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Note to the United Nations High Commissioner for Refugees from the review of quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations

Note of the Joint Inspection Unit

Prepared by Jesús S. Miranda-Hita

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English only

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I. Introduction

1. The review of the quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations was included in the programme of work of the Joint Inspection Unit (JIU) for 2022 to address long-standing requests from the Independent Audit Advisory Committee of the United Nations Secretariat, the United Nations Educational, Scientific and Cultural Organization, the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Maritime Organization and the World Meteorological Organization. The overarching objective of the review was to identify areas for improvement and good practices with regard to the transparency, quality of service, coordination, harmonization, effectiveness, efficiency and long-term financial sustainability of the health insurance schemes of JIU participating organizations for their active and retired staff. Specifically, in the review, health insurance policies and management, including cost-containment policies and practices, were assessed, financial and budgetary perspectives were explored, and the potential for strengthening coordination and cooperation among organizations, including staff mobility, was examined.

2. JIU issued its report on the review in 2023;[1] it was shared with all JIU participating organizations, including UNHCR.

3. Pursuant to the JIU statute and internal working procedures, the present note is issued to the executive head of UNHCR on the basis of a finding from the review that is unique to UNHCR. Specifically, the note addresses the lack of segregation of duties in administering health insurance claims under the UNHCR Medical Insurance Plan. A formal recommendation is contained in the note to enable the executive head to take action on this important matter.

II. Main findings and recommendations from the review

4. The review found that the governing bodies and legislative organs of JIU participating organizations remained largely inactive in health insurance policymaking, despite health insurance being an essential part of the compensation package for staff. The organizations in the United Nations system have an obligation to establish a social security scheme for their staff, but in all cases except one, regulations are limited to recognition of the right to social security and the delegation to the executive heads of the organizations of full authority to establish relevant health insurance policies. This has resulted in the existence of 26 different health insurance schemes in the participating organizations (one of which is specific to dental insurance). While having one health insurance scheme for all participating organizations is not feasible, a minimum set of principles, requirements or standards for an adequate health insurance scheme would assist policy design and enhance coherence.

5. Health insurance packages often depend on the contract and duty station of staff. Most participating organizations offer a specific health insurance package to their active staff based on their contractual status, whether they are internationally or locally recruited and whether they are located at a headquarters location (such as New York, Geneva and Vienna). The 26 health insurance schemes apply varying eligibility criteria for staff, retirees and their family members and associated protected persons. The unharmonized eligibility criteria, especially for those who receive subsidized premium rates from their organizations, create unequal access to health insurance coverage for active and retired staff and their family members, and demonstrate an inequitable use of public funding.

6. In terms of health insurance premiums and the share contributed by organizations and plan members, under most schemes, the ability to pay and the intergenerational solidarity principle inherent in the notion of social security are the basis for allocating premiums among beneficiaries; as such, staff with lower remuneration or larger families tend to receive a larger share of contributions from their organizations and retired staff and their dependants contribute less, receive higher subsidies and potentially incur higher amounts of health

[1] JIU/REP/2023/9.

insurance reimbursements. For its part, the principle of equivalence or cost causation, which usually characterizes private commercial insurance premiums, is also built into some schemes through the use of flat-rate premiums in absolute amounts. The health insurance scheme of only one United Nations system organization collects flat-rate contributions based exclusively on the age of plan members. Overall, the application of varying models in determining the shares of contributions to health insurance premiums by the organizations and staff results in differing rates of contributions for staff within and across the participating organizations and, for many schemes, such models are not adequately based on the principles of ability to pay and intergenerational solidarity. Therefore, there is room for a system-wide approach to create a set of contribution-setting principles that could foster harmonization and comparability and promote equity and solidarity.

7. The review found the coverage and benefits to be considerably different among the 26 health insurance schemes. Even within the same duty station, for example, annual reimbursement limits vary significantly between plans and even within the same organization for different beneficiaries. Coverage for physical therapy, preventive care for adults, optical and dental health care, mental health care, reproductive health, family planning and infertility treatments also varies significantly.

8. The large-scale global staff survey administered for the review revealed that, from the perspectives of the plan members, health insurance coverage for hospitalization, outpatient care and preventive care was rated the highest as most often "fully" or "mostly" meeting the needs of the respondents. On the other hand, long-term care, mental health care and optical care received the lowest number of positive responses, coupled with other areas deserving of particular attention, such as outpatient care for locally recruited staff, conditions related to physical disabilities and medications for chronic illnesses, physical therapy, routine health check-ups, dental care and reproductive health care.

9. The review found that most plan administrators did not have a clear plan for cost containment. There is also limited inter-agency collaboration on joint procurement, exchanges of good practices and lessons on procurement in health insurance and administration. The feedback of plan members through the survey demonstrated considerable variation in their views on the speed of claim reimbursement, the ease of submission of claims and the effectiveness of the claim dispute resolution mechanism.

10. The review assessed the disclosure, funding and budgetary implications of after-service health insurance liabilities. It found that funding for after-service health insurance liabilities remained an unachieved goal, with only 31 per cent already funded and 13 participating organizations not yet setting aside any significant funding to that end.

11. JIU issued seven formal recommendations, of which two were addressed to the legislative or governing bodies and five to the executive heads of JIU participating organizations. The Unit also issued 33 informal recommendations covering areas such as transparency, coordination of policy changes, coverage, contributions and premiums, administrative matters, including contractual arrangements, and cost containment and oversight.

III. Finding specific to the Office of the United Nations High Commissioner for Refugees

12. The review examined the level of protection of the medical and health-related data of staff in relation to the processing of health insurance claims. It found that how the data received through claim submissions were handled and protected largely depended on each plan's claim administration modality and the personal data protection policy of the participating organization. The 22 health insurance plans that are externally insured or externally administered by a third party follow a comprehensive data protection legal framework. An agreement related to the protection of the personal data of plan members, including medical and health-related data, was reached as part of a service-level agreement or contract. In addition, all of the third-party administrators and commercial insurers used by those health insurance plans are based in either the United States of America or Europe,

which require them to comply with the Health Insurance Portability and Accountability Act of 1996, for the former, or the General Data Protection Regulation, for the latter.

13. Four health insurance plans, including the UNHCR Medical Insurance Plan, are self-administered and process health insurance claims themselves. The handling of the medical and health-related data of the plan members is subject to the internal policies and rules of the organizations. The claims administration for the plans of the International Labour Organization, the United Nations Office at Geneva and the World Health Organization is handled by a centralized unit at their headquarters location, which provides an additional layer of protection for the medical data of plan members in structural terms. The UNHCR Medical Insurance Plan is the only plan for which the majority of the claim reviews and approvals are handled locally, at the country and regional office levels. The Plan's claims procedure requires the submission of a receipt of payment showing the name of the patient, dates and detailed costs of the services or treatments rendered. For prescriptions, a detailed receipt, including details on the diagnosis, is required. A human resources staff member at these offices is typically designated to handle the claims. While the staff handling the claims are required to sign a confidentiality agreement, the fact that the claims are handled directly by a local human resources unit, then subsequently approved by the head of the office, poses a serious concern, especially in terms of the risk of the medical and health-related data of staff being potentially misused.[2]

14. Following the finding of the review, the recommendation set out below is made to the United Nations High Commissioner for Refugees. It is expected to strengthen data protection policies and enhance control and compliance.

Recommendation

The United Nations High Commissioner for Refugees should ensure a clear segregation of duties between human resources units and health insurance claim and reimbursement management functions to ensure the highest level of protection of the medical and health-related data of staff.

[2] At the time of the issuance of the present note, JIU was informed that UNHCR had launched a project in July 2024 to centralize the processing of claims under the Medical Insurance Plan, with the aim of completing it for all relevant duty stations by 2026.