EB/CAP/83/6

August 19, 1983

To: Members of the Committee on Administrative Policies

From: The Committee Secretary

Subject: Medical Benefits Plan Review

Attached for the consideration of the Committee on Administrative Policies is a paper on an in-depth review of the Medical Benefits Plan, which will be brought to the agenda of the Committee for discussion on a date to be announced.

If Committee members have technical or factual questions relating to this paper prior to the Committee meeting, they should contact Mr. Checki, ext. 75228.

Att: (1)

Other Distribution:
Members of the Executive Board
Department Heads

INTERNATIONAL MONETARY FUND

Medical Benefits Plan Review

Prepared by the Administration Department

August 18, 1983

In early 1982, members of the Executive Board Committee on Administrative Policies, when considering proposed changes in the Fund's Medical Benefits Plan (MBP), suggested that an in-depth review of the Plan and its coverages should be undertaken. Emphasis was placed particularly on the desirability of studying ways in which the growth in the cost of the medical insurance scheme might be contained. This paper summarizes the results of the staff's review of this matter and its recommendations.

I. Plan Financial Performance

The 1982 review took place against the background of a sharp deterioration in the financial situation of the Medical Benefits Plan in 1981, reflecting primarily a large increase (35 percent) in claim payments. A deficit of $149,000 was incurred in 1981, and another deficit was projected for 1982, if no changes were made to the Medical Benefits Plan. In order to avert this, three steps were taken: (1) the amounts of out-of-pocket expenditure needed to be incurred before payments under the Plan commenced (deductibles) were increased by approximately 20 percent, effective January 1, 1982; (2) premium contribution rates were increased by 5 percent effective May 1, 1982; and (3) reserves were decreased from 30 percent to 25 percent of claims paid. These changes were designed to generate resources in 1982, which would permit the replenishment of the reserve drawdown that had been used to finance the 1981 deficit and leave a net surplus of $22,000.

Results of the financial performance of the Medical Benefits Plan in 1982 were better than anticipated; income was higher than projected and claim payments were lower, so that a net surplus of $238,199 emerged (Table 1). The most important factor, however, contributing to this surplus was the decision to reduce mandatory reserves to 25 percent of claims outstanding. Had the previous reserve formula been in effect, a transfer to reserves of $157,649 would have been needed (instead of the payout from reserves of $27,812) and the net surplus would have fallen from $238,199 to $52,738.

Table 1. Medical Benefits Plan

	1981	1982		Percent Change 1981 to 1982	
	Actual	Projected	Actual	Projected	Actual
A. Income	$3,461,762	$4,197,000	$4,267,065	21.2	23.3
Premiums	3,461,762	4,197,000	4,267,065		
B. Expenses	3,610,516	4,175,000	4,028,866		
Claims paid	3,216,616	3,841,000	3,742,112	19.4	16.3
Reserve accumulation	248,711	17,000	-27,812		
Overhead expenses	145,189	168,000	165,812		
Repayment of advances		149,000	148,754		
C. Surplus/Deficit	-148,754	22,000	238,199		
D. Financing	148,754	--	--		

The 1982 results did not in any way invalidate the need for a review of the Plan. The cost of the Fund's Medical Benefits Plan has been increasing steadily and swiftly over the past decade with no tapering off in prospect (Annex 1). Although this experience is not unique to the Fund, i.e., the cost of health care and medical benefits has been rising rapidly in general in the United States and abroad, the rate of growth in recent years experienced by the Fund has exceeded both the U.S. national and the Washington, D.C. metropolitan area averages, as well as those of both local and international comparators (Table 2).

Table 2. Percentage Increase in Medical Expenses 1977-1982 1/

	Annual Compounded Rates of Increase 1977-1982
Average claim per enrollee (IMF)	12.0
Selected comparator medical expenses:	
- U.S. national average 2/	11.8
- D.C. metropolitan area 3/	10.4
- WHO 4/	9.6
- World Bank 5/	10.7

1/ 1976-1981 for non-IMF data.
2/ Expenditures for personal health care--third party payments and private consumer expenditures.
3/ Cost of hospitalization and hospital services per patient-day and physicians' fees.
4/ Reimbursement for U.S.-based personnel.
5/ Family plan cost per staff member.

On average, over the past five years, the growth in claims has exceeded the growth in premium income by 3.9 percent annually (Table 3). Indeed, the excess would have averaged 4.9 percent per year were it not for the 5 percent increase in the premium contribution rate in 1982.

Table 3. Percentage Increase in Claims and Premium Income 1977-1982

	Annual Compounded Rates of Increase 1977-1982
Total premiums	13.9
Total claims	18.3

Since, with the exception of rate increases, premium income is primarily a function of increases in average salaries and the number of enrollees (staff and pensioners), a continuation of this trend has important implications for the Fund's Administrative Budget as well as

for the disposable income of the staff: total MBP costs, which amounted to 5.2 percent of payroll in 1972, rose to 6.8 percent in 1982.

Table 4 shows the growth in selected measures of compensation compared with the growth in medical claims over the past decade.

Table 4. Percentage Increase in Claims, Average Salary and Salary Structures

	Annual Compounded Rates of Increase	
	1972-1977	1977-1982
Total dollar amount of claims	15.8	18.3
- Number of enrollees	7.0	5.7
- Average claim per enrollee	8.3	12.0
General salary adjustments 1/		
- Minimum of Range A	7.7	8.8
- Minimum of Range G	8.7	9.9
- Minimum of Range I	8.3	9.9
Weighted average	8.3	9.6
Fund average salary	9.2	11.5

1/ Range A is used as a proxy for A-E; Range G as a proxy for F-H; and premiums for I-M are linked to the minimum of Range I.

For a staff member earning less than the contribution ceiling, 1/ the total family premium contribution in 1972 amounted to approximately 3.6 percent of salary versus 7.5 percent today; and, in 1972, that contribution represented an equal sharing of costs between the staff member and the Fund, as opposed to today's one-third/two-thirds ratio. In other words, the Fund's contribution has almost tripled during the period. If this trend were to continue, ceteris paribus, through the end of the decade, premiums could be expected to consume 3.5 percent of the same staff member's salary, with the Fund's contribution rising to the equivalent of 7.0 percent of salary from today's 5.0 percent level. This forecast ignores two factors that might well contribute to even less favorable trends. First, the average age of the Fund staff is increasing, as is the size of the pensioner population (Table 5).

1/ The minimum of salary Range I is the ceiling for premium contributions.

Table 5. Distribution of Participants in the Fund Medical Benefits Plan by Age Group

(In percent)

	Active Staff				
	35 & under	36-45	46-55	56 +	Pensioners
1992 (Projected)	(14)	(23)	(23)	(13)	(27)
1982	26	31	17	7	19
1972	44	22	18	7	9

Second, it is unlikely that the rate of increase of medical costs will cease to outstrip the rate of overall price increases. In this connection, it might be noted that, for the 12 months ended January 1983, consumer prices in the Washington metropolitan area rose only 4 percent, whereas the medical component of the index rose by 17.3 percent. Against this backdrop it seems fairly clear that the best interests of neither the staff nor the Fund will be served by concentrating on revenue measures for the preservation of the financial balance of the Medical Benefits Plan. Accordingly, the review endeavored formally to identify areas where expenditures might be reduced or where greater value could be obtained for the same outlay. These areas are discussed in detail in the following section.

II. Opportunities for Improving Plan Performance

1. Eligibility criteria for Plan participation

The Fund Plan provides coverage not only for the nuclear family but also for not more than two other dependents at the same time. 1/ This phenomenon is doubtlessly a response to the difficulties that elderly expatriates coming to the United States for the first time can experience in obtaining medical insurance coverage. The premiums charged for this type of coverage are slightly higher than those for individual coverage but still cover only a fraction of the costs. Given the broad range of eligible dependents and the absence of a limit on turnover of dependents, this feature of the Plan may lend itself to abuse. During 1981, the latest year for which detailed data are available, enrollees in this category accounted for approximately 10 percent of Plan medical expenses and 19 percent of dental expenses, as against 2 percent of premium contributions (Annex 4). This represents the heaviest per capita subsidization of any group in the Plan.

1/ A comparison of the Fund's criteria in this regard with those of the other international agencies is shown in Annex 3. Annex 2 contains an outline of Plan coverages.

2. Cost sharing

A basic feature that the Fund Plan has in common with most plans introduced in the United States at about the time of its inception (mid-1960's) is that hospital expenses are covered fully for a given period of time, after which the proportion covered falls. For out-of-hospital care, expenses are shared, e.g., in the ratio of 80:20 between the Plan and the enrollee for doctors' fees and prescribed medicines and services. As a result, identical treatments may be reimbursed fully where a person is hospitalized and only partly when treatment is on a less expensive out-patient basis. As noted, this feature is not unique to the Fund Plan. In an effort to combat rapidly rising medical costs, however, many plan designers are giving increasing recognition to redressing the balance toward use of the less expensive alternatives. Cost per treatment aside, plan designers are also questioning the wisdom of offering enrollees comprehensive medical protection with modest deductibles and high premiums. It is felt that this approach removes a major cost containment incentive, i.e., financial involvement of the staff in the use of the service, and may, in fact, contribute to casual usage of benefits. For the Fund, there is empirical evidence that our Plan design in this respect is contributing significantly to costs; hospital and hospital-related expenses account for some 50 percent to 60 percent of total expenses, compared with about 40 percent for the United States generally. The average length of hospital stay for Fund Plan enrollees is almost 34 percent higher than the national average. Typically this might be accounted for by surgery, but this explanation does not hold true for the Fund population, where the incidence of surgery is 38 percent less than the national average.

3. Plan administration

There are many aspects of Plan administration by the John Hancock Company that are satisfactory; administrative costs are in line with industry averages, client assistance is generally courteous, and the timeliness of claims processing is, in most cases, adequate, although lately there have been some complaints of delays in processing. However, there are also numerous administrative aspects where there could be improvement. Attention might focus on the record for cost recoveries, e.g., coordination of benefits, utilization review, eligibility determination (for noncovered charges), and ensuring that claims are within reasonable and customary limits. Available data indicate that during 1981, the only year for which reliable data are available, cost recoveries were equivalent to only 2 percent of total claims, compared with recoveries ranging from 4 to 12 percent for plans surveyed by the Health Research Institute.

4. Management of Plan finances

The accumulated reserves of the Medical Benefits Plan total approximately $1 million. These funds, if invested, would generate significant additional income. Indeed, a reasonable return on these funds, had they been invested, would have all but eliminated the need for the increase in the premium contribution rate which took effect in May of last year.

Recommendations for measures aimed at ameliorating these deficiencies are developed in the following three sections.

III. Cost Containment

1. Plan participation for other dependents

Analysis of the Fund's claims experience shows an abnormally high share of costs concentrated on claims for "other dependents." The average per capita cost for an other dependent is two and one-half times that for an active staff member, and double that for a pensioner, the age group where medical costs are generally highest (Annex 4). There have been a significant number of large claims that have been filed for other dependents within a short period of enrollment. This would suggest that the main reason for enrollment in some cases is to obtain treatment for a previously diagnosed illness.

There are a number of ways of dealing with the problems associated with "other dependents." At the extreme from the Fund position are the United Nations and OAS, where coverage is limited to staff member, spouse and children and excludes other dependents. The IBRD and IDB fall in between, in that coverage is permitted for other dependents, but is restricted to the parent or parent-in-law of staff members. As noted above, the Fund Plan permits coverage for a wide range of dependents, e.g., uncles and aunts, nieces and nephews. The rationale for this extensive coverage, which derives from the definition of "close relatives" under the Fund's Dependency Allowances policy, is unclear.

There are convincing reasons why the Fund should continue to make medical insurance available to parents and parents-in-law of staff members who may be residing in the United States by reason of their children's employment with the Fund. Medical insurance is not easily obtainable for the elderly in the United States and when it is, it is generally very expensive in comparison with its cost in the home country. In the case of other relatives, the argument of insurance being difficult to obtain has considerably less validity. The only argument is that staff members or their spouses may, by reason of the customs of the home country, be expected to provide for the well-being of a broad spectrum of relatives. What is less clear is why the Fund and its staff as a group should assume the overwhelming burden of the costs for such medical care. To illustrate, in 1981, claims paid for "other dependents" amounted to almost five times the premiums collected from this group.

It is suggested to limit Plan participation for other dependents to a total of two dependent parents or parents-in-law residing in the staff member's household, similar to what is done by IDB and IBRD. This would greatly reduce Plan exposure and contribute to a more favorable

cost experience and, at the same time, extend the protective mantle of the Fund to a group that would, in all likelihood, be unable to obtain similar protection on their own. Furthermore, rather than allowing enrollment unconditionally, as is done at present if an other dependent is enrolled within 30 days of joining the staff member's household, we also plan to institute a three-year waiting period for coverage for treatments arising from illnesses or conditions existing at the time of enrollment to ensure that the purpose of enrollment is not to have expensive treatment of a pre-existing condition rendered.

The new eligibility criteria will be applicable to all those seeking future entry into the Plan. In the interest of equity, other dependents enrolled in the MBP at present who do not meet the new eligibility criteria would be permitted to continue their participation in the Plan.

2. Cost sharing for hospital expenses

Under the Fund Plan, all hospital expenses are covered for the first 180 days of treatment in any calendar year. Subsequently reimbursement is at 80 percent of cost. This feature has, in the past, been normal in medical insurance plans throughout the United States. It is, however, being increasingly recognized that to offer a health service without requiring a sharing of costs by the individual may encourage indiscriminate use of the service. This is especially true when co-payment features are not applied to "first-dollar" costs for hospitalization. Accordingly, it is recommended that the regular Plan deductible be extended to include hospital coverage, and that enrollees be required to meet 20 percent of the first $1,000 of hospital charges. These changes would serve to discourage unnecessary one-to-two day confinements and create an awareness of the costs related to hospital confinement, but at the same time provide the needed protection for serious long-term conditions. In addition, in order to minimize the impact of this change on the staff, it is recommended that reimbursement for the cost of diagnostic testing done on an outpatient basis within seven days of a scheduled hospital admission, and for surgery done on an outpatient basis, be increased from 80 percent to 100 percent.

3. Recovery and shifting of expenses

a. Coordination of benefits for pensioners

Many pensioners are eligible for protection under national health insurance schemes, 1/ and when they are, these alternative forms of coverage might be used as a way of shifting the primary burden of

1/ For instance, eligibility for participation in Medicare is not restricted to U.S. citizens. Both the hospital and the medical care portions of Medicare are open to non-U.S. citizens who are 65 or older, have legally entered the United States, and who have resided continuously in the United States for at least five years (and who will be remaining in the United States).

responsibility from the Fund and the staff to a broader social base. However, because any arrangement of this nature would have to take account of the vast differences in such plans in terms of financing, as well as medical protection, it is felt that further study is needed before any formal recommendation can be made in this regard.

b. Coverage for hospice facilities and home hospice care

Hospice care is designed to provide the needed supportive environment for the terminally ill and their families. Because of the singular purpose of such facilities/care, the terminally ill are generally better served than they would be in an acute care hospital setting. In addition, the attendant costs are generally less because this care is delivered in either dedicated facilities or in the home.

This type of care was not generally available when the MBP was first developed and thus was not provided for. However, it is recommended that such coverage be added to the Plan at this time.

IV. Revenue Enhancement

1. Premiums

Because the premium structure is based on incomes rather than on actuarial variables or size of family unit, it can be said that, to some extent, the contributions of the younger staff members subsidize those of the older staff, and those without families subsidize the cost of those with.

This is not seen as particularly troublesome because, for the most part, the disparities are not that large, and because, taking the long view, most staff members can be expected to go through a similar cycle--young to old, single to married, active to retired, etc. The two main anomalies are other dependents (discussed above), and short-service retirees.

Under the present Plan, other dependents also pay an arbitrary rate, unrelated to actuarial cost, i.e., the difference between the rates charged for individual and family coverages. If the premium contribution rate were indexed to the individual rate and to claims (Annex 5), it should be more than double, on a subsidized basis, the present 1.34 percent of salary. No changes are being suggested at this time, in the hope that the change in eligibility recommended above will correct this imbalance. However, experience with this group will need to be monitored carefully and, if the situation does not improve over time, steps may have to be taken to adjust the premium to reflect the risk represented by enrollees in this category.

The present premium structure for pensioners, regardless of length of service prior to retirement, is based on pension income. By and large this practice is consistent with the "ability to pay" criterion that characterizes the Fund's approach to medical insurance. Staff members taking early retirement are eligible to continue coverage under the MBP only if they have worked in the Fund for ten years prior to retirement. However, this condition does not apply to staff reaching mandatory retirement age. In such cases, for enrollees who have served for only a short period before reaching normal retirement age, premiums are only a fraction of what they would have been for an enrollee with, say, 30 years of service before retirement. To illustrate, under current policy, two staff members retiring from the Fund at the same $35,000 salary, one after five years of service and the other after 30 years of service, the former would pay a premium of less than $250 per year for family coverage, while the latter would pay $850. In the case of the short-service retiree, premiums are not indicative of "ability to pay" but of pension received, and, indeed, the relatively small pension received from the Fund is probably only a minor source of retirement income. A similar problem arises for a pensioner who, by reason of electing to commute up to one third of pension, will frequently end up paying premiums that are less than someone in similar circumstances who chooses not to commute. It is only reasonable to expect these two categories of retirees to bear a more representative share of the cost than they do at present. A straightforward and justifiable solution to these problems would be to base premiums on final salary. This approach, however, would result in very large increases in premiums for some existing pensioners, and a less drastic approach is therefore recommended, as follows:

a. For those who reach normal retirement age with less than ten years of service, the monthly contribution rate to the Medical Benefits Plan would be based on their net annual salary on the last day of service. Subsequent to such an individual's retirement, whenever the MBP contribution schedule schedule is adjusted, the required monthly contribution would be linked to the same bracket in the revised schedule as was used to determine the premium at the time of the individual's retirement.

b. For those with ten or more years of service, the present contribution formula would be retained. However, for those who elect to commute a portion of their pension, the contribution would be based on the unreduced pension that the individual would have been entitled to had he not commuted. This formula would be similar to that used in the World Bank. The ten-year cutoff limit would echo the policy followed with regard to staff retiring before age 65, who are eligible to continue participation in the Plan only if they have worked at the Fund for ten years prior to retirement.

2. Investment of Plan reserves and cash balances

Plan reserves and cash balances should be invested on behalf of the Fund and Plan enrollees, using a trust set up specifically for this purpose, to help offset increases in Plan costs.

When the Fund switched to a self-insured Plan at the beginning of 1978, it was decided that the new Plan's reserves could not be invested to earn interest (although the reserves had previously been invested when they were held by the insurance carrier), because this would require the Fund to pay a larger remuneration to the United States. As it now stands, the balance in the reserve account is reflected in the Fund holdings of U.S. dollars and, to that extent, results in modest savings in remuneration payments on the U.S. net creditor position.

However, by giving up interest on MBP funds in order to keep down the cost of remuneration, the Administrative Budget (and specifically the Health Benefits Account) is higher than it would otherwise have to be; and enrollees' costs are also higher than they would otherwise be. Of the $1 million in Plan reserves shown on the Fund's books, one third are attributable to staff contributions. Even if it is assumed that the remuneration argument is valid insofar as the Fund's portion of the MBP contributions is concerned, it is difficult to understand how this same line of reasoning has any applicability to staff contributions. In effect, the Fund is using monies earmarked for the MBP to offset the cost of operations. Under the circumstances, it would seem appropriate for the Fund to reimburse enrollees for the use of their contributions by imputing interest (perhaps equivalent to the average rate of remuneration) on the average monthly premium contribution collected during the course of the year. However, the preferred position would be for the Fund to treat the MBP reserve and cash balances in a manner similar to that of the Staff Retirement Plan, i.e., to pay both Fund and staff contributions into an employee benefits trust that will serve as an earning asset of the Plan.

V. Administrative Measures

1. Plan administration

Administrative costs levied by John Hancock, the Plan administrator, average between 4 percent and 5 percent of Plan expenses and are in line with industry averages. However, there are some aspects of administrative performance that need attention. In particular, cost recoveries are well below industry standards, amounting to only 2 percent of expenses in 1981. Recoveries arising from the application of "usual, customary, and reasonable" (UCR) criteria alone are typically equivalent to about 4 percent of expenses, and further economies usually accrue from coordination of benefits, disqualification of ineligible charges, ineligible persons, etc. Although the Plan stipulates that UCR criteria apply, the low rate of recovery has been largely a consequence of a conscious choice not to enforce them stringently. It has been argued that an international staff, many unfamiliar with the United States, may find it difficult to challenge excessive billings of physicians or dentists. A corollary has been that the Plan is perceived by providers of medical service as one where the application of cost containment procedures is not vigorously pursued. Attitudes developed over the years may have to be changed gradually. In this connection, it

is intended to ask the Plan administrator to review all claims against UCR criteria, to report periodically on Plan experience against these criteria, and to limit reimbursement where charges exceed the local UCR standards by 10 percent or more.

2. Flexible reserves

In 1978, when the Fund began self-insuring the Plan, a reserve of 30 percent of claims paid was established. As noted earlier, this ratio was reduced from 30 percent to 25 percent last year on the strength of assurances from the Plan administrator that a reserve of 25 percent would be within the bounds of financial prudence.

It is judged that a reserve of 25 percent should be sufficient for the purpose intended, viz., to meet outstanding claims should the Plan ever be terminated. However, there can be wide fluctuations from year to year in claims payments. For instance, leading or lagging by one week in settling claims at the end of a year results in a shift of 2 percent of expenses from one year to another. These considerations point toward retaining any surplus of up to 5 percent of claim payments above and beyond the 25 percent "mandated" reserve. Any surplus that might increase reserves beyond 30 percent of claims would be returned to enrollees and the Fund in proportion to contributions. Conversely, when there is a deficit, part or all of the 5 percent reserve could be drawn upon if it is felt that the increase in claims is exceptional and is not expected to continue.

Attachments

MEDICAL BENEFITS PLAN

Premiums and Claims Paid

Year	Premiums U.S.$	Premiums Percent Increase	Claims Paid U.S.$	Claims Paid Percent Increase	Number of Enrollees 1/ Number	Number of Enrollees 1/ Percent Increase	Average Claim per Enrollee U.S.$	Average Claim per Enrollee Percent Increase	Claims as Percent of Premium
1968	322,201		331,409						102.9
1969	417,023	29.4	457,061	+37.9	962		475		109.6
1970	567,615	36.1	496,789	+8.7	1,061	+10.3	468	-1.5	87.5
1971	699,922	23.3	655,308	+31.9	1,157	+9.0	566	+20.9	93.6
1972	825,418	17.9	772,946	+18.0	1,243	+7.4	622	+9.9	93.6
1973	924,884	12.1	812,013	+5.1	1,321	+6.3	615	-1.1	87.8
1974	1,017,812	10.1	982,420	+21.0	1,376	+4.2	714	+16.1	96.5
1975	1,123,645	10.4	1,149,649	+17.0	1,405	+2.1	818	+14.6	102.3
1976	1,470,388	30.9	1,498,660	+30.4	1,485	+5.7	1,009	+23.3	101.9
1977	2,231,180	51.7	1,612,683	+7.6	1,741	+17.2	926	-8.2	72.3
1978	2,331,862 2/	4.5	1,889,254	+17.2	1,939	+11.4	974	+5.2	81.0
1979	2,462,923 3/	5.6	2,073,684	+9.8	1,962	+1.2	1,057	+8.5	84.2
1980	2,898,836 4/	17.7	2,387,576	+15.1	2,050	+4.5	1,165	+10.2	82.4
1981	3,461,762	19.4	3,216,616	+34.7	2,182	+6.4	1,474	+26.5	92.9
1982	4,267.065	23.3	3,742,112	+16.3	2,293	+5.1	1,632	+10.7	87.7

1/ Average of enrollees at beginning and at end of the year.
2/ Includes $329,000 (16 percent) in excess premiums refunded to Plan enrollees at the conclusion of the Plan year.
3/ Includes $349,000 (15 percent) in excess premiums refunded to Plan enrollees at the conclusion of the Plan year.
4/ Includes $445,000 (16 percent) in excess premiums refunded to Plan enrollees at the conclusion of the Plan year.

Health Insurance Benefits: Comparator Organizations

MIP Provisions	OAS 1/	IDB	IBRD	IMF	UN	WHO	U.S. Government				Major New York Banks			
							Blue Cross / Blue Shield		Aetna		Bank A			
							High Option	Low Option	High Option	Low Option	High Option	Low Option	Bank B	Bank C
Contributions														
Employer share of cost (in %)	67	67	67	67	50	50	47	75	64	75	80		77	80
Employee share of cost (in %)	33	33	33	33	50	50	53	25	36	25	20		23	20
Employees Monthly Cost (Family Plan)														
Annual Salary: $15,000	$ 73.31	$65.00	$ 27.88	$31.86	--	--	$118.08	$32.16	$58.23	$31.70	$27.67	$11.47	$34.47	$24.00
40,000	111.31	92.00	75.94	83.28	--	--	118.08	32.16	58.23	31.70	27.67	11.47	34.47	24.00
60,000	113.61	92.00	105.08	93.58	--	--	118.08	32.16	58.23	31.70	27.67	11.47	34.47	24.00
Deductibles, Annual														
Medical - per person	$100.00	0	$100.00	$100.00	--	--	$200.00	$250.00	$200.00	$250.00	$100.00	$300.00	$100.00	$100.00
- per family	200.00	0	250.00	230.00	--	--	400.00	500.00	600.00	750.00	250.00	750.00	250.00	250.00
Dental - per person	$100.00	0	$100.00	$100.00	--	--	N/A	250.00	200.00	N/A	N/A	N/A	N/A	N/A
- per family	200.00	0	$250.00	230.00	--	--	N/A	500.00	600.00	N/A	N/A	N/A	N/A	N/A
Deductible or Coinsurance														
A. Hospital Charges	None	80% after 165 days	80% after 180 days	80% after 180 days	None	80%	$50 per admission	$100 per admission, 75% after 180 days	80%	75%	80% after 120 days	None	50% after 120 days	None
B. Surgical Fees	None	None	80%	80%	80%	80%	--	--	--	--	--	--	--	80%
Psychiatric Care														
A. In-hospital limitations	same as any other condition	45 days/year	same as any other condition	same as any other condition	30 days/year	Total of 1100 days in 5 years	60 days/year	30 days/year	$20,000.00	$15,000.00	same as any other condition		same as any other condition	30 days/year
B. Out-patient reimbursement	100% first 5 visits, 50% thereafter	80% first 5 visits, 50% thereafter	80% first 10 visits, 50% thereafter	70%	80% first 5 visits, 50% thereafter	80%	70%	75%	80%	75%	50%	--	50%	50%
Maximum reimbursement per visit	$72/36	R + C	$32.50	$40.00	$48.00	None	R + C	R + C	R + C	R + C	R + C	--	R + C	R + C
Annual limit	$2,000.00	$2,400.00	None	None	None	--	None	None	$1,000.00	$750.00	52 visits	--	$1,500.00	$1,800.00
Lifetime limit	$25,000.00	None	$25,000.00	$30,000.00	100 visits	750 visits	$50,000.00	$50,000.00	None	None	$7,000.00	--	None	$50,000.00
Dental														
A. Coinsurance	50%	50%	80%	70%	GHI	80% 1/	--	--	--	--	N/A	N/A	N/A	N/A
B. Maximum Benefit:														
Orthodontics - Lifetime	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$720.00	$300 in 5 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All Charges - Annual	$600.00	$300.00 to $500.00	$2,500.00	$5,000.00	--	$90.00 1/	--	Scheduled amounts	$750.00	--	N/A	N/A	N/A	N/A
Eyeglass Coverage														
Provision for routine examinations	Yes	No	No	Yes 80%	No	Yes 80%	No	No	No	No	No	No	No	No
Maximum	$40 annually	N/A	N/A	$40 annually	N/A	$50 in 2 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stop Loss Provision														
Out-of-pocket starting point	$2,500 per individual (annual)	10% Family income (annual)	$2,000 per individual (annual)	10% Family income (annual)	500 per individual (annual)	5% Family income (annual)	$2,000.00	$2,500.00	$2,500 per individual $5,000 per family	$3,000 per individual $6,000 per family	$2,000 per individual $4,000 per family	--	Greater of $2,000 or 5% annual salary	$2,000 per individual
Excluded Charges	None	None	Dental & Psychiatric	None	--	Dental and Psychiatric	Psychiatric	Psychiatric	Psychiatric Alcoholism Drug Abuse	Psychiatric Alcoholism Drug Abuse	Psychiatric		None	Psychiatric and Private duty nursing

1/ Proposed--currently awaiting management approval.

Survey of the Coverage of Other Dependents Under the Medical Plans
of the International Monetary Fund, World Bank, Inter-American Development Bank,
World Health Organization, Organization of American States and United Nations

Organization	Other Dependents Eligible	Maximum Number	Eligibility Requirements		Waiting Period/ Exclusions	Remarks
IMF	Mother, Father Parents-in-law Stepmother, Stepfather, Sister, Brother Stepsister Stepbrother Grandmother Grandson Grandfather Granddaughter Uncle, Aunt Nephew, Niece	2	1. Eligible for dependency allowance. 2. Permanent member of staff member household.	Difference between cost of an individual contract and family contract. (1.34% of salary to a maximum of $49.42 per month)	None that staff member does not have.	
WORLD BANK	Parent Parent-in-law	2 (One person from each set of parents)	1. Widowed, divorced or legally separated. 2. Meets tests for dependency allowance. 3. Resides in staff member's household on a permanent basis.	Flat, unsubsidized rate of $90.68 per month.	None	
IDB	Parent(s) Parent-in-law	1 person (of the possible 4) from 2 sets of parents (for married staff) 2 parents (for single staff)	1. Meets test for dependency allowance. 2. Resides in staff member's household on a permanent basis.	Flat rate per month of $60 for one person and $76 for two.	5 year waiting period for declared pre-existing conditions.	
WHO	Parent, brother, sister	1	Staff member who does not receive dependency allowance for spouse or child may receive dependency allowance for secondary dependent.	1.43% salary.	3 year waiting period for illness or condition existing at time of entering the Plan.	Surveillance committee that meets regularly to resolve questions of policy.
OAS	No other dependents covered					Same as above.
UN	No other dependents covered					

Per Capita MBP Costs by Covered Group

1981

Covered Group	Number Covered	Average Claim per Capita			As % Total Claims Paid 1/		
		Medical	Dental	Total	Medical	Dental	Total
Staff	1,764	577	110	687	36.3	47.0	37.7
Spouses 2/	1,105	669	9	678	26.4	2.3	23.3
Children 2/	1,500	315	64	379	16.8	23.4	17.0
Pensioners	235	662	95	757	5.6	5.4	5.5
Experts	110	322	56	378	1.3	1.5	1.3
IMF Inst./BWRC	73	546	88	634	1.4	1.5	1.4
Other Dependents	206	1,283	376	1,659	9.4	18.8	10.6

1/ Excludes 2.5 percent medical attributable to claims for dependents of pensioners; 0.3 percent medical and 0.01 percent dental attributable to claims for dependents of experts.

2/ Number covered estimated.

MBP Average Cost per Capita

1981

	Average Cost per Capita 1981	Index Staff Cost = 100.0
Staff Member	$687	100.0
Spouse	678	98.7
Child	379	55.2
Other Dependent	1,659	241.5

Premiums Indexed to Costs

Type of Coverage	Number Covered	Actual Premium Rate	Premium Rate Adjusted to Relative Claims Index	Excess (+)/ Deficit (-)
Single---No Children	466	1.13%	1.13%	-
" ---1 Child	25	2.47	1.75	+0.72
" ---2 Children	28	2.47	2.37	+0.10
" --->2 Children	7	2.47	2.99	-0.52
Married--No Children	431	2.47	2.25	+0.22
" --1 Child	196	2.47	2.87	-0.40
" --2 Children	288	2.47	3.49	-1.02
" -->2 Children	190	2.47	4.11	-1.64
Other Dependents	206	1.34	2.73	-1.39