FOR AGENDA

EBAP/08/73

CONFIDENTIAL

July 11, 2008

To: Members of the Executive Board

From: The Acting Secretary

Subject: **Medical Benefits Plan—Review and Proposed Further Reform**

Attached for consideration by the Executive Directors is a paper on a review and proposed further reform of the Medical Benefits Plan, which is tentatively scheduled for discussion on **Friday, July 25, 2008**. A draft decision appears on page 10.

This paper also provides background for an informal briefing on the review and proposed further reform of the Medical Benefits Plan tentatively scheduled for Thursday, July 17, 2008, at 2:30 p.m. in the Executive Board Committee Room.

Questions may be referred to Ms. Brookbank (ext. 36764) and Mr. Clarke (ext. 34086) in HRD.

This document will shortly be posted on the extranet, a secure website for Executive Directors and member country authorities.

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INTERNATIONAL MONETARY FUND

Medical Benefits Plan—Review and Proposed Further Reform

Prepared by the Human Resources Department

In consultation with the Finance and Legal Departments and
the Office of Budget and Planning

Approved by Diana Serrano

July 11, 2008

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EXECUTIVE SUMMARY

This paper outlines a set of proposals to revise the benefits provided by the Medical Benefits Plan (MBP) effective September 1, 2008.

The revisions preserve the overall attractiveness of the MBP to prospective and current staff and retirees, and the main structural changes and the majority of savings introduced in January 2008 to improve the medium-term financial outlook for the plan: (1) A new Preferred Provider Organization (PPO) network administrator (Aetna), with a broader provider network and deeper discounts than previously available;[1] (2) continue to encourage utilization of a new PPO, through reduced out-of-pocket costs for use of in-network providers and lower-cost, effective drugs; and (3) maintains plan features to facilitate efficient claims processing.

The key changes in Plan benefits: (1) bring the coverage for use of out-of-network providers to about the pre-January reform level (80 percent, from 70 percent currently), while improving it slightly for in-network providers; and (2) return to percentage coverage ("coinsurance") for prescription drugs, while maintaining a tiered structure depending on the type of drug used (generic/preferred/brand). In addition, an out-of-pocket expense maximum is introduced for prescription drugs, to protect participants requiring a large number of prescriptions. The revisions would take effect for services received on or after September 1, 2008.

The proposed revisions in plan benefits are affordable and would fit within the medium-term budget (MTB). The January 2008 plan was projected to lower total medical costs by $10–12 million annually relative to the old plan, and the proposed revisions would reduce the anticipated savings to around $6 million. In consequence, participants and Fund contributions would need to rise to meet the long-term financial needs of the Plan. Staff and retiree contribution increases would be initially linked to annual salary adjustments, but would eventually need to be aligned to medical costs which have historically grown faster than salaries. The administrative budget would be charged an additional $1 million in FY 2009 increasing to $3 million by FY 2011. These charges would fit within the MTB expenditure ceiling by finding offsetting savings, or if necessary, by using the contingency reserve. Staff are committed to staying within the MTB ceiling and achieving the $100 million savings objective.

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[1] *Medical Benefits Plan—Proposed Reforms (EBAP/07/135, Revision 1*, 9/19/07)

I. INTRODUCTION

1. The Executive Board in September 2007 adopted a set of reforms to the Medical Benefits Plan (MBP) which became effective on January 1, 2008.[2] In May 2008, the Managing Director reconvened the Task Force on MBP Reform to review and address problems that had surfaced in the first few months of implementing the reform. Based on the review, this paper outlines proposals to revise plan benefits and its funding framework, both effective September 1, 2008.

II. REVIEW OF JANUARY 2008 REFORM

2. Following a period of difficult MBP financial experience, the Managing Director in 2006 appointed a task force to recommend changes to the MBP that would strengthen its financial health without compromising its coverage.[3]

3. The key recommendations were to move to a new PPO offering a broader network of healthcare providers with deeper discounts with industry standard features to facilitate administrative efficiency through a new Plan administrator (Aetna), and plan design changes to encourage use of lower-cost providers in the new PPO network.

4. The January 2008 reforms were the most significant change in the MBP since its inception. Accordingly, the implementation plan provided for close monitoring and a review before the end of FY 2009.

5. A number of concerns surfaced in the first few months of implementation. Close to 20 percent of plan participants responded to an informal survey, with about 70 percent raising concerns about the cost of prescription drugs, availability of network doctors, and cost of out-of-network services. The remaining 30 percent of the issues related mainly to plan administration/service.

6. The transition to Aetna as the new Plan administrator was marred by start-up issues involving provision of inaccurate information and payments to Plan participants. In response to service problems, Aetna has revised and re-audited its claims system, issued corrected payments to participants or healthcare providers, and retrained customer service

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[2] *Medical Benefits Plan—Proposed Reforms (EBAP/07/135, Revision 1*, 9/19/07). The task force on MBP reform was chaired by the Deputy Managing Director, Takatoshi Kato. Members included Liam Ebrill (HRD), Frank Harnischfeger (TGS), Paula De Masi (AFR), Marco Cangiano (OBP), Kevin Fletcher (EUR), and Elisabeth Baker (EXR) representing the Staff Association Committee (SAC). Following the election of the 2007 SAC, Sean Culhane represented SAC. The Fund's Retiree's Association, included in the task force during the latter part of its work, was represented by its President, Klaus Boese.

[3] Mercer Health & Benefits was retained as the consultant and actuary to assess the MBP, work with the task force, and offer views based on its experience with market practices.

representatives. Notwithstanding these transition issues, it is anticipated that Aetna will be able to deliver a high level of service over the longer term.

III. PROPOSED DESIGN CHANGES

7. Following is an overview of the proposed design changes as compared to the current and previous plan. Table 1 and the supporting text describe the proposed changes in more detail.[4]

- ***Prior MBP*:** Paid one level of benefit for most services, after the annual deductible was satisfied.
- ***Current plan*:** Pays a slightly higher level of benefits for use of in-network providers and lower-cost drugs, but lower benefits for out-of-network providers and brand drugs. Annual deductible raised by $100.
- ***Proposed plan*:** Addresses the main concerns identified in the review of the January 2008 reform, by improving benefit levels for prescription drugs and out-of-network care, while maintaining the incentives toward greater use of in-network providers and effective but less expensive drugs. Returns to pre-reform coverage for out-of-network providers; increases the level of benefits for in-network providers; and returns to "coinsurance" (instead of flat dollar copayments) for prescription drugs. Also introduces an out-of-pocket expense maximum for prescription drugs, while maintaining the increased deductibles in effect under the current plan.

[4] Appendix II compares the current and proposed MBP Plan designs with those of the World Bank, United Nations, and Inter-American Development Bank.

Table 1: Comparison of Plan Design Components

	Prior Plan	Current Plan Effective 1/1/2008	Proposed Plan Effective 9/1/2008
Annual deductible	$200/$500	$300/$600	$300/$600
RX drugs	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand
Retail, 30-day supply	80%	$10/$25/$40	90/85/75%
Mail order, 90-day supply	$20 if cost < $400 $20 + 10% if cost > $400	$20/$50/$80 (3-month supply for 2 month cost)	90/85/75% (3-month supply for 2 month cost)
Doctor visit			
In-network	80% after deductible 1/	$20/$40 regular/specialist (no deductible)	$20 regular/specialist (no deductible)
Out-of-network			
Reasonable & customary level	80% after deductible 1/ 90th percentile + 15% + $10	70% after deductible 90th percentile + $10	80% after deductible 90th percentile + 10%
Hospital & lab services			
In-network	80% after deductible	85% after deductible	90% after deductible
Out-of-network 2/	80% after deductible	70% after deductible	80% after deductible
Annual out-of-pocket maximum	Individual/family	Individual/family	Individual/family
Medical	5% of salary/pension	$2,500/$5,000	$2,500 / $5,000
Prescription	N/A	N/A	$1,000/$2,000

1/ Annual physical was covered at 100 percent of the first $250, then 80 percent of the balance, no deductible.
2/ Reasonable and customary levels also apply to out-of-network hospital and lab services.

Annual deductible

8. No change from the current annual deductible structure is proposed.

Prescription drugs

9. It is proposed to move from participant payments of flat dollar amounts ("copayments") to a percentage of the cost ("coinsurance") based on the designated level of the prescription.[5] The designation of levels of prescriptions encourages the use of generic and preferred drugs which are effective and less costly than brand drugs.

Doctor visits

10. Two revisions are proposed to broadly return the coverage of out-of-network doctor visits to the pre-January reform level. First, the plan benefit would increase from 70 percent to 80 percent (both after the annual deductible is satisfied); and second, it is proposed to raise the cap on allowable fees under the Plan, referred to as the level of 'reasonable and

[5] A copayment is a fixed fee to be paid by the participant at the time of each office visit, outpatient service, or filling of a prescription. Coinsurance is a percentage of charges for which the participant is responsible.

customary' fees. 'Reasonable and customary' does not apply to in-network charges as healthcare providers in the network have agreed upon fee levels.

11. For in-network doctor visits, it is proposed to have a uniform $20 copayment per doctor visit, regardless of type of doctor.[6]

Hospital and lab services

12. It is proposed to increase the coverage of out-of-network hospitals and lab services to 80 percent, from the current 70 percent (after the annual deductible). To maintain an incentive toward in-network use, its coverage would be raised to 90 percent, from 85 percent (after the annual deductible). This would apply to hospital care as well as outpatient services not included in the billing for a doctor's visit (e.g., in the case of an in-network doctor visit, for lab services billed separately by a different healthcare provider). Reasonable and customary levels would apply to out-of-network charges for hospitals and lab services.

Annual out-of-pocket expense maximums

13. ***Medical.*** The current level of protection ($2,500 per person and $5,000 per family annual out-of-pocket expense maximum for services covered by the Plan) would be maintained. In-network doctor visit copayments (currently excluded) would be included in the amount counted toward the annual out-of-pocket expense maximum.[7]

14. ***Prescriptions.*** It is proposed to add an annual out-of-pocket expense maximum for prescriptions ($1,000 per person and $2,000 per family).[8] The proposed change would provide protection primarily for those participants who have a large number of prescriptions in the top 'brand' tier.

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[6] Certain preventive care, such as mammograms and PSA tests, would be covered at 100 percent without a copayment for in-network service.

[7] Once a participant's annual out-of-pocket expenses (such as deductibles and coinsurance) reach the annual out-of-pocket expense maximum, benefits for covered expenses are paid for the remainder of the year at 100 percent of the negotiated rate if services are in-network or 100 percent of the reasonable and customary charges if services are out-of-network.

[8] With $1,000 in out-of-pocket prescription drug charges for an individual (or $2,000 for a family), benefits would be paid at 100 percent for the remainder of the year for covered expenses.

Other issues

15. ***Medical services abroad.*** Participants who reside and incur claims outside the United States would continue to be treated as if using in–network benefits. These claims would be paid at 90 percent subject to reasonable and customary levels, after the deductible.[9]

16. ***Implementation.*** All plan design changes are proposed to be effective for services received on or after September 1, 2008.[10]

IV. PROPOSED FINANCING

A. Funding within the Medium-Term Budget

17. The proposed revisions to the MBP are affordable and additional expenses can fit within the MTB spending ceilings. The revised Plan could contribute about $6 million in annual savings through network efficiencies, after taking the estimated $4.1 million cost increase (annual rate at 2008 prices) for plan changes into account.

18. The higher plan costs would be financed by contribution increases by participants, the administrative budget, and the Retired Staff Benefits Investment Account (RSBIA).[11] Contributions would be determined by existing rules, in particular the 1:3 formula under which the administrative budget and RSBIA contribute $3 for each $1 of staff and retiree contributions. For FY 2009, staff and retiree contributions would increase by 4.2 percent on September 1, the approved structural increase for staff and very close to the 4 percent cost of living adjustment given to retirees.[12] A similar increase is planned for May 1, 2009. Administrative budget and RSBIA contributions would rise proportionally. For FY 2009, plan reserves would be $1 million lower than under the current plan, but would still increase relative to the previous year reflecting the $6 million in anticipated savings.

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[9] Since there are no in-network providers available outside the United States, participants who reside abroad and receive care outside the United States do not have the option to use in-network providers. Therefore, the plan provides coverage for those services at the same level as in-network in the United States. For participants who live outside the United States and use services in the United States, coverage for services in the United States would be the same as for United States based participants with in-network and out-of-network benefit levels.

[10] The exception to the September 1, 2008 implementation would be a retroactive feature for the annual out-of-pocket expense maximum for prescriptions back to January 1, 2008. For 2008, this would be administratively handled after the end of 2008.

[11] The RSBIA was established in 1995 to hold, invest, and administer resources contributed by the Fund for meeting the accruing obligations of the Fund with respect to the medical and life insurance costs of current and future retirees. Additional plans related to post-separation benefits were added in later years.

[12] Appendix I shows the current and proposed contribution schedules. The contribution increase will begin September 1, 2008 for retirees and the first full payroll period in September for Fund staff.

19. The projected increase in administrative budget contributions to the medical plan can fit within the MTB ceiling. Staff is committed to the three-year budget envelope and the path to achieve $100 million in savings by FY 2011. Staff recommendation is to shift some of the planned RSBIA prefunding to MBP contributions. The MTB assumed $37 million in annual funding, well above the minimum actuarially-determined contribution for FY 2009 of $26 million based on the improved plan design. Reducing planned RSBIA funding to $36 million from $37 million in FY 2009 to pay for higher MBP contributions would leave total spending within the MTB ceiling, keep the mix of personnel and non personnel costs unchanged, and still provide for significant prefunding in the RSBIA for FY 2009. In a similar vein, the projected required contribution declines to $18 million a year in FY 2010–2011, enabling a similar financing strategy in these years. Longer- term options will need to be assessed, however, as RSBIA minimum required contributions are projected to increase steadily in future years.

B. The Funding Model

20. Staff proposes that the current pay-as-you-go funding model be modified to be more in line with the MTB multiyear budgeting framework. In the current system, contributions are set to cover current year projected expenses while maintaining an actuarially-determined minimum reserve. Although under the current system contributions would be increased in order to keep income in line with expenditures (even with the existence of excess reserves), it is prudent to ensure that contribution increases are smoothed to avoid any unanticipated increases that would put pressure on other budget priorities.

21. Smoothing rate increases and prefunding by pre-announcing annual adjustments in line with the structural increase in staff salaries at a minimum, would simplify planning for the administrative budget and reduce the risk of unanticipated costs on the contingency. Similarly, staff and retirees would see more predictable rate increases, thus facilitating their own financial planning. A consequence of this approach would be that reserves would be above the actuarially-determined minimum level for the next several years. This could be seen as an advantage in view of the uncertainties of medical costs. Annual actuarial reviews would continue to be done to closely monitor the financial experience over time and to evaluate the necessity for any changes to the funding model.

C. Ten-Year Projections

22. Ten-year projections indicate that the revised MBP would be healthy through FY 2011 in terms of a projected surplus as shown in Table 2. Assuming that medical costs rise in line with past experience, and contributions are aligned with salary adjustments, implies that contributions would remain above expenses through FY 2011 and the nominal level of reserves would rise. After that the plan surplus would turn to deficit, and in FY 2014, reserves would fall below the minimum and the contribution rate would need to increase by more than the salary adjustment rate.

23. These projections suggest that, while MBP finances are currently sound, contributions and expenses will need to be reviewed over the medium term to align plan revenues and medical costs. In all years, expenses are projected to rise by 10 percent. The projections show that from FY 2009–FY 2013, the increase in costs could be accommodated by a combination of the estimated 4–4.2 percent annual contribution increase and reserve drawdown. From 2014 onwards, the projections reflect the additional contributions needed to meet the actuarially-determined reserve targets. However, expenditures are expected to exceed contributions by FY 2012, thus necessitating additional review.

Table 2. Medical Benefits Plan Funding Projection FY 2009–FY 2018
Proposed Automatic Contribution Increases

	Fiscal Year									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
A. Beginning reserves	17.5	25.4	30.0	31.4	29.2	22.6	13.3	14.7	16.1	17.7
B. Total contributions 1/	58.7	62.0	64.6	67.2	69.9	74.8	93.9	103.1	113.5	124.9
C. Expenditures 2/	50.8 3/	57.4	63.2	69.5	76.4	84.1	92.5	101.7	111.9	123.1
D. Change in reserves (B–C)	7.9	4.6	1.4	-2.3	-6.5	-9.3	1.4	1.4	1.6	1.8
E. Ending reserves	25.4	30.0	31.4	29.2	22.6	13.3	14.7	16.1	17.7	19.5
F. Actuarially-determined required reserves	8.3	9.1	10.0	11.0	12.1	13.3	14.7	16.1	17.7	19.5

1/ Assumptions: automatic contribution increase of 4.2 percent on September 1, 2008, May 1, 2009, and May 1, 2010; 4.0 percent automatic contribution increases thereafter and additional contributions as needed (beginning in FY 2014) to meet the reserve target. Contributions do not reflect a) any additional interest on reserves over 2008 levels or b) growth in contributions due to staff/retiree movement upward in income-based contribution bands.

2/ Expenditures are projected to increase 10 percent per year.

3/ 2009 expenditures are based on the Actuary's projected cost of $48.1 million for the current plan plus $2.7 million for the proposed plan changes ($4.1 million projected annual cost increase prorated 8 months from September 1, 2008 to the end of FY2009).

V. FUTURE MEDICAL BENEFITS PLAN WORK PROGRAM

24. The proposed plan revisions address the main issues that have arisen in implementing the January 2008 reform, while preserving its key structural elements. A key priority will be to ensure smooth implementation of the proposed changes, in particular to avoid the kind of transition problems experienced with the January 2008 reform.

25. Following implementation of the proposed changes effective September 1, 2008, it is proposed to return to the previously envisaged next stage of the MBP work program to encourage more participation by retirees in national health schemes, especially Medicare. United States medical costs are projected to continue to rise by about 10 percent on average each year—well above the rate of salary and pension increases. As long as this trend continues, there will be a need periodically to revisit plan features comprehensively, to realign contributions and expenditures. With the plan revisions proposed in this paper, including the move to automatic contribution increases in line with annual increases in the salary structure, it is recommended that the next such review would be necessary in about 5–6 years.

VI. PROPOSED DECISION

It is recommended that the Executive Board approve the following decision:

1. The Managing Director is authorized to implement plan design reforms to the Medical Benefits Plan as set out in paragraphs 8–16 of EBAP/08/73, to go into effect on September 1, 2008.

2. The Managing Director is authorized to implement funding reforms to the Plan as set out in paragraphs 20–21 of EBAP/08/73. Specifically,

   a. The Managing Director is authorized to increase the Plan contribution rates by 4.2 percent effective September 1, 2008, as reflected in the proposed contribution schedule set forth in Appendix I of EBAP/08/73;

   b. The Managing Director is authorized to increase the Plan contribution rates, effective May 1 each year, by the percentage structural increase to staff compensation that is incorporated into the administrative budget for that financial year.

APPENDIX I: CURRENT AND PROPOSED CONTRIBUTION SCHEDULES

Current Schedule of the Monthly Enrollee Contributions For the Medical Benefits Plan MBP Contribution Rates Effective May 1, 2007					
Annual Income in US dollars [1]	Types of Coverage				
	Single	Couple	One-Parent Family	Two-Parent Family	Each "Other Dependent"
25,269 & below	$39.37	$78.73	$68.89	$98.42	$168.47
25,270-28,319	$41.74	$83.48	$73.05	$104.36	$178.63
28,320-31,679	$46.74	$93.47	$81.79	$116.84	$200.00
31,680-35,489	$52.32	$104.64	$91.56	$130.80	$223.90
35,490-39,809	$58.65	$117.31	$102.64	$146.63	$251.00
39,810-44,479	$65.66	$131.31	$114.90	$164.14	$280.97
44,480-49,889	$73.51	$147.01	$128.64	$183.77	$314.57
49,890-55,879	$82.39	$164.77	$144.18	$205.97	$352.57
55,880-59,409	$89.80	$179.60	$157.15	$224.50	$361.12
59,410-68,359	$99.52	$199.05	$174.17	$248.81	$361.12
68,360-78,509	$114.40	$228.80	$200.20	$286.00	$361.12
78,510-87,909	$129.63	$259.26	$226.85	$324.07	$361.12
87,910-98,499	$145.20	$290.40	$254.10	$363.00	$361.12
98,500-110,309	$162.65	$325.29	$284.63	$406.62	$361.12
110,310 & above	$171.85	$343.69	$300.73	$429.61	$361.12

[1] Fund net salary or gross pension, as applicable, on annual basis

Proposed Schedule of the Monthly Enrollee Contributions For the Medical Benefits Plan MBP Contribution Rates Effective September 1, 2008					
Annual Income in US dollars [1]	Types of Coverage				
	Single	Couple	One-Parent Family	Two-Parent Family	Each "Other Dependent"
25,269 & below	$41.02	$82.04	$71.79	$102.55	$168.47
25,270-28,319	$43.50	$86.99	$76.12	$108.74	$178.63
28,320-31,679	$48.70	$97.40	$85.22	$121.75	$200.00
31,680-35,489	$54.52	$109.04	$95.41	$136.29	$223.90
35,490-39,809	$61.12	$122.23	$106.95	$152.79	$251.00
39,810-44,479	$68.41	$136.83	$119.72	$171.03	$280.97
44,480-49,889	$76.59	$153.19	$134.04	$191.49	$314.57
49,890-55,879	$85.85	$171.69	$150.23	$214.62	$352.57
55,880-59,409	$93.57	$187.15	$163.75	$233.93	$376.29
59,410-68,359	$103.70	$207.41	$181.48	$259.26	$376.29
68,360-78,509	$119.21	$238.41	$208.61	$298.01	$376.29
78,510-87,909	$135.07	$270.15	$236.38	$337.68	$376.29
87,910-98,499	$151.30	$302.59	$264.77	$378.24	$376.29
98,500-110,309	$169.48	$338.96	$296.59	$423.69	$376.29
110,310 & above	$179.06	$358.13	$313.36	$447.66	$376.29

[1] Fund net salary or gross pension, as applicable, on annual basis

APPENDIX II: OTHER INTERNATIONAL ORGANIZATIONS

1. A review was conducted of the medical benefit plans offered by three United States-based international organizations, to assess how those comparator organizations have adapted to market realities and how the provisions of the MBP might be modified. The first table below compares the current and proposed Fund plans to those of the World Bank (Bank). The second table compares the current and proposed Fund plans to those of the United Nations (UN) and the Inter-American Development Bank (IDB). Both the Bank and the UN offer their staff the choice of two PPO plans.[1] The IDB offers a single PPO.[2] All of the Bank and UN plans and the IDB's single plan are shown below and compared to the current and proposed MBP designs.

2. The Bank and the IDB provide medical coinsurance at 90 percent in-network and 80 percent out-of-network after the deductible. The Bank's plans vary primarily by having different deductible and medical out-of-pocket maximum levels. One level of copayment is used in network for services like doctor's visits. One Bank plan has no in-network deductible. The UN provides coinsurance of 100 percent in-network and, with one exception for hospital benefits, 80 percent out-of-network after the deductible. The UN's HMO covers services at 100 percent but there is no out-of-network coverage.

3. With respect to the prescription drug plans, the Bank's design uses three-tired coinsurance with no out-of-network coverage as proposed for the MBP. Like the proposed MBP, the Bank also uses a prescription drug out-of-pocket expense maximum. With one exception (the UN HMO), the IDB and UN plans use one level of coinsurance for all types of drugs subject to a dollar maximum. IDB and UN allow out-of-network drug purchases but at a low level of coinsurance reimbursement.

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[1] In addition, the Bank offers a Point-of-Service plan (POS), while the UN offers a Health Maintenance Organization plan (HMO).

[2] The Bank and the UN each offer three plans. For the Bank, the plan with the highest enrollment is the Aetna Open Choice PPO—Option A. For the UN, the plan with the highest enrollment is the Empire Blue Cross PPO. The IDB's single plan is a CIGNA PPO.

Appendix II: Table 1. Comparison of Fund and Bank Plans

	Current Fund Plan	Proposed Fund Plan	Bank Staff Option A	Bank Staff Option B	Bank Staff Option C	Bank Retiree Plan 1	Bank Retiree Plan 2
Deductible							
(individual/family)	$300/$600	$300/$600	$250/$500	$600/$1,200	$300/$600	$400/$800	$600/$1,200
RX drugs	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand	Generic/Preferred/Brand
Retail, 30-day supply	$10/$25/$40	90/85/75%	100/80/70% (after $50 deductible if preferred or brand)	100/80/70% (after $50 deductible if preferred or brand)	100/80/70% (after $50 deductible if preferred or brand)	100/80/70% (after $100 deductible if preferred or brand)	100/80/70% (after $100 deductible if preferred or brand)
Mail order, 90-day supply	$20/$50/$80	90/85/75%	100/80/70%	100/80/70%	100/80/70%	100/80/70%	100/80/70%
Doctor visit							
In-network	$20/$40 regular/specialist (no deductible)	$20 regular/specialist (no deductible)	$15 regular/specialist (no deductible)	$20 regular/specialist (no deductible)	$15 regular/specialist (no deductible)	$15 regular/specialist (no deductible)	$20 regular/specialist (no deductible)
Out-of-network	70% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Reasonable & customary level	90th percentile + $10	90th percentile + 10%	90th percentile + 10%	90th percentile + 10%	90th percentile + 10%	85th percentile + 10%	85th percentile + 10%
Hospital and lab services							
In-network	85% after deductible	90% after deductible	90% after deductible	90% no deductible	100% if referred	90% after deductible	80% after deductible
Out-of-network	70% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	90% hospital 80% lab after deductible	80% after deductible
Out-of-pocket maximum	Individual/family	Individual/family	Individual/family	Individual/family	Individual/family	Individual/family	Individual/family
Medical	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$3,000/$6,000	$3,250/$6,500	$4,000/$8,000
Prescription	N/A	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000	$1,250/$2,500	$1,250/$2,500

Appendix II: Table 2. Comparison of Fund Plans with UN and IDB Plans

	Current Fund Plan	Proposed Fund Plan	UN HMO	UN Aetna PPO	UN Blue Cross PPO	IDB
Deductible				Out-of-network only	Out-of-network only	Out-of-network only
Individual family	$300/$600	$300/$600	$0/$0	$125/$375	$150/$450	$200/$400
RX Drugs	Generic/Preferred/Brand	Generic/Preferred/Brand				
Retail, 30-day supply	$10/$25/$40	90/85/75%	$5.00	15% copay up to $15 60% out-of-network	15% copay up to $15 60% out-of-network	$10 50% out-of-network
Mail order, 90-day supply	$20/$50/$80	90/85/75%	$7.50	After $10	After $10	100% no copay no out-of-network
Doctor visit						
In-network	$20/$40 regular/specialist (no deductible)	$20 Regular/specialist No deductible	100%	$10	$10	90%
Out-of-network	70% after deductible	80% after deductible	No out-of-network	80% after deductible	80% after deductible	80% after deductible
Regular & customary fee	90th percentile + $10	90th percentile + 10%	N/A	90th percentile	90th percentile	90th percentile
Hospital & lab services						
In-network	85% after deductible	90% after deductible	100%	100%	100%	100% for hospital services; 90% lab services outside hospital
Out-of-network	70% after deductible	80% after deductible	No out-of-network	100% hospital; 80% lab after deductible	80% after deductible	80% after deductible
Out-of-pocket maximum	Individual family	Individual family	Individual family	Individual family	Individual family	Individual family
Medical	$2,500/$5,000	$2,500/$5,000	N/A	N/A in-network $1,125/$3,375 out-of-network	N/A in-network $1,150/$2,950 out-of-network	$1,000/$2,000 in-network $2,000/$4,000 out-of-network
Prescription	N/A	$1,000/$2,000	N/A	N/A	N/A	