BMA

The British Medical Association's response to the Public Service Pension Schemes consultation: changes to the transitional arrangements to the 2015 schemes

October 2020

British Medical Association
bma.org.uk

BMA House
Tavistock Square
London WC1H 9JP

BMA

Public Service Pensions, Policy and Legislation Branch
Pensions Division
Department of Finance
Waterside House
75 Duke Street
Londonderry
BT47 6FP

26 October 2020

Public service pension schemes: changes to the transitional arrangements to the 2015 schemes

As Chair of the BMA Northern Ireland, I am elected to represent the interests of all doctors in Northern Ireland. I am therefore, writing to you in this capacity to respond to the consultation published by the Department of Finance (Northern Ireland). This relates to the proposals to remedy the age discrimination resulting from the offer of protection to older, but not to younger members as part of the introduction of the new public sector pension schemes in 2015. This is an area of great importance to BMA members and we therefore, welcome the opportunity to present our views on these proposals.

The consultation is wide ranging and therefore, the BMA Pension Committee has undertaken extensive work to ensure we fully appreciate the effects that this transition to the 2015 scheme has had on our members. We have consulted widely with our membership to ensure that our response fully reflects their concerns and have suggested actions that should be taken to mitigate the detriments that have arisen from this unlawful age discrimination.

One of the key aspects the consultation is looking at is the point at which members choose which scheme they wish to be a member of during the remedy period. It is clear that for our members, deferred choice underpin is the only suitable option as it ensures that members can base their decision on actual rather than assumed benefits. This option also resolves the difficulty of how to deal with those who do not respond to a choice exercise.

A further key area of concern for our members is how to deal with consequential decisions that they have made as a result of their transition to the 2015 scheme. Doctors have been the most adversely impacted by the current system of pensions taxation. In particular, due to anomalies within the taxation system, those who were members of both the legacy and reformed pension scheme faced much higher levels of annual allowance taxation, despite often receiving a lower pension than those protected members who remained solely in the legacy scheme. As a result, large numbers of doctors made decisions to reduce their tax liability; a decision that would not have been required had they not been subject to this age discrimination. These decisions include opting out of the scheme, taking early retirement and reducing their work commitments. The proposal outlined in the consultation is to assess these on a ‘case by case’ basis. It is our belief that this would be impractical and have therefore, suggested that for certain circumstances, such as the ones outlined, members should automatically be entitled to reverse these decisions and be eligible to ‘buy-back’ any lost pension entitlement.

The Health and Social Care Northern Ireland (HSC) pension scheme and associated tax rules are exceedingly complicated. To compound matters, attempting to understand the remedy proposals and what is best for an individual member is extremely difficult. We are clear in our

response that any costs incurred by members seeking individual financial advice should be borne by the government. We also stress the importance of providing clear and detailed information in relation to a member's benefits under both schemes, including the impact of the remedy period being in either the legacy or the reformed scheme. The documentation must also demonstrate a member's benefits, in respect of both options, based on a number of different retirement ages.

The consultation suggests that after the remedy period, all scheme members will move to the 2015 scheme, in April 2022. As outlined in our response, we believe there are a number of anomalies in the 2015 scheme that need to be addressed. In a career averaged revalued earnings (CARE) scheme, there is no justification for tiered contribution rates and the fact that those working less than full time pay higher pension contributions per pound of accrued pension than their full-time colleagues is extremely unfair. Additionally, due to the interaction between the two schemes and current tax rules, members in both the legacy and reformed schemes pay more in annual allowance tax, often despite accruing less pension. Furthermore, it is unfair that members cannot draw their 1995 scheme benefits whilst continuing to contribute to the 2015 pension scheme. This significantly devalues the benefit of the 1995 pension. We have therefore, stressed the need to fix the anomalies in 2015 scheme before members are moved into this scheme in our response.

We note that you have included cost estimates of remedying the unlawful discrimination within your consultation. We have stressed that this cost is a direct result of the unlawful age discrimination imposed by the government and was not the fault of the scheme members. It is essential therefore that the costs of this remedy are borne directly by department and that employee contribution rates, accrual rates and overall pension benefits are not adversely impacted by your proposed remedy. We need absolute assurance this will not be the case as otherwise members will still be paying for this detriment through an alternative mechanism and this is wholly unacceptable.

Furthermore, over the past several years members have experienced significant delays in receiving their annual pay uplifts. This is problematic as doctors are unable to accurately project their income for the financial year and given the complexities of the current pension taxation rules, small changes in pay can result in them receiving large additional tax bills as a result of exceeding their annual allowance. This demonstrates the need to introduce the annual allowance repayment scheme, to guarantee that any annual allowance tax charge for eligible clinicians will be compensated for at the time of retirement.

In recent years, the separate changes to the HSC pension scheme and the unintended interaction with the pension taxation system have created a workforce crisis in the Health and Social Care NI (HSCNI), which is demonstrated by the fact that NI has the highest number of vacancies across the UK, as well as the emerging trend of more doctors leaving the profession than joining. Although the increasing of threshold income announced in the budget in March 2020, has offered some mitigation, significant problems remain, and it is vital that these are resolved so that we can retain doctors within the HSC NI.

Please get in touch for further clarification or information.

Yours sincerely,

Dr Tom Black

BMA Northern Ireland Council Chair

Foreword

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives. Over the past several years we have been advocating for a resolution to the discrimination our members have suffered through the pension scheme changes. The BMA has also been clear on its opposition to the 2015 public sector pension reform, which we have briefly detailed below. We therefore welcome the opportunity to respond to the consultation.

Response to consultation

Question 1: Do you have any views about the implications of the proposals set out in this consultation for people with protected characteristics as defined in section 75 of the Northern Ireland Act 1998? What evidence do you have on these matters? Is there anything that could be done to mitigate any impacts identified?

Whilst the department's proposal seeks to remedy the unlawful discrimination suffered by those who were members of a legacy scheme on or before 31st March 2012, the proposals fail to recognise the detriment suffered by those who joined such a legacy scheme between 1st April 2012 and 31st March 2015 (the "Unprotected Period") and were then removed from that scheme against their will in the same way as other members without tapered or full protection. The government has throughout this process sought to rely on the position that those individuals were allegedly afforded sufficient notice of the change so as not to have expected to be placed in the legacy schemes. Those members have suffered discrimination which the government is not seeking to rectify under this consultation.

The department must accept that a significant number, if not the vast majority, of those joining schemes during the "Unprotected Period" would have been younger than their colleagues who had joined schemes prior to 1st April 2012. Indeed, some of these younger colleagues may have made alternative decisions, such as not taking career breaks or seeking to join the legacy scheme prior to 1st April 2012 had they known the detrimental implications of not doing so. The BMA do not agree with the government that there was a sufficient notice period for these individuals, the vast majority of whom will have spent many years training to work in the NHS.

In addition, we are aware that the legacy final salary pension benefits were a major recruitment incentive for overseas doctors planning to work in the UK. Many of these doctors spent a long period of time preparing to work in the UK, often incurring significant expense to complete the necessary examinations and regulatory processes. These doctors who commenced work during the "Unprotected Period" were also given insufficient notice of the intended changes to the NHS pension scheme and have therefore been placed at a disadvantage because of them joining the NHS from overseas.

Consequently, the BMA believe that all members who had joined legacy schemes prior to 1st April 2015 must be afforded the same choice between the legacy and reformed schemes options with respect to the remedy period as those joining before 1st April 2012.

Question 2: Is there anything else you would like to add regarding the equalities impacts of the proposals set out in this consultation?

The BMA believe there are significant equalities impacts with the proposal of immediate choice for younger members. Younger members will have far less certainty regarding their future career path, their final salary or planned retirement date. Consequently, there is far greater risk that by basing decisions on assumed pension values, younger members are more likely to choose the less favourable option, resulting in a lower pension. This is a serious limitation of the immediate choice proposal that may be subject to future legal challenge.

Question 3: Please set out any comments on our proposed treatment of members who originally received tapered protection. In particular, please comment on any potential adverse impacts. Is there anything that could be done to mitigate any such impacts identified?

Whilst in its introduction of tapered protection the department attempted to afford some manner of protection, it placed the vast majority of scheme members at a disadvantage. In seeking to remedy its unlawful discrimination, the department is now seeking to withdraw, without choice, tapered protection all together.

In its consultation, the department acknowledges that some members will be disadvantaged should their tapered protection be removed. We believe that no member should be left disadvantaged as a consequence of the department's proposal to remedy its unlawful discrimination, particularly without their consent. To remove this tapered protection from the concerned members, without consultation and their express consent, would be unlawful.

Question 4: Please set out any comments on our proposed treatment of anyone who did not respond to an immediate choice exercise, including those who originally had tapered protection.

The BMA feels that further clarity is needed regarding how members who did not respond to an immediate choice exercise would be treated. In particular, we would be interested in the method of communication that is being considered and at what stage communications will be made. We note that the consultation suggests that contact will be made at 3, 6, 9 and 12 months but given the vital importance of the choice to members, we feel that they need to be notified of the need to make a choice in advance of any 'choice' window opening. In addition, we feel that a 12-month period is too short before defaulting members to the reformed scheme. We think this would need to be significantly longer than 12 months and as a minimum we would expect any members who do not reply within a given a time frame to be able to submit late applications if there are extenuating circumstances.

Furthermore, we note that for many members whose 'default' position is in the reformed scheme, they may be financially better off in the legacy scheme. Consequently, if they have failed to respond in the timeframe suggested and their ability to choose to move to the legacy scheme for the remedy period is lost, the department will have failed to adequately remedy the unlawful discrimination for this group of members. In addition, for those with tapered protection, it is possible that by simply returning them to the legacy scheme without their express consent will result in them receiving a lower pension than they may have been expecting.

The difficulty in dealing with those members who do not respond within the suggested time period is a fundamental problem with the option of immediate choice and the BMA's view is that this is a powerful argument, among others, to proceed with Deferred Choice Underpin.

Previous choice exercises have shown that, when placed under pressure to make choice based on assumptions affecting the remainder of their career and beyond, members may not make the best choice because they do not have the correct level of information to make an informed choice. As such, members are very likely to unwantedly place themselves at a disadvantage.

On a broader point, the department and scheme administrators must be flexible and considerate of the on-going COVID-19 pandemic in dealing with the date by which an immediate choice is to be made and the timescales for members to respond. It would be wrong to require members to spend significant time and substantial energy in reviewing and determining their pension positions at a time when the nation requires our members to be focused on the delivery of front-line services.

Finally, we also note the fact that the department anticipates not being able to contact all affected members successfully during such an exercise simply reinforces the arguments in favour of deferred choice underpin.

Question 5: Please set out any comments on the proposals set out above for an immediate choice exercise.

The BMA has significant concerns with this option. This requires members to make an irrevocable decision on which scheme they would like to accrue benefits in during the remedy period, likely in 2022/3, without full foresight of the impact of this choice to their ultimate pension at retirement.

As outlined in the consultation, the fundamental problem with this approach is that members will need to make their choice based on assumptions of their career pathway, future retirement date, salary progression etc. Particularly for younger members who were most disadvantaged by this unlawful discrimination, there is little certainty regarding this and given the complexities of the HSC pension scheme, small changes can have a significant bearing of the final pension received.

Consequently, if career plans change, there is a significant risk that a member may have chosen an option under immediate choice that results in them receiving a lower benefit than if they were able to make the choice at the point of retirement. If a member were to choose to be in the legacy scheme for the remedy period, the value of the pension accrued during that period would be determined by the final salary. This will not be known for certain at the time of choice and if the final salary is lower than anticipated this will result in a lower value of their pension for the remedy period. Similarly, if they were to choose the reformed scheme, whilst there would be more certainty regarding the value of the accrued pension during the remedy period, any future changes to state pension age will potentially affect the value of this accrued pension, particularly if they need to retire early and actuarial reduction is considered.

The consultation lists one of the advantages of immediate choice as being that members will have clarity regarding which scheme, they are in for the remedy period relatively quickly. Whilst this is true, the BMA does not believe this to be an important consideration for scheme members, particularly those that are younger. Members will want clarity regarding their actual rather than hypothetical pension benefits and these can only be known for certain at the point of retirement.

Furthermore, there are several tax implications to which this option will provide little comfort (see our response to question 24 for more detail).

Question 6: Please set out any comments on the proposals set out above for a deferred choice underpin.

Deferred Choice Underpin (DCU) is the BMA’s preferred option for members to decide their preferred scheme for the remedy period. As outlined above, DCU will ensure that members make choices based on known final pension values informed by the schemes, with direct comparison figures at retirement. This means that members will be able to make a more informed decision, rather than making assumptions at the end of the remedy period.

Furthermore, this option avoids the problem of 'unresponsive' members who do not make a choice within a given timeframe. At the point of retirement all members will need to inform the schemes of their intention to retire and will be able to engage and confirm their choice at that stage. Although this takes longer to resolve the issue, the BMA feels that this is preferable, not only for the member, but for both scheme administrators and trade unions as they will be able to provide better levels of support for members given that the numbers needing to choose at any given time will be spread out over a much longer period.

We do, however, recognise that this option will result in more complicated annual benefit and pension saving statements, as figures will be provided for both legacy and reformed pension schemes for the remedy period until retirement. Sufficient explanatory notes will need to be developed to help members understand these statements. It is essential that annual benefit and pensions savings statements are provided in a timely manner and are up to date to ensure that members can accurately assess any annual allowance tax liability. If due to the added complexity of these statements, additional financial advice is required by members to assess either their tax liability or for retirement planning, this advice should be provided by the scheme or members compensated for reasonable additional costs.

We note that under this option, members will be returned to their legacy scheme for the remedy period and tax reassessed in a similar way for immediate choice. We acknowledge that this may present as an administrative burden to the department and the scheme administrators in remedying the unlawful discrimination, however the BMA and its members require assurances that sufficient resources will be designated to manage this task within set timescales, and not at the cost of the scheme or its members.

Due to the interaction between the pension scheme and the current pensions taxation system, those members who have suffered discrimination and are members of both the reformed scheme and the legacy scheme pay significantly more in annual allowance taxation, often despite accruing a lower pension than those on the legacy scheme alone. Consequently, for doctors, the largest group affected by annual allowance taxation, in the majority of cases, reverting to the legacy scheme will mean they have overpaid rather than underpaid tax. Therefore, the BMA believes that the amount of underpaid tax that is payable will be negligible and is unlikely to be cost effective to seek to collect. We note that if a member chooses to move to the reformed scheme at the point of retirement, their tax position will be reassessed and where an annual allowance tax charge arises from the choice, the scheme will compensate them for the charge. We are comforted by the consultation providing that there will be no additional tax charge payable and therefore, neither their pension nor any tax-free lump sum will be reduced as a result of any additional tax charge arising from their choice.

Question 7: Please set out any comments on the administrative impacts of both options.

As we have outlined above, under either immediate choice or DCU, all members should be provided with sufficient information and support so that they are able to make an informed choice as to their preferred scheme for the remedy period. However, we do not consider that the impact of providing this or of administering either of the immediate or DCU options should be borne by members.

The need to provide this choice has only now arisen because of the department's unlawful discrimination. The consequences of remedying this should not be felt by any scheme member.

Any costs associated with the administration and/or implementation of either choice should not in any way fall to scheme members and must be borne by the department in all circumstances.

Furthermore, the BMA believe it to be fair and reasonable that scheme members should be compensated for having to seek financial and/or actuarial advice in order to be able to make an informed decision, should the information provided by the scheme be insufficient, at the date of retirement.

From a logistical perspective, the immediate choice option would generate a huge immediate burden of case work, made worse by the impossibility of providing adequate information to describe all the possible outcomes. DCU will spread the required case work over many years, making it more manageable for the scheme administrators. DCU involves tracking two sets of potential pension benefits over a member's career. However, the systems for calculating the two sets already exist so the additional burden of running them twice for each member is relatively small. As such the administrative burden and cost of the immediate choice option would far outweigh that of the preferred DCU alternative.

Question 8: Which option, immediate choice or DCU, is preferable for removing the discrimination identified by the Courts, and why?

As outlined in response to question 6, the BMA's strongly preferred option is DCU as members would be able to make their decision with fuller information about what they would receive under the two schemes. Indeed, we think that immediate choice is fundamentally flawed and would be unacceptable to our members.

Question 9: Does the proposal to close legacy schemes and move all active members who are not already in the reformed schemes into their respective reformed scheme from 1 April 2022 ensure equal treatment from that date onwards?

The BMA continues to have concerns with the Public Service Pensions Act (Northern Ireland) 2014, which reformed the public sector pensions scheme. We have always accepted that the NHS Pension Scheme must offer a fair deal to taxpayers as well as to staff. However, we do not believe there was justification for the scale of the changes introduced by the legislation or the speed at which they were implemented. Additionally, as previously highlighted we felt that the reformed pension scheme entrenched significant disparities across and within public sector schemes, and our position was that such important issues of unfairness should have been addressed by introducing a coherent approach to public sector pensions.

Thus, we strongly opposed the changes that were introduced in 2015 and have never accepted the new scheme. Indeed, the NHS was treated particularly unfairly as trade unions worked collaboratively with the department to undertake a 'once in a generation' reform of the NHS pension scheme. This new jointly agreed scheme was introduced in 2008 and not only did these changes result in a later normal pension age, but unions agreed to tiered contribution rates being introduced that resulted in higher earners paying 8.5% in employee contributions. Despite this change, following the Public Sector Pay Bill, contribution rates were increased across all public sector schemes by an average of 3.2%, regardless of the employee contribution rates that were payable prior to that point. For doctors these changes resulted in them paying significantly more for their pensions than other public sector employees earning similar salaries. For example, at the top end of the pay scales, doctors pay almost twice as much a year in contributions for a similar pension as civil servants or high court judges. The HSC Pension Scheme also compares unfavourably with schemes for teachers, local authority staff, police and parliamentarians.

Furthermore, we were also opposed to the reformed scheme because it linked the normal pension age to the state pension age, which is expected to rise to 68 by 2046. This blanket approach takes no account of how physically, mentally or emotionally demanding working for the HSC NI can be, which makes it difficult for some of our members to continue to work at the same intensity as they get older. This issue is compounded by the fact that although under the regulations and for tax purposes, the reformed and legacy schemes are separate pension schemes, members must retire from both schemes simultaneously. This precludes the option of drawing benefits from the 1995 section of the legacy scheme at the age of 60 and continuing to accrue benefits in the reformed scheme. This significant reduces the overall value of the pension and is unfair for those forced to be on both the legacy and reformed schemes.

The BMA strongly urges the department to consider the option to allow members to draw their legacy scheme pension at normal pension age, whilst continuing to contribute to the reformed scheme and/or introduce Late Retirement Factors in the 1995 scheme (aligning it with 2008 and 2015 schemes) to remove this strong disincentive to working beyond 60. This would also align with the Department of Health (Northern Ireland) stated intentions in the '*Health and Social Care Workforce Strategy 2026: Delivering for Our People,'* for retaining the workforce.

The switch to a new career average revalued earnings (CARE) scheme for all HSC NI staff, with an accrual rate of 1/54th meant that some would see a reduction in value. This reduction is compounded by the interaction between the pension taxation system and the NHS pension schemes that result in members who were forced to be on both the reformed and legacy scheme paying significantly more in terms of annual allowance taxation, often despite receiving lower pension benefits. What is more, higher and steeper contribution rate tiers were introduced for NHS Pension Scheme members. We felt this could not be justified in a CARE pension scheme, as staff on all career pathways will receive the same CARE accrual rate, but steep tiering of contribution rates means that lower paid HSC NI staff will receive better value for each £1 of contributions over the whole of their careers than higher earners. Indeed, this aggressive tiering in the reformed CARE scheme more than offsets any benefit of higher rate tax relief on pension savings in the HSC pension scheme.

Steep tiers in contributions in a CARE scheme also discriminated against part-time staff, as the contribution rate relates to the equivalent full-time salary rather than actual salary. This meant that a member of staff on a higher salary band working three days a week would pay significantly more for the same pension as a member of staff on a lower salary band working full time, even if they had the same level of actual pensionable pay.

Furthermore, statistics and evidence provide that women are more likely to work part-time than men. As such, the proposed CARE Scheme would place women at a particular disadvantage compared to their male colleagues and would therefore be inherently discriminatory on the grounds of sex, aside from issues relating to age (considered below).

The BMA believes that members should have been able to remain in their old scheme and that members should be put back in the position in which they would have been had they been allowed to remain in the legacy scheme on and after 1 April 2015. This includes being in receipt of all of the benefits that would have flowed from their continued membership of the legacy schemes, including the Mental Health Officer (MHO) status available under the 1995 Scheme. Furthermore, for members with MHO status, there is a lack of clarity regarding how they would be affected if they are forced onto the reformed scheme after 1 April 2022. Some members are concerned that they could lose their accrued legacy benefit, if for example they were unable to remain in employment in a mental health setting post 2022. This is a particular concern given the demands

of working in this setting coupled with the later retirement age in the reformed scheme. In addition, members with MHO status may have expected to continue to receive 'doubling' of the benefit beyond 1 April 2022. This would no longer be possible in the reformed scheme and would place those members at a disadvantage, as their pension benefits will be lower than they had expected they would be when they chose to work in a mental health setting.

Question 10: Please set out any comments on our proposed method of revisiting past cases.

The BMA is broadly content with the proposed method outlined in the consultation document, for revisiting members who retired during the remedy period and are currently in receipt of a pension, except for the concern noted below. There needs to be clarity however, on how the department plans to address members who retired during the remedy period when they were transitioned onto the reformed pension scheme but would not have done so had they been able to remain on the legacy scheme.

We would expect the department and the scheme to be responsible for the administration of revisiting past cases, to include but not limited to, contacting any affected members. On the basis that this step is being proposed to remedy the department's unlawful discrimination, it should not be for the members to be responsible for actioning this.

As outlined above, there is a particular area of concern in relation to members who have retired with tapered protection. In some cases, their tapered protection may offer a higher level of benefit than either the legacy or reformed scheme. The BMA does not believe that it would be appropriate or indeed lawful to seek to reduce the level of pension benefit that members have based their retirement decisions on.

Question 11: Please provide any comments on the proposals set out above to ensure that correct member contributions are paid, in schemes where they differ between legacy and reformed schemes.

The contribution rates payable under the reformed and legacy schemes in the HSC are the same and consequently, the BMA has no direct comments to make with regards to this question.

However, we do have a concern in relation to differential contribution rates applied to locum general practitioners (GP) in the reformed scheme. Contribution rates in the legacy practitioner schemes were based on actual rather than whole time equivalent pay. However, in the reformed scheme, contributions are inappropriately based on 'annualised' pay. As a consequence, a GP locum working 2 days a week may pay employee contributions at a rate of 14.5% in the reformed scheme; whereas the corresponding rate in the legacy scheme would be 9.3%. Under immediate choice, if the scheme member opted to revert to the legacy scheme, these excess contributions would need to be refunded. Under the proposal of deferred choice underpin, all members will revert to the legacy scheme for the remedy period and those affected by annualisation should receive a refund of these excess contributions. The BMA believe that the process of annualisation of pay is unfair and that in a CARE scheme, contributions should be based on actual pensionable pay. Consequently, we feel that if choosing the reformed scheme at retirement, members should not be asked to repay these additional contributions at the time of choice. Furthermore, post 2022 all contributions should be based on actual not whole-time equivalent pay if all scheme members are on a CARE scheme.

There are some further points to make regarding member contributions in the response to question 20.

Question 12: Please provide any comments on the proposed treatment of voluntary member contributions that individuals have already made.

As stated in the consultation document, members who decided to take advantage of the Early Retirement Reduction Buy Out (ERRBO) in the reformed scheme, who subsequently decide to transition back to a legacy scheme, are unable to convert the ERRBO they purchased for the remedy period to legacy scheme pension. The BMA note the difficulty in converting both ERRBO and additional pension contributions purchased in the reformed scheme to a pension benefit payable under the legacy schemes. However, this additional pension was part of the members retirement planning and if they choose to move to the legacy scheme (a choice which may be based on factors other than final pension value), we would welcome a mechanism by which members affected by this can transfer these additional contributions to a private pension or an alternative workplace pension scheme. In addition, we would welcome the option for ERRBO and additional pension payments already made to be 'carried forward' to the reformed scheme post 2022 if the member elects to revert to the legacy scheme during the remedy scheme.

Furthermore, the 1995 pension scheme gave members the option to buy added years with additional contributions. Due to the punitive tax arrangements that were applied to those members who were in both the legacy and reformed scheme, many members gave up added years contracts in order to minimise their tax liabilities. If they choose to move to the legacy scheme for the remedy period, they should be given the option to resume these added years contracts. Conversely, some members who choose to transition into the reformed pensions scheme for the remedy period may work longer as a result of the increased pension age in the reformed scheme and therefore, may no longer be in need of an added years contract. These members should be given the option of a refund on these added years if they feel that they are no longer required. Should members request a refund of these added years, they should not be disadvantaged because of that decision. As such, and by way of non-exhaustive example, in receiving a refund no member should be subject to adverse tax treatment, to include but not limited to any impact on a member's annual allowance or income tax threshold. Had members not been subjected to this unlawful discrimination they would not have to receive such a refund and should not be in a worse position than if the unlawful discrimination had taken place.

In the legacy scheme, the option to purchase added years closed in 2008. Part-time workers and those who take career breaks are adversely impacted by the inability to purchase added years. This group is predominantly female and the BMA believe that reopening the ability to purchase added years contracts would be important to help bridge the gender pensions gap.

Some members have been subjected to increased tax bills as a result of being in both the legacy and reformed pension schemes. Consequentially, they cancelled any enhanced pension benefits they were paying towards. These members should be given the option of restarting any other voluntary member contributions as they may no longer be subjected to such tax charges.

Question 13: Please set out any comments on our proposed treatment of annual benefit statements.

Members must be provided with full and detailed information in their annual benefit statements. The information currently being provided to members is insufficient and does not provide the level of detail required.

All annual statements must provide clear and detailed information and breakdowns in relation to a member's benefits under both schemes, including the impact of the remedy period being under either the legacy or the reformed scheme. The documentation must also demonstrate a member's benefits, in respect of both options, based on a number of different retirement ages.

In providing such a sufficient level of detail, the schemes will reduce members' potential future expenditure in seeking financial and/or actuarial advice as to their pension benefits and entitlements.

The BMA believes that all scheme members should receive annual benefits statements and Pensions Savings Statements as a matter of course, and it should not be for the member to request these themselves. Given the importance of the annual benefit statement under the DCU, these statements must be provided to all members in a timely manner each year.

Question 14: Please set out any comments on our proposed treatment of cases involving ill-health retirement.

In principle we do not oppose the proposed treatment of cases involving ill-health retirement, however as noted in the addendum to this response, we would appreciate further details on the management of these cases.

It is crucial that no member should be disadvantaged by the differences between the legacy and reformed schemes as to ill-health retirement. Not only should those members who have been declined under the reformed scheme be permitted reassessment under their legacy scheme, those members who have been accepted for ill-health retirement under the reformed scheme should also be able to choose under which scheme they should receive their benefit.

In circumstances where benefits would be greater under the alternative scheme, the scheme administrators should write to the members concerned outlining this so that they can then chose under which scheme they would prefer to receive their benefits.

Question 15: Please set out any comments on our proposed treatment of cases where members have died since 1 April 2015.

We are agreeable to the proposal outlined however, when such an unfortunate event occurs, the schemes should proactively support the members' survivors. In this regard, the scheme should identify those relevant members who have died, and it should be for the scheme to make contact with the members' survivors in a sensitive and compassionate way. It should be for the schemes to provide the members' survivors with full calculations and breakdowns in respect of both schemes for the remedy period in order to enable the survivors to make an informed choice. At such a distressing time, it should not be for the members' survivors to have to seek detailed financial and/or actuarial advice in order to make the required choice.

Question 16: Please set out any comments on our proposed treatment of individuals who would have acted differently had it not been for the discrimination identified by the Court.

We firmly believe that no member should be disadvantaged because of the department's unlawful discrimination and as such members should be placed in the same position as if the discrimination had never occurred.

We do not believe that schemes should put members through unnecessary and potentially protracted procedures so they can be restored to their previous positions had it not been for the

unlawful discrimination. To this extent, members should have the automatic entitlement, should they choose, for the following to be restored to them without any requirement to provide evidence or representations:

- Any members who have opted out of the schemes shall be entitled to re-join the schemes from the date they left, subject to retrospective payment of the correct employee and employer contributions. No interest should be charged by the schemes as the schemes will not have suffered any loss which would attract interest and any employer contributions should be met by the employer and not the member. For GP principals, there should be no recoupment from practice monies and furthermore the additional cost of employer pension contributions should not be borne by the schemes.

- Any member who decided to take early retirement due to the perceived impact of the reformed scheme shall be entitled to re-join the scheme, should they gain reemployment, subject to retrospective payment of the correct employee and employer contributions. No interest should be charged by the schemes as the schemes will not have suffered any loss which would attract interest and any employer contributions should be met by the employer and not the member. Again, for GP principals, there should be no recoupment from practice monies and the additional cost of employer pension contributions should not be borne by the schemes.

- Any member who had reduced or cancelled added years due to the real or perceived negative impact of the reformed scheme, shall be entitled to purchase added years in the legacy scheme or additional pension in the reformed scheme on no less favourable terms than that under their legacy scheme.

- Any member who reduced their clinical sessions or reduced their employment to part-time, shall be entitled to buy back any lost pensionable service as a result of this decision, subject to retrospective payment of the correct employee and employer contributions. No interest should be charged by the schemes as they will not have suffered any loss which would attract interest and any employer contributions should be met by the employer and not the member. Again, for GP principals, there should be no recoupment from practice monies and the additional cost of employer pension contributions should not be borne by the schemes.

- Some members may have opted, under the previous choice exercise run from October 2014 to March 2015, to transfer their benefits from the 1995 scheme to the 2008 scheme because of their concerns surrounding the reformed scheme. These members should be allowed to reverse this decision and transfer their benefits back to the 1995 scheme should they now wish to do so. In addition to this, all members of the 1995 legacy scheme should be afforded a further opportunity to transfer their benefits to the 2008 legacy scheme should they now wish to do so.

The above is a non-exhaustive list. We would however highlight that a failure to offer automatic entitlement in defined circumstances and instead rely on case-by-case determinations by the schemes would be much more onerous for both members and scheme administrators. It will also

bring significant additional costs for the scheme administrators as members who receive a negative response to their request would of course be entitled to refer the matter to the Pensions Ombudsman.

We accept that there will be some decisions in respect of which scheme members will reasonably have to make representations and to provide evidence, however any such application should be considered fairly and not unreasonably refused. Such circumstances would include, but would not be limited to:

- Any member who sought financial and/or actuarial advice due to the implementation, or perceived impact, of the reformed scheme shall be entitled, on production of appropriate invoices, to receive a refund of the professional fees paid.

The above is a non-exhaustive list.

There are consequential issues which must also be considered should members take up the options outlined above, one being the impact on GP practices and principals. Practices will have made financial decisions on sums previously earmarked for employer contributions during the remedy period, where members chose to opt out after making a consequent decision as a consequence of the discriminatory provisions of the reformed scheme. As such it would be unreasonable to suggest that practice or principal should meet the cost of retrospective contributions should a member wish to buy back service following a "contingent decision". As such, there should be no recoupment from practice monies, and nor should the additional cost of employer pension contributions be borne by the schemes as part of the department's steps to remedy the unlawful discrimination. Indeed, as GP principals are employers of a number of medical and non-medical staff, many of whom were affected by this unlawful discrimination, the requirement to retrospectively repay employer contributions for a large number of staff, possibly covering a period of several years could be extremely detrimental to the financial position of already stretched GP practices.

Similarly, members will have made financial decisions having opted out and received their personal pension contributions as pay. It would be unfair and unreasonable to expect them to pay for such lost service as a lump sum. We ask therefore that where members are given the choice to buy back service, without interest or penalty, at a rate no greater than they would have paid had they not opted out. For example, if a member was buying back 4 years of service, this should be bought back over no less than 4 years and receiving the same tax relief that the member would have received had they not opted out."

Question 17: If the DCU is taken forward, should the deferred choice be brought forward to the date of transfer for Club transfers?

We do not agree that such a decision should be taken at the date of transfer in these circumstances, as this would be contrary to and undermine the purposes of the DCU option. Any decision should be taken at the date of retirement (or when the pension benefit is taken, if earlier).

Whilst we acknowledge that the decision being taken at retirement will create a further administrative burden, this should not be a reason to deny a member the fundamental benefit of the DCU option.

Question 18: Where the receiving Club scheme is one of those schemes in scope, should members then receive a choice in each scheme or a single choice that covers both schemes?

On the basis of the difference between schemes, we consider it only fair and reasonable for members to be provided with a choice for each respective scheme. We do not consider that a single choice would be practicable in circumstances where schemes are not uniform.

Question 19: Please set out any comments on our proposed treatment of divorce cases.

The BMA is broadly happy with the proposals set out in the consultation document and therefore, do not have anything further to add on the proposals put forward, other than it should be recognised that divorces cases can be difficult and therefore, we would not support a wholesale review of divorce cases and as a point of principle, if a review was deemed necessary neither partner should be disadvantaged by the outcome.

Question 20: Should interest be charged on amounts owed to schemes (such as member contributions) by members? If so, what rate would be appropriate?

We do not agree that members should be charged any interest on amounts owed to schemes. This situation, and the potential for amounts to be owed to schemes, has arisen due to the department's unlawful discrimination. Members should not be penalised as a consequence of the department seeking to remedy that unlawful discrimination.

Furthermore, in such a situation the schemes will not have suffered any ongoing loss or denial of benefit to which one would expect interest to be charged. As such it would be disproportionate and unreasonable for the schemes to charge interest to their members. This is particularly the case that at the last scheme valuation, the HSC pension scheme was found to be in surplus and triggered the cost cap control mechanism in the reformed scheme. Despite recommendations to address this cost cap breach being put forward by the Scheme Advisory Boards, the department unilaterally paused the cost cap review process. This further serves to highlight that the schemes have not suffered financial loss as a result of any underpaid contributions and as such interest on this should not be payable.

In any event we feel that any interest to amounts owed to schemes by members would be immaterial and perhaps cost more to administer than the actual value of any interest due.

There is a further consideration on the issue of the department's cost cap mechanism and the scheme's current surplus. For the avoidance of doubt the choice to be made by members (whether immediate or DCU) is being introduced to remedy the department's unlawful discrimination. The costs of remedying its discrimination should not be borne by members, through reduced accrual or increased contributions, and nor would the scheme surplus be used to pay for these remedies. Those costs must be borne by the department.

Question 21: Should interest be paid on amounts owed to members by schemes? If so, what rate would be appropriate?

As with our response to Question 20, we submit that members should not be penalised and/or unnecessarily disadvantaged as a consequence of the department seeking to remedy its unlawful discrimination. A significant number of doctors will have taken out loans and/or re-mortgaged their properties to pay for any unexpected annual allowance tax bills. As above, the differential tax treatment of those younger members subject to the discrimination who were forced to be members of both the reformed and legacy scheme was significant leading them to pay significant

more in annual allowance taxation. This must be accounted for when monies are refunded back to members.

Should any monies be owed by the scheme to members, they should not be disadvantaged by their money having been paid incorrectly into said scheme and in so doing losing the benefit of that amount. As such, we consider that the schemes should pay interest to members on any monies owed to them, with an applicable and reasonable interest rate of 2% above the base rate of the Bank of England at the time of the decision/repayment or 2% above the average base rate throughout the remedy period, whichever is greater.

Question 22: If interest is applied, should existing scheme interest rates be used (where they exist), or would a single, consistent rate across schemes be more appropriate?

See response to questions 20 and 21 above.

Question 23: Please set out any comments on our proposed treatment of abatement.

The system of abatement in the HSC pension scheme is unfair and unnecessarily limits the amount of work that members who have drawn their pension can do for the HSC NI and its patients. Whilst the proposal as outlined ensures that a member would not be disadvantaged by the abatement rules if moving to an alternative scheme, the BMA do not believe that the proposal goes far enough and feel that the abatement rules should be scrapped completely. Indeed, we note that the UK department's coronavirus action plan, published on the 3 March 2020, recognised the detrimental impact of the abatement rules on the workforce and these rules were temporarily suspended. The BMA believe that this suspension should be made permanent which will avoid any issue resulting from choice.

Question 24: Please set out any comments on the interaction of the proposals in this consultation with the tax system

Firstly, it is important to note that although the consultation document states that a *small minority of individuals may be liable for AA tax charges*, our submission is made on behalf of all doctors working in the NHS. The majority of senior doctors will have been affected in some way by pension taxation during the remedy period.

As we have argued previously, the annual allowance (AA) and lifetime allowance provisions in both the legacy and reformed schemes are inherently unfair to our members and the nation's doctors. This is because the HSC Pension scheme is a defined benefit scheme which means doctors have no control over their pension growth. What is more, for consultants there are nationally determined pay increments with pensionable pay rises and there is a multiplication factor applied to any in year pension growth which means that even a small rise in pensionable pay can trigger large pension growth.

With regard to immediate choice, detailed modelling by the BMA has demonstrated that those doctors who are members of both the legacy and reformed schemes are treated unfavourably in terms of AA taxation compared to those who are members of a single HSC pension scheme. This will be a major consideration for doctors when choosing which scheme is more favourable for them. We agree that any overpaid tax that has been incurred during any part of the remedy period should be repaid.

If, however as a result of choice, additional AA taxation is payable then the proposal is that any underpaid tax will apply for the 4-years prior to the point at which the choice is made in line with

HMRC guidance. Whilst we understand the rationale for this, in practice, the BMA believe that very few members will be in a situation where they have underpaid annual allowance tax. In addition, we note that there are 4 separate tax regimes that will apply during the remedy period (a standard £40,000 AA, a tapered AA with threshold income of £110,000, and minimum £10,000 AA, the NHS England & Wales AA repayment scheme and a standard AA of £40,000 with threshold income of £200,000 and minimum of £4,000). Consequently, the BMA believes that the additional time spent in trying to address and collect underpaid tax is not cost effective.

Whereas with DCU, we take comfort from the proposals set out in the consultation document, in that the department will compensate individuals for the difference in their annual allowance charge liability arising from their decisions to take reformed rather than legacy scheme benefits for the remedy period. As such, there will be no additional tax charge payable by members and therefore, their pension will not be reduced as a result of any additional tax charge arising from choice. Furthermore, we note that:

- the 4-year statutory tax period for the purposes of any tax that may be due from the scheme member will count from the point at which the choice between schemes is made, and

- the department will refund any overpaid tax in respect of the entire remedy period, regardless of when the choice is exercised by the scheme member.

For the reasons outlined above, we would again reiterate our position and belief that DCU would be the preferred option for our members and the wider medical profession, being more reasonable than immediate Choice.

ENDS