

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**BLUE CROSS BLUE SHIELD OF
SOUTH CAROLINA OVERSTATED
ITS ALLOCABLE MEDICARE
EXCESS PLAN COSTS FOR
CALENDAR YEARS
2006 THROUGH 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**December 2014
A-07-14-00445**

Office of Inspector General

<http://oig.hhs.gov/>

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The designation of financial or management practices as questionable,
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operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Blue Cross Blue Shield of South Carolina overstated its allocable Medicare Excess Plan costs by approximately \$17.6 million for calendar years 2006 through 2011.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) reimburses a portion of its contractors' nonqualified defined-benefit plan (NQDBP) costs. In claiming NQDBP costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation (FAR), Cost Accounting Standards (CAS), and the Medicare contracts. Previous Office of Inspector General reviews found that Medicare contractors did not always correctly identify NQDBP costs (referred to in this report as "Excess Plan costs").

For this review, we focused on one entity, Blue Cross Blue Shield of South Carolina (BCBS South Carolina). In particular, we examined the costs that BCBS South Carolina calculated for its Excess Plan. BCBS South Carolina calculated Total Company Excess Plan costs (which for this report we will refer to as "allocable costs") and allocated these costs to its subsidiaries (including its Medicare segments of: Palmetto Government Benefits Administrator, LLC (Palmetto), TrailBlazer Health Enterprises, LLC (TrailBlazer), CGS Administrators, LLC (CGS), and Companion Data Services, LLC (CDS)). In turn, Palmetto, TrailBlazer, CGS, and CDS used their allocated Excess Plan costs to calculate the indirect cost rates on each Medicare segment's incurred cost proposals (ICPs).

The objective of this review was to determine whether the allocable Excess Plan costs that BCBS South Carolina calculated, under the provisions of Palmetto's, TrailBlazer's, CGS's, and CDS's Medicare administrative contractor (MAC) contracts, for calendar years (CYs) 2006 through 2011 complied with Federal requirements.

BACKGROUND

During our audit period, Palmetto, TrailBlazer, CGS, and CDS were subsidiaries of BCBS South Carolina and administered Medicare functions for CMS. Specifically, Palmetto and TrailBlazer administered Medicare Part A fiscal intermediary and Medicare Part B carrier contract operations under cost reimbursement contracts with CMS. CGS administered Medicare Part B carrier contract operations under cost reimbursement contracts with CMS and continued to do so after its acquisition by BCBS South Carolina in June 2011.

With the implementation of Medicare contracting reform, Palmetto continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 1 and Jurisdiction 11 effective October 25, 2007, and May 21, 2010, respectively. TrailBlazer continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 4 effective August 2, 2007, until the segment closed effective April 30, 2013. CGS continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 15 effective July 8, 2010. CDS began performing Medicare

functions after being awarded the enterprise data centers contract with CMS effective March 10, 2006.

With the implementation of Medicare contracting reform, Palmetto, TrailBlazer, CGS, and CDS amended their disclosure statements to implement pooled costing. Under the provisions of their MAC-related contracts, Medicare contractors use pooled costing to calculate the indirect cost rates that they report on their ICPs. The FAR requires Medicare contractors to file final indirect cost rates on their ICPs 6 months after the year end. In turn, CMS uses the indirect cost rates in reimbursing costs under cost-reimbursement contracts.

Under the provisions of Medicare contracting reform, CMS transitioned the functions of the fiscal intermediaries and carriers, which had executed the Medicare fiscal intermediary and carrier contracts, to MACs. As part of this transition, the method by which Medicare reimbursed pension costs to the contractor changed from a cost reimbursement basis to an indirect cost basis. In accordance with the FAR and the MAC contract, reimbursement of indirect costs was now based on indirect cost rates that met the negotiated indirect cost rates determined by the contract.

This report addresses the Total Company allocable Excess Plan costs calculated by BCBS South Carolina under the provisions of Palmetto's, TrailBlazer's, CGS's, and CDS's MAC-related contracts. We are addressing the Excess Plan costs claimed by Palmetto, TrailBlazer, and CGS under the provisions of their fiscal intermediary and carrier contracts in separate reviews.

We reviewed \$31,958,072 of Total Company Excess Plan costs used by BCBS South Carolina in the calculation of its indirect cost rates for Palmetto, TrailBlazer, CGS, and CDS, under the provisions of their MAC-related contracts, for CYs 2006 through 2011.

WHAT WE FOUND

The Excess Plan costs that BCBS South Carolina calculated did not comply with Federal requirements. Specifically, for CYs 2006 through 2011, BCBS South Carolina identified allocable Excess Plan costs of \$31,958,072; however, we determined that the allocable Excess Plan costs during this period were \$14,320,197. Thus, BCBS South Carolina overstated its allocable Excess Plan costs by \$17,637,875. This overstatement occurred because BCBS South Carolina did not calculate costs in accordance with Federal regulations.

WHAT WE RECOMMEND

We recommend that BCBS South Carolina decrease the allocable Excess Plan costs by \$17,637,875 for CYs 2006 through 2011.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, BCBS South Carolina did not concur with our recommendation, for two reasons. BCBS South Carolina said that the change it made in its Excess Plan (which formed the basis of our finding) was unintentional. BCBS South Carolina also said that because it was amending the Excess Plan document to make the plan compliant

with the FAR as a pension plan, it would be burdensome for BCBS South Carolina to have to account for the Excess Plan as initially compliant with the FAR, and then as noncompliant for a time period, and then as compliant once again.

BCBS South Carolina suggested, as an alternative to our recommendation, a course of action in which BCBS South Carolina would correct its “inadvertent change” to the Excess Plan by amending it retroactively and restoring the offer of a benefit that is payable for life at the option of the employee. BCBS South Carolina also stated that it had established a policy that its defined-benefit plans may not be amended without considering the CAS effects, so as to avoid any future unintended changes to its plans.

Nothing in South Carolina’s comments caused us to change our finding or recommendation. We based our audit on the plan document in effect at the time of our review. Moreover, BCBS South Carolina’s statement that it would be burdensome to account for the plan using different methodologies has no bearing on our finding or recommendation. Our prior audit of the Excess Plan (A-07-07-00235, issued October 18, 2007) accounted for costs using the pay-as-you-go methodology because the plan did not satisfy the requirements of CAS 412.50(c)(3).

We suggest that BCBS South Carolina consult with CMS (the cognizant Federal agency) to explore whether a retroactive plan amendment is permissible and what effects such an amendment would have on future cost accounting periods. We maintain that our finding and recommendation, as stated, remain valid and solidly supported by Federal regulations.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) reimburses a portion of its contractors' nonqualified defined-benefit plan (NQDBP) costs. In claiming NQDBP costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation (FAR), Cost Accounting Standards (CAS), and the Medicare contracts. Previous Office of Inspector General reviews found that Medicare contractors did not always correctly identify NQDBP costs (referred to in this report as "Excess Plan costs").

For this review, we focused on one entity, Blue Cross Blue Shield of South Carolina (BCBS South Carolina). In particular, we examined the costs that BCBS South Carolina calculated for its Excess Plan. BCBS South Carolina calculated Total Company Excess Plan costs (which for this report we will refer to as "allocable costs") and allocated these costs to its subsidiaries (including its Medicare segments of: Palmetto Government Benefits Administrator (Palmetto), TrailBlazer Health Enterprises, LLC (TrailBlazer), CGS Administrators, LLC (CGS), and Companion Data Services, LLC (CDS)). In turn, Palmetto, TrailBlazer, CGS, and CDS used their allocated Excess Plan costs to calculate the indirect cost rates on each Medicare segment's incurred cost proposals (ICPs).

OBJECTIVE

Our objective was to determine whether the allocable Excess Plan costs that BCBS South Carolina calculated, under the provisions of Palmetto's, TrailBlazer's, CGS's, and CDS's Medicare administrative contractor (MAC) contracts, for calendar years (CYs) 2006 through 2011 complied with Federal requirements.

BACKGROUND

Blue Cross Blue Shield of South Carolina and Medicare

During our audit period, Palmetto, TrailBlazer, CGS, and CDS were subsidiaries of BCBS South Carolina and administered Medicare functions for CMS. Specifically, Palmetto and TrailBlazer administered Medicare Part A fiscal intermediary and Medicare Part B carrier contract operations under cost reimbursement contracts with CMS. CGS administered Medicare Part B carrier contract operations under cost reimbursement contracts with CMS and continued to do so after its acquisition by BCBS South Carolina in June 2011.

With the implementation of Medicare contracting reform,¹ Palmetto continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 1² and Jurisdiction 11³ effective October 25, 2007, and May 21, 2010, respectively. TrailBlazer continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 4⁴ effective August 2, 2007, until the segment closed effective April 30, 2013. CGS continued to perform Medicare work after being awarded the MAC contracts for Medicare Parts A and B Jurisdiction 15⁵ effective July 8, 2010. CDS began performing Medicare functions after being awarded the enterprise data centers contract with CMS effective March 10, 2006.

With the implementation of Medicare contracting reform, Palmetto, TrailBlazer, CGS, and CDS amended their disclosure statements to implement pooled costing. Under the provisions of their MAC-related contracts, Medicare contractors use pooled costing to calculate the indirect cost rates that they report on their ICPs. The FAR requires Medicare contractors to file final indirect cost rates on their ICPs 6 months after the year end. In turn, CMS uses the indirect cost rates in reimbursing costs under cost-reimbursement contracts.

Blue Cross Blue Shield of South Carolina Excess Plan

BCBS South Carolina sponsors an Excess Plan whose primary purpose is to provide a benefit to a select group of management or highly compensated employees. The Excess Plan is designed to restore benefits to participants who lost benefits under the BCBS South Carolina qualified defined-benefit plan because of the Internal Revenue Code, section 401(a)(17), limit.

BCBS South Carolina defined its Excess Plan as an NQDBP and calculated its costs pursuant to CAS 412.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to MACs between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term “Medicare contractor” means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² Medicare Parts A and B Jurisdiction 1 consists of the States of California, Hawaii, and Nevada, and the territories of American Samoa, Guam, and the Northern Mariana Islands.

³ Medicare Parts A and B Jurisdiction 11 consists of the States of North Carolina, South Carolina, Virginia, and West Virginia (but excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia). Jurisdiction 11 also includes home health and hospice services provided in the States of Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas.

⁴ Medicare Parts A and B Jurisdiction 4 consists of the States of Colorado, New Mexico, Oklahoma, and Texas.

⁵ Medicare Parts A and B Jurisdiction 15 consists of the States of Kentucky and Ohio. Jurisdiction 15 also includes home health and hospice services provided in the States of Colorado, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia and Wyoming, and in the District of Columbia.

Medicare Reimbursement of Excess Plan Costs

Under the provisions of the contracts that CMS developed with the Medicare contractors as part of the implementation of the MMA, the method by which Medicare reimbursed pension costs to the contractor changed from a cost reimbursement basis to an indirect cost basis. In accordance with the FAR and the MAC contract, reimbursement of indirect costs was now based on indirect cost rates that met the negotiated indirect cost rates determined by the contract.

This report addresses the Total Company allocable Excess Plan costs calculated by BCBS South Carolina under the provisions of Palmetto's, TrailBlazer's, CGS's, and CDS's MAC-related contracts. We are addressing the Excess Plan costs claimed by Palmetto, TrailBlazer, and CGS under the provisions of their fiscal intermediary and carrier contracts in separate reviews.

HOW WE CONDUCTED THIS REVIEW

We reviewed \$31,958,072 of Total Company Excess Plan costs used by BCBS South Carolina in the calculation of its indirect cost rates for Palmetto, TrailBlazer, CGS, and CDS, under the provisions of their MAC-related contracts, for CYs 2006 through 2011.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDING

The Excess Plan costs that BCBS South Carolina calculated did not comply with Federal requirements. Specifically, for CYs 2006 through 2011, BCBS South Carolina identified allocable Excess Plan costs of \$31,958,072; however, we determined that the allocable Excess Plan costs during this period were \$14,320,197. Thus, BCBS South Carolina overstated its allocable Excess Plan costs by \$17,637,875. This overstatement occurred because BCBS South Carolina did not calculate costs in accordance with Federal regulations.

TOTAL COMPANY EXCESS PLAN COSTS

BCBS South Carolina calculated allocable Excess Plan costs of \$31,958,072 for CYs 2006 through 2011. BCBS South Carolina calculated its Excess Plan costs under the premise that the Excess Plan was an NQDBP.

OVERSTATED ALLOCABLE EXCESS PLAN COSTS

Costs Based on Nonqualified Defined-Benefit Pension Plan

The Medicare contracts require that Excess Plan costs be calculated in accordance with the FAR and the CAS. BCBS South Carolina defined its Excess Plan as an NQDBP and, accordingly, calculated the plan's costs as specified in CAS 412. However, BCBS South Carolina's Excess Plan did not offer a benefit that is payable for life; therefore, it did not qualify as a "pension plan" as defined in FAR 31.001. Thus, BCBS South Carolina did not calculate costs in accordance with Federal regulations.

BCBS South Carolina should have calculated its Excess Plan costs in accordance with FAR 31.205-6(k) and CAS 415. Specifically, BCBS South Carolina should have identified its Excess Plan costs in accordance with the regulations for a deferred compensation plan and should then have calculated those costs in accordance with the FAR and CAS 415.

For details on the Federal requirements, see Appendix B.

Overstatement of Allocable Excess Plan Costs

In light of these considerations, we recalculated BCBS South Carolina's Excess Plan costs in accordance with CAS 415 and determined that the Total Company allocable Excess Plan costs for CYs 2006 through 2011 were \$14,320,197. In accordance with CAS 415, we based the allocable costs on actual payments to Excess Plan participants. Thus, BCBS South Carolina overstated the Total Company Excess Plan costs for this period by \$17,637,875. This overstatement occurred because BCBS South Carolina did not calculate costs in accordance with Federal regulations.

The table below shows the difference between the Total Company allocable Excess Plan costs that we calculated and the Total Company Excess Plan costs that BCBS South Carolina used to calculate Palmetto's, TrailBlazer's, CGS's, and CDS's indirect cost rates for CYs 2006 through 2011.

Calendar Year	Per Audit	Per BCBS South Carolina	Difference
2006	\$2,910,454	\$4,962,661	(\$2,052,207)
2007	620,091	4,022,432	(3,402,341)
2008	4,229,362	4,150,603	78,759
2009	441,849	6,267,962	(5,826,113)
2010	5,479,198	5,952,095	(472,897)
2011	639,243	6,602,319	(5,963,076)
Total	\$14,320,197	\$31,958,072	(\$17,637,875)

CMS should use the information contained in this report and the related fiscal intermediary and carrier contract reports when determining the allowable Medicare segment Excess Plan costs for Palmetto, TrailBlazer, CGS, and CDS.⁶

RECOMMENDATION

We recommend that BCBS South Carolina decrease the allocable Excess Plan costs by \$17,637,875 for CYs 2006 through 2011.

AUDITEE COMMENTS

In written comments on our draft report, BCBS South Carolina did not concur with our recommendation, for two reasons. BCBS South Carolina said that the change it made in its Excess Plan (to remove the benefit that is payable for life at the option of the employee) was unintentional, in the sense that BCBS South Carolina sought to simplify elections for its retirees. BCBS South Carolina stated that its intent was that the Excess Plan would continue to be recognized as a pension plan, but added that it "... did not consider that removing the life time payout option would change this status."

BCBS South Carolina also said that because it was amending the Excess Plan document to reinstate the lifetime payout option and make the plan compliant with the FAR as a pension plan, it would be burdensome for BCBS South Carolina to have to account for the Excess Plan as initially compliant with the FAR, and then as noncompliant for a time period, and then as compliant once again.

BCBS South Carolina thus suggested, as an alternative to our recommendation, a course of action in which BCBS South Carolina would correct its "inadvertent change" to the Excess Plan by restoring the offer of a benefit that is payable for life at the option of the employee. BCBS South Carolina requested that this corrective action be considered effective retroactive to the effective date of the amendment removing the lifetime payout option. BCBS South Carolina also stated that it had established a policy that its defined-benefit plans may not be amended without considering the CAS effects, so as to avoid any future unintended changes to its plans.

BCBS South Carolina's comments are included in their entirety as Appendix C.

⁶ Our review of the allocable Excess Plan costs for BCBS South Carolina identified the amount of Excess Plan costs that should have been used to allocate Excess Plan costs to Palmetto, TrailBlazer, CGS, and CDS. CMS should use the information in this report, as well as the information from our review of the fiscal intermediary and carrier contract Excess Plan costs claimed by Palmetto (A-07-14-00443), TrailBlazer (A-07-14-00444), and CGS (A-07-14-00448), to determine the allowable Excess Plan costs for Palmetto, TrailBlazer, CGS, and CDS. In addition, CMS will use the information provided by the audit organization that reviews the ICPs (regarding their compliance with the CAS) to determine the final indirect cost rates for Palmetto, TrailBlazer, CGS, and CDS.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in BCBS South Carolina's comments caused us to change our finding or recommendation. We based our audit on the plan document in effect at the time of our review. This document did not offer a benefit that is payable for life, as required by FAR 31.001; therefore, the Excess Plan as constituted at the time of our review did not meet the definition of a pension plan as specified in the relevant criteria.

Moreover, BCBS South Carolina's statement that it would be burdensome to account for the plan using different methodologies has no bearing on our finding or recommendation. Since the inception of the Excess Plan, we have audited the plan using the pay-as-you-go accounting method. Our prior audit of the Excess Plan noted that the plan document contained language that would allow the benefits to be forfeitable, which did not satisfy with the requirements of CAS 412.50(c)(3).⁷ Therefore, our prior audit accounted for costs using the pay-as-you-go methodology. To claim that it would now be burdensome to account for the plan using different accounting methods is therefore inaccurate.

We suggest that BCBS South Carolina consult with CMS (the cognizant Federal agency) to explore whether a retroactive plan amendment is permissible and what effects such an amendment would have on future cost accounting periods. We maintain that our finding and recommendation, as stated, remain valid and solidly supported by Federal regulations.

⁷ *Review of Excess Plan Costs Claimed by Blue Cross Blue Shield of South Carolina for Medicare Reimbursement for Fiscal Years 1996 – 2004* (A-07-07-00235, issued October 18, 2007).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$31,958,072 of allocable Excess Plan costs calculated by BCBS South Carolina, under the provisions of Palmetto's, TrailBlazer's, CGS's, and CDS's MAC contracts, for CYs 2006 through 2011.

Achieving our objective did not require that we review BCBS South Carolina's overall internal control structure. We reviewed the internal controls related to the Excess Plan costs claimed for Medicare reimbursement to ensure that those costs were allocable in accordance with the CAS and allowable in accordance with the FAR.

We conducted our audit work in July 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed the portions of the FAR, CAS, and Medicare contracts applicable to this audit;
- reviewed BCBS South Carolina's Excess Plan document;
- reviewed accounting records and ICP information provided by BCBS South Carolina to identify the amount of Total Company Excess Plan costs used by BCBS South Carolina in the calculation of its indirect cost rates for Palmetto, TrailBlazer, CGS, and CDS; and
- provided the results of our review to BCBS South Carolina officials on June 9, 2014.

We performed this review in conjunction with the following audits and used the information obtained during this audit:

- *Palmetto Government Benefit Administrators, LLC, Claimed Unallowable Medicare Excess Plan Costs for Fiscal Years 2005 Through 2011 (A-07-14-00443);*
- *TrailBlazer Health Enterprises, LLC, Claimed Some Unallowable Medicare Excess Plan Costs for Fiscal Years 2005 Through 2011 (A-07-14-00444); and*
- *CGS Administrators, LLC, Claimed Some Unallowable Medicare Excess Plan Costs for Fiscal Years 2010 and 2011 (A-07-14-00448).*

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS RELATED TO REIMBURSEMENT OF EXCESS PLAN COSTS

FEDERAL REGULATIONS

FAR 31.001 defines a pension plan as follows:

“Pension plan” means a deferred compensation plan established and maintained by one or more employers to provide systematically for the payment of benefits to plan participants after their retirements, provided that the benefits are paid for life or are payable for life at the option of the employees. Additional benefits such as permanent and total disability and death payments, and survivorship payments to beneficiaries of deceased employees, may be an integral part of a pension plan.

Federal regulation (FAR 52.216-7(a)(1)) addresses the invoicing requirements and the allowability of payments as determined by the Contracting Officer in accordance with FAR subpart 31.2.

The allowability of costs for deferred compensation plans is governed by FAR 31.205-6. FAR 31.205-6(k) states that costs shall be measured, assigned, and allocated in accordance with CAS 415.

Federal regulation (CAS 415.40(a)) states that the cost of deferred compensation shall be assigned to the cost accounting period in which the contractor incurs an obligation to compensate the employee.

Federal regulation (CAS 415.50(a)) states:

The contractor shall be deemed to have incurred an obligation for the cost of deferred compensation when all of the following conditions have been met. However, for awards which require that the employee perform future service in order to receive the benefits, the obligation is deemed to have been incurred as the future service is performed for that part of the award attributable to such future service:

- (1) There is a requirement to make the future payment(s) which the contractor cannot unilaterally avoid.
- (2) The deferred compensation award is to be satisfied by a future payment of money, other assets, or shares of stock of the contractor.
- (3) The amount of the future payment can be measured with reasonable accuracy.
- (4) The recipient of the award is known.

- (5) If the terms of the award require that certain events must occur before an employee is entitled to receive the benefits, there is a reasonable probability that such events will occur.
- (6) For stock options, there must be a reasonable probability that the options ultimately will be exercised.

MEDICARE CONTRACTS

The contracts state: “Once each month following the effective date of this contract, the Contractor may submit to the Government an invoice for payment, in accordance with FAR clause 52.216-7, ‘Allowable Cost & Payment.’”

APPENDIX C: AUDITEE COMMENTS



South Carolina

BlueCross BlueShield of South Carolina
1-20 East at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

September 29, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-14-00445

Dear Mr. Cogley:

We are responding to the U.S. Department of Health and Human Services, Office of Inspector General, draft report dated August 29, 2014 and entitled *Blue Cross Blue Shield of South Carolina Overstated Its Allocable Medicare Excess Plan Costs for Calendar Years 2006 Through 2011*.

The report contains the following recommendation:

We recommend that BCBS South Carolina decrease the allocable Excess Plan costs by \$17,637,875 for CYs 2006 through 2011.

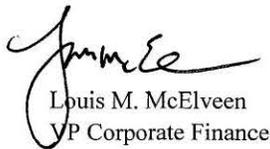
We do not concur with the recommendation and offer an alternative corrective action. Our reason for non-concurrence is two-fold. First, and most significantly, the change to the Excess Plan was unintentional. The amendment was made to conform the Excess Plan election options to those provided under the Preferred Savings Plan (our non-qualified defined contribution plan) and thereby simplify elections for our retirees. The amendment would enable them to manage both of their nonqualified plans with one election. Of course the intent was that the plan would continue to be recognized as a pension plan but, unfortunately, we did not consider that removing the life time payout option would change this status.

Second, since we are in the process of amending the plan to reinstate the lifetime payout which will make the plan FAR compliant as a pension plan it would be burdensome to account for the plan as being initially FAR compliant followed by a noncompliant period and then finally revert back to being FAR compliant again. This would create the need for future calculations to account for the plan as a deferred compensation plan as well as a pension plan.

Our alternative action is to correct our inadvertent change to the Excess Plan by restoring the offer of a benefit that is payable for life at the option of the employee. This amendment is not complicated and will be completed as soon as possible. We request that this corrective action be considered effective retroactively to the effective date of the amendment removing the lifetime payout option. Further, we have established a policy that our defined benefit plans may not be amended without considering the CAS effects to avoid any future unintended changes to our plans such as this.

We appreciate the opportunity to comment on the recommendation. Please let me know if you have questions or need additional information regarding our response. My contact information is 803-264-6443 or Louis.McElveen@bcbsc.com.

Sincerely,



Louis M. McElveen
VP Corporate Finance