March 23, 2011
Approval: 3/30/11

INTERNATIONAL MONETARY FUND

Minutes of Executive Board Meeting 10/120-2

11:05 a.m., December 15, 2010

2. Medical Benefits Plan—Medicare Participation and Related Savings; Response to U.S. Health Care Reforms

Documents: EBAP/10/114; EBAP/10/115 and Supplement 1

Staff: Clarke, HRD; Lester, LEG

Length: 20 minutes

Executive Board Attendance

M. Portugal, Acting Chair

Executive Directors	Alternate Executive Directors
M. Majoro (AE)	M. Saho (AE)
K. Assimaidou (AF)	
	J. Maciel (AG), Temporary
	W. Chetwin (AU), Temporary
	I. Ábel (BE), Temporary
	J. Estrella (BR), Temporary
	Q. Chen (CC), Temporary
	J. Rojas (CE)
	J. Rolle (CO), Temporary
	A. Terracol (FF), Temporary
K. Stein (GR)	
	N. Choudhary (IN), Temporary
	N. Giammarioli (IT), Temporary
	M. Makino (JA), Temporary
	S. Rouai (MD), Temporary
	S. Geadah (MI)
	Y. Yakusha (NE)
	A. Sutt (NO), Temporary
	A. Tolstikov (RU), Temporary
	A. Al Nassar (SA)
	E. De Leon (ST), Temporary
	S. Antic (SZ), Temporary
	E. Meyer (UA), Temporary
	R. Elder (UK)

J. Lin, Acting Secretary
S. Maxwell, Assistant

Also Present
Asia and Pacific Department: A. Win. European Department: K. Moran. External Relations Department: A. Kumar. Finance Department: D. Hicks. Human Resources Department: C. Clarke, S. Mariano, J. Nicoson, M. Rodlauer, S. Siegel, M. Vicini. Legal Department: J. Lester, P. Morris, B. Patterson. Office of Budget and Planning: G. Conway, M. Henderson, R. Mariduena. Secretary's Department: L. Bonato, P. Martin. Statistics Department: B. Shannon. Western Hemisphere Department: E. Baker. Senior Advisors to Executive Directors: M. Sidi Bouna (AF). Advisors to Executive Directors: S. Meyer (GR), G. Sargsyan (NE), J. Tucker (AE), R. Ward (UK).

2. MEDICAL BENEFITS PLAN—MEDICARE PARTICIPATION AND RELATED SAVINGS; RESPONSE TO U.S. HEALTH CARE REFORMS

The staff representative from the Human Resources Department (Mr. Clarke) submitted the following statement:

Management's proposals to encourage retiree participation in Medicare and other national health schemes are contained in EBAP/10/114. The proposals had been discussed at the formative stages earlier this year with the Staff Association Committee (SAC) and the IMF Retirees Association (IMFRA), and in November the SAC and IMFRA had the opportunity to review the paper and provide written comments. More recently, some retirees have pressed a broader issue that, although not the focus of the current proposals, has been a long-standing concern for some U.S. staff and retirees. We believe it would be useful for Executive Directors to have staff's views on the concern they have raised.

Retiree Hospitalization Coverage in the United States

U.S. nationals are required to contribute towards Medicare Part A, which covers hospitalization costs for eligible participants upon reaching age 65. Some U.S. staff and retirees have expressed concern that they have had to pay substantial payroll taxes during their Fund career for Medicare Part A coverage, and during their retirement they pay the same MBP premiums as others who are not enrolled in Medicare or in comparable national health programs. Thus, they argue, U.S. nationals are charged twice for their retiree hospitalization coverage, and are subsidizing MBP coverage for non-U.S. participants.

However, that assessment overlooks several complex issues of comparability. Some background is in order.

Medicare Part A is funded through a payroll tax (currently 2.9 percent) that is part of the Social Security taxes paid quarterly by U.S. staff, and partially reimbursed by the Fund through the tax allowance system. Once an individual has paid the Medicare tax for ten years, he or she is automatically eligible for the Part A hospitalization coverage at age 65. Covered individuals pay no annual premium for Part A coverage.

Medicare Part A hospitalization coverage differs in substantial ways from MBP hospitalization coverage. It is the policy of the MBP, like other health insurance in the United States, that when a retiree is covered by a national health scheme, such as Medicare Part A, the national scheme is the

primary insurer, and the MBP only pays excess costs not covered by the national scheme. Therefore, retiree enrollment in national health schemes creates significant savings for the MBP but also confers a benefit to these retirees. The $7 discount for participation in Medicare Part A was adopted in 1992 as part of a program to encourage such savings.

The concerns about perceived "double payment" to Medicare and the MBP were thoroughly considered in 1999 and 2000, when a number of proposals to address this issue were presented to Executive Directors. Ultimately, no acceptable solutions could be found, and the discussions identified numerous difficulties with the Fund attempting to equalize the different circumstances of U.S. nationals who have paid Medicare taxes and those of non-U.S. nationals. We offer three examples:

In return for their payroll taxes, U.S. staff has the security of becoming eligible for Medicare hospitalization coverage for which no premium is charged. That security is significant to a staff member who might not qualify for MBP retiree coverage. Non-U.S. staff does not face payroll taxes during their Fund careers, but many of them lack the security of a national health scheme when they reach old age, or if they are eligible for a scheme they often face premiums or taxes on their pensions as a condition of coverage.

In contrast to the premiums paid by some non-U.S. retirees for national health coverage, the Medicare payroll tax is not a payment for one's own retiree hospitalization coverage. The Medicare taxes that current workers pay are funding the current benefits of retirees, who pay no premiums. During the 1999 and 2000 discussions, this inter-generational element of Medicare funding gave rise to concerns about the appropriateness of fully reimbursing Medicare taxes for U.S. staff. Whereas U.S. staff and retirees favored increasing the Fund's rate of reimbursing the Medicare tax through the tax allowance system, to 75 percent or 100 percent of the tax, such an approach was not supported by a number of Executive Directors. Among the concerns voiced by some Directors was that it would have been costly, nontransparent, and poorly targeted because many of the staff who would receive such tax reimbursements would not be participants in the MBP during their retirement; therefore, they would receive the benefit from the Fund but the MBP would not receive the savings corresponding to their Medicare coverage.

Executive Directors also took into consideration a 1992 study which concluded that most U.S. staff paid considerably more payroll taxes than the benefits they could expect to receive. However, the study indicated this was largely the result of increases in payroll tax rates and the adoption of a more

progressive approach to the payroll taxes. Some Directors observed that the perceived "double payment" for retiree hospitalization coverage is largely a subsidy of lower-income participants in Medicare Part A.

With the current proposal, we have chosen not to revisit the intractable issues arising from the Medicare payroll tax, although we acknowledge this remains an area of concern for some U.S. staff and retirees.

Instead, we have focused on the shared interest that the Fund, the staff, and retirees have in a financially sustainable MBP. Financial stability requires greater levels of participation in national health schemes than the trends we have been seeing. It should be recalled that when the $7 discount for Medicare Part A was introduced in 1992, the stated objective was to encourage retirees to make use of these national health plans and thereby to reduce the costs to the MBP. It is proposed to eliminate the Part A discount because it is not needed as an incentive, would be difficult and confusing to administer in its current form alongside the proposed Part B incentive, which is a reimbursement to retirees rather than a discount on the MBP premium paid by retirees, and more generally the MBP is not a proper vehicle for addressing perceived inequities arising from the different tax treatment of Fund staff. The enhanced and more targeted incentive that is proposed would more effectively encourage participation in national health schemes at a reasonable cost, and it would be simpler to understand and to administer than the alternatives.

Finally, we have consulted with the Legal Department, which has advised that the proposal is consistent with the Executive Board's authority to establish and amend the terms and conditions of employment, including the provisions of the MBP.

Ms. Lundsager and Mr. Meyer submitted the following statement:

Reviewing and updating the Medical Benefits Plan (MBP), as with other staff and retiree benefits, are vital to ensuring that they remain up to date with changing legal and regulatory frameworks, as well as grounded by financial sustainability. We can support the proposed decisions to alter the MBP, in response to recent U.S. health care reforms, and to encourage Medicare participation by eligible plan enrollees. We note, however, the following points that elaborate on our support.

The 2012 comprehensive review of the MBP is a critical opportunity to take stock of the plan's design and funding, with a view to ensuring its financial soundness. We urge management to engage the Board early in this

process, including through informal technical briefings given the complexity of the issues involved. As we have noted before, we believe a more comprehensive review of benefits is warranted as the growth in costs for such benefits now exceeds the pace for overall compensation growth.

The driver for declining MBP retiree enrollment in Medicare Plan B is not entirely clear. The staff asserts that this appears to be linked to premium increases, but convincing data remains unavailable. Nevertheless, we can support the effort to encourage eligible retirees to enroll in Medicare B by providing a partial subsidy in lieu of the current $7 discount. We strongly support the elimination of the $7 discount for Medicare A, which is mandatory and has already been paid for through payroll taxes underwritten by the Fund. A review of results of this endeavor, as part of the 2012 MBP review along with further data on retiree motivations, will be important to assessing the success of this change or to making further adjustments.

Similarly, we appreciate the staff's explanation of the World Bank and IADB experience with making Medicare B participation mandatory. Nonetheless, we believe such an approach deserves further consideration. The 2012 review provides an opportunity for more detailed explanations of these IFI experiences and justifications for why the IMF should take a different approach.

Mr. Hockin and Mr. Rolle submitted the following statement:

We support the proposed amendments to the MBP in so far as the plan would remain competitively aligned with U.S. health care reforms and provide stronger preventive care incentives that could reduce long-run costs. Although the net effect is not a significant increase in operating costs, we look forward to the next comprehensive review of the MBP, as the plan's reserves are expected to be significantly depleted from 2015 onwards, even in the absence of the proposed changes.

We also endorse the proposals to provide larger cost-sharing incentives for retirees to participate in national health insurance schemes, including the U.S. Medicare plan. Since the Fund's portion of Medicare expenses per participant will no longer be static, it is prudent that the cost sharing ratio would be reviewed periodically, as health care premiums evolve. However, we would expect recalibrations to occur in a fashion that minimizes the uncertainty for participants.

Mr. Lushin and Mr. Tolstikov submitted the following statement:

The participation of the Fund's retirees in Medicare Part B helps to reduce the Fund's MBP expenditures and should be encouraged. The decline in Medicare Part B participation level may indicate that the $7 monthly subsidy currently in place may be seen as an insufficient compensation against the growing Medicare B premium. In order to increase participation, some additional incentives should be provided.

As for the proposed scheme, its effect on the level of participation and on the MBP resources depends on many factors and risks, which are difficult to assess. Some parameters of the scheme could be different. For example, we believe that even with the level of reimbursement somewhat lower than 75 percent, the scheme will still remain financially attractive for retirees, while generating more sustainable savings for the MBP. However, as far as staff is confident that the envisaged level of subsidy will secure net savings, we are ready to support the proposed approach. We support the review of the effectiveness of the scheme after two years of operations.

The $7 monthly payment for participants in Medicare Part A is a good example of a poorly designed subsidy since participation in Part A is mandatory anyway. Therefore, we agree with its cancellation.

Mr. Majoro submitted the following statement:

Enhancing the responsiveness of the Fund's Medical Benefits Plan (MBP) with a view to minimizing the financial burden on enrollees, improving the quality of service provision, and ensuring the plan's long-term financial viability should form an integral part of program monitoring. It is in this context that we welcome efforts at encouraging increased retiree participation in national health schemes, notably the U.S. Medicare system, and ensuring that the MBP appropriately reflects changes to these schemes. Against this backdrop, we support the proposed decisions on increasing the financial incentive to encourage Fund retirees' enrollment in national health care schemes. We would, nonetheless, welcome staff's comments on the following issues:

While we welcome the proposal to review the enhanced incentive program after two years of operation if approved, we are concerned that the financial incentive to ensure Fund's retirees participation in national health schemes have not trended with changes in the national schemes' premiums, thus rendering participation in the latter increasingly unattractive. One

possible approach to enhancing the MBP's responsiveness would be to introduce an automatic incentive mechanism. In staff's view, is this approach plausible? If not, what would staff recommend to address the problem?

Also, we note that other Washington-based international financial institutions (IFIs), including the World Bank, employ mandatory approaches. While we acknowledge that a mandatory enrollment system entails higher cost implications, one is inclined to believe that unlike the other IFIs, the Fund's MBP tends to place much more emphasis on maximizing savings. The staff's comments are welcomed.

On the proposal to update the MBP to reflect recent changes to the U.S health care reform program, we support the draft decision. We consider the elimination of cost-sharing in respect of preventive services quite appropriate and agree that, over the long run, the return on investment would be positive. However, we would appreciate staff's comments on the following issues:

We note that implementation of the U.S. health care reform program continues to be subject to political developments. In the instance where the U.S. legislature or judiciary suspends implementation of the reform program or expunges aspects of the program relating to the proposed changes, what would staff's recommendation be? Is there an exit strategy or a need for it?

Finally, we would welcome staff's clarification on their assertion that the MBP has no lifetime dollar limits on benefits given that certain benefits, including dental and fertility treatment, are still subject to dollar caps.

Mr. Mori and Mr. Estrella submitted the following statement:

We thank staff for the informative reports.

Medicare Participation and Related Savings

The changes proposed by staff would, in the medium term, have a financial net saving to the Medical Benefits Plan (MBP). The changes are basically creating incentives to Fund retirees to enroll in the voluntary Part B of the Medicare.

We support the proposed approach to eliminate the current US$7 incentive for Part B in 2011 and replacing it with the reimbursement of 75 percent of the Part B basic premium, including the proposed 75 percent reimbursement of the penalties for late Medicare enrollees. The proposal

would be consistent with the MBP cost-sharing formula and the premium reimbursement would be based on Fund pension income instead of taxable income used by Medicare.

Medicare Part A is not voluntary; therefore, the actual incentive to participate in this part of the Medicare is not necessary. We agree with its elimination in 2012.

We support the voluntary nature of the IMF MBP in relation to the Part B of the Medicare, since the mandatory approach followed in other international organizations would be difficult and costly to administer.

We agree to review the effectiveness of the program after two years of implementation.

Response to U.S. Health Care Reforms

The staff is proposing changes to the Fund's MBP to make it more comparable to other plans, specifically to the new USA Patient Protection and Affordable Care and Health Care and Education Reconciliation Acts of 2010.

To this end, we agree with the three main proposed changes, namely extending coverage to children up to age 26, regardless of the marital and financial status of the dependent child, zero cost-sharing to staff for preventive care recommended by the U.S. Preventive Services Task Force and the elimination of pre-existing medical condition exclusion.

Mr. Sadun and Mr. Giammarioli submitted the following statement:

We are pleased to learn that the IMF Medical Benefit Plan (MBP) broadly meets or exceeds the new standards set by the U.S. health care reform legislation. Against this background, we are in favor of the proposed amendments to the MBP aimed at closing the remaining gaps with respect to the U.S. system. Accordingly, we support the extension of the coverage to children up to age 26, the provision of preventive care services at no cost, and the elimination of the pre-existing medical condition exclusion that currently applies to short-term contractual employees.

On Medicare participation, we can go along with the proposed enhancement of the current incentive program through a stronger and more-targeted incentive system. We are confident that the elimination of the current Medicare Part A incentive and the substitution of Part B, lump sum

contribution with the reimbursement of 75 percent of the basic premium (including eventual penalties), would deliver the expected savings, benefitting at the same time the enrolled retirees.

Given that the results provided in the staff report seems to be based more on anecdotal evidence than on detailed analysis, we are looking forward to the next review to better evaluate the impact of the reform on the enrollment and the finances of the MBP.

Mr. Assimaidou submitted the following statement:

We note from the paper Medical Benefits Plan—Medicare Participation and Related Savings that the sharp increase in Medicare premiums will lead to a decline in participation in Medicare programs by U.S. nationals working at the IMF, who will tend to rely exclusively on the IMF's Medical Benefits Plan (MBP) for their medical insurance coverage. Since Medicare is the primary insurance—paying benefits first and then MBP coordinating to pay residual claim costs—the decline in participation in Medicare programs, along with the projected rapid increase in the number of IMF retirees in the coming years will put strong pressure on MBP finances.

We therefore support the proposed decision to enhance the current incentive program to encourage U.S. nationals to participate in Medicare by raising the incentive to participate in Medicare Part B, from $7 per month reduction in MBP contributions to approximately $72 (representing approximately the reimbursement of 75 percent of the basic premium for Medicare Part B, including late enrollment penalties). Indeed, Part B, as the voluntary part of Medicare, is particularly affected by the decline in IMF retiree participation, as opposed to the mandatory participation in Part A.

The paper also proposes that the incentive to participate in Medicare Part A and also participation in similar non-U.S. programs be eliminated. In this regard, while the motives for eliminating the incentive to participate in Part A presented in paragraph 9 are clear (notably the fact that the incentive had been initially poorly targeted), could staff elaborate on the reasons for eliminating the incentive to participate in non-U.S. programs?

Finally, we note the risks associated with the newly proposed incentive program discussed in paragraph 21, and agree with the course of action proposed, i.e., to review the program after two years of operation to assess its impact on enrollment and the finances of the MBP.

From the paper on Medical Benefits Plan—Response to U.S. Health Care Reforms, we are pleased to note that the MBP complies with the main provisions of the new U.S. health care legislation. However, the plan would lose competitiveness in the medical insurance market in three important areas: coverage of dependent children aged 25 and 26, preventive care, and pre-existing conditions limitation for short-term contractual employees. We agree that the MBP should be changed to match the new provisions of the new U.S. health care legislation in those areas. Given the modest financial impact of the proposed changes to the MBP, we support the proposed decision, and ask staff to continue to inform the Board on its ongoing assessment of the impact of the legislation on other areas of the MBP.

Mr. Al Nassar submitted the following statement:

I welcome the staff's assessment that the Fund's Medical Benefits Plan (MBP) broadly meets or exceeds the provisions of the recently enacted U.S. healthcare reform legislation. In this regard, I support the proposed changes to the MBP to address the identified shortfalls against the new standards. While the impact of these changes on MBP finances would be modest, especially as the greater use of preventive care services over time is expected to offset the cost of the proposed changes, I look forward to the planned review of the MBP's design and its funding in FY2012, given the projected emergence of plan deficits beginning in FY2015 even without the proposed changes.

On Medicare participation and related savings, I support the proposals to enhance the current incentive program to encourage retiree participation in national health schemes, primarily the U.S. Medicare system, to help further reduce the MBP's costs. I also endorse the proposal to eliminate the current contribution for Medicare Part A and other national health schemes with mandatory participation to better target the incentive. While savings are expected over time with the introduction of the new incentive program, I welcome the plan to assess the impact on enrollment and the finances of the MBP after two years of operation considering the risks identified in the paper.

The Acting Chair (Mr. Portugal) asked for, and noted, the Board's consent for representatives of the Staff Association Committee (SAC) and the Retirees Association to attend the discussion, subject to the attorney-client privilege exception. He suggested that Directors raise questions of a legal nature before the representatives of the SAC and the Retirees Association were invited to enter the boardroom.

Mr. Rouai sought clarification about why the decision on the Medical Benefits Plan (MBP) had been modified to remove the reference to dependent children.

Mr. Stein noted that the newspapers were reporting that parts of the health care reforms in the United States were still under litigation, with some rulings in favor and some opposed. He sought clarification about what extent if any the aspects under legal review affected the changes being proposed to the Fund's MBP.

The staff representative from the Human Resources Department (Mr. Clarke) clarified that the decision had been corrected to eliminate some redundant text that had been inadvertently included from the MBP plan document, and emphasized that nothing had changed in terms of the substance of the proposal.

The staff representative from the Legal Department (Ms. Lester) stated that there had been much activity in the U.S. courts on the health care reform legislation, underlining that the part of the legislation that was being challenged in the courts was related to the individual mandate provision. The recent decision in the Virginia courts was not the end of the story on litigation and the staff paper indicated that staff would be reviewing the legislation and making any necessary changes. The proposals for consideration now were not affected by the current legal activity.

The Acting Chair (Mr. Portugal) invited the SAC representatives and also the representatives of the Retirees Association to join the meeting.[1]

Ms. Terracol made the following statement:

> We support the two proposed decisions and since we did not issue a preliminary statement, we would like to make two general comments.
>
> First, of all, on the response to the U.S. health care reform, we agree that from a general point of view, it could be necessary for the Fund to reflect U.S. law in order to maintain alignment with comparator plans. However, this alignment should not be automatic, but assessed on a case-by-case basis, notably taking into account the impact on each modification on the MBP financial sustainability.
>
> In this specific case we agree that the changes are justified, and modest in cost, although it should also be underscored that the reserve will be below the target from 2019 onward.

[1] Prior to the Board meeting, members of the SAC and the Retirees Association each circulated statements by email. For information, these are included as an annex to this minute.

Finally, like Ms. Lundsager and Mr. Meyer, we think that the 2012 review of the MBP will be an important step, and that a more comprehensive review of benefits will be also useful, and we look forward to staff's analysis and recommendations in this area.

Mr. Rouai thanked staff for the earlier bilateral clarification and noted that his chair had no difficulty to support the proposed decisions to enhance the incentive program to encourage participation in Medicare and other national health care schemes, and to modify the MBP to implement changes enacted by the U.S. health care reform.

Mr. Stein expressed support for the staff proposals as presented, and like several other Directors found it sensible to look into the Medicare participation issue again in 2012.

Mr. Elder supported the proposed decisions as well as the statement by the U.S. chair, in particular the suggestion for a comprehensive review in the future.

Mr. Yakusha expressed support for the proposed decision and the modification of the MBP in line with the new U.S. health care legislation incentives to encourage retirees to participate in the Medicare program. While the staff's idea to preserve the initial cost-treating formula 2 to 1 had merit, it should not be a panacea. The staff's review of the ratio in subsequent reviews was welcome, as well as future opportunities to review the benefits of the proposed approach. In that regard, staff was encouraged to reconsider the possibility of the mandated approach of the Medicare participation by the next review, as currently done in the World Bank and the Inter-American Development Bank.

Mr. Meyer made the following statement:

We appreciated the staff's additional information that was circulated last night. It was very useful for putting into context what is oftentimes a divisive and emotional issue. That is what we have seen in the United States and most Directors have noticed over the past couple of years as we grappled with health care reform. Nobody is happy with it usually, it raises a number of issues, and makes many, many people nervous, which is understandable.

I appreciate the staff's note last night, which laid out some of the broader issues involved. Those are issues with which we continue to grapple in this country, and I would like to say we fully agree with the comments in the staff's note that indicate the MBP is not necessarily the appropriate vehicle to try to address what may be perceived as tax inequities and inequalities. As someone wrote today a $750 check to pay for my Medicare contributions at some point in time in the future, I am particularly supportive of the proposals

in the paper, as they seem balanced and reasonable. I just wanted to put that on the table.

The staff representative from the Human Resources Department (Mr. Clarke), in response to comments and questions by Executive Directors, made the following statement:

There were a few questions posed by Directors. Mr. Majoro noted that in the past the financial incentive for retiree participation has not really kept pace with the increase in premiums, particularly Medicare premiums, and he wondered whether there was some sense in which we could introduce some automaticity into the incentive. Indeed, there is an element of automaticity in the proposed approach. With respect of Medicare, the Part B premiums are reviewed every year by the Social Security Administration and can change. The proposed incentive is anchored on the basic premium for Part B with reimbursement set as a percentage of that premium, unlike the current system in which there is a fixed nominal dollar amount which does not change frequently, as we are experiencing. The proposed approach will keep pace with the premium increases over time as reflected in the Medicare base premium increases.

There was a question on the mandatory approach, also from Mr. Majoro. Beyond the points made in the paper, I would just emphasize that we have a very similar plan design to the World Bank in most respects. We are no more and no less cost conscious. It is just that in the Fund we have traditionally relied on voluntary approaches, and in particular there is a reluctance here to compel participation in a voluntary program like Medicare Part B. The mandatory approach is also, as we understand it is being applied elsewhere, rather difficult to administer and enforce in some cases on a worldwide basis.

There was a question about why would we eliminate the Part A discount for non-U.S. programs? The reason we propose to do that is simply to maintain an equitable approach across borders. What we are proposing to do is eliminate the counterpart of the Part A discount for retirees who have access to national health schemes in other countries, and symmetrically, we would provide a 75 percent reimbursement where those national schemes require a contribution. The approach is intended to treat retirees both in the United States and in other countries on the same basis.

One final question of a more technical nature, also from Mr. Majoro, was on clarifying the extent to which the MBP has no dollar limits on benefits. The U.S. legislation has eliminated annual and lifetime dollar limits

on what is generally referred to as essential benefits. These are things like hospitalization, emergency services, prescription drugs, laboratory services, preventive care, mental care, and pediatric care. To use the examples cited in the question, neither fertility treatment nor dental benefits are included in this definition, and for these benefits the MBP has dollar limits. If the definition of essential benefits changes, we would look at the MBP coverage limits as well, but beyond this one area there are essentially no comparable dollar limits in the MBP.

Mr. Rouai sought clarification about the cases of retirees who were members of the national health care scheme in another country and Medicare at the same time. It was not clear whether a retiree who settled part of the year in the United States and part of the year in his own country could be a member of two health care systems.

The staff representative from the Human Resources Department (Mr. Clarke) noted that Medicare did not pay for services provided outside the United States. On the particular question about the coordination of health schemes, staff did not have a clear answer as the situation had not arisen.

The Executive Board took the following decisions:

Medical Benefits Plan—Medicare Participation and Related Savings

The Managing Director is authorized to implement an enhanced program to encourage participation in national health schemes as follows:

a. Effective January 1, 2011, eliminate the monthly $7 contribution reduction for Part and reimburse Medicare beneficiaries 75 percent of the basic Medicare Part premium (i.e., the first income tier, currently $110.50 for new enrollees in CY 2010) and 75 percent of the penalties for late enrollment, regardless of income tier, only for those enrolling during January through March 2011 and January through March 2012;

b. Effective January 1, 2011, reimburse retirees enrolled in other voluntary national health schemes 75 percent of their basic premia, if applicable, and 75 percent of any corresponding penalties for late enrollment, if they enroll at the earliest opportunity in 2011 or 2012;

c. Effective January 1, 2012, eliminate the monthly $7 contribution reduction for Medicare Part A and other national health schemes with mandatory participation; and

d. For late Medicare enrollees, offer the enhanced program for a limited time to encourage their enrollment, i.e., during the next two Medicare general enrollment periods, January 1, 2011 through March 31, 2011 and January 1, 2012 through March 31, 2012;

e. The Part premium reimbursement will increase in line with Medicare Part premium increases each January 1. A similar annual procedure will apply for other national health schemes with participant premia increases;

f. Part premia and penalty reimbursements would be accounted for in the same way as Fund contributions to the MBP on behalf of retirees, i.e., through the Retired Staff Benefits Investment Account.

In addition, the Managing Director is authorized to reduce or suspend the annual increases in such reimbursements, taking into account the effectiveness of the incentive program.

In summary, the changes are effective from January 1, 2011, with the exception of the change described in paragraph c, which is effective January 1, 2012.

The enhanced program will be reviewed after two years of operation. (EBAP/10/114, 12/02/10)

Decision No. A/13355-(10/120), adopted
December 15, 2010

Medical Benefits Plan—Response to U.S. Health Care Reforms

The Managing Director is authorized to implement changes to the Medical Benefits Plan in response to the U.S health care reform legislation as follows:

a. Extend eligibility for a dependent child until the attainment of 26 years of age, and eliminate the conditions relating to the marital and financial status of the dependent child.

b. Eliminate participant cost-sharing for those preventive services recommended by the U.S. Preventive Services Task Force; and

c. Eliminate the pre-existing condition exclusion for participants enrolled for Limited coverage.

The changes will take effect January 1, 2011. (EBAP/10/115, Supplement 1, 12/14/10)

Decision No. A/13356-(10/120), adopted
December 15, 2010

APPROVAL: March 30, 2011

SIDDHARTH TIWARI
Secretary

Statement by the Chair of the Staff Association Committee
Medical Benefits Plan-Integration of Medicare Part B Board Meeting
December 15, 2010
on Medical Benefits Plan—Medicare Participation and Related Savings (EBAP/10/114) and Medical Benefits Plan—Response to U.S. Health Care Reforms (EBAP/10/115)

We welcome the opportunity to comment on the two papers before you today - *MBP changes – Medicare Incentives and Health Care Reform.*

The proposals are broadly consistent with agreed initiatives and SAC supports the adoption of the changes in response to U.S. health care reform and the spirit of the Medicare proposal, with the following specific remarks:

A. **MBP Changes – Health Care Reform:**

We fully support the recommended changes to the MBP to support reintroduction of coverage for preventive care, extension of dependent coverage to age 26, and the elimination of pre-existing conditions for short-term contractual staff. We encourage HRD to ensure that implementation of these changes is completed as quickly as possible with minimal disruption to staff.

B. **Medical Benefits Plan – Medicare Participation and Related Savings:**

In principle, we support the proposal to increase the incentives for voluntary retiree participation in Medicare Part B and agree that there is potential for financial savings to be realized by the MBP. However, we support the IMFRA proposal to strengthen participation incentives by providing a 75 percent reimbursement to all income groups, including Tiers 2 and 3 of Medicare Part B. We also encourage the Board to hear the concerns, and give consideration to the issues raised, by the IMF Retirees Association regarding participation incentives and the elimination of the Part A reimbursement.

December 14, 2010

IMF Retirees Association

Note to Executive Directors on Medical Benefits Plan—Medicare Participation and Related Savings; Medical Benefits Plan—Response to U.S. Health Care Reforms

For a number of years, the IMF Retirees Association has urged the Fund to increase the incentives for retirees to participate in national insurance schemes, including the U.S. Medicare system. Such participation not only brings benefits to the participants but also provides very substantial savings to the Fund and the MBP.

We welcome the decision of management to bring this issue to the Executive Board's attention, since such action is long overdue. We also strongly support management's decision to keep participation in Medicare Part B and other national schemes voluntary. We regret, however, that the management proposal, as currently formulated, is likely to achieve only partially the intended result of increasing enrolment in national insurance schemes and may even encourage a number of current participants to opt out of such schemes.

Medicare Part A: We can see no justification in a proposal that is designed to provide incentives to *increase* enrolment in national insurance schemes to advocate the elimination of the $7 "discount" for those retirees who participate in Medicare Part A. In effect, MBP participants aged over 65 who are eligible for Part A are charged twice for a single (hospitalization) insurance benefit. Under the MBP's coordination of benefits, Medicare, rather than the MBP, is the first payer of hospitalization costs, and the MBP generally pays little or nothing toward such hospitalization costs. Given the significant savings to the MBP from Medicare Part A and the large share borne by eligible participants (who have contributed at least one-half of the qualifying costs for Part A), we urge that the $7 discount be reinstated for retirees participating in Medicare Part A.

Medicare Part B: In IMFRA's opinion, the proposal to reimburse 75 percent of the basic (first tier) premium of Medicare Part B represents only an initial step toward compensating retirees for the very real costs of participating in Medicare and other national insurance schemes. Those in the higher tiers who receive Fund pensions of more than $85,000 a year would have little or no incentive to participate. Indeed, IMFRA has already received a number of communications from retirees stating that they intend to drop their participation in Medicare Part B unless meaningful steps are taken to alleviate their situation. Their concerns are intensified by the fact that Medicare B premiums are now income-related and have continued to rise steadily, which leads current participants to question the value of their participation in the system if there is no tangible relief. We urge Board members to extend upward the 75 percent reimbursement for participation in Medicare Part B, at least to retirees who are in the second and third tiers. The effect of this extension would also have the effect of increasing savings to the MBP.

U.S. Health Care Reform. We are pleased to support the proposals in the second paper prepared by HRD relating to the reforms included in the U.S. health care legislation. These bring the MBP in line with other insurance plans and U.S. government legislation, which affects all health practitioners in the United States.