Review Committee of the Life and Medical Insurance Programs

ANNUAL REPORT 2013

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REVIEW COMMITTEE OF THE LIFE AND MEDICAL INSURANCE PROGRAMS

Inter-American Development Bank and Inter-American Investment Corporation

ANNUAL REPORT 2013

The Review Committee of the Life and Medical Insurance Programs (hereinafter, the Committee) is pleased to submit the report on activities for the year 2013 to plan participants. This report includes the Medical Insurance Benefits Account Independent Accountant's Review Report and Financial Statements for the aforementioned period. These financial statements were reviewed by the independent accountant firm KPMG.

The Life and Medical Insurance Programs (hereinafter, the Plan) recorded a deficit of US$1,205,000, resulting in net assets available for the payment of benefits (reserves) totaling US$36,556,000 as of December 31, 2013. This is equivalent to 8.1 months of claims. This deficit, which represents approximately 2% of total paid claims, was the result of medical expenses exceeding the levels of premium contributions. The main drivers of this increase in paid claims are: the large number of catastrophic cases, medical inflation, and higher utilization of medical services. These factors, along with other cost drivers, will be described in detail further in the report.

Given the number of previous annual surpluses and the adequate level of reserves, the IDB has not considered the need to raise premium contributions since 2010. Prior to that, premium charged to employees and retirees was increased in 2008 and 2010 by 1%. As a result, the difference between premium contributions and claim expenses has been reduced over time, and at year-end 2013, there was a small deficit.

Table 1

Year	Surplus / (Deficit)	Reserves
2012	US$1,209,000	US$37,761,000
2013	(US$1,205,000)	US$36,556,000

Source: IDB Financial Statements

As part of its permanent mandate, the Committee continues to closely monitor the Plan's financial situation in order to ensure a solid financial standing.

At the end of 2013, the level of premiums was adequate to maintain the reserves at a solid level given the financial soundness of the Plan and premium rates were not increased.

Given the financial situation presented in this report, including the decrease in net assets, the Committee will analyze premiums levels for 2015. Plan members will be informed of the results of the analysis, and any applicable premium changes before the end of 2014.

THE COMMITTEE

Background

The Committee was established in 1995 as an advisory group for the administration of the Life and Medical Insurance Programs. It was assigned to review the plans, ensure the efficiency thereof, recommend an adjustment in the premiums each year to the Bank, and make recommendations to improve the functioning of the Life and Medical Insurance Programs.

The Committee has tripartite representation: two representatives for active employees and one representative for retirees—with their respective alternates—elected by the participants of each group, and six officials designated by the Bank (three Principals and three alternates). The Chief of the Bank's Compensation, Benefits and HR Services Division (HRD/COB) assumes the role of Committee Secretary. The Committee also has the support of members of the Well-Being and Health Benefits Group in HRD/COB. The Committee elects one of its members to serve as chairman. It normally issues recommendations by consensus.

Health Committee Activities and Achievements

The Committee's work program for the year 2013 included several topics of importance to plan participants:

1. **Handbook review.** The Committee substantially advanced the review of the Handbooks (for both Nationals and Internationals). While updates were incorporated early in 2013, the revision continues and the Committee expects to have both Handbooks updated by January 2015.

2. **Completion of election process and induction of new members to the Committee upon commencement of activities and their new terms.**

   Call for Candidates. In January 2013, a call for candidates was sent to plan participants. The Committee acted as a Selection Panel and met with the 5 candidates to learn about each candidate's background as well as discuss the Committee's roles and responsibilities.

   Election Period. The election was held during March and April of 2013. Elections results were announced on May 23, 2013.

   In addition, new members were appointed by the Bank's President, Mr. Luis Alberto Moreno, to fill vacant roles within the Committee.

3. **Plan Performance and Utilization Review.** The Committee reviewed documents and participated in presentations made by the Plan's Third Party Administrators (TPAs) Cigna Healthcare and Vanbreda, consulting firms, and the Administration, related to utilization and financial reports, status and overall performance of the Plan. These meetings are part of the Committee's program schedule during the course of each calendar year, and serve as an opportunity for members of the Committee to inquire and be informed of the Plan's standing.

4. **Completion of 2008 – 2012 Annual Report.** The Committee finalized the 2008 - 2012 Annual Report. The report was completed in 2013 and made available to plan participants (active and retirees) in January 2013. The Committee also hosted a presentation of the report on to plan members on February 20, 2014 which was live-streamed to country offices.

5. **Claims Audit.** The Committee, in keeping with its mission to analyze reports from external auditors and other audit reports, was periodically updated on the status of a comprehensive claims and operational audit of the TPAs, launched by the Administration in 2013. Towers Watson began the audit work in 2013. Full results of the audit reports will be presented to the Committee during the third quarter of 2014.

6. **Review and approval of new Pharmacy Benefit Manager (PBM) contract.** Several discussions were held to review the proposals received for the Pharmacy Benefits Manager (PBM), including a report and presentation by consulting firm Towers Watson. The Committee decided to support the renewal of the contract with CIGNA Pharmacy.

The Committee's Agenda

The work program for 2014 includes:

a) **Review of Summary Plan Description (SPD).** Perform a thorough review of the SPD used by the Plan's TPAs to ensure that benefits' design has been correctly coded into their systems.

b) **Premium level and Reserve Considerations.** Analyze the annual financial review of the medical insurance program, along with other relevant financial information, and recommend any premium changes needed, if applicable, to maintain the financial integrity of the Plan.

c) **Health Care Reform.** Continue to monitor the final upcoming changes stemming from the Affordable Care Act (ACA), and discuss potential adjustments to the Plan based on current market approaches and best practices of peer organizations such as the World Bank and IMF.

d) **Dental and Vision Benefits Review.** Review the Plan's dental and vision benefits to ascertain their competitiveness against market practices, industry norms, and benefits offered by peer organizations.

e) **2013 Annual Report.** Prepare and distribute the 2013 Annual Report to plan members. The report will be issued after the Auditor's Review Report and Financial Statements for 2013 become available in 2014.

f) **Premium Structure Study.** Initiate studies of the structure of premiums applied to active employees and retirees, which was established over 10 years ago. The purpose of these studies is to ensure that the premium structure is consistent with the principles of equity.

g) **Claims Audit.** Review the results of the claims audit performed by Towers Watson in the second half of 2013 and beginning of 2014.

The Review Committee of the Life and Medical Insurance Programs

Committee President

Isabel Larson (2012 - Present)

Representatives of Active Participants

Valentina Sequi, Principal (2011 - Present)
Leslie Stone, Principal (2013 - Present)
Diana Margarita Pinto Masís, Alternate (2013 - Present)
Jose Juan Gomez, Alternate (2013 - Present)

Representatives of the Administration

Alberto Suria, Principal (2007 – Present)
Juan Carlos de la Hoz, Principal (2010 – 2013)
Kurt Focke, Principal (2013 - Present)
Marta Abello, Alternate (2013 - Present)
Rita Bettiol, Alternate (2013 - Present)
Diego Buchara, Alternate (2013 - Present)

Representatives of Retirees

Isabel Larson, Principal (2008 - Present)
Helmuth M. Carl, Alternate (2009 - Present)

Committee Secretary and Division Chief, Compensation, Benefits & HR Services

Diego Murguiondo (2012 to Present)

Committee Secretariat

Alejandra Vallejo (2012 - Present)
Marcelo Wright (2013 - Present)
Tatiani Fontes (2013 - Present)

THE MEDICAL INSURANCE PLAN

Self-Funding or Self-insurance

The IDB health plan is self-funded, which is a term that describes an employer that is 100% responsible for the medical bills of its employees. The IDB retains all the legal and financial responsibilities of the health plan.

In a self-insured arrangement, the employer and plan member contributions (i.e., employees and retirees) are placed in a special fund for the sole purpose of paying employees' medical bills and fees as they are incurred. IDB assumes the financial risk as it must pay the medical bills of its employees that fall within the scope of the plan. It must also calculate and ensure there are sufficient reserves to support the benefit plan.

The IDB pays a third-party administrator, in this case Cigna Healthcare and Vanbreda International, an administrative fee to process claims and access its network of credentialed providers.

Third Party Administrator (TPA)

A TPA is defined as a company that administers self-funded employee benefit plans such as medical, dental and vision, among others. TPAs can also assist their clients with designing and implementing benefit plans, managing plans, and with billing/collecting of funds (or premiums) and they work on behalf of employers, also known as plan sponsors.

Demographic Analysis

Table 2

Plan Members	2012	2013
Staff	2,070	2,040
Retirees	1,843	1,904
Dependents	5,499	5,584
Total Members	9,412	9,528
Location		
USA	64%	65%
Outside the USA	36%	35%

Source: Bank Records

General Data: As of December 31, 2013, the Program covered a total of 9,528 plan members: 2,040 IDB Group employees, 1,904 retirees, and 5,584 dependents. The total plan membership increased by 1.1% from 2012.

Place of Residence: Approximately two-thirds (65%) of the plan members covered resided in the United States, and the remainder (35%) resided abroad. These percentages in the geographic distribution of our membership did not change from 2012.

Ratio of Dependents per Participant: The average for the Plan as a whole was 1.41 dependents per participant in 2013 compared to 1.40 in 2012.

Health Plan Highlights – Cigna Healthcare and Vanbreda International

Medical

In 2013, the overall medical trend[1] for the Cigna plan was 6.6%. This percentage increase reflected a comparison between the total dollars spent in 2012 for healthcare claims vs. 2013. However, a more meaningful number, which is the Per Member Per Year (PMPY) cost, shows a trend of 3.9%.

The main drivers in 2013 compared to 2012 were: 1) increase in catastrophic claims by 18% (in dollar terms); 2) increase in frequency and costs of Emergency Room visits; 3) Higher utilization of diagnostic tests (i.e., more MRIs, Cat Scans, and lab work); 4) Medical inflation – overall cost increased for office visits, outpatient services and surgical procedures.

As for Vanbreda, total medical spend in 2013 was higher than 2012, but it is still early to establish a trend since 2013 was the first full year of claims experience the IDB had with Vanbreda, being a new TPA. Due to what in the healthcare industry is called a "claims lag"[2], 2012 is considered an incomplete ("immature") claim year because there were claims paid in 2012, but which were incurred in 2011 under Cigna International.

[1] Healthcare cost trend is defined as the rate at which medical costs are increasing due to services being used more frequently; an increase in the costs for these services; and/or more expensive services being used. Components of healthcare trend include: Price inflation, deductible leveraging, utilization, and technological advances.

Trend contribution is a measure of each individual line item's impact on the overall cost change. It is calculated by subtracting the current period result for the item minus the base period result, and dividing this amount by the base period total plan spend.

[2] Claims Lag relates to claims backlog, meaning liability for claims reported but not paid (RBNP) and the liability for claims incurred but not reported (IBNR).

At a macro-level overview of claims activity under Vanbreda in 2013, the following figured were observed:

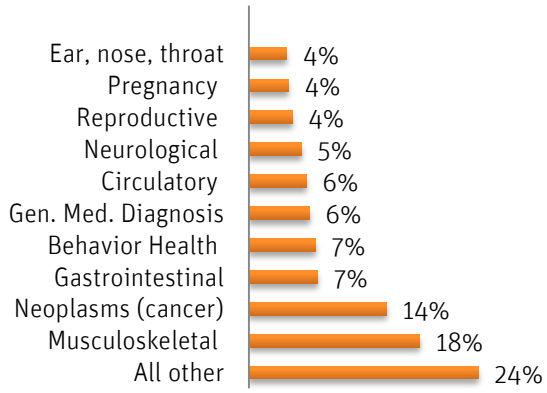
Five countries accounted for 56.1% of all claims incurred. They are: USA (17.1%), Brazil (16.8%), Argentina (7.8%), Chile (7.8%) and Peru (6.6%).

Medical benefits, including dental and vision, totaled US$11,954,139 of paid claims. Claims paid for retirees and their dependents totaled approximately 60.5% of all paid claims. Hospitalizations amounted to 38.3% of all paid claims.

There were 681 Guarantee of Payments (GOP) issued, whereby the requests were primary done by e-mail (88.3%), followed by phone (9.1%), fax (2.3%) and letters (0.3%).

In 2013, the top ten condition categories were:

Graph 1



Source: CIGNA Healthcare

Network Savings

The strength and penetration of the Cigna PPO network continued to increase during 2013, representing net savings to the Plan of US$14.7 million (vs. US$14.1 million in 2012). This increase is a function of two positive trends: One, our plan members are seeking more in-network providers; two, Cigna continues to add more providers to our PPO network.

Outside the United States, there is no provider network of contracted physicians and facilities per se. Vanbreda International has direct pay arrangements with many international providers, but they are not part of a network. Thus, the plan administrator will always try to negotiate favorable payment options and discounts; those often happen on a case by case basis and there is no guarantee that the foreign provider will agree to a discount. However, Vanbreda International continues to obtain agreements in favor of our members.

Pharmacy

The Cigna Pharmacy plan experienced a trend of 2.3%. The drivers of this trend were medical inflation and increased utilization of specialty pharmaceutical medication (10.2% over 2012).[3]

There were three positive drivers of the IDB's pharmacy spend in 2013: 1) increased utilization of generic medication, 2) more brand name drugs losing patent protection, and 3) fewer scripts being filled per plan member.

Prescription utilization decreased by 2.1% in 2013 vis-à-vis 2012. The generic prescription utilization rate increased from 65.7% to 69.0% resulting in US$921,646 in savings.

Vanbreda Pharmacy claims incurred by plan members and their dependents are reimbursed in full after a US$5 copayment. The total pharmacy spend under Vanbreda amounted to US$1.5 million or 13.2% of total claims.

Dental

The Cigna dental plan had an overall cost trend increase of 3.9%, driven primarily by inflationary pressures in healthcare and higher utilization in the following categories: diagnostic/preventive, basic restorative, major restorative, endodontics and periodontics. This indicates that our plan members are very committed towards dental health.

The numbers reflecting this trend are: a) the total expenditure for dental care in 2013 increased 3.9% compared to 2012 figures; b) Total dental claims amounted to US$4,224,909 in 2013.

The use of in-network service providers decreased from 36.3% in 2012 to 33.7% in 2013. The number of unique members receiving a preventive cleaning experienced a slight decrease – from 67.0% in 2012 to 66.2% – but still compares very favorably to a norm of 60.4%.

Plan members outside the United States also showed similar experience regarding strong dental hygiene and good oral care through the high utilization of preventive dental services. Total dental claims paid in the Vanbreda plan amounted to US$860,000, which is equivalent to 7.2% of total paid claims.

[3] Specialty drugs are a new category of very expensive (i.e., protein-based, biologically engineered) drugs now being used frequently for the treatment of cancer, rheumatoid arthritis, HIV, multiple sclerosis, and other chronic diseases.

Catastrophic Claims

A catastrophic claim is defined as one reaching an annual cost of at least US$50,000. 2013 saw an increase of 58.5% in the number of catastrophic claims compared to 2012. There were a total of 82 catastrophic claims: 53 with Cigna Healthcare and 29 with Vanbreda International. In 2012, there were a total of 48 catastrophic cases.

The total catastrophic healthcare spend was US$ 8.3 million. The average catastrophic claim cost under Vanbreda was US$106,300, while at Cigna it was US$97,800.

Under the Cigna plan, catastrophic spend increased 17.8% in 2013 compared to the prior year, and contributed 3.3% to the overall medical costs increase of 6.6%. In dollar terms, the catastrophic claim total in 2013 was US$5,183,280 vs US$4,402,426 in 2012.

Under Vanbreda, catastrophic spend increased compared to the prior year. In dollar terms, the catastrophic claim total in 2013 was US$2.8 million vs US$1.5 million in 2012.

The main drivers of this upturn in catastrophic claims are related to an increase in number of plan members experiencing chronic or acute health conditions, all requiring more intensive and complex care. There was also a 15% cost increase in in-patient care / hospitalizations in 2013 over 2012 for catastrophic cases alone. To a lesser extent, but always a driver of higher medical costs is medical inflation, which usually runs at two to three times higher than CPI year-in and year-out. Medical inflation in the United States in 2013 closed the year at 7.5%.[5]

The main condition categories for catastrophic claims were: neoplasms, multiple bone fractures, premature births, cerebrovascular, respiratory and substance disorder.

[5] Source: PricewaterhouseCoopers' Health Research Institute

Table 3

Number of Catastrophic Cases

Plan Administrator	Cigna	Vanbreda	Total
Plan Year - 2012	40	8	48
Plan Year - 2013	53	29	82

Source: Cigna and Vanbreda Reports

Table 4

Total Medical Spend on Cases

Categories	Total
Avg. Spend per Claimant - 2012	US$106,780
Avg. Spend per Claimant - 2013	US$102,050
Total Spend (> US$50K) - 2012	US$5.1 million
Total Spend (> US$50K) - 2013	US$8.3 million

Source: Cigna and Vanbreda Reports

In order to avoid a higher financial impact to the Plan and mitigate risk volatility stemming from unpredictable catastrophic claims, the Plan is protected by a stop loss insurance policy, which has a specific retention amount of US$350,000 per covered person, plus a corridor retention amount of US$114,000. In 2013, the plan received a stop loss reimbursement of US$50,000.[6]

Another mitigating factor in these cases was the coordination of payments with Medicare. These savings totaled US$640,000.

[6] This works similar to a second level deductible, where the US$114,000 corridor is applied on top of the US$350,000 specific deductible. In other words, a high dollar claim is only eligible for reimbursement once the claim amount exceeds US$464,000.

LIFE INSURANCE AND LONG TERM DISABILITY

AIG continues as the Bank's Life, Accidental Death & Dismemberment (AD&D) and Long-Term Disability insurer. Highlights of 2013 include:

1) Revision of policy document. Updating changes in rates and other benefits such as the life insurance benefit maximum that increased from $1 million to US$1.5 million of combined basic & supplemental life insurance, but had not been reflected in the SPD.

2) Flat renewal. We renewed the policies with AIG with no increase in premiums.

3) There were a total of four death claims (from two dependents and two staff who were on LTD), and there were no additional long-term disability (LTD) claimants in 2013.

4) One LTD claimant reached age 62, which stopped benefits, but started receiving a pension.

CIGNA HEALTHCARE CONTRACT RENEWAL

In 2013, Cigna was selected to continue as the Bank's Health Plan administrator in the United States as the result of a competitive process. A new contract with Cigna Healthcare was signed on January 31, 2014.

FINANCIAL ANALYSIS

The Bank's independent accountants KPMG reviewed the financial statements of the Bank's Medical Insurance Benefits Account for 2013.

KPMG issued their corresponding review reports on the financial statements. Based on their review they are not aware of any material modifications that should be made to the financial statements in order for them to be in conformity with U.S. generally accepted accounting principles.

As shown in Annex 2, premium contributions to the Plan in 2013 amounted to US$52.9 million, plus US$253,000 in investment and other income, minus US$53.9 million in net deductions, resulted in a net deficit of US$1.2 million for the year. Even though 2013 ended with a small deficit, the Plan still has reserves of US$36.6 million. This strong reserve level provides the Plan with adequate financial resources to cover all medical, dental and pharmacy services for at least 8.1 months.

ANNEX 1

DEMOGRAPHIC DATA FOR THE MEDICAL INSURANCE PROGRAM

As of December 31, 2013

Type of Participant	Residents		Total
	USA	Other Countries	
Active employees and their dependents	4,012	2,089	6,101
Active employees	1,355	668	2,023
Dependents	2,626	1,409	4,035
Other	31	12	43
Retirees and their dependents	2,132	1,295	3,427
Retirees	1,175	729	1,904
Dependents	957	566	1,523
Total population covered	**6,144**	**3,384**	**9,528**

Source: Bank records

ANNEX 2

FINANCIAL PERFORMANCE OF THE PROGRAM
For the years ended December 31, 2013 and 2012

(In thousands of United States dollars)

		2013	2012
Contributions			
	Active employees	$ 9,432	$ 9,174
	Bank	$ 18,178	$ 17,700
Total contributions	Active employees	$ 27,610	$ 26,874
	Retirees	$ 8,436	$ 8,255
	Bank	$ 16,872	$ 16,508
	Total contribution Retirees	$ 25,308	$ 24,763
	Total contributions	$ 52,918	$ 51,637
Benefits			
	Active employees	$ 28,177	$ 27,216
	Retirees	$ 25,763	$ 24,410
	Total	$ 53,940	$ 51,626
Operating surplus (deficit)		$ (1,022)	$ 11
	Active employees	$ (567)	$ (342)
	Retirees	$ (455)	$ 353
Other			
	Reinsurance receipts & US Medicare Part D Subsidy	$ 288	$ 1,093
	Active employees	$ (152)	$ 220
	Retirees	$ 440	$ 873
	(Increase) decrease in unclaimed benefits	$ (724)	$ (267)
	Active employees	$ (349)	$ (275)
	Retirees	$ (375)	$ 8
Contributions over (below) than claims paid and other items		$ (1,458)	$ 837
	Active employees	$ (1,068)	$ (397)
	Retirees	$ (390)	$ 1,234
Interest and income from investments		$ 253	$ 372
Program surplus (deficit)		$ (1,205)	$ 1,209
Reserves		$ 36,556	$ 37,761

Source: IDB Financial Statements

ANNEX 3

INDEPENDENT ACCOUNTANTS' REVIEW REPORTS AND FINANCIAL STATEMENTS

AS OF DECEMBER 31, 2013

INDEPENDENT ACCOUNTANTS' REVIEW
REPORT AND FINANCIAL STATEMENTS

Inter-American Development Bank
Health Insurance Benefit Account
December 31, 2013 and 2012

KPMG LLP
Suite 12000
1801 K Street, NW
Washington, DC 20006

INDEPENDENT ACCOUNTANTS' REVIEW REPORT

To the President of the
Inter-American Development Bank

We have reviewed the accompanying statements of net assets available for benefits of the Inter-American Development Bank (Bank) – Health Insurance Benefit Account as of December 31, 2013 and 2012, and the related statements of changes in net assets available for benefits for the years then ended. A review includes primarily applying analytical procedures to management's financial data and making inquiries of Bank management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with U.S. generally accepted accounting principles and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the review in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance that there are no material modifications that should be made to the financial statements. We believe that the results of our procedures provide a reasonable basis for our report.

Based on our review, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with U.S. generally accepted accounting principles.

KPMG LLP

Washington, D.C.
July 15, 2014

INTER-AMERICAN DEVELOPMENT BANK
HEALTH INSURANCE BENEFIT ACCOUNT

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

(Expressed in thousands of United States dollars)

	December 31, 2013	December 31, 2012
Assets		
Cash	$ 3,778	$ 4,602
Investments, at fair value	40,305	40,125
Accounts receivable	110	192
Total assets	44,193	44,919
Liabilities		
Accounts payable	801	1,045
Claims incurred but not reported	6,836	6,113
Total liabilities	7,637	7,158
Net assets available for benefits	$ 36,556	$ 37,761

The accompanying Independent Accountants' Review Report and the notes to financial statements should be read in conjunction with these statements.

INTER-AMERICAN DEVELOPMENT BANK
HEALTH INSURANCE BENEFIT ACCOUNT

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

(Expressed in thousands of United States dollars)

	Years ended December 31,	
	2013	2012
Additions		
Contributions		
Employer direct contributions	$ 18,178	$ 17,700
Postretirement Benefits Fund contributions	16,872	16,508
Participant contributions	17,868	17,429
Total contributions	52,918	51,637
Net appreciation in fair value of Investments	230	357
Other income	23	15
Total additions	53,171	52,009
Deductions		
Benefits to participants		
Claims paid	53,940	51,626
Increase in claims incurred but not reported	724	267
Insurance recoveries	152	(220)
US Medicare part D subsidy	(440)	(873)
Total deductions	54,376	50,800
Net (decrease) increase in net assets during the year	(1,205)	1,209
Net assets available for benefits:		
Beginning of year	37,761	36,552
End of year	$ 36,556	$ 37,761

The accompanying Independent Accountants' Review Report and the notes to financial statements should be read in conjunction with these statements.

NOTE A - DESCRIPTION OF THE PROGRAM

The following description of the Health Insurance Benefit Program (Program) of the Inter-American Development Bank (Bank) is provided for general information purposes only. Participants should refer to the Medical Insurance Program Handbook for a complete description of the Program's provisions.

The Bank is the sponsor of the Program and has the responsibility to establish benefits and participant contributions. The Program is for the benefit of current and retired national and international staff members of the Bank and the Inter-American Investment Corporation (IIC) (herein jointly referred to as the Employer) and their dependents. Indefinite-term, fixed-term and turnover positions, their respective spouses and authorized dependent children are generally required to participate in the Program. Executive Directors and their staff, retirees and their qualified dependents, can participate on a voluntary basis. Staff members employed under indefinite-term or fixed-term appointments are eligible to continue subsidized coverage as retirees, provided they meet certain minimum years of continuous coverage under the Program. Retirees not complying with the minimum years of coverage, employees absent on leave-without-pay and those who end their employment with the Bank may elect to continue coverage under certain conditions.

The Program provides health benefits (medical, hospital, surgical, major medical, prescription drug, dental and vision) to participants and covered dependents. Participants' claims are processed by contracted program administrators, but the responsibility for payments to participants and providers is retained by the Bank. The payment of claims is coordinated with participant's benefits under other health benefit programs, including U.S. Medicare.

The overall objective of the Program is for the Employer to share in two thirds of the costs of the Program, except for administrative and other expenses which are fully paid by the Employer. The Employer, as well as current and retired participants, contributes with proportional amounts that the Bank determines periodically to finance the Program.

The Employer contributes two thirds of the total contributions to the Program, excluding contributions from participants on leave-without-pay. The Employer also pays the full cost of U.S. Medicare B for certain eligible participants as well as administrative and other expenses of the Program. The Employer contributions for retirees are provided from the Postretirement Benefits Fund (PRF).

The Program has a stop-loss insurance policy for claims exceeding $350. Under the stop-loss insurance policy, the Program is reimbursed for paid claims exceeding $350 up to $1,650 per medical condition.

For the year ended December 31, 2013, administrative and other expenses of the Program funded by the Employer included: (i) contracted program administrator fees of $2,025 (2012 – $1,927); (ii) the premium for stop-loss insurance of $592 (2012 – $580) and (iii) the premium for Medicare B of $2,004 (2012 - $1,868).

The Bank applies for a subsidy under the U.S. Medicare part D program on all Medicare eligible retirees who were not enrolled in this program. A subsidy of $440 was received in 2013 (2012 – $873) and recognized as a reduction of Benefits to participants.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements are expressed in United States dollars and prepared in conformity with U.S. generally accepted accounting principles (GAAP). The preparation of financial statements in conformity with GAAP requires Management to make estimates and assumptions that affect the reported amounts of net assets available for benefits, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of additions to and deductions from net assets available for benefits during the reporting period. Actual results could differ from these estimates.

Investments

Investments are carried and reported at fair value using trade date accounting. Realized and unrealized gains and losses are included in Net appreciation in fair value of Investments in the Statements of Changes in Net Assets Available for Benefits.

Claims incurred but not reported

Claims incurred by participants but not reported are estimated based on an actuarial determination, which takes into consideration the timing of the claims paid, and are reported as a liability in the Statements of Net Assets Available for Benefits. Adjustments made to Claims incurred but not reported are shown in the Statements of Changes in Net Assets Available for Benefits.

Related parties transactions

As part of the administration of the Program's resources, the Bank may pay claims and receive contributions and other payments on behalf of the Program. The net amount receivable or payable related to these activities is included in Accounts receivable in the Statements of Net Assets Available for Benefits.

NOTE C – INVESTMENTS

The Bank invests the Program's resources in the same type of securities in which it invests its own funds under its investment authority. Such resources are invested in high quality securities through two investment pools managed by the Bank. As of December 31, 2013, all of the Program's securities have a credit quality equivalent to ratings ranging from AAA to A (short-term securities carry the highest short-term credit rating).

The Bank limits the Program's investment activities to a list of authorized dealers and counterparties. Further, exposures and term limits have been established for these counterparties based on their size and creditworthiness.

Net unrealized gains on investments held at December 31, 2013, in the amount of $222 (2012 – $335), were included in Net appreciation in fair value of Investments. The average return on investments, including realized and unrealized gains and losses, during 2013 and 2012 was 0.57% and 0.87%, respectively.

The following table sets forth the Program's investments accounted for at fair value as of December 31, 2013 and 2012:

	2013	2012
Investment pools [1]:		
Obligations of the United States Government	$ 17,166	$ 18,033
U.S. government-sponsored enterprises	40	828
Obligations of non-U.S. governments and agencies	10,822	10,999
Bank obligations[2]	9,488	7,680
Corporate securities	879	-
Mortgage-backed securities:		
U.S. residential	-	406
Non-U.S. residential	455	572
Asset-backed securities	1,455	1,607
	$ 40,305	$ 40,125

[1] Detail of investments by class represents the Program's proportionate share of the investment pools assets.

[2] May include bank notes and bonds, certificates of deposit, commercial paper, and money market deposits.

NOTE D – FAIR VALUE MEASUREMENTS

The framework for measuring fair value establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are as follows:

Level 1 - Unadjusted quoted prices for identical assets or liabilities in active markets;

Level 2 - Quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in markets that are not active; or pricing models for which all significant inputs are observable, either directly or indirectly, for substantially the full term of the asset or liability;

Level 3 - Prices or valuation techniques that require inputs that are both significant to the fair value measurement and unobservable.

Obligations of the United States Government amounting to $17,166 as of December 31, 2013 (2012 – $18,033), are valued based on quoted market prices in active markets, a valuation technique consistent with the market approach, and are classified within Level 1 of the fair value hierarchy.

All of the remaining investment pools securities are measured at fair value based on quoted prices in markets that are not active or external pricing services, where available. These methodologies represent valuation techniques consistent with the market and income approaches. These investments are classified within Level 2 of the fair value hierarchy and amount to $23,139 at December 31, 2013 (2012 - $22,092).

The main methodology of external pricing service providers involves a "market approach" that requires a predetermined activity volume of market prices to develop a composite price. The market prices utilized are provided by orderly transactions being executed in the relevant market; transactions that are not orderly and outlying market prices are filtered out in the determination of the composite price. Other external price providers utilize evaluated pricing models that vary by asset class and incorporate available market information through benchmark curves, benchmarking of like securities, sector groupings, and matrix pricing to prepare valuations.

The Program's policy for transfers between levels is to reflect these transfers effective as of the beginning of the reporting period. There were no transfers between levels during 2013 and 2012.

NOTE E – FUNDING

The funding to provide the benefits specified in the Program consists of contributions by the participants and the Employer. Participant contributions are provided by employees and retirees, as established by the Bank. Employer contributions for retirees are provided through the PRF. Employer contributions for active participants are provided directly. Contributions to the Program for the year ended December 31, 2013 amounted to $52,918 (2012 – $51,637), of which $35,050 (2012 – $34,208) was contributed by the Employer and $17,525 (2012 – $17,106) by active employees and retirees. An additional $343 (2012 – $323) was contributed by participants on leave-without-pay.

NOTE F – PROGRAM CONTRIBUTIONS AND BENEFITS TO PARTICIPANTS

The following table shows contributions and benefits by employee status for the years ended December 31, 2013 and 2012 :

	2013			2012		
Contributions	**Active Employees**	**Retirees**	**Total**	**Active Employees**	**Retirees**	**Total**
Employer	$ 18,178	$ 16,872	$ 35,050	$ 17,700	$ 16,508	$ 34,208
Active participants	9,089	8,436	17,525	8,851	8,255	17,106
Participants on leave-without-pay	343	-	343	323	-	323
	27,610	25,308	52,918	26,874	24,763	51,637
Claims Paid to Participants						
Medical	20,413	15,698	36,111	19,603	15,677	35,280
Dental	3,032	2,158	5,190	2,987	2,076	5,063
Medicines	4,732	7,907	12,639	4,626	6,657	11,283
	28,177	25,763	53,940	27,216	24,410	51,626
Contributions higher (lower) than claims paid	(567)	(455)	(1,022)	(342)	353	11
Other Items						
(Increase) decrease in Claims incurred but not reported	(349)	(375)	(724)	(275)	8	(267)
Insurance recoveries	(152)	-	(152)	220	-	220
US Medicare part D subsidy		440	440	-	873	873
	(501)	65	(436)	(55)	881	826
Contributions higher (lower) than claims paid and other items	$ (1,068)	$ (390)	$ (1,458)	$ (397)	$ 1,234	$ 837

NOTE G – CONCENTRATION OF CREDIT RISK

Credit risk represents the accounting loss that would be recognized at the reporting date if counterparties fail completely to perform as contracted. At December 31, 2013, the Program had cash in one bank of $3,778 (2012 – one bank of $4,602). The Bank does not anticipate nonperformance by any of its counterparties. The amount of credit risk shown, therefore, does not represent expected losses.

NOTE H – SUBSEQUENT EVENTS

Management has evaluated subsequent events through July 15, 2014, which is the date the financial statements were available to be issued. As a result of this evaluation, there are no subsequent events that require recognition or disclosure in the Program's financial statements as of December 31, 2013.