

The key message in IMFRA's comments is that splitting the Medical Benefits Plan into separate staff and retiree components would be a mistake unless there is clear actuarial evidence that it is necessary. At the moment, the case for separation seems to be driven more by demographics—especially the fact that retirees now outnumber active staff—than by actual financial instability. That is an important distinction, because demographic change on its own does not justify structural reform.

IMFRA's view is that keeping a unified plan preserves economies of scale, spreads risk more efficiently, and avoids creating unnecessary inequities. Retirees have contributed to this plan throughout their careers, often using fewer benefits while they were working, and their medical coverage is financed through the RSBIA rather than the administrative budget. That context matters when evaluating fairness.

The comments also argue that the finance paper overstates retiree cost pressure in a few important ways. First, it references Medicare without properly recognizing the savings Medicare generates by absorbing a significant portion of retiree claims. Second, it suggests retirees contribute less than staff, but that comparison is misleading because staff contributions are based on net salary while retiree contributions are based on gross pension income. In practical terms, many retirees may actually be contributing more relative to their disposable income than the paper implies.

IMFRA also challenges the treatment of catastrophic claims. The recent high-cost cases appear to have come mainly from infant and neonatal care, not retiree usage, and the paper does not provide the staff-versus-retiree breakdown needed to support its conclusions. So using catastrophic claims as a rationale for restructuring the plan is not well supported.

More broadly, IMFRA notes that the plan is not in a weak position. The 40 percent reserve target has significantly strengthened financial stability, giving the plan a meaningful cushion against volatility. Short-term cost pressures, including GLP-1 drugs, should also be viewed carefully, since there is emerging evidence that these treatments may reduce overall costs over time through better health outcomes.

So the recommendation is clear: keep the plan unified, undertake an earlier and more frequent actuarial review, and explore internal risk-management options—such as a dedicated catastrophic claims reserve within the RSBIA—instead of moving prematurely toward a structural split.