relevance, efficiency, effectiveness and impact and allow for continuing critical review of achievements and formulation of subsequent plans.

47. Neither OPPBA nor DFS had evaluated the administration and management of the MIP or assessed the satisfaction of MIP members to identify critical improvements needed. TPA performed periodic surveys of members who had received a settlement note, e-mail or phone call. According to survey data in TPA's stewardship report of December 2017, 85 per cent of respondents were satisfied with TPA's services.

48. OIOS survey inquired about broader aspects of member satisfaction with the administration and management of the MIP. About 47 per cent of respondents were satisfied with the overall professionalism and quality of service of their HR offices, 57 per cent with enrolment procedures, and 19 per cent with briefings or trainings. Some respondents cited: (i) no guidance, briefing or training on MIP by their HR offices; (ii) careless attitude by some HR office staff; (iii) long delays (up to 12 months) for enrolment and withdrawal of staff and family members in MIP Umoja records, resulting in long delays to receive TPA's membership cards or no cards received at all; (iv) incorrect enrolments and withdrawals, resulting in incorrect deductions of contributions in payroll and inaccurate personal data on membership cards; and (v) no advice about the short time limit (31 days) for enrolment of family members, resulting in infants and young children not covered for long period.

49. Fifty-six per cent of respondents were satisfied with the overall professionalism and quality of service of TPA. However, only 17 per cent were satisfied with training by TPA, 60 per cent with TPA's website, 33 per cent with its smartphone application, 36 per cent with waiting time to reach TPA by phone, and 30 per cent with clarity of TPA's settlement notes of reimbursements. For some members, particularly retirees, it was difficult to reach out to the TPA from field locations with limited access to internet and international phone calls. With regard to promptness of service, 49 per cent were satisfied with responses to medical requests, 48 per cent with responses to queries in writing, 38 per cent with responses to queries by phone, and 47 per cent with processing of medical claims. Therefore, opportunities exist for improvement of TPA's performance through monitoring timeliness of the provided services, including: issuance of the membership cards; responses by phone and to written queries; processing pre-approvals for hospitalization; processing long outstanding claims; and payments to medical providers. OPPBA commented that it would share the results of the OIOS survey with the TPA and review areas for improvement of its performance and customer service.

50. With regard to HLIS, only 36 per cent of respondents were satisfied with the overall professionalism and quality of service provided by the Section. Regarding overall satisfaction with MIP, respondents mentioned: (i) that members should have a choice of health insurance, because contributions are regularly deducted from the payroll, although medical providers may not be available, or benefits may not be provided when needed; and (ii) unfair treatment of local staff, receiving more restricted benefits, compared to international staff.

51. The low member satisfaction was primarily due to the limited knowledge of MIP policies and procedures and unrealistic expectations of members. In addition, recent transition of MIP membership records to Umoja, limited training provided to members by HR offices and TPA, and delays in updating

membership records that delayed coverage and receipt of membership cards contributed to negative responses.

> **(12) OPPBA should periodically evaluate the efficiency and effectiveness of the administration and management of health insurance plans and assess member satisfaction.**
>
> *OPPBA accepted recommendation 12 and stated that it was reviewing the resources needed for periodic evaluations.* Recommendation 12 remains open pending receipt of the results of the first evaluation.

OPPBA needed to improve performance management of the TPA

52. The United Nations contract with TPA includes a detailed statement of work and relevant performance standards. It also defines contractual penalties for unmet standards.

53. TPA's stewardship report of December 2017 provided a comprehensive overview on its performance. According to the TPA internal audit results included in the report, most performance standards were met, and two standards were nearly met: the "payment accuracy" (scoring 95.3 per cent against the 96 per cent target); and the average claims turnaround time (scoring 3.7 to 3.9 days against the 3 days target). TPA explained that the challenges in processing claims accurately were partly due to the inadequate format of medical bills received from MIP member countries, and that it had received 3.5 times more claims than expected, impacting turnaround time. However, TPA reported no data on the time taken to issue membership cards, as required in the contract.

54. As stated above, OIOS identified material discrepancies in TPA's MIP membership records. OIOS was not able to confirm the frequency of use of TPA's network providers ("hit ratios"), because the TPA's provided database of processed claims did not identify the network providers.

55. HLIS had not conducted any formal performance assessments of its TPAs. The current TPA was waived from any contractual penalties in 2015 and 2016, considering the implementation challenges of migrating MIP membership data to Umoja at the time, and TPA's efforts in maintaining membership data through alternative means as well as implementing cost containment measures. At the time of the audit, no decision had been made regarding TPA's performance in 2017. HLIS routinely follows up on TPA's performance through meetings, teleconferences and communications. However, it has few autonomous means to assess TPA's performance against the defined standards, other than based on TPA's self-assessment. In 2016, it intended to conduct an "open-book audit" of the TPAs but could not identify a party to undertake the audit.

56. OIOS report 2015/051 requested OPPBA to institutionalize adequate performance management processes for the TPAs of health insurance plans. Therefore, OIOS does not issue an additional recommendation on this issue.

IV. ACKNOWLEDGEMENT

57. OIOS wishes to express its appreciation to the management and staff of DM, offices participating in MIP, and the TPA for the assistance and cooperation extended to the audit.

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

ANNEX I

STATUS OF AUDIT RECOMMENDATIONS

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts

Rec. no.	Recommendation	Critical[4]/ Important[5]	C/ O[6]	Actions needed to close recommendation	Implementation date[7]
1	DM should establish an adequate governance mechanism for the Medical Insurance Plan that allows members to participate in strategic issues affecting the administration of the Plan.	Important	O	Receipt of evidence of the increase in HLIC membership, including representation from MIP participants to provide governance and oversight of MIP issues.	31 January 2020
2	OPPBA should review and deploy adequate resources for the efficient and effective management of the Medical Insurance Plan that are commensurate to its size and complexity.	Important	O	Receipt of evidence that adequate resources have been deployed in the management of the MIP.	31 January 2020
3	OPPBA should, in coordination with offices participating in the Medical Insurance Plan and the third-party administrator, follow up on discrepancies identified by the audit and implement corrective actions, including for the technical errors in the "eligibility file" generated by Umoja.	Important	O	Receipt of evidence that identified discrepancies and gaps have been addressed.	30 September 2019
4	OPPBA should initiate the migration of health insurance plan membership and contributions records for retirees to Umoja.	Important	O	Receipt of evidence that the migration of retiree records to Umoja has been initiated.	31 January 2021
5	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, establish monitoring mechanisms over accuracy of health insurance plan membership records and contributions.	Important	O	Receipt of evidence of the established monitoring mechanisms on the accuracy of health insurance plan membership records and contributions.	31 January 2021
6	OPPBA should review the Medical Insurance Plan contribution rates to better match annual contributions with expenses and maintain reserves at a desirable level.	Important	O	Receipt of results of the review and relevant action plan to better match annual contributions with expenses.	31 January 2020

[4] Critical recommendations address critical and/or pervasive deficiencies 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.
[5] Important recommendations address important (but not critical or pervasive) deficiencies in governance, risk management or control processes, such that reasonable assurance may be at risk regarding the achievement of control and/or business objectives under review.
[6] C = closed, O = open
[7] Date provided by DM in response to recommendations.

ANNEX I

STATUS OF AUDIT RECOMMENDATIONS

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts

Rec. no.	Recommendation	Critical[4]/ Important[5]	C/ O[6]	Actions needed to close recommendation	Implementation date[7]
7	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, recover the outstanding patient shares identified by the audit.	Important	O	Receipt of evidence of recovery of outstanding patient shares.	31 December 2019
8	OPPBA should establish a monitoring mechanism for the timely recovery of patient shares through the payroll.	Important	O	Receipt of evidence of the established monitoring mechanism for the timely recovery of patient shares.	31 January 2021
9	OPPBA should establish a log of presumptive health insurance fraud cases and follow up on their resolution.	Important	O	Receipt of the OPPBA log of presumptive health insurance fraud cases and their status.	31 December 2019
10	DM should, in coordination with offices participating in the Medical Insurance Plan and OIOS Investigation Division, implement an action plan to develop capacity for investigating cases of health insurance fraud.	Important	O	Receipt of an action plan to develop capacity for investigating health insurance fraud cases by a "responsible official" upon referral from OIOS.	31 January 2021
11	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, develop guidelines and training on health insurance administration for relevant human resources and finance office staff, and require them to brief newly enrolled staff on the Plan's rules, procedures and benefits, and staff obligation to report suspected cases of fraud.	Important	O	Receipt of the issued guidelines and evidence of delivered training on health insurance administration.	31 January 2021
12	OPPBA should periodically evaluate the efficiency and effectiveness of the administration and management of health insurance plans and assess member satisfaction.	Important	O	Receipt of results of the first evaluation of the efficiency and effectiveness of the administration and management of health insurance plans.	31 January 2021

APPENDIX I

Management Response

DM/OUSG
Out:6-Dec-2018
DM-2018-00634

United Nations — INTEROFFICE MEMORANDUM
Nations Unies — MEMORANDUM INTERIEUR

TO: / A: Ms. Muriette Lawrence-Hume, Chief, New York Audit Service, Internal Audit Division, Office of Internal Oversight Services

DATE: 3 December 2018

THROUGH: / S/C DE: Olga de la Piedra, Director, Office of the Under-Secretary-General for Management

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

SUBJECT: / OBJET: **Draft report on the audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts (Assignment No. AH2017/511/02)**

1. We refer to your memorandum dated 29 October 2018 regarding the above-subject draft report and provide you with comments from the Department of Management (DM) in the attached Appendix I.

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

DM-2018-00634
6-Dec-2018

APPENDIX I

Management response

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts

Rec. no.	Recommendation	Critical[1]/ Important[2]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
1	DM should establish an adequate governance mechanism for the Medical Insurance Plan that allows members to participate in strategic issues affecting the administration of the Plan.	Important	Yes	Controller	31 January 2020	At its last session (SMC VII, held from 18-23 June 2018), the SMC agreed to increase the membership of the current Health and Life Insurance Committee (HLIC) from six to ten members, maintaining equal representation of staff and management, to include representatives from beneficiaries from outside New York and from the Funds and Programmes. DM trusts that the upcoming revised membership of the committee will allow for the active participation of offices away from Headquarters in the review of matters pertaining to health and life insurance and should satisfy this recommendation.
2	OPPBA should review and deploy adequate resources for the efficient and effective management of the Medical Insurance Plan that are commensurate to its size and complexity.	Important	Yes	Controller	31 January 2020	Depending on availability of resources. OPPBA is undertaking a review of dedicated resources needed for the proper management of Medical Insurance Plan (MIP) including monitoring and analysis work.
3	OPPBA should, in coordination with offices participating in the Medical Insurance Plan and the third-party administrator, follow up on discrepancies identified by the audit and implement corrective actions, including for the technical errors in the "eligibility file" generated by Umoja.	Important	Yes	Chief, Health and Life Insurance Section	30 September 2019	Umoja is not aware of any technical issues with the creation of eligibility files for the MIP with respect to active staff members and no technical defects are pending with Umoja. OPPBA is in the process of reviewing each item and working with the necessary parties to rectify the discrepancies identified. In addition, OPPBA is reviewing the MIP processes and procedures to identify gaps that may have contributed to the discrepancies.

[1] Critical recommendations address critical and/or pervasive deficiencies 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.
[2] Important recommendations address important (but not critical or pervasive) deficiencies in governance, risk management or 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

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts

Rec. no.	Recommendation	Critical[1]/ Important[2]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
4	OPPBA should initiate the migration of health insurance plan membership and contributions records for retirees to Umoja.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for handling the migration of retirees into Umoja's insurance processes to establish the target date of implementation.
5	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, establish monitoring mechanisms over accuracy of health insurance plan membership records and contributions.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for establishing monitoring mechanisms for accuracy of health insurance plan membership records and contributions to establish the target date of implementation.
6	OPPBA should review the Medical Insurance Plan contribution rates to better match annual contributions with expenses and maintain reserves at a desirable level.	Important	Yes	Chief, Health and Life Insurance Section	31 January 2020	OPPBA is currently working with the current third-party administrator to review the current contribution rates and hopes to have a preliminary review completed by July 2019.
7	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, recover the outstanding patient shares identified by the audit.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for establishing monitoring mechanisms to establish the target date of implementation.
8	OPPBA should establish a monitoring mechanism for the timely recovery of patient shares through the payroll.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for establishing monitoring mechanisms to establish the target date of implementation. However, OPPBA is currently reviewing the process in conjunction with the third-party administrator regarding the uploading of the recovery files to streamline the process and number of files received.
9	OPPBA should establish a log of presumptive health insurance fraud cases and follow up on their resolution.	Important	Yes	Chief, Health and Life Insurance Section	31 December 2019	OPPBA is working with the vendor to revisit the log regarding fraud cases.
10	DM should, in coordination with offices participating in the Medical Insurance Plan and OIOS Investigation Division, implement	Important	Yes	Controller	31 January 2020	Under the current policy, the Health and Life Insurance Section (HLIS) submitted more than 140 fraud cases to the OIOS Investigation

Management response

Audit of administration and management of the Medical Insurance Plan by the Office of Programme Planning, Budget and Accounts

Rec. no.	Recommendation	Critical[1]/ Important[2]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
	an action plan to develop capacity for investigating cases of health insurance fraud.					Division between 2011 and 2018. There are currently about 20 cases for which HLIS is awaiting a finding.
11	OPPBA should, in coordination with offices participating in the Medical Insurance Plan, develop guidelines and training on health insurance administration for relevant human resources and finance office staff, and require them to brief newly enrolled staff on the Plan's rules, procedures and benefits, and staff obligation to report suspected cases of fraud.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for development and/or implementation of additional guidelines, training and communication items to establish the target date of implementation. However, OPPBA is currently working with the third-party administrator to review and improve their communication items.
12	OPPBA should periodically evaluate the efficiency and effectiveness of the administration and the management of health insurance plans and assess member satisfaction.	Important	Yes	Chief, Health and Life Insurance Section	Implementation date for this item is based on the completion of Rec. no. 2.	OPPBA is undertaking a review of dedicated resources needed for periodically evaluate the efficiency and effectiveness of processes and procedures to establish the target date of implementation.