
# REVIEW COMMITTEE OF THE MEDICAL AND LIFE INSURANCE PROGRAMS

ANNUAL REPORT 2014

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# REVIEW COMMITTEE OF THE MEDICAL AND LIFE INSURANCE PROGRAMS

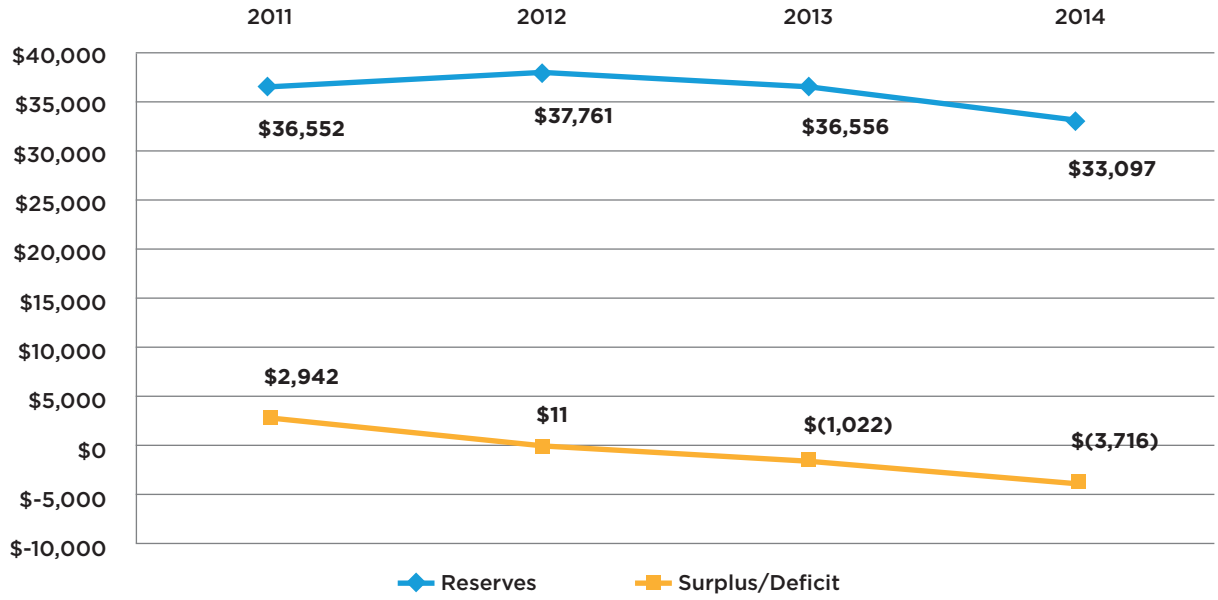
## ANNUAL REPORT 2014

The Review Committee of the Medical and Life Insurance Programs (hereinafter, the Committee) is pleased to submit the report on activities for the year 2014 to plan participants.

This report includes the Medical Insurance Benefits Account Independent Accountant's Review Report and Financial Statements for the aforementioned period. The financial statements were reviewed by the independent accountant firm KPMG.

The Medical Insurance Program (hereinafter, the Plan) spent US$57.3[1,2] million in claims in 2014. Available reserves at the end of the year totaled US$33 million or the equivalent to 7 months of claims. Figure 1 shows a decline in the level of reserves compared to 2013 due to a deficit between premium contribution and claims expenditures.

**Figure 1**




Source: Bank Records

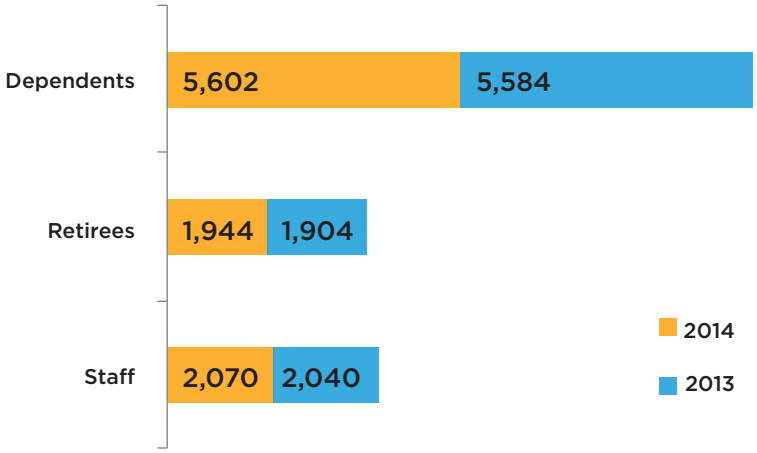
1 All amounts in US dollars
2 This amount includes pharmacy rebates deductions

## DEMOGRAPHICS ANALYSIS

As of December 31, 2014 the Plan had 9,616[3] members including active staff, retirees, and their eligible dependents.

General Data: As of December 31, 2014, the Plan covered 2,070 active employees, 1,944 retirees, and 5,602 dependents. The total plan membership increased by 0.9% from the previous year. 45% of plan members are 51 years of age or older and 31% are 61 years and older.

### Figure 2




Source: Bank Records

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 2013.

Ratio of Dependents per Participant: The average was 1.98 dependents per active participant and 0.78 dependent for every retiree participant in 2014.

3 Includes plan members on offline status (or Cobra); a temporary continuation of coverage upon discontinuation of employment. Plan members can elect to continue in offline status while paying the full cost of the coverage for up to 23 months.

## PLAN UTILIZATION

In 2014, the Plan incurred US$59.8[4] million in claims of which, 65% were medical, 26% were pharmacy and 9% were related to dental services.

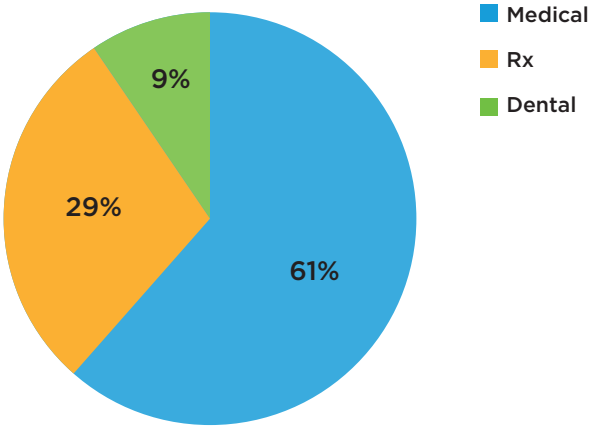
### Table 1

| | US-based | Non-US based | Total |
|---|---|---|---|
| Medical | $28,927 | $10,053 | $38,980 |
| Rx | $13,740 | $1,553 | $15,293 |
| Dental | $4,443 | $1,120 | $5,563 |
| | $47,109 | $12,726 | $59,836 |

Source: Third Party Administrators Records[5]

## US-BASED POPULATION UTILIZATION

### Figure 3




Source: Third Party Administrators records

## MEDICAL

In 2014, the US-based population incurred US$47.1 million in claims up from US$42.0 million in 2013. Of this amount, US$28.9 million was related to medical claims.

4 Plan utilization figures do not take into account deductions or inclusions (e.g. pharmacy rebates, recoveries et al)

5 Third Party Administrators (TPAs) are defined in section Administrative Fees

US-based medical claims experienced an increase of 8% per member per year (PMPY) compared to 6.6% in 2013.

Non-catastrophic claims increased by 2.9% percentage points PMPY in 2014 and contributed 1.8% to the overall PMPY increase.

Catastrophic[6] claims increased by 51.9% PMPY and contributed 5% to the overall PMPY increase. The cost of medical care and increased utilization were the main factors, consecutively, in the PMPY increase.

The following figures provide a snapshot of the medical plan in 2014 based on data provided by CIGNA:

- US$4,663 cost PMPY
- 49.3% of population have chronic[7] conditions
- 77.6% of expenditures are related to chronic conditions
- 32 catastrophic cases accounted for 13.6% of the total cost (including pharmacy related costs)
- Emergency room utilization was 55% above the norm[8]
- Utilization of advanced radiological services (MRI, PET, & CT Scans) was more than 50% above the norm
- The top five conditions (musculoskeletal, neoplasms, mental disorder, cardiovascular, general medical visits) contributed 53% of the cost. Musculoskeletal was the largest expenditure contributor in the current period, at 17.8%

6 Catastrophic cases: claims exceeding a specific annual cost. For the purposes of this report US$75,000 for non-US based claims, and US$100,000 for US-based claims

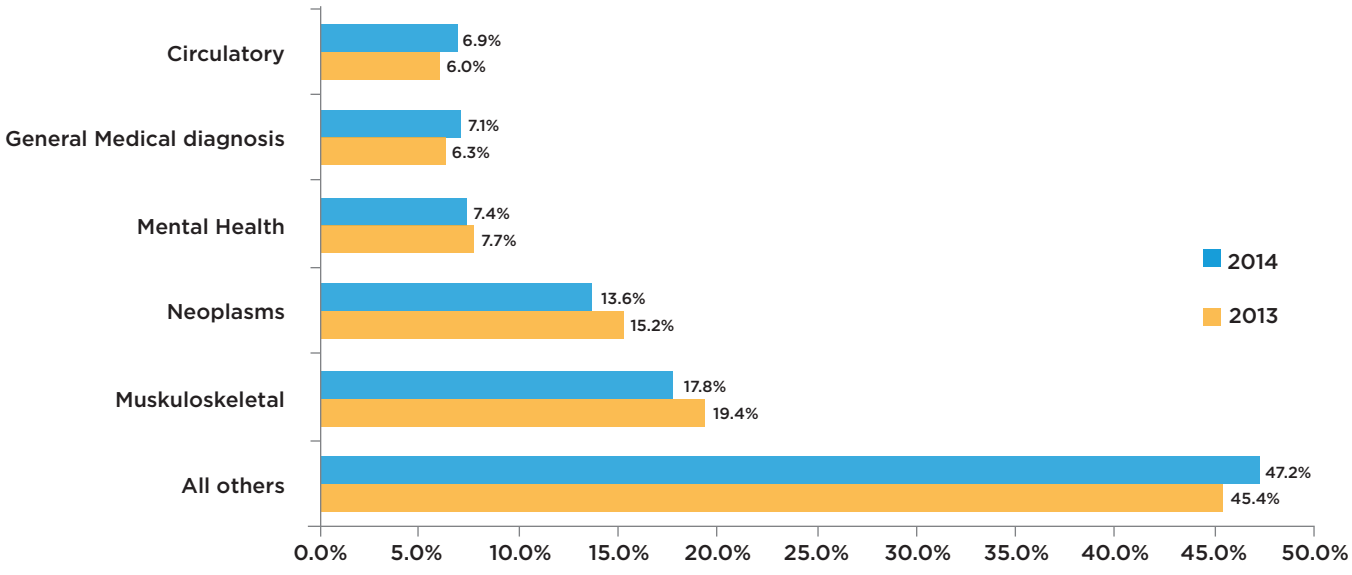
7 A chronic disease is a long-lasting condition that can be controlled but cannot be cured

8 Norm: refers to claims experience of plans of similar demographics

## TOP CONDITIONS US-BASED POPULATION

In 2014, the top 5 condition categories PMPY were:

**Figure 4**




Source: TPAs records

The top five conditions contributed to 52% of the overall plan spend. Of the catastrophic related claims, 46% were related to neoplasms (cancers), and 21.4% to circulatory conditions.

## US-BASED POPULATION COST DRIVERS

The cost drivers unique to this group included:

1. Pharmacy costs represent a significant portion of the overall claims spend (29%). Generic utilization is still below benchmarks. 6% of prescriptions are filled with brand name drugs that have a generic equivalent. Single source (brand name) drugs account for 23% of the volume but represent 62% of the total pharmacy costs. Lastly, since pharmacy co-pays have not been increased in approximately 18 years, the Plan has been absorbing the difference or the current equivalent of 97% of pharmacy costs.
2. Increase in the frequency of emergency room (ER) related claims associated with non-emergency situations which can cost up to 3 times more to the Plan versus visits to an urgent or convenient care clinic. This trend continues from previous years.
3. Dependent parents have claims costs approximately twice the cost per member per month than other member types.
4. Higher than norm utilization of diagnostic tests (i.e., more MRIs, cat scans, and lab work). This trend continues from previous years.
5. Medical inflation –overall cost increased for office visits, outpatient services and surgical procedures.

## PHARMACY

In 2014, the US-based population spent US$13.7 million in pharmacy related claims. This represents a 10.6% overall increase compared to 2013. Specialty drugs increased by 14.5% and non-specialty drugs by 9.7%. 6% of drug prescriptions are filled with options which have a generic equivalent. The overall generic utilization (71.9%) fared below the norm (82%). 23% of specialty drugs spend under the medical benefit is being driven by drugs used to treat neoplasms (cancers).

The top 10 drugs by total spend in 2014:

**Table 2**

| | Drug | Treats | Amount |
|---|---|---|---|
| 1 | Crestor | Cholesterol | $609,191 |
| 2 | Nexium | Ulcer/heart burn | $432,222 |
| 3 | Revlimid | Cancer | $388,288 |
| 4 | Follistim Aq | Infertility | $216,695 |
| 5 | Syprine | Poisoning | $185,456 |
| 6 | Restasis | Dry eyes | $175,880 |
| 7 | Jakafi | Cancer | $174,786 |
| 8 | Cialis | Erectile dysfunction | $173,092 |
| 9 | Xenazine | Movement disorder | $167,868 |
| 10 | Enbrel | Arthritis | $165,156 |

Source: TPAs records

The next 5 drugs by total spend treat asthma, erectile dysfunction, psychosis, infertility, and arthritis.

The top 10 drugs by cost per prescription:

**Table 3**

| | Drug | Treats | Cost per Prescription | # of Prescriptions |
|---|---|---|---|---|
| 1 | Sovaldi | Hepatitis C | $28,560 | 3 |
| 2 | Olysio | Hepatitis C | $22,562 | 3 |
| 3 | Simponi | Arthritis | $18,553 | 1 |
| 4 | Syprine | Poisoning | $18,456 | 10 |
| 5 | Jakafi | Cancer | $17,479 | 10 |
| 6 | Stelara | Psoriasis | $15,308 | 1 |
| 7 | Avonex | Multiple Sclerosis | $14,946 | 1 |
| 8 | Gilenya | Multiple Sclerosis | $14,893 | 1 |
| 9 | Avonex Pen | Multiple Sclerosis | $14,047 | 5 |
| 10 | Xenazine | Movement disorder | $13,989 | 12 |

Source: TPAs records

The next 5 drugs by cost per prescription treat cancer, Parkinson's disease, multiple sclerosis, and narcolepsy.

In 2014, the top 10 drugs plus the next 10 accounted for 0.1% of the overall prescription volume (121 prescriptions) and 11.7% of the total spend in pharmacy.

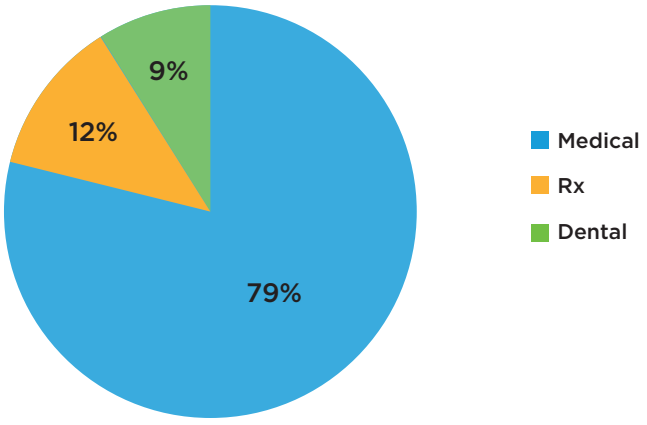
## DENTAL

In 2014, the US-based population spent US$4.4 million in dental services related claims compared to US$4.2 in 2013.

Overall, the Plan experienced higher utilization of diagnostic and preventive care services and lower utilization in other service categories. After preventive care, US-based plan members utilized the most; major restorative, basic restorative, and periodontics dental services.

## NON-US-BASED POPULATION UTILIZATION

**Figure 5**




Source: TPAs records

In 2014 the non-US-based spent US$12.7 million in claims. This represents a 6.5% increase from 2013. Of this amount, US$10.0 was related to medical claims.

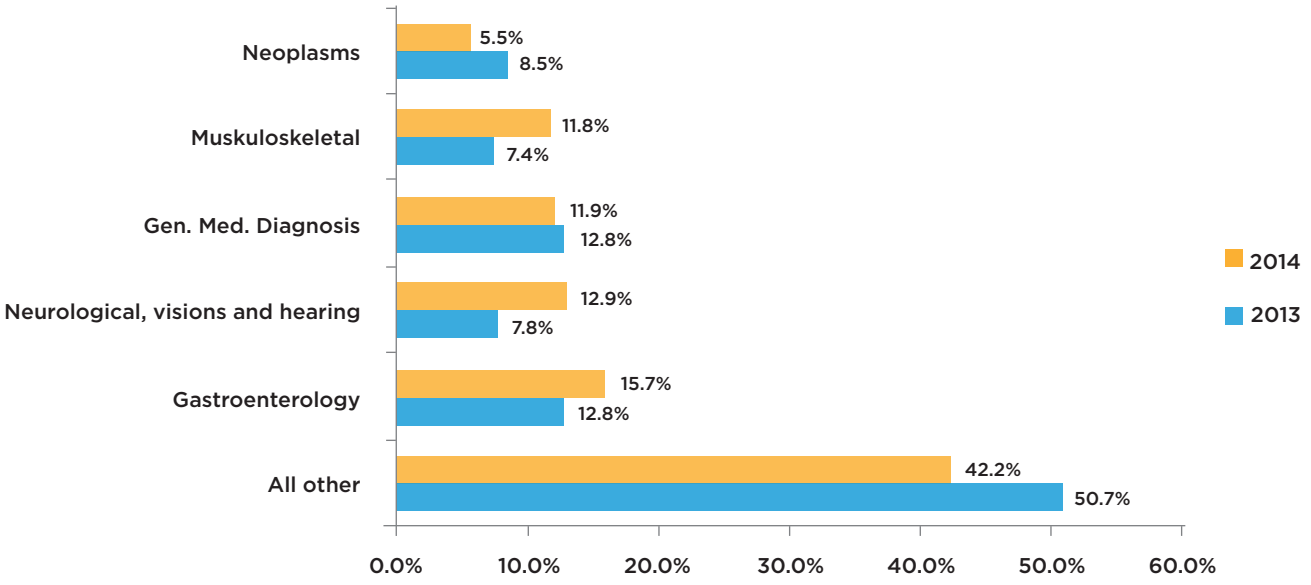
Some notable figures in 2014:

- US$3,654 cost PMPY
- 38% of the population (retirees) account for 60% of claims cost
- 19% of the claims expenditures were incurred in the USA
- 17.2%, increase in the number of inpatient care (hospitalizations)
- Chile, Peru and Brazil were the top countries with the most claims related to inpatient care
- Uruguay, Chile and Costa Rica were the top countries with the highest daily cost of inpatient care
- Besides the USA; Chile, Argentina, and Uruguay were the top 3 destinations for members seeking care outside of their own countries
- 77% of claims are linked to in-country care

## TOP CONDITIONS NON-US-BASED POPULATION

In 2014, the top condition categories PMPY:

**Figure 6**




Source: TPAs records

## NON-US-BASED POPULATION COST DRIVERS

The cost drivers unique to this group include:

1. Total spend for prescription drugs purchased in the USA have increased by 14.3% for the retiree population.
2. Few countries account for a majority of costs. Some notable examples: Brazil has 8% of enrolled members and 12.6% of the claims expenditures, Chile has 5.6% of members and spent 7.2% of the total claims cost.
3. Continued shift of plan members seeking care in the United States (19% of total costs) and other countries where the cost of medical care has also increased in recent years.

## CATASTROPHIC CLAIMS

In 2014, the Plan spent approximately US$7.38 million in catastrophic claims.

Compared to 2013, catastrophic claims as a percentage of total claims increased for the US-based and decreased for non-US-based population.

The TPA for US-based claims defines catastrophic claims as those over US$100,000 per claimant. The non-US-based TPA defines catastrophic claims as those over US$75,000 per claimant.

**Table 4**

| Percentage of Total Claims | | |
|---|---|---|
| Year | US-based | Non-US-based |
| 2013 | 9.7% | 18.9% |
| 2014 | 13.6% | 13.7% |

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[9], which in 2014 had a specific deductible amount of US$450,000 per covered person.

In 2014, the Plan did not experience claims above the deductible amount.

## US-BASED CATASTROPHIC CLAIMS

In 2014, the Plan expenditures in catastrophic claims totaled US$5.64 mi. in 2013, this figure totaled US$2.84 mi.

The average cost of a catastrophic claim was US$176,225 in 2014, compared to US$142,163 in 2013. Catastrophic claims contributed to 5% of the overall increase in costs while in 2013 it contributed 3.3%.

32 claims reached the US$100,000 threshold compared to 20 in 2013. These claimants were treated for neoplasms, general medical diagnosis, neurological, and musculoskeletal condition categories.

## NON-US-BASED CATASTROPHIC CLAIMS

In 2014, the Plan experienced US$1.74 mi in catastrophic claims compared to US$2.25 in 2013.

The average cost of a catastrophic claim decreased to US$124,694 in 2014.

There were a total of 14 catastrophic claims compared to 15 in 2013. 69% of the catastrophic claims for the non-US-based population were associated to retirees.

Leading causes of catastrophic claims included neoplasms treatments, accidents, gastroenterological and musculoskeletal conditions.

9 Stop loss coverage: Insurance that provides protection against catastrophic or unpredictable losses

## LIFE INSURANCE AND LONG TERM DISABILITY

AIG was the Bank's Life, Accidental Death & Dismemberment (AD&D) and Long-Term Disability (LTD) insurer in 2014.

**LTD Program highlights:**

1. 7 members in LTD status
2. 3 new cases
3. One claimant exited LTD due to retirement and another to death

**Life Insurance Program highlights:**

1. 4 death claimants; 3 employees and 1 spouse

## ADMINISTRATIVE FEES

Plan members' claims are processed by Third Party Administrators (TPAs). CIGNA Healthcare processes claims for US-based members. CIGNA IGO processes claims for non-US-based members.

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 clients such as the IDB with designing and implementing benefit updates, network access, billing/collecting of funds among other tasks on behalf of the IDB.

In addition to TPA related administrative fees, the Bank also incurs costs related to the life insurance & long-term disability insurance carriers' premium fees, Medicare part B premium reimbursements for eligible retirees, premium fees for stop loss coverage, among others.

In 2014, the Bank incurred US$2.55 mi in administrative fees which are currently not paid out of the Medical fund and therefore, are not included in the Plan funding rate development.

**Table 5**

| | 2014 | 2013 |
|---|---|---|
| Third Party Administrators | $2,003 | $2024 |
| Life & LTD coverage | $12 | $11 |
| Stop loss coverage | $537 | $592 |
| Total | $2,552 | $2,627 |

Source: Bank Records

## FINANCIAL ANALYSIS

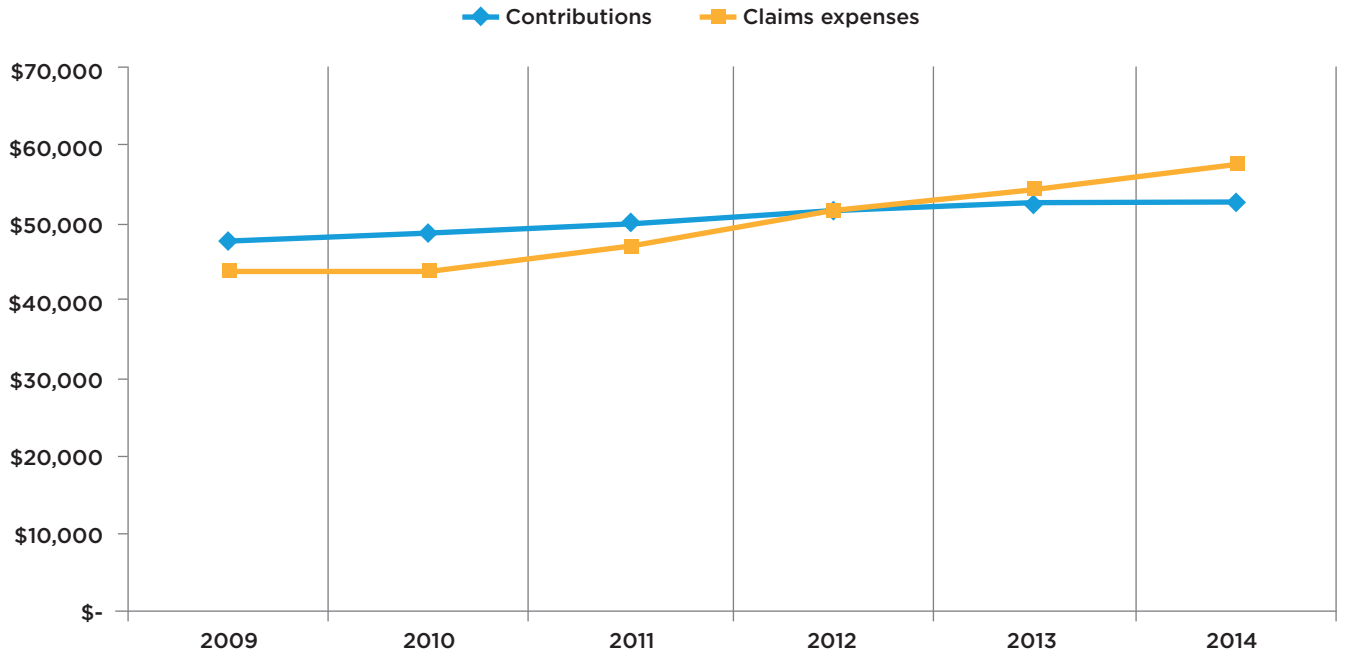
The Bank's independent accountants KPMG reviewed the financial statements of the Bank's Medical Insurance Benefits Account for 2014.

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 detail in Annex 4, the Plan experienced a net deficit of US$3.5 million in 2014. This deficit further decreased the Plan reserves down to US$33 million from US$36.6 million in 2013.

This downward trend, shown in figure 7, commenced in 2013 indicates current premium levels are not adequate to fund the plan and warrants a premium increase in 2016.

**Figure 7**




This conclusion follows a detailed analysis of the Plan utilization and financial sustainability. The results of which will be used by the Committee and Management to guide the design and implementation of cost containment strategies.

## THE COMMITTEE WORK PLAN AND ACHIEVEMENTS IN 2014[1]

The Committee is an advisory group for the administration of the Medical and Life Insurance Programs. It was assigned to review the plans, ensure the efficiency thereof, recommend an adjustment if needed in the structure, and make recommendations to improve the functioning of the Medical and Life Insurance Programs.

**The Committee's activities for the year 2014 included:**

1. Review of Summary Plan Description (SPD). Thorough review of the SPD used by the Plan's TPAs to ensure that benefits' design has been correctly coded into their systems.
2. Premium level and Reserve Considerations. Annual financial review of the medical insurance program along with other relevant financial information.
3. Review new TPA contract for US plan based member claims
4. Health Care Reform. Monitor the 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.
5. Dental and Vision Benefits Review. Review the Plan's dental and vision benefits.
6. 2013 Annual Report. Prepare and distribute the 2013 Annual Report to plan members.
7. Claims Audit. Review the results of the claims audit performed in the 2013-2014 period.
8. Review information related to the Post-Retirement Benefit Plan for 2013.
9. Review coverage levels and funding rates for the life and accidental death & dismemberment insurance coverages.

**The Committee's work program for the year 2015 included:**

1. Review medical program handbooks
2. Discuss the cost and financial impact of including speech therapy and autism intervention coverage for plan members with developmental delays and autism
3. Review financial statements
4. Review the Plan's sustainability, premium levels, and reserves' utilization
5. Review of 2014 utilization reports by both Cigna Healthcare and Cigna IGO

1 See annex 1 for Committee members information

# ANNEX 1

## THE REVIEW COMMITTEE OF THE LIFE AND MEDICAL INSURANCE PROGRAMS 2014 MEMBERS

### 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)
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)

# ANNEX 2

## DEMOGRAPHIC DATA FOR THE MEDICAL INSURANCE PROGRAM
### As of December 31, 2014

| | Residents | | |
|---|---|---|---|
| Type of Participant | USA | Other Countries | Total |
| Active employees and their dependents | 4,089 | 2,054 | 6,143 |
| Active employees | 1,384 | 651 | 2,035 |
| Dependents | 2,680 | 1,393 | 4,073 |
| Other | 25 | 10 | 35 |
| Retirees and their dependents | 2,159 | 1,314 | 3,473 |
| Retirees | 1,201 | 743 | 1,944 |
| Dependents | 958 | 571 | 1,529 |
| Total population covered | 6,248 | 3,368 | 9,616 |

Source: Bank records

# ANNEX 3

## FINANCIAL PERFORMANCE OF THE PROGRAM
### For the years ended December 31, 2014 and 2013

| | | 2014 | 2013 |
|---|---|---|---|
| Contributions | | | |
| | Active employees | $9,469 | $9,432 |
| | Bank | $18,293 | $18,178 |
| Total contributions | Active employees | $27,762 | $27,610 |
| | | | |
| | Retirees | $8,618 | $8,436 |
| | Bank | $17,236 | $16,872 |
| | Total contribution Retirees | $25,854 | $25,308 |
| | | | |
| | Total contributions | $53,616 | $52,918 |
| | | | |
| Benefits | | | |
| | Active employees | $29,790 | $28,177 |
| | Retirees | $27,542 | $25,763 |
| | Total | $57,332 | $53,940 |
| | | | |
| Operating surplus (deficit) | | $(3,716) | $(1,022) |
| | Active employees | $(2,028) | $(567) |
| | Retirees | $(1,688) | $(455) |
| | | | |
| Other | | | |
| | Reinsurance receipts & US Medicare Part D Subsidy | $188 | $288 |
| | Active employees | $ - | $(152) |
| | Retirees | $188 | $440 |
| | | | |
| | (Increase) decrease in unclaimed benefits | $(130) | $(724) |
| | Active employees | $(9) | $(349) |
| | Retirees | $(121) | $(375) |
| | | | |
| Contributions over (below) claims paid and other items | | $(3,658) | $(1,458) |
| | Active employees | $(2,037) | $(1,068) |
| | Retirees | $(1,621) | $(390) |
| | | | |
| Interest and income from investments | | $199 | $253 |
| | | | |
| Program surplus (deficit) | | $(3,459) | $(1,205) |
| Reserves | | $33,097 | $36,556 |

Source: IDB Financial Statements

# ANNEX 4

## INDEPENDENT ACCOUNTANTS' REVIEW REPORTS AND FINANCIAL STATEMENTS

As of December 31, 2014

KPMG

INDEPENDENT ACCOUNTANTS' REVIEW
REPORT AND FINANCIAL STATEMENTS

Inter-American Development Bank
Health Insurance Benefit Account
December 31, 2014 and 2013

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, 2014 and 2013, 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 reviews 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 reviews, 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

July 31, 2015

**INTER-AMERICAN DEVELOPMENT BANK**
**HEALTH INSURANCE BENEFIT ACCOUNT**

## STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

*(Expressed in thousands of United States dollars)*

| | December 31, 2014 | December 31, 2013 |
|---|---|---|
| **Assets** | | |
| Cash | $ 3,302 | $ 3,778 |
| Investments, at fair value | 36,066 | 40,305 |
| Accrued Pharmacy rebates | 1,598 | 110 |
| Total assets | 40,966 | 44,193 |
| **Liabilities** | | |
| Accounts payable | 902 | 801 |
| Claims incurred but not reported | 6,967 | 6,836 |
| Total liabilities | 7,869 | 7,637 |
| Net assets available for benefits | $ 33,097 | $ 36,556 |

*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, | |
|---|---|---|
| | 2014 | 2013 |
| **Additions** | | |
| Contributions | | |
| Employer direct contributions | $ 18,293 | $ 18,178 |
| Postretirement Benefits Fund contributions | 17,236 | 16,872 |
| Participant contributions | 18,087 | 17,868 |
| Total contributions | 53,616 | 52,918 |
| Net appreciation in fair value of Investments | 111 | 230 |
| Other income | 88 | 23 |
| Total additions | 53,815 | 53,171 |
| **Deductions** | | |
| Benefits to participants | | |
| Claims paid | 57,332 | 53,940 |
| Increase in claims incurred but not reported | 130 | 724 |
| Insurance recoveries | - | 152 |
| US Medicare part D subsidy | (188) | (440) |
| Total deductions | 57,274 | 54,376 |
| **Net decrease in net assets during the year** | (3,459) | (1,205) |
| **Net assets available for benefits:** | | |
| **Beginning of year** | 36,556 | 37,761 |
| **End of year** | $ 33,097 | $ 36,556 |

*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 Staff Rules PE-375 and PN-8.03 (and related Annexes) on the "Medical Insurance Program" as well as 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 premium amounts. 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. All Bank staff with employment contracts defined in Staff Rule PE-311 and PN-5.02 "Types of Appointments", and their respective spouses and dependent children, must participate in the Medical Insurance Program, unless a waiver is requested and accepted.

Executive Directors, their Alternates, Counselors and Co-Terminous Office Assistants, and their dependents can participate on a voluntary basis. Participation is also voluntary for children (biological or adopted) of the staff member or spouse of the staff member who do not qualify as dependent children for purposes of Bank policy, regardless of whether (a) they reside with the staff member, or (b) are married. Such coverage ceases on the child's 26th birthday.

Bank retirees, vested in the Medical Insurance Program, along with their respective dependents have the option to participate in the Medical Insurance Program. The applicable vesting criteria depend in part on the staff member's corresponding date of hire. There are three groups that regulate vesting criteria: (1) Staff hired prior to September 1, 1995, (2) Staff hired on or after September 1, 1995 and prior to January 1, 2015, and (3) Staff hired on or after January 1, 2015. Starting January 2015, there is a gradual vesting criteria for cohort 3 established in the above mentioned Staff Rules.

Retirees not complying with the minimum years of coverage (in groups 1 and 2), staff 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 provide a benefit, with relevant premiums paid by employees and retirees, (depending on their cohort), except for administrative and other expenses which are fully paid by the Bank. The Bank determines periodically the premiums required by current and retiree participants to finance the Program.

At present, the Bank pays two thirds of the total contributions to the Program for employees and retirees that were hired before January 1, 2015, 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).

Effective January 1, 2014, the Bank negotiated and signed a new administration agreement with CIGNA, which included an important change to the calculation of pharmacy rebates providing a full pass through of all rebates (100% pharmacy rebate from a previous 50% cap), resulting in higher pharmacy rebate dollars. In addition, effective January 1, 2015, the Program has a new stop-loss insurance policy for claims exceeding $500. Under the stop-loss insurance policy, the Program is reimbursed for paid claims exceeding $500 per individual, and there is no maximum limit on the reimbursement amount the IDB can receive from its stop loss carrier.

For the year ended December 31, 2014, administrative and other expenses of the Program funded by the Employer included: (i) contracted program administrator fees of $2,003 (2013 – $2,025); (ii) the premium for stop-loss insurance of $537 (2013 – $592) and (iii) the premium for Medicare B of $1,684 (2013 - $2,004).

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 $188 was received in 2014 (2013 – $440) 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 related to these activities is included in Accounts receivable in the Statements of Net Assets Available for Benefits. There were no amounts receivable at December 31, 2014 or 2013.

## 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, 2014, 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, 2014, in the amount of $108 (2013 – $222), were included in Net appreciation in fair value of Investments. The average return on investments, including realized and unrealized gains and losses, during 2014 and 2013 was 0.29% and 0.57%, respectively.

The following table sets forth the Program's investments accounted for at fair value as of December 31, 2014 and 2013:

| | 2014 | 2013 |
|---|---|---|
| Investment pools [1]: | | |
| Obligations of the United States Government | $ 12,647 | $ 17,166 |
| U.S. government-sponsored enterprises | 40 | 40 |
| Obligations of non-U.S. governments and agencies | 13,197 | 10,822 |
| Bank obligations[2] | 6,953 | 9,488 |
| Corporate securities | 1,395 | 879 |
| Mortgage-backed securities | 355 | 455 |
| Asset-backed securities | 1,479 | 1,455 |
| | $ 36,066 | $ 40,305 |

[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 $12,647 as of December 31, 2014 (2013 – $17,166), 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 $23,419 at December 31, 2014 (2013 - $23,139).

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 2014 and 2013.

## 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, 2014 amounted to $53,616 (2013 – $52,918), of which $35,529 (2013 – $35,050) was contributed by the Employer and $17,765 (2013 – $17,525) by active employees and retirees. An additional $322 (2013 – $343) 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, 2014 and 2013:

| | 2014 | | | 2013 | | |
|---|---|---|---|---|---|---|
| **Contributions** | Active Employees | Retirees | Total | Active Employees | Retirees | Total |
| Employer | $ 18,293 | $ 17,236 | $ 35,529 | $ 18,178 | $ 16,872 | $ 35,050 |
| Active participants | 9,147 | 8,618 | 17,765 | 9,089 | 8,436 | 17,525 |
| Participants on leave-without-pay | 322 | - | 322 | 343 | - | 343 |
| | 27,762 | 25,854 | 53,616 | 27,610 | 25,308 | 52,918 |
| **Claims Paid to Participants** | | | | | | |
| Medical | 22,446 | 16,760 | 39,206 | 20,413 | 15,698 | 36,111 |
| Dental | 3,220 | 2,343 | 5,563 | 3,032 | 2,158 | 5,190 |
| Medicines | 4,124 | 8,439 | 12,563 | 4,732 | 7,907 | 12,639 |
| | 29,790 | 27,542 | 57,332 | 28,177 | 25,763 | 53,940 |
| **Contributions lower than claims paid** | (2,028) | (1,688) | (3,716) | (567) | (455) | (1,022) |
| **Other Items** | | | | | | |
| Increase in Claims incurred but not reported | (9) | (121) | (130) | (349) | (375) | (724) |
| Insurance recoveries | - | - | - | (152) | - | (152) |
| US Medicare part D subsidy | - | 188 | 188 | - | 440 | 440 |
| | (9) | 67 | 58 | (501) | 65 | (436) |
| **Contributions lower than claims paid and other items** | $ (2,037) | $ (1,621) | $ (3,658) | $ (1,068) | $ (390) | $ (1,458) |

## 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, 2014, the Program had cash in one bank of $3,302 (2013 – one bank of $3,778). 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 31, 2015, 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, 2014.