# REVIEW COMMITTEE OF THE LIFE AND MEDICAL INSURANCE PROGRAMS

# ANNUAL REPORT 2008-2012

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## Annexes

# REVIEW COMMITTEE OF THE LIFE AND MEDICAL INSURANCE PROGRAMS

## Inter-American Development Bank and Inter-American Investment Corporation

## ANNUAL REPORT 2008-2012

The Review Committee of the Life and Medical Insurance Programs (hereinafter, the Committee) is pleased to submit the report on activities for the years 2008-2012 to all participants. This report includes the Medical Insurance Benefits Account Independent Auditors' Review Report and Financial Statements for the aforementioned period. These financial statements were reviewed by the independent audit firms Ernst and Young LLP (2008 – 2011) and KPMG (2012). Also included in this report is an explanation of why the issuance of the Annual Reports from 2008 to 2011 was postponed.

The Program recorded surpluses during each of the past five years, resulting in net assets available for the payment of benefits (reserves) totaling US$37,761,000 as of December 31st, 2012. This is equivalent to approximately 8.6 months of claims.

During this five-year period, the reserve level doubled mostly due to actual claims experience of the health plan significantly below participant contributions, as our plan's trend was better than that of the market, among others. Recognizing this favorable performance of our plan, the Committee agreed to increase the premium charged to employees and retirees during 2008 and 2010 by only 1%, while maintaining the same premium level thereafter.

Further to the aforementioned points, the following table provides a visual illustration and summary of the surpluses achieved and corresponding reserves at the end of each year.

Table 1

| Years | Surplus | Reserves |
|---|---|---|
| 2008 | $2,283,000 | $18,667,000 |
| 2009 | $6,577,000 | $25,244,000 |
| 2010 | $7,494,000 | $32,738,000 |
| 2011 | $3,814,000 | $36,552,000 |
| 2012 | $1,209,000 | $37,761,000 |

Source: IDB Financial Statements

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

## 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 mechanism 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 and Benefits Division (HRD/COB) assumes the role of Committee Secretary. The Committee also has the support of members of the well-being and medical benefits team of HRD/COB. The Committee elects one of its members to serve as chairman. It normally issues recommendations by consensus.

### Health Committee Achievements

#### 2008

The Committee's work program for the year 2008 included: a) review of the financial structure of the Plan as presented to the Administration of the Bank in the second semester of the year 2007; b) analysis of the impact of the implementation of the Medicare D plan on our plan; c) evaluation and review of the CIGNA administration contract of the medical program; and d) annual review of premiums.

Implementation of the Review Committee's agenda was delayed by the change of leadership in the Human Resources Department, plus by the departure of several members representing active staff and retirees. The Committee requested assistance from HRD to carry out elections in 2009.

#### 2009

Elections were carried out in 2009 and the new reconstituted Committee prepared a very detailed agenda. There was a full review to track pending topics on the agenda. Main items: Review of the 2008 Financial Report, preparation of Request for Proposal (RFP) for the administration of the medical insurance plan, and annual review of premiums.

The Committee carried out meetings with the Bank's Office of the Executive Auditor to ensure the transfer of funds from the Bank to the medical plan reserve resulting from the use of plan funds to finance mandatory medical exams for employment purposes. In general terms, there were no substantial advances from the previous year.

#### 2010

The agenda for the year included a review of the new healthcare law and its possible impact on the Bank's plan. The consulting firm Towers Watson made a presentation to clarify, which mandatory benefits would take place in subsequent years. The new requirements would not, in principle, affect greatly the financial status of the plan as most of those benefits were already part of the Bank's medical insurance program. Any impact from the healthcare law would be included in the premium review carried out annually.

The Committee also conducted a review of the low income subsidy for retirees and its implementation, as errors were detected in the methodology used in 2009 to establish the correct amounts and beneficiaries. This required a careful verification of beneficiaries and a review of the reasons for the benefit. This review was still being carried out at the end of 2010.

There was also an evaluation and recommendation proposed by the Review Committee regarding the results of the RFP for a new program administrator. After lengthy

discussions and analysis, the Review Committee issued recommendations to the HRD Manager approving the document submitted by the RFP Evaluation Committee. The terms of reference submitted by the Review Committee called for the administration of an indemnity medical program with the option for US residents to use a PPO network for administrative purposes only. (Also, on page 8, please see the header titled "Competitive Selection Process for TPA of the IDB's Medical Program" for more information about this.)

The Committee called for a special election on January 2011 to cover the departure of three active staff representatives.

### 2011

The Bank did not act on the award of the contracts for the firms recommended by the Procurement and Review Committees. Letters to the Vice President for Finance and Administration were sent expressing concern on the loss of potential financial benefits due to the delay on the part of the Administration to make a final decision. The response from the Administration was that the delays were due to a fraud investigation against the medical plan then underway, but that steps had been taken to ensure the offers of the recommended providers would still be valid.

There were other items from the 2010 agenda still pending decisions such as the publication of the annual reports for 2008, 2009 and 2010. Also, the financial information was waiting for release by the Bank's external auditors. Finally, a revision of the premium table structure needed to be conducted.

### 2012

The Review of the subsidy program for low income retiree participants was finalized and corresponding amounts due were reimbursed to the beneficiaries of the subsidy.

The Review Committee requested updates on the state of negotiations with CIGNA pertaining to the contract renewal for the administration of the medical insurance program for international staff and retirees living in the US. The Bank awarded the contract for the administration of the medical insurance program for international and national staff, and retirees residing outside the US to Vanbreda International with an effective date of January 1st, 2012. The remaining RFP results; medical and pharmacy for US staff and retirees - have yet to be announced.

A revised manual of the medical insurance program was submitted by HRD for comments from the Review Committee. After an exchange of comments regarding the new document, including features of the HRD manual, the Committee decided to continue to work on the revision, including the new features, until it is finalized.

## The Committee's Agenda

During the last few years there were many changes in the Committee's representatives, as well as the Secretariat Office, mostly due to staff turnover and other Bank changes.

This has delayed the Committee's consideration of various items in its agenda. Now that the Committee is more stable, it has adopted an agenda for 2013-2014 that includes the following activities:

a) **Plan Document Review.** The provisions governing our medical plans are in a variety of different places/documents - in Staff Rules, summary plan descriptions, benefit summaries, the staff intranet, etc. Participants need one document that contains all plan information that can be referenced upon when members ask where a particular rule or coverage was stated.

b) **Premium Level and Reserve Considerations.** After five years of

almost no premium increases to plan members, premium contributions are starting to level with paid claims. If nothing is done, claims paid will surpass the plan funding in another year or two. So, the Committee is vigilant and will be conducting studies on medical insurance premiums for 2014-15 and their impact, based on the analyses and scenarios presented by the consulting firm to make recommendations to Bank's Management.

c) **Health Care Reform.** The Committee will continue to monitor the upcoming changes to the health care system and policies as a result to Health Care Reform and decide on adjustments to our plan based on current practices and best practices of peer organizations such as the World Bank and IMF.

d) **Benefits Review.** The Committee will review our dental and vision benefits to ascertain their competitiveness against market practices, industry norms, and benefits offered by peer organizations.

e) **2013 Annual Report.** After a five year hiatus, the Committee will return to publishing its annual report on a yearly basis in 2013 as soon as the Auditor's Review Report and Financial Statements for 2013 are available in 2014.

f) **Premium Structure Study.** Initiate studies for an update 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. The Committee will also review the issue of premium caps for low-income retirees.

g) **Claims Audit.** Starting in 2013 the Bank will contract with an external claims auditing firm to perform periodic audits of its medical, dental, vision and pharmacy claims administrators for both the International and National programs.

## The Review Committee of the Life and Medical Insurance Programs

### Committee President

Sixto Aquino (2008 - 2010)
André Medici (Jan - Apr 2008)
Roberto Iunes (2010 - 2011)
Isabel Larson (2012 - present)

### Committee Secretary and Division Chief, Compensation and Benefits

Previously: Sergio Del Barco and Guillermo Pareja-Lecaros (2008 - 2011)
Diego Murguiondo (2012 to present)

### Representatives of Active Participants

Sixto Aquino, Principal (2008- 2010)
André Medici, Principal (2008)
Ana-Mita Betancourt, Principal (2009 - 2010)
Amanda Glassman, Alternate (2009 - 2010)
Roberto Iunes, Principal (2010 - 2011), Alternate (2009 - 2010)
Krystina Bishop, Alternate (2011 - 2012)
Silvia Raw, Principal (2011 - 2013); Alternate (2008 - 2011)
Hector Salazar, Principal (2011 - 2013); Alternate (2009 - 2011)
Valentina Sequi, Alternate (2011 – 2013); Principal (2013 - present)

### Representatives of the Administration

Alberto Suria, Principal (2007 - present, by position)
Juan Carlos de la Hoz, Principal (2010 - present)
Alejandra Vallejo, Principal (2010 - 2012); moved to Secretariat (2012 – present)

### Representatives of Retirees

Isabel Larson, Principal (2008 - present)
Roberto Lopez-Porras, Alternate (2008 - 2009)
Helmuth M. Carl, Alternate (2009 - present)

### Committee Secretariat

Michael P. Gagnon (2008 - 2012)
Sergio Del Barco (2008 - 2011)
Lidia A. de Pareja (2008 - 2010)
Humberto Caffagi (2008 - 2012)
Alejandra Vallejo (2012 - present)
Adriana Araujo (2012 - 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.

In turn, 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 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| Staff | 1,961 | 1,932 | 1,962 | 2,021 | 2,070 |
| Retirees | 1,640 | 1,709 | 1,774 | 1,819 | 1,843 |
| Dependents | 4,981 | 4,991 | 5,075 | 5,346 | 5,499 |
| Total Members | 8,582 | 8,632 | 8,811 | 9,186 | 9,412 |
| **Location** | | | | | |
| USA | 66% | 66% | 65% | 65% | 64% |
| Outside the USA | 34% | 34% | 35% | 35% | 36% |

Source: Bank records

**General Data**: As of December 31, 2012, the Program covered a total of 9,439 plan members: 2,112 Bank and Corporation employees, 1,840 retirees, and 5,487 dependents.

**Place of Residence**: Approximately two-thirds (65%) of the plan members covered resided in the United States, and the remainder (35%) resided abroad.

**Ratio of Dependents per Participant**: The average for the Program as a whole was 1.40 dependents per participant.

### Medical and Pharmacy Utilization 2008 – 2012 [1]

In 2012, the overall medical trend[2] for our plan came in at 8.1% (9.7% for medical and 4.8% for pharmacy). This is in line with Cigna's book of business for organizations similar in size and profile to the IDB. Over the 2008 – 2012 claims period, our average annual medical plan trend was less than 1% (0.9%). The three year (2009-2011) average annual medical plan trend was approximately -1.9%. In sum, this represents a

[1] Source: Annual Reports from Cigna Healthcare, Cigna International and Vanbreda International.

[2] 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.

healthy and manageable trend over a five year period.

Taken as a whole, 2012 saw increases in costs and utilization for all service areas (i.e., outpatient appointments, inpatient stays, office visits and ER, among others), with catastrophic claimants driving the greatest increase in cost.

The top four chronic conditions have ranked exactly the same over the past five years: Musculoskeletal, Neoplasm, Mental Disorders, and Gastrointestinal.

On the pharmacy side, the biggest increase in Rx spend in the past five years has come from specialty drugs, which are a new category of very expensive - protein-based, biologically engineered (with live organisms) - drugs now being used frequently for the treatment of Cancer, Rheumatoid Arthritis, HIV, Multiple Sclerosis, and other chronic diseases.

Notwithstanding, there were two positive trends coming out of IDB's pharmacy spend during this same period: 1) a noticeable jump in generic utilization (but still below industry norms); and 2) lower ingredient costs overall (i.e., brand-name Rx losing patents). In 2012 alone, generic utilization increased by almost 7% from the prior year and the ingredient costs for both generics and brand name drugs decreased by almost 4%. Every 1% increase in generic utilization reduces IDB's Rx claims spend by $218,261.

The decrease in ingredient costs and increase in generic utilization is a function of several blockbuster drugs coming off patent in recent years.

Despite these positive trends, overall drug utilization and total pharmacy spend for IDB plan members have increased year over year since 2008. This increase can also be attributed to these overarching general condition: 1) higher cost of medications in general (i.e., specialty pharma and blockbuster brand name Rx); and 2) higher use (than industry norm) of brand name drugs vs. generic.

What follows is a macro-level view of some claims activity in 2012.

- The top five countries: US, Brazil, Chile, Argentina and Colombia, accounted for 51% of all claims incurred.
- Claims from retirees and their dependents was approximately half of all paid claims.
- Hospitalizations amounted to 38.5% of all paid claims.
- Medical benefits, including dental and vision, totaled 78% of paid claims, while pharmacy amounted to 22%.

### Dental Care (2008 – 2012)[3]

Total expenditure for dental care experienced a very slight increase between 2008 and 2012, reaching a total of US$3.87 in 2012.

The use of in-network service providers increased from 21.2% (2008) to 36.4% (2012), reflecting a positive trend.

[3] This information is based on the U.S. dental plan only.

## Catastrophic Claims

### Table 3

| IDB - Catastrophic Cases | | | | | |
|---|---|---|---|---|---|
| Plan Administrator | 2008 | 2009 | 2010 | 2011 | 2012 |
| Cigna Healthcare | 40 | 43 | 40 | 37 | 40 |
| Cigna International | 21 | 14 | 14 | 16 | ---- |
| Vanbreda International | ---- | ---- | ---- | ---- | 8 |
| Total | 61 | 57 | 54 | 53 | 48 |

Catastrophic claimant threshold of $50,000 was used for this analysis.

In 2012, there were 40 catastrophic claims with Cigna Healthcare and 8 with Vanbreda International. The largest single claim was just shy of $500,000 and the top five claims totaled over $1.2 million. One positive factor is that the number of high claimants has been dropping year after year since 2008, although the average cost per claimant has gone up.

There were 24 members within the active employee population that generated claims in excess of $50,000 in 2012.

Seven non-Medicare retirees generated over $50,000 in claims, and the average cost per claimant was $100,802.

There were nine Medicare primary members who incurred catastrophic claims. This group has infrequent catastrophic activity as Medicare generally pays the majority of claims, while the medical fund through CIGNA pays what is left. The Cigna plan also covers the pharmaceutical costs for all plan members. Therefore, the high costs of medications oftentimes associated with large claims, can result in catastrophic payments for this group. These statistics do not consider the Medicare Part D subsidy received by the Program from the government.

The Plan is protected by stop loss insurance, which has a specific retention amount of $350,000 per covered person.

## Cigna International (2008-2011) and Vanbreda International (2012)

In 2010 the IDB conducted a carrier RFP and Vanbreda International won the global plan administration for the IDB's non-U.S. business.

Against this background, Cigna International was the plan administrator between 2008 and 2011, while Vanbreda took over from January 1st, 2012 to present.

## Network Savings

The strength and penetration of the Cigna PPO network has increased during the time period of this report, from the low-40s in 2008 (42.5%) to 48% in 2011 and 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. In 2012 alone, the Cigna network savings were worth $14.1 million.

Outside the United States, there is no provider network of contracted physicians and facilities per se. Cigna International and Vanbreda International have 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.

## LIFE INSURANCE

In May 2011, AIG Life Insurance Company officially confirmed to the Bank that effective January 1, 2010 they had reduced their rate for the Basic and Supplemental life for IDB insureds.

The actual rate reduction for Basic Life was from $0.055 to $0.045. For the Supplemental coverage the reduction was varied because the cost is age driven.

This resulted in a combined premium refund of $221,859: a) $164,837 for Basic Life; and b) $57,021 for Supplemental Life. Employees were informed via InfoLinks of the premium refund, which was paid in the second payroll of May 2011.

## Competitive Selection Process for Third Party Administrator (TPA) of the IDB's Medical Program

In 2009, the Executive Auditor's Office recommended an initiative of the Review Committee that a competitive selection process should be conducted to solicit proposals for third-party administration of the Bank's medical, dental and pharmacy self-insured benefit program. In December 2009, the IDB released RFP #09-053: Consulting Services – Administrative Claim Services and selected the consulting firm Towers Watson to assist with the medical, dental and pharmacy benefit administration marketing process. The Bank appointed an RFP Evaluation Team, with two members of the Committee onboard that worked closely with Towers Watson in preparing the RFP materials and evaluating the responses.

In April 2010, the IDB issued an RFP to potential administrators, soliciting a three-year contract for U.S. and international medical, dental and pharmacy plan administration. The parameters of this RFP included the following objectives:

- IDB preferred to "bundle" its employee benefits (medical, dental, vision) under one administrator.
- IDB could consider carving out pharmacy administration to a standalone Pharmacy Benefit Manager (PBM) if there were better financial terms.
- IDB was seeking synergies between U.S. and international benefit administration, although the possibility of awarding the business to two separate administrators was available in the RFP.
- A standalone dental offering was not requested as the IDB prefers to keep medical and dental coverages with the same administrator.

In the second half of 2010, Vanbreda International was awarded the non-U.S. coverage administration of IDB's medical, dental and vision plans and replaced Cigna International effective January 1st, 2012.

Due to a variety of factors, the IDB did not change plan administrators for the U.S. health plan in 2011. A complex medical insurance claim fraud had been identified, which led the IDB to begin a series of investigations and negotiations with Cigna. In order to maintain continuity of services, the Bank extended the existing contract with Cigna. Cigna offered to match their RFP pricing for the new policy term (effective 2011) without incorporating any terms or conditions from the new RFP, resulting in savings for the Plan.

Concurrently, the Bank also incorporated, as an amendment, robust anti-fraud language into the existing contract.

## Annual Report Postponement

The publication of the financial statements for the Inter-American Development Bank's health plan for the years ended 2009, 2010 and 2011 was deferred to 2013 pending the Bank's comprehensive response to a series of fraudulent claims, ending in 2010, from a single plan participant. Upon discovery of the fraud, the Bank undertook a series of reviews, conducted by internal and external parties, in order to fully understand the nature of the fraud and to confirm the financial integrity of the plan. The fraud did not affect the Bank's ability to provide full coverage in accordance with the terms of the plan. The Bank's comprehensive response included improvements in the plan's

administration for the prevention and detection of fraud and other wrongdoing, consisting of: 1) strengthening of internal and external controls; 2) monitoring of claims reporting; 3) greater coordination with the Bank's claims administrator, 4) enhanced claims eligibility review; and 5) additional training for Bank and Cigna staff working with the plan.

## FINANCIAL ANALYSIS

The Bank's independent auditors for the period in question, Ernst & Young (E&Y) (2008-2011) and KPMG (2012) reviewed the financial statements of the Bank's Medical Insurance Benefits Account for the corresponding period(s). In the financial statements for the three-years period ended December 31, 2011, Management concluded and E&Y concurred that the effect of the fraudulent claims in those financial statements was not material. Adequate disclosure was included in the notes to those financial statements.

E&Y and KPMG issued their corresponding review reports on the financial statements and indicated that they were not aware of any material modifications that should be made to those statements in order for them to be in conformity with U.S. generally accepted accounting principles.

As shown in Table 1, contributions to the Program exceeded benefit payments in each of the last five years, ending 2012 with a surplus of $1.2 million. In addition, throughout the five year period from 2008 to 2012, the Program had a solid financial position, with reserves increasing from $18.7 million to $37.7 million. This level of reserves provides the financial resources necessary to cover: (a) unexpected increases in the cost of medical services; (b) potential improvements to the Program and (c) catastrophic cases. The reserves at December 31, 2012 are sufficient to cover unexpected increases in the costs of health care and about 100 catastrophic cases[4].

At the end of 2012, the Committee reaffirmed its previous position that the level of premiums was adequate to maintain the reserves at a solid level given the financial soundness of the Program and did not increase the premium rates.

[4] Catastrophic cases have been defined as those claims exceeding $50,000. However, claims exceeding $350,000 and up to $1.6 million are covered by the Bank's stop-loss insurance program.

ANNEX 1

DEMOGRAPHIC DATA FOR THE MEDICAL INSURANCE PROGRAM

As of December 31, 2012

| Type of Participant | Residents USA | Residents Other Countries | Total |
|---|---|---|---|
| Active employees and their dependents | 3,972 | 2,135 | 6,107 |
| Active employees | 1,363 | 685 | 2,048 |
| Dependents | 2,573 | 1,415 | 3,988 |
| Other | 36 | 35 | 71 |
| **Retirees and their dependents** | 2,069 | 1,236 | 3,305 |
| Retirees | 1,147 | 696 | 1,843 |
| Dependents | 922 | 540 | 1,462 |
| **Total population covered** | **6,041** | **3,371** | **9,412** |

Source: Bank records

ANNEX 2

FINANCIAL PERFORMANCE OF THE PROGRAM

FOR THE YEARS ENDING DECEMBER 31, 2008 THROUGH 2012

(In thousands of United States dollars)

| | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| Contributions | | | | | |
| Active employees | 8,134 | 8,602 | 8,738 | 8,925 | 9,174 |
| Bank | 15,775 | 16,591 | 16,781 | 17,220 | 17,700 |
| Total contributions Active employees | 23,909 | 25,193 | 25,519 | 26,145 | 26,874 |
| Retirees | 7,101 | 7,466 | 7,779 | 7,986 | 8,255 |
| Bank | 14,213 | 14,932 | 15,564 | 15,973 | 16,508 |
| Total contribution Retirees | 21,314 | 22,398 | 23,343 | 23,959 | 24,763 |
| Total contributions | 45,223 | 47,591 | 48,862 | 50,104 | 51,637 |
| Benefits | | | | | |
| Active employees | 21,010 | 22,745 | 22,149 | 23,776 | 27,216 |
| Retirees | 20,825 | 20,877 | 21,150 | 23,386 | 24,410 |
| Total | 41,835 | 43,622 | 43,299 | 47,162 | 51,626 |
| Operating surplus (deficit) | 3,388 | 3,969 | 5,563 | 2,942 | 11 |
| Active employees | 2,899 | 2,448 | 3,370 | 2,369 | (342) |
| Retirees | 489 | 1,521 | 2,193 | 573 | 353 |
| Other | | | | | |
| Reinsurance receipts and US Medicare Part D Subsidy | 535 | 767 | 1,216 | 816 | 1,093 |
| Active employees | 20 | 174 | 24 | 29 | 220 |
| Retirees | 515 | 593 | 1,192 | 787 | 873 |
| (Increase) decrease in unclaimed benefits | (758) | 450 | 305 | (256) | (267) |
| Active employees | (30) | 113 | 214 | (88) | (275) |
| Retirees | (728) | 337 | 91 | (168) | 8 |
| Contributions over (below) benefits paid and other | 3,165 | 5,186 | 7,084 | 3,502 | 837 |
| Active employees | 2,889 | 2,735 | 3,608 | 2,310 | (397) |
| Retirees | 276 | 2,451 | 3,476 | 1,192 | 1,234 |
| Interest and income from investments | (882) | 1,391 | 410 | 312 | 372 |
| Program surplus (deficit) | 2,283 | 6,577 | 7,494 | 3,814 | 1,209 |
| Reserves | 18,667 | 25,244 | 32,738 | 36,552 | 37,761 |

Source: IDB Financial Statements

ANNEX 3

ANNUAL SAVINGS BY THE PLAN
YEARS 2008 TO 2012
(In United States dollars)

## SAVINGS MADE BY THE PLAN

The access to the CIGNA PPO Network with negotiated rates and the use of Medicare by retirees generated savings equivalent to US$20.7 million in 2012, representing 28.6% of the potential total costs of the Program consistent with previous years. As a result, the adjustments made to the premiums paid by the Bank and participants have been moderate, compared to similar medical insurance plans.

| Years | Total Cost of the Program (1) = (2) + (5) | Costs Paid by the Program (2) | Savings | | Total Savings (5) | Savings as a percentage of Total Costs of the Program (5)/(1) (%) |
|---|---|---|---|---|---|---|
| | | | Medicare (3) | PPO Discount (4) | | |
| 2008 | 59,093,371 | 41,835,000 | 4,504,627 | 12,753,744 | 17,258,371 | 29.2 |
| 2009 | 62,353,574 | 43,622,000 | 5,870,910 | 12,860,664 | 18,731,574 | 30.0 |
| 2010 | 60,101,119 | 43,299,000 | 5,602,119 | 11,200,000 | 16,802,119 | 27.9 |
| 2011 | 65,210,364 | 47,162,000 | 5,948,364 | 12,100,000 | 18,048,36 | 27.6 |
| 2012 | 72,358,344 | 51,626,000 | 6,632,344 | 14,100,000 | 20,732,344 | 28.6 |

Source: CIGNA and Towers Watson reports

ANNEX 4

# INDEPENDENT ACCOUNTANTS' REVIEW REPORTS AND FINANCIAL STATEMENTS

AS OF DECEMBER 31, 2012, 2011, 2010, 2009, and 2008

INDEPENDENT ACCOUNTANTS' REVIEW
REPORT AND FINANCIAL STATEMENTS

Inter-American Development Bank
Health Insurance Benefit Account
December 31, 2012 and 2011

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 statement of net assets available for benefits of the Inter-American Development Bank (Bank) – Health Insurance Benefit Account as of December 31, 2012, and the related statement of changes in net assets available for benefits for the year 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. The 2011 financial statements of the Inter-American Development Bank – Health Insurance Benefit Account were reviewed by other accountants whose report dated April 24, 2013, stated that based on their procedures, they were not aware of any material modifications that should be made to those statements in order for them to be in conformity with U.S. generally accepted accounting principles.

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 2012 financial statements in order for them to be in conformity with U.S. generally accepted accounting principles.

KPMG LLP

Washington, D.C.

July 26, 2013

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

## STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

*(Expressed in thousands of United States dollars)*

| | December 31, 2012 | December 31, 2011 |
|---|---|---|
| **Assets** | | |
| Cash | $ 4,602 | $ 4,330 |
| Investments | 40,125 | 39,537 |
| Accounts receivable | 192 | 69 |
| Total assets | 44,919 | 43,936 |
| **Liabilities** | | |
| Accounts payable | 1,045 | 1,538 |
| Claims incurred but not reported | 6,113 | 5,846 |
| Total liabilities | 7,158 | 7,384 |
| Net assets available for benefits | $ 37,761 | $ 36,552 |

*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, | |
|---|---|---|
| | 2012 | 2011 |
| **Additions** | | |
| Contributions | | |
| Employer direct contributions | $ 17,700 | $ 17,220 |
| Postretirement Benefits Fund contributions | 16,508 | 15,973 |
| Participant contributions | 17,429 | 16,911 |
| Total contributions | 51,637 | 50,104 |
| Investment income | 357 | 240 |
| Other income | 15 | 72 |
| Total additions | 52,009 | 50,416 |
| **Deductions** | | |
| Benefits to participants | | |
| Claims paid | 51,626 | 47,162 |
| Increase in claims incurred but not reported | 267 | 256 |
| Insurance recoveries | (220) | (29) |
| US Medicare part D subsidy | (873) | (787) |
| Total deductions | 50,800 | 46,602 |
| **Net increase in net assets during the year** | 1,209 | 3,814 |
| **Net assets available for benefits:** | | |
| **Beginning of year** | 36,552 | 32,738 |
| **End of year** | $ 37,761 | $ 36,552 |

*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 the 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, as well as 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 $350,000. Under the stop-loss insurance policy, the Program is reimbursed for paid claims exceeding $350,000 up to $1,650,000 per medical condition.

For the year ended December 31, 2012, administrative and other expenses of the Program funded by the Employer included: (i) contracted program administrator fees of $1,926,699 (2011 – $2,171,476); (ii) the premium for stop-loss insurance of $580,174 (2011 – $541,072) and (iii) the premium for Medicare B of $1,868,235 (2011 $1,927,550).

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 $873,336 was received in 2012 (2011 – $787,466) 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.

***New accounting pronouncements***

In 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-04 which, among other changes, expanded existing disclosure requirements for fair value measurements to achieve common disclosure requirements with international standards, and clarifies the FASB's intent about the application of existing fair value measurement requirements. This update was effective in 2012 and the required applicable disclosures/amendments did not have an impact on the Program's Statements of Net Assets Available for Benefits and Statements of Changes in Net Assets Available for Benefits.

***Investments***

Investments are carried and reported at fair value using trade date accounting. Realized and unrealized gains and losses are included in Investment income 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. Substantially 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 activities of investing in securities to a list of authorized dealers and counterparties. Credit limits have been established for each counterparty and the Bank does not anticipate non-performance by any of the counterparties.

Net unrealized gains on investments held at December 31, 2012, in the amount of $334,718 (2011 – $217,281), were included in Investment income. The average return on investments, including realized and unrealized gains and losses, during 2012 and 2011 was 0.87%, and 0.61%, respectively.

The following table sets forth the Program's investments accounted for at fair value as of December 31, 2012 and 2011 (in thousands):

| | 2012 | 2011 |
|---|---|---|
| Investment pools [1]: | | |
| Obligations of the United States Government | $ 18,033 | $ 800 |
| U.S. government-sponsored enterprises | 828 | 464 |
| Obligations of non-U.S. governments and agencies | 10,999 | 9,897 |
| Bank obligations | 7,680 | 8,577 |
| Mortgage-backed securities: | | |
| U.S. residential | 406 | 206 |
| Non-U.S. residential | 572 | 391 |
| Asset-backed securities | 1,607 | 2,295 |
| | 40,125 | 22,630 |
| Direct investments: | | |
| Obligations of the United States Government | - | 16,907 |
| | $ 40,125 | $ 39,537 |

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

**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 $18,033,000 as of December 31, 2012 (2011 – $17,707,000), 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, external pricing services, where available, prices derived from alternative pricing models, utilizing available observable market inputs and discounted cash flows. 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 $22,092,000 at December 31, 2012 (2011 - $21,830,000).

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.

## 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, 2012 amounted to $51,637,000 (2011 – $50,104,000), of which $34,208,000 (2011 – $33,193,000) was contributed by the Employer and $17,106,000 (2011 – $16,596,000) by active employees and retirees. An additional $323,000 (2011 – $315,000) 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, 2012 and 2011 (in thousands):

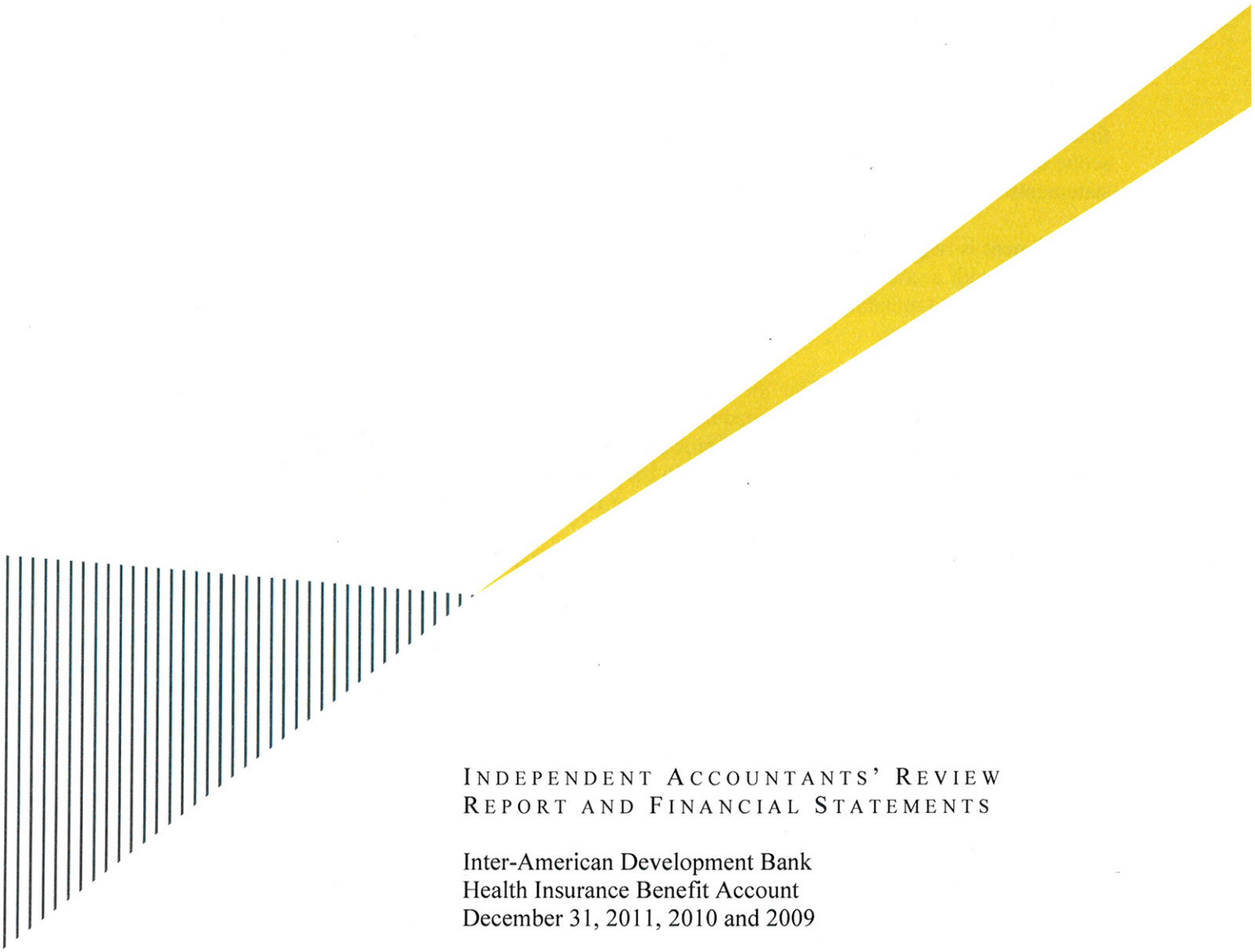
| | 2012 | | | 2011 | | |
|---|---|---|---|---|---|---|
| **Contributions** | **Active Employees** | **Retirees** | **Total** | **Active Employees** | **Retirees** | **Total** |
| Employer | $ 17,700 | $ 16,508 | $ 34,208 | $ 17,220 | $ 15,973 | $ 33,193 |
| Active participants | 8,851 | 8,255 | 17,106 | 8,610 | 7,986 | 16,596 |
| Participants on leave-without-pay | 323 | - | 323 | 315 | - | 315 |
| | 26,874 | 24,763 | 51,637 | 26,145 | 23,959 | 50,104 |
| **Claims Paid to Participants** | | | | | | |
| Medical | 19,603 | 15,677 | 35,280 | 16,684 | 14,135 | 30,819 |
| Dental | 2,987 | 2,076 | 5,063 | 2,546 | 1,811 | 4,357 |
| Medicines | 4,626 | 6,657 | 11,283 | 4,546 | 7,440 | 11,986 |
| | 27,216 | 24,410 | 51,626 | 23,776 | 23,386 | 47,162 |
| **Contributions higher (lower) than claims paid** | (342) | 353 | 11 | 2,369 | 573 | 2,942 |
| **Other Items** | | | | | | |
| (Increase) decrease in Claims incurred but not reported | (275) | 8 | (267) | (88) | (168) | (256) |
| Insurance recoveries | 220 | - | 220 | 29 | - | 29 |
| US Medicare part D subsidy | - | 873 | 873 | - | 787 | 787 |
| | (55) | 881 | 826 | (59) | 619 | 560 |
| **Contributions higher (lower) than claims paid and other items** | $ (397) | $ 1,234 | $ 837 | $ 2,310 | $ 1,192 | $ 3,502 |

## 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, 2012, the Program had cash in one bank of $4,602,000 (2011 – one bank of $4,330,000). 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 26, 2013, 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, 2012.



# Independent Accountants' Review Report and Financial Statements

Inter-American Development Bank
Health Insurance Benefit Account
December 31, 2011, 2010 and 2009

Ernst & Young LLP

Ernst & Young

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# Independent Accountants' Review Report

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, 2011, 2010 and 2009, 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 company 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 accounting principles generally accepted in the United States 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 accounting principles generally accepted in the United States.

Ernst & Young LLP

April 24, 2013

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

## STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

*(Expressed in thousands of United States dollars)*

| | December 31, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| **Assets** | | | |
| Cash | $ 4,330 | $ 1,018 | $ 5,174 |
| Investments | 39,537 | 38,311 | 27,104 |
| Accounts receivable | 69 | 279 | 57 |
| Total assets | 43,936 | 39,608 | 32,335 |
| **Liabilities** | | | |
| Accounts payable | 1,538 | 1,280 | 1,196 |
| Claims incurred but not reported | 5,846 | 5,590 | 5,895 |
| Total liabilities | 7,384 | 6,870 | 7,091 |
| Net assets available for benefits | $ 36,552 | $ 32,738 | $ 25,244 |

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

**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, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| **Additions** | | | |
| Contributions | | | |
| Employer direct contributions | $ 17,220 | $ 16,781 | $ 16,591 |
| Postretirement Benefits Fund contributions | 15,973 | 15,564 | 14,932 |
| Participant contributions | 16,911 | 16,517 | 16,068 |
| Total contributions | 50,104 | 48,862 | 47,591 |
| Investment income | 240 | 323 | 1,364 |
| Other income | 72 | 87 | 27 |
| Total additions | 50,416 | 49,272 | 48,982 |
| **Deductions** | | | |
| Benefits to participants | | | |
| Claims paid | 47,162 | 43,299 | 43,622 |
| Increase (decrease) in claims incurred but not reported | 256 | (305) | (450) |
| Insurance recoveries | (29) | (24) | (174) |
| US Medicare part D subsidy | (787) | (1,192) | (593) |
| Total deductions | 46,602 | 41,778 | 42,405 |
| **Net increase in net assets during the year** | 3,814 | 7,494 | 6,577 |
| **Net assets available for benefits:** | | | |
| **Beginning of year** | 32,738 | 25,244 | 18,667 |
| **End of year** | $ 36,552 | $ 32,738 | $ 25,244 |

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

## NOTE A – DESCRIPTION OF THE PROGRAM

The following description of the Health Insurance Benefit Program (the Program) of the Inter-American Development Bank (the 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 the 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, turnover, and certain temporary employees, their respective spouses and authorized dependent children are generally required to participate in the Program. Certain other staff members, including 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 $350,000. Under the stop-loss insurance policy, the Program is reimbursed for paid claims exceeding $350,000 up to $1,650,000 per participant.

For the year ended December 31, 2011, administrative and other expenses of the Program paid for by the Employer included: (i) fees paid to the contracted program administrator of $2,171,476 (2010 – $3,233,906; 2009 – $3,035,974); (ii) the premium for stop-loss insurance of $541,072 (2010 – $531,327; 2009 – $574,055) and (iii) the premium for Medicare B of $1,927,550 (2010 – $1,710,820; 2009 – $1,506,000).

In 2007, under the U.S. Medicare part D program, the Bank applied for a subsidy on all Medicare eligible retirees who were not enrolled in this program. A subsidy of $787,466 was received in 2011 (2010 – $1,191,860; 2009 – $593,323) and recognized as a reduction of Benefits to participants.

## NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements are prepared in conformity with United States 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.

***New accounting pronouncements***

In May 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2011-04, "Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS." The ASU, among others, expands existing disclosure requirements for fair value measurements to achieve common disclosure requirements with international financial reporting standards (IFRS), and clarifies the FASB's intent about the application of existing fair value measurement requirements. ASU No. 2011-04 is effective for the Program as of December 31, 2012. The amendments and relevant disclosures required by the new standard are not expected to have a material impact on the Program's financial condition or statements of changes in net assets available for benefits.

In January 2010, the FASB issued the ASU No. 2010-06 "Improving Disclosures about Fair Value Measurements". This update improved the disclosure requirements related to Fair Value Measurements in FASB ASC Subtopic 820-10. ASU No. 2010-06 required separate disclosure of transfers in and out of Levels 1 and 2 and a description of the reasons for these transfers. It also required disclosures on a gross basis of purchases, sales, issuances, and settlements in the reconciliation for fair value measurements using significant unobservable inputs (Level 3). In addition, ASU No. 2010-06 clarified the requirement to provide fair value measurement disclosures for each class rather than major categories of assets and liabilities. This update also clarified the requirement to disclose the valuation techniques and significant inputs used to measure fair value for both recurring and nonrecurring fair value measurements classified as either Level 2 or Level 3. The new disclosures and clarifications of existing disclosures were effective for annual reporting periods beginning in 2010, except for the disclosures about purchases, sales, issuances, and settlements in the reconciliation of activity in Level 3 fair value measurements, which were effective for periods beginning in 2011. The applicable new disclosures and clarification of existing disclosures have been incorporated in Note D – "Fair Value Measurements."

In June 2009, the FASB issued an amendment to the accounting standard on the GAAP hierarchy (FASB ASC 105-10-65-1). This amendment changed the GAAP hierarchy and established the FASB Accounting Standards Codification (FASB ASC) as the source of authoritative accounting principles recognized by the FASB to be applied by non-governmental entities in the preparation of financial statements in conformity with GAAP in the United States. The adoption of this amendment had no impact on the Program's financial statements.

In April 2009, the FASB issued FASB ASC 820-10-65-4 to provide guidelines for making fair value measurements more consistent with the principles presented in the accounting standard for Fair Value Measurements and Disclosures; in addition, this amendment required enhanced disclosures regarding financial assets and liabilities that are recorded at fair value. This accounting pronouncement had no effect on the Program's financial position or changes in net assets available for benefits.

In May 2009, the FASB issued the Subsequent Events accounting standard (FASB ASC 855-10). The objective of this pronouncement was to establish general standards of accounting for and disclosure of events that occur after the date of the financial statements but before they are issued or are available to be issued. The Program adopted FASB ASC 855-10 in 2009 and the related disclosure is included in Note H – Subsequent Events.

***Investments***
Investments are carried and reported at fair value. Realized and unrealized gains and losses are included in Investment income 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.

## 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 directly or through an investment pool managed by the Bank. Substantially all of the Program's securities have a credit quality equivalent to ratings ranging from AAA to A.

The Bank limits the Program's activities of investing in securities to a list of authorized dealers and counterparties. Credit limits have been established for each counterparty and the Bank does not anticipate non-performance by any of the counterparties.

Net unrealized gains on investments held at December 31, 2011, in the amount of $217,281 (2010 – $307,104; 2009 – $1,363,998), were included in Investment income. The average return on investments, including realized and unrealized gains and losses, during 2011, 2010 and 2009 was 0.61%, 1.00%, and 6.24%, respectively.

The following table sets forth the Program's investments accounted for at fair value as of December 31, 2011, 2010 and 2009 (in thousands):

| | 2011 | 2010 | 2009 |
|---|---|---|---|
| Investment pool [1]: | | | |
| Obligations of the United States Government | $ 800 | $ - | $ - |
| U.S. government-sponsored enterprises | 464 | 48 | 53 |
| Obligations of non-U.S. governments and agencies | 9,897 | 10,055 | 8,390 |
| Bank obligations | 8,577 | 7,807 | 8,016 |
| Mortgage-backed securities: | | | |
| U.S. residential | 206 | 402 | 418 |
| Non-U.S. residential | 391 | 1,569 | 2,408 |
| Asset-backed securities | 2,295 | 2,533 | 2,822 |
| | 22,630 | 22,414 | 22,107 |
| Direct investments: | | | |
| Obligations of the United States Government | 16,907 | 15,897 | 4,997 |
| | $ 39,537 | $ 38,311 | $ 27,104 |

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

## 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 in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities;

Level 2 - Quoted prices in markets that are not active, or inputs that 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 (i.e., supported by little or no market activity).

The Program's investment instruments valued based on quoted prices in active markets, a valuation technique consistent with the market approach, include Obligations of the United States Government for an amount of $17,707,000 at December 31, 2011 (2010 – $15,897,000; 2009 – $4,997,000). Such instruments are classified within Level 1 of the fair value hierarchy. As required by the fair value measurement framework, the Program does not adjust the quoted price for such instruments.

All of the remaining securities are measured at fair value based on quoted prices in markets that are not active, external pricing services, where available, prices derived from alternative pricing models, utilizing available observable market inputs and discounted cash flows. These methodologies represent valuation techniques consistent with the market and income approaches. As of December 31, 2011, 2010 and 2009, these investments are classified within Level 2 of the fair value hierarchy.

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.

## 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, 2011 amounted to $50,104,000 (2010 – $48,862,000; 2009 – $47,591,000), of which $33,193,000 (2010 – $32,345,000; 2009 – $31,523,000) was contributed by the Employer and $16,596,000 (2010 – $16,169,000; 2009 – $15,762,000) by active employees and retirees. An additional $315,000 (2010 – $348,000; 2009 – $306,000) 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, 2011, 2010 and 2009 (in thousands):

| | 2011 | | | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|---|---|---|
| Contributions | Active Employees | Retirees | Total | Active Employees | Retirees | Total | Active Employees | Retirees | Total |
| Employer | $ 17,220 | $ 15,973 | $ 33,193 | $ 16,781 | $ 15,564 | $ 32,345 | $ 16,591 | $ 14,932 | $ 31,523 |
| Active participants | 8,610 | 7,986 | 16,596 | 8,390 | 7,779 | 16,169 | 8,296 | 7,466 | 15,762 |
| Participants on leave-without-pay | 315 | - | 315 | 348 | - | 348 | 306 | - | 306 |
| | 26,145 | 23,959 | 50,104 | 25,519 | 23,343 | 48,862 | 25,193 | 22,398 | 47,591 |
| Claims Paid to Participants | | | | | | | | | |
| Medical | 16,684 | 14,135 | 30,819 | 15,526 | 12,630 | 28,156 | 16,476 | 12,708 | 29,184 |
| Dental | 2,546 | 1,811 | 4,357 | 2,440 | 1,625 | 4,065 | 2,326 | 1,657 | 3,983 |
| Medicines | 4,546 | 7,440 | 11,986 | 4,183 | 6,895 | 11,078 | 3,943 | 6,512 | 10,455 |
| | 23,776 | 23,386 | 47,162 | 22,149 | 21,150 | 43,299 | 22,745 | 20,877 | 43,622 |
| **Contributions higher than claims paid** | 2,369 | 573 | 2,942 | 3,370 | 2,193 | 5,563 | 2,448 | 1,521 | 3,969 |
| Other Items | | | | | | | | | |
| Increase (decrease) in Claims incurred but not reported | (88) | (168) | (256) | 214 | 91 | 305 | 113 | 337 | 450 |
| Insurance recoveries | 29 | - | 29 | 24 | - | 24 | 174 | - | 174 |
| US Medicare part D subsidy | - | 787 | 787 | - | 1,192 | 1,192 | - | 593 | 593 |
| | (59) | 619 | 560 | 238 | 1,283 | 1,521 | 287 | 930 | 1,217 |
| **Contributions higher than claims paid and other items** | $ 2,310 | $ 1,192 | $ 3,502 | $ 3,608 | $ 3,476 | $ 7,084 | $ 2,735 | $ 2,451 | $ 5,186 |

## 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, 2011, the Program had cash in one bank of $4,330,000 (2010 – one bank of $1,018,000; 2009 – one bank of $5,174,000). 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 – BENEFITS PAID

Benefits paid for the year ended December 31, 2010 and 2009 include certain medical claim payments to a single participant that were determined to be fraudulent. The impact of this matter on the financial statements of the Program was an increase in Claims paid of $24,000 for the year ended December 31, 2010, net of returned checks and stop-payments of $324,000, and $638,000 for the year ended December 31, 2009. In addition, there were $336,000 fraudulent claims for the same case that were paid prior to January 1, 2009.

## NOTE I – SUBSEQUENT EVENTS

Management has evaluated subsequent events through April 24, 2013, 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, 2011.

Ernst & Young LLP

Assurance | Tax | Transactions | Advisory

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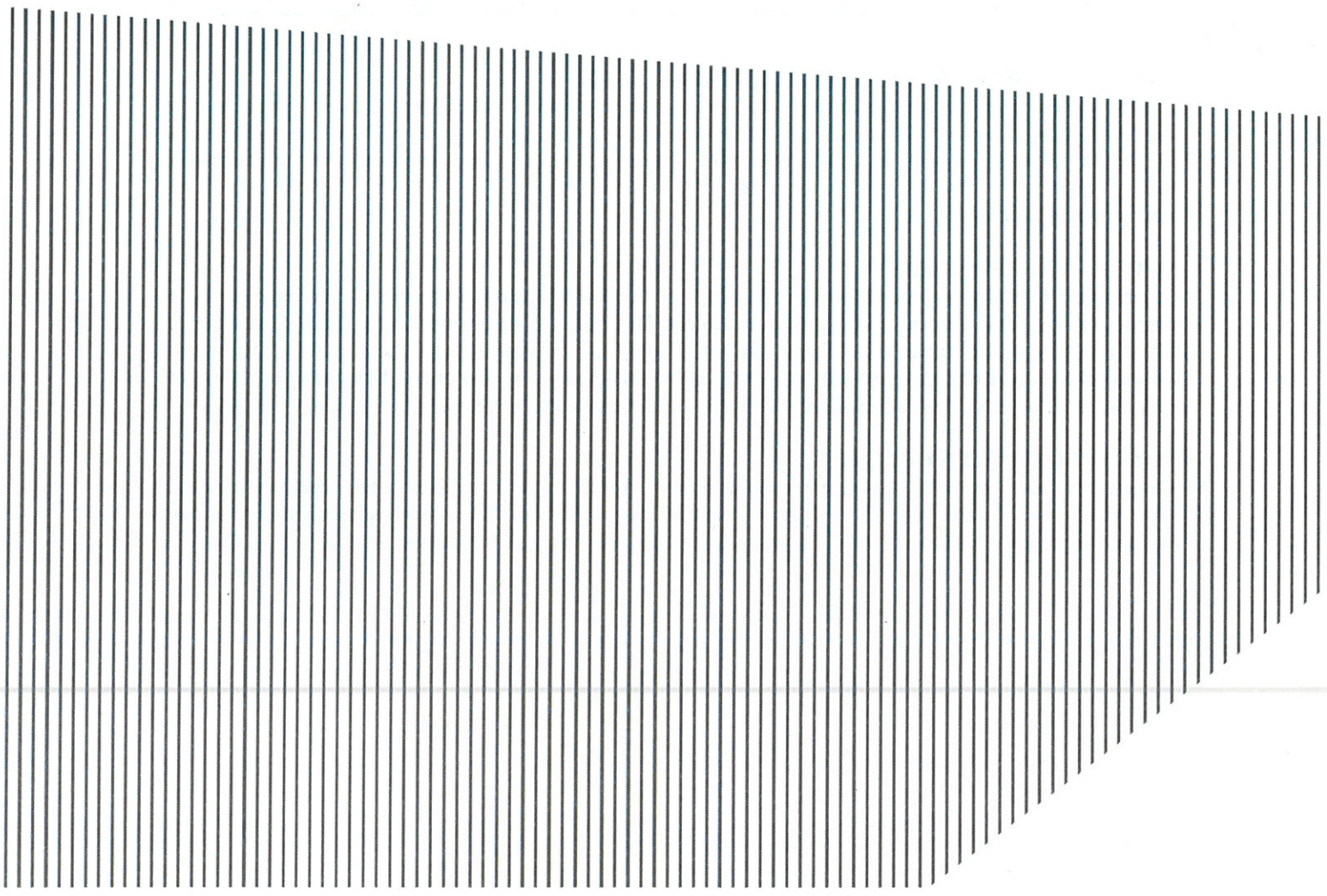

# AUDITORS' REVIEW REPORT AND FINANCIAL STATEMENTS

Inter-American Development Bank
Health Insurance Benefit Account
December 31, 2008 and 2007

0904-1048748-MCL

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## REPORT OF INDEPENDENT AUDITORS

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, 2008 and 2007, and the related statements of changes in net assets available for benefits for the years then ended, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. All information included in these financial statements is the representation of the management of the Bank.

A review consists principally of inquiries of Bank personnel and analytical procedures applied to financial data. It is substantially less in scope than an audit in accordance with auditing standards generally accepted in the United States, the objective of which is the expression of an opinion regarding the financial statements taken as a whole. Accordingly, we do not express such an opinion.

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

Ernst & Young LLP

Washington, D.C.
March 31, 2009

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

## STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

*(Expressed in thousands of United States dollars) (Unaudited)*

| | December 31, 2008 | December 31, 2007 |
|---|---|---|
| **Assets** | | |
| Cash | $ 5,358 | $ 3,958 |
| Investments | 20,743 | 18,774 |
| Accounts receivable | 152 | 47 |
| **Total assets** | $ 26,253 | $ 22,779 |
| **Liabilities** | | |
| Accounts payable | $ 1,241 | $ 808 |
| Claims incurred but not reported | 6,345 | 5,587 |
| **Total liabilities** | 7,586 | 6,395 |
| **Net assets available for benefits** | $ 18,667 | $ 16,384 |

*The accompanying auditors' review report and the notes to financial statements should be read in conjuntion with these statements (unaudited).*

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

## STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

*(Expressed in thousands of United States dollars)(Unaudited)*

| | Years ended December 31, | |
|---|---|---|
| | 2008 | 2007 |
| **Additions** | | |
| Contributions | | |
| Employer direct contributions | $ 15,775 | $ 15,902 |
| Postretirement Benefits Fund contributions | 14,213 | 12,596 |
| Participant contributions | 15,235 | 14,491 |
| **Total contributions** | 45,223 | 42,989 |
| Investment income (loss) | (947) | 692 |
| Interest and other income | 65 | 116 |
| **Total additions** | 44,341 | 43,797 |
| **Deductions** | | |
| Benefits to participants | | |
| Claims paid | 41,835 | 36,778 |
| Increase (decrease) in claims incurred but not reported | 758 | (5) |
| Insurance recoveries | (20) | (31) |
| US Medicare part D subsidy | (515) | - |
| **Total deductions** | 42,058 | 36,742 |
| **Net increase in net assets during the year** | 2,283 | 7,055 |
| **Net assets available for benefits:** | | |
| **Beginning of year** | 16,384 | 9,329 |
| **End of year** | $ 18,667 | $ 16,384 |

*The accompanying auditors' review report and the notes to financial statements should be read in conjuntion with these statements (unaudited).*

**INTER-AMERICAN DEVELOPMENT BANK**
**HEALTH INSURANCE BENEFIT ACCOUNT**
**NOTES TO FINANCIAL STATEMENTS (UNAUDITED)**
**December 31, 2008 and 2007**

**Note A - Description of the Program**

The following description of the Health Insurance Benefit Program (the Program) of the Inter-American Development Bank (the 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 the 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. Permanent, fixed-term, and certain temporary employees, their respective spouses and authorized dependent children are generally required to participate in the Program. Certain other staff members, including retirees and their qualified dependents, can participate on a voluntary basis. Staff members employed under permanent 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, provided they pay both the Employer's share and the participants' share of premiums.

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 $350,000. Under the stop-loss insurance policy, the Program is reimbursed for paid claims exceeding $350,000 up to $1,650,000 per participant.

For the year ended December 31, 2008, administrative and other expenses of the Program, including fees paid to the contracted program administrator in the amount of $2,934,513 (2007- $2,745,644); the premium for stop-loss insurance in the amount of $536,000 (2007- $470,000) and the premium for Medicare B in the amount of $1,326,000 (2007- $1,155,000), were paid by the Bank.

In 2007, under the U.S. Medicare part D program, the Bank applied for a subsidy on all Medicare eligible retirees who were not enrolled in this program. A subsidy of $514,966 was received on October 3, 2008 and recognized as income.

**Note B - Summary of Significant Accounting Policies**

**Basis of accounting**

The financial statements are prepared in conformity with United States 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 and deductions to net assets available for benefits during the reporting period. Actual results could differ from these estimates.

**New accounting pronouncement**

On January 1, 2008, the Program adopted Statement of Financial Accounting Standards (SFAS) No. 157, "Fair Value Measurements", which defines fair value, establishes a framework for measuring fair value under GAAP, and expands disclosures about fair value measurements. The adoption of this standard did not have a material impact on the Program's financial status and changes in its financial status.

**Investments**

Investments are carried and reported at fair value, with realized and unrealized gains and losses included in Investment income (loss) in the Statement of Changes in Net Assets Available for Benefit.

**Fair values of financial instruments**

The following methods and assumptions were used by the Administrator in measuring the fair value for its financial instruments:

***Cash:*** The carrying amount reported in the Statement of Net Assets Available for Benefits for cash approximates fair value.

***Investments:*** Fair values for investment securities are based on quoted prices, where available; otherwise they are based on external pricing services, independent dealer prices, or discounted cash flows.

**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 Statement of Net Assets Available for Benefits. Adjustments made to Claims incurred but not reported are shown in the Statement of Changes in 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 currently invested in high quality securities through an investment pool managed by the Bank. The investment pool may include government, agency, corporate and bank obligations, and asset-backed and mortgage-backed securities, substantially all with credit quality equivalent to ratings ranging from AAA to A+.

The Bank limits the Program's activities of investing in securities to a list of authorized dealers and counterparties. Credit limits have been established for each counterparty and the Bank does not anticipate non-performance by any of the counterparties.

Net unrealized losses on investments, for the years ended December 31, 2008 and 2007, in the amount of $796,350 (2007 – gain $121,000) were included in Investment income (loss). The average return on investments, including realized and unrealized gains and losses, during 2008 and 2007 was (4.64)% and 4.46%, respectively.

**Note D – Fair Value Measurements**

Effective January 1, 2008, the Program adopted SFAS 157, which provides a new framework for measuring fair value under GAAP. SFAS 157 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 in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities;

Level 2 - Quoted prices in markets that are not active, or inputs that 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 (i.e., supported by little or no market activity).

Substantially all of the investment pool securities are measured at fair value based on quoted prices in markets that are not active, solicited broker/dealer prices or prices derived from alternative pricing models, utilizing discounted cash flows. These methodologies represent valuation techniques consistent with the market and income approaches, which have been applied without change. At December 31, 2008, the Program investments are classified within Level 2 of the SFAS 157 fair value hierarchy.

**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, 2008 amounted to $45,223,000 (2007 - $42,989,000), of which $29,988,000 (2007 - $28,498,000) was contributed by the Employer and $14,988,000 (2007 - $14,249,000) by active employees and retirees. An additional $247,000 (2007 - $242,000) 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, 2008 and 2007 (in thousands):

| | 2008 | | | 2007 | | |
|---|---|---|---|---|---|---|
| **Contributions** | **Active Employees** | **Retirees** | **Total** | **Active Employees** | **Retirees** | **Total** |
| Employer | $ 15,775 | $ 14,213 | $ 29,988 | $ 15,902 | $ 12,596 | $ 28,498 |
| Active participants | 7,887 | 7,101 | 14,988 | 7,951 | 6,298 | 14,249 |
| Participants on leave-without-pay | 247 | - | 247 | 242 | - | 242 |
| | 23,909 | 21,314 | 45,223 | 24,095 | 18,894 | 42,989 |
| **Claims Paid to Participants** | | | | | | |
| Medical | 14,996 | 13,348 | 28,344 | 14,691 | 9,928 | 24,619 |
| Dental | 2,284 | 1,594 | 3,878 | 2,360 | 1,258 | 3,618 |
| Medicines | 3,730 | 5,883 | 9,613 | 3,718 | 4,823 | 8,541 |
| | 21,010 | 20,825 | 41,835 | 20,769 | 16,009 | 36,778 |
| **Contributions higher than claims paid** | 2,899 | 489 | 3,388 | 3,326 | 2,885 | 6,211 |
| **Other Items** | | | | | | |
| (Increase) decrease in Claims incurred but not reported | (30) | (728) | (758) | 116 | (111) | 5 |
| Insurance recoveries | 20 | - | 20 | 31 | - | 31 |
| US Medicare part D subsidy | - | 515 | 515 | - | - | - |
| | (10) | (213) | (223) | 147 | (111) | 36 |
| **Contributions higher than claims paid and other items** | $ 2,889 | $ 276 | $ 3,165 | $ 3,473 | $ 2,774 | $ 6,247 |