MEDICARE INTERMEDIARIES AND CARRIERS SHOULD BE REQUIRED TO USE SEGMENT ACCOUNTING FOR CLAIMING PENSION COSTS

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Memorandum

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From Richard P. Kusserow /Bryan Mitchell
for Inspector General

Subject OIG Report - Medicare Intermediaries and Carriers Should be Required to Use Segment Accounting for Claiming Pension Costs - ACN: 07-62013

To C. McClain Haddow
Acting Administrator
Health Care Financing Administration

The attached report summarizes the results of our audits of the procedures used by four intermediaries and carriers to charge pension costs to the Medicare program. The audits were done at the request of a committee organized by HCFA and consisting of personnel from the Office of Inspector General (Office of Audit), HCFA's Bureau of Program Operations, HCFA's Office of the Actuary, and the Office of General Counsel. A HCFA actuary, Ronald Solomon, provided technical advice to us during these audits and we appreciated his valuable assistance.

These audits confirmed what was reported in other earlier audit reports: amounts contributed to the pension funds and charged to the Medicare program by the Medicare contractors substantially exceeded the pension liabilities for the Medicare workforces. We estimate that these four contractors overcharged Medicare about $21.9 million for pension costs since the inception of the program. Assuming these results are representative, we estimate that overcharges by all contractors may amount to $200 to $230 million.

Based upon the results of our current and prior audits of pension costs, we recommend that HCFA amend the Medicare contracts to require intermediaries and carriers to treat Medicare as a separate business segment in determining and charging pension costs to the Medicare program. This will eliminate the overcharges which are resulting from current procedures, and will enable HCFA to recover most of the prior overcharges. In addition, HCFA will be in a better position to evaluate future charges by Medicare contractors for pension costs.

Your staff agreed with our recommendation that Medicare contractors should be required to use segment accounting in claiming pension costs. HCFA plans to issue instructions to the Medicare contractors requiring use of segment accounting unless a contractor can prove that Medicare is not a separate recognizable segment of its operations.

Please advise us, within 60 days, of any further actions taken or planned on our recommendations. Copies of this report are being provided to other Departmental officials.

Attachment

TABLE OF CONTENTS

HIGHLIGHTS OF AUDIT RESULTS

Each year intermediaries and carriers are paid, as part of the overall cost of administering the Medicare program, about $25 million for pension costs. Since past audits pointed out that a substantial portion of these payments were inappropriate, the Health Care Financing Administration (HCFA) became concerned as to whether pension costs, as applicable to all Medicare contractors, 1/ were being properly charged to the Medicare program. HCFA, therefore, organized a committee comprised of personnel from the Office of Inspector General (Office of the Audit), HCFA's Bureau of Program Operations, HCFA's Office of the Actuary, and the Office of General Counsel to fully explore avenues for determining whether pension costs were properly charged to the Medicare program.

One avenue taken by the committee was to arrange for additional audits by the Office of Inspector General to determine if pension costs had been charged to the Medicare program in accordance with contract requirements. These requirements include certain provisions of the Federal Acquisition Regulations 2/ and the Cost Accounting Standards dealing with employee compensation. The audits of four such intermediaries and carriers, which are the subject of this report, confirmed what was reported in earlier audit reports on other contractors, that amounts contributed to the pension funds and charged to the Medicare program for reimbursement substantially exceeded the pension liabilities for the Medicare workforces.

At the four contractors audited, Medicare's combined pension liability was proportionately overfunded by about $21.9 million. Based on this, we estimate that Medicare may have overcontributed as much as $200 to $230 million to pension plans at all Medicare contractors since the inception of the program.

The overcontributions occurred because each contractor's Medicare workforce was not segmented for accounting purposes, but instead was treated as an indistinguishable part of its overall workforce. As a result, the annual pension cost was treated as an indirect cost and allocated to the Medicare program. When pension costs are charged indirectly to Medicare, we have found them to be higher than if they had been charged directly. Inequities result because certain conditions which make Medicare's cost proportionately lower than the overall company-wide cost are not considered in an indirect cost allocation process.

1/ The term "contractor" is used interchangeably throughout this report with the terms "intermediaries" and "carriers."

2/ The Federal Procurement Regulations, which were applicable to Government contracts since inception of the Medicare program, were consolidated and redesignated as the Federal Acquisiton Regulations as of April 1, 1984. The term "Federal Acquisition Regulations" is used interchangeably with the term "Federal Procurement Regulations" throughout this report.

At each of the four contractors, we carefully examined a wide variety of historical data pertaining to cost accounting and allocation, pension cost computations, personnel, pension plan provisions and benefits paid, and organizational structure in order to identify probable reasons for the overfunding. At one of the four, we could not determine specific reasons; however, that contractor had the least data available for our analysis, covering only a 5-year period. At the other three contractors, we identified a number of specific conditions which materially and inequitably increased Medicare's pension costs. Variations of these conditions are likely to exist at the other Medicare contractors. These conditions were:

-- The rate of non-vested terminations for Medicare participants exceeded the rate for non-Medicare participants at the three contractors. Additionally, Medicare's average actual non-vested terminations exceeded the average expected non-vested terminations by a greater margin than was experienced by the non-Medicare workforce. These terminations produced gains which were spread over the entire workforce, instead of having been applied to the segment which produced the gain.

-- Enhancements were made to pension plans by the three contractors that did not apply evenly to all employees. When pension plans are enhanced, benefits are often increased for individuals already retired. Costs associated with enhancements, referred to as unfunded actuarial liabilities, are amortized over future funding periods. The unfunded actuarial liabilities applicable to both active and retired participants were allocated based upon the salaries of and/or the actuarial liabilities associated with active participants. This resulted in inequitable charges to the Medicare program since proportionately fewer Medicare employees had retired.

-- Pension plans include provisions for paying annuities to surviving spouses of certain participants. At one of the contractors the cost of this benefit was calculated on the basis of the participants currently eligible for the benefit. Since a disproportionately greater percentage of non-Medicare employees qualified for the benefit, allocating the costs to Medicare on a salary basis produced an inequitable charge to Medicare.

-- An uneven age distribution between non-Medicare and Medicare workforces existed at one of the contractors. Pension costs for younger plan participants are less than for older participants. However, when pension costs are allocated on salary dollars, this difference is ignored.

-- Certain factors unique to the Medicare workforce were not recognized or considered in the actuarial valuation by two contractors. Had these factors been recognized by using separate actuarial assumptions appropriate to the Medicare workforce, pension costs for Medicare would have been materially lower.

-- One contractor paid lump sum rather than monthly benefits to all retirees. Lump sum settlements were computed using assumed rather than actual rates of earnings. Settlement amounts, therefore, were greater than necessary to provide monthly benefits at the level specified by the plan. By removing assets from the fund equal to the entire actuarial liability associated with retirees, actuarial gains to the extent formerly experienced were no longer possible. Since Medicare had fewer retirees and costs were not computed separately for the Medicare segment, a disproportionate share of the resultant losses were allocated to Medicare.

In addition to the above conditions, we found that abnormal forfeitures by Medicare participants were experienced at three contractors. Abnormal forfeitures occur when terminations significantly exceed the actuarially assumed turnover rate. Since 1964, prior to the inception of the Medicare program, the Federal Acquisition Regulations have provided that abnormal forfeitures should be reflected by an adjustment to allowable pension costs or by a credit to the Government. None of the three contractors made the required adjustments or credits.

The Federal Acquisition Regulations provide that any costs which can be identified with a specific cost objective -- Medicare, for example -- should be charged directly to that objective, not indirectly as was done. Cost Accounting Standard 413, which is applicable to Medicare contracts, provides that when pension costs are materially different for any segment of a contractor's operation, pension costs for that segment shall be calculated separately. Finally, the Medicare contracts themselves state that there shall be no profit or loss to the contractor. But, by treating the cost of a pension plan as an indirect cost, a profit inures to the contractor to the extent that Medicare pays more than it should.

To eliminate the above problems and, at the same time, make it easier for the Health Care Financing Administration to exercise oversight of contractor-operated pension programs, we are recommending that segment accounting for pension costs be made a requirement in future contracts with intermediaries and carriers. Under segment accounting, the Medicare workforce is treated as a separate pension plan. This allows equitable and appropriate pension costs to be identified directly to the Medicare program. We are also recommending that HCFA identify and recover past overcontributions.

In addition to on-going contracts, there are about 25 terminated contracts with intermediaries and carriers awaiting final settlement of pension assets. To determine the status of Medicare's interest in these assets will require long, complex audits. Had these contractors been required to segment the Medicare workforce, Medicare's claim to pension assets would have been readily determinable.

HCFA agreed with our recommendation that Medicare contractors should be required to use segment accounting in claiming pension costs (see Appendix D). HCFA plans to issue instructions to its contractors requiring use of segment accounting unless a contractor can prove that Medicare is not a separate recognizable segment of its operations.

INTRODUCTION

BACKGROUND

Health Insurance for the Aged and Disabled (Medicare), Title XVIII of the Social Security Act, provides for a hospital insurance program and a related medical insurance program for (a) eligible persons age 65 and over; (b) disabled persons under 65 who have been entitled to Social Security or railroad retirement disability benefits for at least 24 consecutive months; and (c) individuals under age 65 with chronic kidney disease insured by or entitled to Social Security benefits.

The hospital insurance program, Part A - Hospital Insurance Benefits for the Aged and Disabled, provides protection against the costs of hospital inpatient care, post-hospital extended care, and post-hospital home health care. The medical insurance program, Part B - Supplementary Medical Insurance Benefits for the Aged and Disabled, is a voluntary program providing protection against the cost of physician services, hospital outpatient services, home health care services, and other health services.

Title XVIII provides that public or private organizations, known as intermediaries (Part A) and carriers (Part B), may assist in administering the Medicare programs. Intermediaries and carriers are reimbursed for the reasonable and allowable costs they incur in administering the program, determined in accordance with their contracts, the Federal Acquisition Regulations, and the Cost Accounting Standards.

This report discusses only one item of cost claimed by contractors in connection with administering the Medicare programs. That item is pension costs. Pension costs are among the major items of administrative costs claimed. We estimate that charges to the Medicare program for pension costs by the 93 intermediaries and carriers currently amount to about $25 million per year.

Problems associated with the calculation and allocation of pension costs were first noted in the middle 1970's during audits of two Medicare contractors. The main finding of these audits was that the actuarial cost methods employed did not recognize differences in actuarial characteristics and participation rates between Medicare and non-Medicare employees. As a result, each audit concluded that pension costs were overcharged to the Medicare program.

The Health Care Financing Administration (HCFA) attempted to negotiate settlement of pension issues with the two contractors but concluded that an impasse existed. Therefore, in about 1980, HCFA requested that the Office of General Counsel make a review and advise HCFA of the legal considerations involved with disallowing pension overcharges recommended by the audit reports.

In their response, the Office of General Counsel recommended that, since Cost Accounting Standards (CAS) 412 and 413 (described below) had become effective in Medicare contracts, a determination letter of noncompliance with CAS 413 be issued to the contractors. This letter would require that prospective changes be made to comply with the Standard. Both contractors declined to comply with the determination letters and subsequently appealed the decision to the U.S. Claims Court where the cases are still pending.

The two pension cost audits raised concern that other contractors were also overclaiming pension costs. However, HCFA was unaware of the extent by which pension costs were being overclaimed and the intricacies of the various actuarial cost and accounting methods used by contractors to calculate and allocate pension cost. Therefore, in 1982, HCFA employed an enrolled pension actuary within the Office of the Actuary to assist in reviewing pension costs claimed by Medicare contractors. In addition, HCFA organized a committee to determine the magnitude of pension costs overcharged by Medicare contractors. The committee includes representatives from HCFA's Bureau of Program Operations, HCFA's Office of the Actuary, the Office of Inspector General (Office of Audit) and the Office of General Counsel.

The committee's first action was to develop a questionnaire which was submitted during 1983 to seven selected Medicare contractors. An indepth audit of pension costs was subsequently made at four of these contractors. The selection of contractors was based on the following criteria: size, geographical considerations, type of contractor (commercial or Blue Cross/ Blue Shield). This report represents conditions found during the four audits.

REQUIREMENTS FOR COMPUTING PENSION COSTS

All Medicare contracts provide that allowable and allocable administrative costs shall be determined in accordance with the Federal Acquisition Regulations, formerly the Federal Procurement Regulations, and the Cost Accounting Standards.

Contract Requirements

Medicare contracts provide for the reimbursement of administrative expenses incurred by contractors in fulfilling their obligations under the contract. The contractually stated fundamental principal for calculating these expenses is that there shall be no profit and no loss to the contractor, that the costs are to be equitable and reasonable.

Federal Acquisition Regulations

These regulations provide that the total cost of a contract is the sum of allowable direct and indirect costs allocable to the contract, less any applicable credits.

Direct and indirect costs are defined as follows:

-- Direct Costs - any cost which can be identified specifically with a particular final cost objective. Costs identified specifically with the contract are direct costs of the contract and are to be charged directly thereto. Costs identified specifically with other final cost objectives of the contractor are direct costs of those objectives and are not to be charged to the contract directly or indirectly.

-- Indirect Costs - any cost not directly identified with a single, final cost objective, but identified with two or more final cost objectives or an intermediate cost objective. It is not subject to treatment as a direct cost. After direct costs have been determined and charged directly to the contract or other work, indirect costs are those remaining to be allocated to the several cost objectives.

These regulations also provide guidelines for determining the allowability of pension costs. As early as 1964, they contained a specific provision requiring that abnormal forfeitures should be reflected by an adjustment to allowable pensions costs or as a credit to the Government.

Cost Accounting Standards

In 1980, Cost Accounting Standards 412 and 413 were incorporated into both the Federal Acquisition Regulations and the Medicare contracts between the Health Care Financing Administration and the intermediaries and carriers. CAS 412 provides guidance for determining and measuring the components of pension cost while CAS 413 provides guidance for adjusting pension cost by measuring actuarial gains and losses and assigning such gains and losses to cost accounting periods. One significant provision of these standards is 413.50(c)(2), which states that separate pension costs for a segment shall be calculated whenever certain conditions exist for that segment which materially affect the amount of pension costs allocated to the segment.

These conditions are:

1. There is a material gain or loss (abnormal forfeiture) attributable to the segment;

2. The level of benefits, eligibility for benefits, or age distribution is materially different for the segment than for the average of all segments; or

3. The appropriate assumptions relating to termination, retirement age, or salary scale are, in the aggregate, materially different for the segment than for the average of all segments.

Both the Federal Acquisition Regulations and Cost Accounting Standards provisions cited above are intended to insure that pension costs are equitably assigned to segments of businesses which have contracts with the Government.

SCOPE OF AUDIT

Our audits were directed at evaluating the procedures used by four Medicare contractors to compute annual pension costs and to charge these costs to the Medicare program. The primary purpose was to determine if the procedures resulted in correct and equitable pension charges to the Medicare program in accordance with applicable contract provisions. As previously mentioned, Federal Acquisition Regulations and Cost Accounting Standards requirements are part of the Medicare contracts.

In accomplishing our audits, we evaluated plan benefits for consistency and general applicability to all plan participants and the actuarial method for compliance with contract requirements. We also reviewed the assumptions utilized in the actuarial calculations and their relationship to the actuarial characteristics of both the total company workforce as well as the Medicare workforce. We also analyzed Medicare's operations and the placement of the Medicare unit within the organizational structure of each contractor. We did not verify past pension contributions for Medicare to the administrative cost proposals, nor did we review or analyze formulas or calculations actually used by each contractor's actuary in making actuarial projections. All matters in the report which deal with actuarial cost projections, assumptions, or demographic considerations were reviewed by HCFA's pension actuary.

Our audits included pension costs that were claimed by 4 of the 93 Medicare intermediaries and carriers. The review period covered 4 to 8 years depending on the availability of data.

In some cases, Medicare contributions had to be estimated due to lack of available data for the 1960's and early 1970's. Estimates were based on the percentage relationship of Medicare to total company pension costs for those years that cost records were available. This rate was then applied to annual company-wide pension costs for years during which records of Medicare contributions were not available in arriving at the estimated portion charged to Medicare. Since pension costs in these early years were generally much lower than they have been since about 1975, the impact of any errors in these estimates would be relatively insignificant.

Audit field work was performed during the period of July 1983 through September 1984 at each contractor's office.

FINDINGS AND RECOMMENDATIONS

REASONS FOR SEGMENTING PENSION COSTS

Our audits found extensive indications of noncompliance with specific provisions of the Federal Acquisition Regulations and the Cost Accounting Standards which resulted in inequitable pension charges to the Medicare program. Since the four Medicare contractors audited do not segregate and thereby identify the Medicare workforce when computing annual pension costs, the pension liability of the Medicare workforce cannot readily be determined. Furthermore, the annual pension contribution necessary to meet the Medicare liability cannot be identified. Compliance with the segmenting requirement of CAS 413 should correct this situation.

In past years, HCFA has reimbursed Medicare pension costs much the same way as other costs were -- based on representations by the intermediaries and carriers as to Medicare's share of the total cost. However, pension costs are not like most other costs. Most costs can be readily measured and related to specific fiscal periods since they represent payments for goods and services purchased or consumed during those periods, such as wages, rent, or supplies. Pension costs, on the other hand, are actually annual contributions 1/ made on an estimated basis to a trust fund. The assets of the trust fund, less expenses and payments, plus contributions and interest earnings, accumulate until some future period when they are paid to employees after retirement as a pension.

In estimating the amount of the annual pension contributions, intermediaries and carriers can use any of several different actuarial cost methods. The annual contributions arrived at under each method can vary significantly even though the sum of all annual contributions plus investment earnings must ultimately be the same, since the benefits to be paid out are defined by the terms of the plan.

Actuarial cost methods develop costs on either an aggregate or individual participant basis. Under an indvidual participant actuarial cost method, Medicare's portion of pension costs could be determined on a direct basis simply by identifying those participants involved in Medicare work.

Aggregate cost methods utilize individual data for some steps in developing annual pension costs. However, at some point in the process, all the individual values are aggregated. While this

1/ In referring to annual payments to the pension fund, the terms "cost" and "contribution" are used interchangeably in this report.

aggregation is usually done for pension participants as a whole, it could be done separately for specific cost centers, divisions, subsidiaries, or segments. When done for the company as a whole, the costs must be reassigned or allocated on an indirect basis to company components or segments.

The four Medicare contractors audited used two different actuarial cost methods. Two contractors used the frozen entry age normal method while the other two used the entry age normal cost method.

The frozen entry age normal method is an aggregate actuarial cost method which develops pension cost on a company-wide basis. Under this method, pension cost by individual participant is lost since the aggregate represents all participants. To determine Medicare's share, the aggregate cost was allocated on an indirect basis to Medicare cost centers. The basis used was Medicare salaries to total company salaries. Although salaries can be an equitable cost allocation method, it results in an average or equal portion of total pension cost being assigned to each salary dollar and thus does not reflect the actual pension costs incurred by the Medicare workforce.

The entry age normal cost method is essentially an individual participant cost method. That is, pension costs are identified directly to individual employees and the cost centers to which the employees are assigned. This method for the most part treats pension cost as a direct cost. Exceptions are the annual amortized portion of the unfunded actuarial liability and any actuarial gains or losses. These indirect cost elements normally are allocated on the basis of each participant's actuarial liability. Assets under this method, however, are accumulated on an overall plan basis. As such, no recognition is given to gains or losses which apply more to one group of employees or company segment than to others.

Most intermediaries and carriers use actuarial cost methods similar to the methods described above. As is evident from the description, the actual pension liability of the Medicare workforce or any other population group never emerges. Instead, the status of the pension fund as it is affected by the Medicare workforce is only determined through indirect methods which are far less than precise.

In addition, actuarial cost methods rely heavily on a number of assumptions about future events. Actuarial assumptions estimate such things as salary increases, turnover, mortality, investment return, and retirement age. Consequently, the degree to which these assumptions vary from actual experience can have a significant effect on the estimates of both projected benefits and the amount of annual pension contributions.

Actuarial gains or losses result from variances between assumptions and actual experience. The gains or losses often relate more to one segment than to others; however, they are spread over the entire pension fund -- not only to that segment which was responsible for the gain or loss. If the gains or losses are substantial, the affected segment can significantly over or undercontribute to the pension fund.

Intermediaries and carriers can change from one type of pension plan to another -- from a defined benefit to a defined contribution plan for example -- or terminate a plan entirely. In these situations, intermediaries and carriers are only liable for accrued benefits which plan participants have a vested interest in and not for the entire actuarial liability associated with the participants. And, since annual contributions are made for the purpose of funding projected benefits, pension fund assets often exceed vested accrued benefits at the time of change or termination. In these situations, the excess assets, including that portion contributed by Medicare, would revert to the contractor. The Federal Acquisition Regulations require that Medicare receive an appropriate credit for these excess contributions. Had the Medicare workforce been segmented, Medicare's credit would be readily determinable.

Because pension costs are not incurred for common or joint objectives, they are not indirect costs within the meaning of the Federal Acquisition Regulations. Instead, pension costs are an element of compensation which can be identified specifically to Medicare cost centers just as salaries and wages and, therefore, meet the definition of a direct cost.

We recognize that some pension costs would still be allocated to Medicare even if most pension costs were directly charged to Medicare. As with most business operations, there are various indirect services provided to direct operations. The costs of these services which are allocated to direct operations include labor and other cost elements such as pension costs. To compensate for pension costs that must be allocated, we made appropriate adjustments in the calculations throughout the report.

The pension costs discussed in this report relate to those contractor cost centers which work primarily on Medicare functions. At the four contractors audited, the total administrative costs associated with these cost centers ranged from 78 to 85 percent of total costs charged to the Medicare program.

In the following paragraphs, a number of conditions are discussed which demonstrate the inequities that result from treating pension costs as an indirect cost. Accounting for these costs in the future on a segment basis in accordance with CAS 413 would eliminate these inequities.

Termination Gains

One of the assumptions made by actuaries in computing annual pension plan contributions deals with the numer of employees who will be terminated before earning a vested right to receive retirement benefits (non-vested terminations). If the actual terminations exceed those projected, pension costs will have been higher than necessary since the terminated employees will receive no benefits. These "excess" contributions are then available within the pension fund to offset future contributions. This is referred to as a termination gain. Inequities arise when the termination gains do not originate evenly throughout the entire workforce.

We reviewed non-vested terminations at each of the four intermediaries and carriers. The rate of Medicare non-vested terminations was consistently higher than the rate of non-vested terminations for non-Medicare employees at three of the four contractors.

The results follow:

COMPARISON OF NON-VESTED TERMINATIONS

	Contractors		
	A	B	C
Period of Audit	1978-82	1978-82	1979-82
Average Percentage of Non-Vested Terminations:			
Medicare	14.8%	26.5%	25.8%
Non-Medicare	9.6%	21.4%	17.4%
Percent that Medicare Non-Vested Terminations Exceeded Non-Medicare Non-Vested Terminations	54%	23.8%	48.3%

We also compared actual to expected (assumed) turnovers at all four contractors. Medicare's average actual non-vested terminations exceeded the average expected non-vested terminations by a greater margin than was experienced by the non-Medicare workforce at three of the four contractors.

The average percentages by which actual non-vested terminations exceeded expected non-vested terminations were as follows:

	Contractors		
	A	B	C
Period of Audit	1978-82	1978-82	1979-82
Medicare	119.9%	147.0%	117.6%
Non-Medicare	104.7%	135.8%	104.3%

Whenever the ratio exceeded 100 percent in a given year a termination gain was produced. When the ratio was very high in one of more years, an abnormal forfeiture was indicated.

Special conditions noted at each contractor follow:

Contractor A High Medicare termination gains (abnormal forfeitures) occurred in 2 of the 5 years reviewed. These gains resulted from changes in the operation of the Medicare program. As a result of phasing out several Part A offices and consolidating several Part B offices, the number of plan participants declined substantially from 913 to 728 or 20.3 percent. As a percent of total participants, Medicare employees decreased from 4.2 to 3.3 percent. While the Medicare workforce was declining, non-Medicare participants remained relatively constant.

The rate of Medicare terminations for 1978 was more than double the rate of non-Medicare terminations, 26.3 versus 11.0 percent, and over 50 percent more in 1979, 18.6 versus 11.7 percent. The ratio of actual to expected turnover for Medicare in 1978 was 185.7 percent while the non-Medicare ratio was 107.9 percent. If the fund were segmented, a larger termination gain would have accrued to the Medicare segment.

Contractor B High termination gains resulted from computer mechanization in the Medicare operation. The non-vested Medicare termination rate for 1982 was more than 60 percent greater than the non-Medicare rate, 23.7 versus 14.7 percent.

Employee count for the period 1978 through 1982 showed that non-Medicare employees increased from 29,918 to 35,323 or 18.1 percent. During the same period, Medicare employees decreased from 1,100 to 858, or 22 percent. As a percentage of total company employees, Medicare employees decreased from 3.5 to 2.4 percent during this period.

Contractor C Medicare had high terminations for 1980 and 1982. The non-vested Medicare termination rate for 1980 was more than 50 percent greater than the non-Medicare rate, 26.4 versus 17.0 percent. In 1982, the Medicare rate was one third more than the non-Medicare rate, 37.0 versus 27.7 percent.

During the 4-year period audited, Medicare participants decreased from 1,227 to 721, or 41.2 percent. During the same period, non-Medicare participants experienced only a 5.3 percent decrease, from 2,616 to 2,478.

In 1982, Medicare's ratio of actual to expected turnover was 277 percent, while the non-Medicare ratio was 172 percent. While both of these percentages indicate an abnormal forfeiture, the resultant gains would be applied equitably only on a segment basis. Medicare's non-vested terminations also had a longer employment period than other company non-vested terminations. This was parcticularly true for 1982, the year of the abnormal forfeiture. Contributions were made over a longer period on behalf of those employees thereby increasing the amount forfeited upon termination.

The Federal Acquisition Regulations address such inequities by requiring that abnormal forfeitures (material termination gains) be reflected by an adjustment to annual pension costs or by a credit to the Government. These three contractors did not make any such adjustments or credits.

CAS 413, which has been applicable to the Medicare contracts since 1980, requires pension costs to be computed separately when a material termination gain is associated with a Government segment. The three Medicare contractors had not complied with this provision even though non-vested terminations experienced for the Medicare workforce was considerably higher than for the non-Medicare workforce.

Had the pension fund been segmented, prior pension contributions for terminated Medicare employees, released as actuarial gains due to higher than expected turnover, would have accrued to the Medicare segment of the pension fund. However, since the fund is not segmented, gains from Medicare terminations were spread throughout the workforce and Medicare only shared in the gains along with all other pension plan participants, even though the Medicare workforce was the primary cause of the gain.

Levels of Benefits, Eligibility for Benefits, and Age Distribution

The level of benefits associated with a pension plan can be increased or decreased by the pension fund administrator after the plan is established. Since there have been no prior contributions for improvements at the time they are effective, they create additional unfunded actuarial liabilities. While some of these liabilities are associated with prior funding periods, they must be paid over future funding periods regardless of the cost method used.

Under Contractors A and B's actuarial cost method, a portion of these liabilities is allocated proportionately to all active employees on a salary basis as part of the annual pension contribution. The actuarial cost method used by Contractors C and D allocated these liabilities on the basis of each active participant's actuarial liability. These methods of allocating costs result in inappropriate charges to certain segments of the plan population unless all segments benefit from the particular enhancement to the same extent.

We found several instances where Medicare was inequitably charged due to this situation:

Contractor A The Medicare program did not start until 1966. And, available information indicated that through December 31, 1978, only a few Medicare employees had retired. Benefit payments made to retired Medicare employees ranged from .03 to .36 percent during the 4-year period reviewed. In contrast, pension costs charged to Medicare during the same period ranged from 3.47 to 4.12 percent.

On January 1, 1980, annuities were increased for pension plan participants who retired prior to January 1, 1979. This increased the unfunded actuarial liability by $23,659,673 which was being amortized with interest at $266,276 per month over a 10-year period. Because of the allocation method used, a $1 million share of the unfunded actuarial liability connected with the above enhancement was inequitably charged to the Medicare program.

Additionally, the remaining balance of the retired actuarial liability, about $225 million, was allocated to Medicare on the same basis as the actuarial liability associated with active participants. This also resulted in an inequity because the liability associated with retired Medicare employees is considerably lower than the liability associated with other retired employees.

Contractor B A similar situation was found at this contractor. Benefit payments to retired Medicare employees ranged from 0 to .532 percent during the 4-year reviewed. The percentage of pension costs charged to Medicare during the same period ranged from 2.90 to 3.28.

On January 1, 1971, annuities for pension plan participants who retired prior to January 1, 1968 were increased. This resulted in an increased actuarial liability of $5,576,000.

On April 1, 1974, pre-1968 retirees were awarded a one time cost-of-living increase. This increased the actuarial liability by $4,581,000. On November 1, 1979, the pension plan was again amended to increase the pensions of all retirees up to that time as well as those participants retiring through 1980. This enhancement added $19,974,405 to the actuarial liability.

Because of the allocation method used, an inequitable share of the unfunded actuarial liability connected with the above enhancements -- which, including interest, totaled $40.1 million -- was inequitably charged to the Medicare program. As of January 1, 1982, we calculated that $701,523 of these costs had been allocated to Medicare.

Additionally, the remaining portion of the retired actuarial liability -- about $196 million -- was allocated to Medicare on the same basis as the actuarial liability associated with active participants. This also resulted in an inequity to the Medicare program because the liability associated with retired Medicare employees is considerably lower than the liability associated with other retired employees.

Contractor C Payments to retired Medicare employees ranged from .17 to 5.11 percent during the 8-year period reviewed. In contrast, the percentage of pension costs charged to Medicare during the same period ranged from 26.51 to 36.98.

As of April 1, 1974, Contractor C changed the basis for computing benefit payments. The new basis considered not only basic compensation but also bonuses to the extent that bonuses did not exceed 26 percent of basic pay. This enhancement increased the unfunded actuarial liability by $354,096. Since Medicare employees are not paid bonuses, Medicare should not be allocated costs associated with this enhancement. However, due to the allocation method used by Contractor C, $144,562 of the unfunded actuarial liability connected with the above enhancement -- which with interest totals $492,048 -- was being charged to the Medicare program.

The remaining portion of the unfunded actuarial liability -- $9,694,751 plus interest -- was being charged to Medicare on the basis of the actuarial liability associated with active participants. Since the liability associated with retired Medicare employees is considerably lower than the liability associated with other retired employees, this results in an inequity to the Medicare program.

Eligibility for benefits and whether the benefits apply equally to the participating workforce also affects contributions. An inequitable distribution of benefits was noted at one of the four contractors.

Contractor A's pension plan provides that benefits be paid to the surviving spouse of certain participants who die prior to retirement or termination. An actuarial assumption applicable to this benefit is that 95 percent of the eligible male employees and 50 percent of the eligible female employees are married and therefore would benefit from this provision.

This benefit is funded on a 1 year term cost basis, that is, only those participants eligible for the benefit are considered in determining the annual cost. While the demographic data available did not precisely identify the participants eligible for this benefit, we were able to estimate that approximately 6 percent of the Medicare workforce was eligible versus 23 percent of the non-Medicare workforce. In addition, Medicare had fewer male employees eligible, 3 percent versus 10 percent. They were the employees assumed to be the most likely to benefit from this provision. Since the cost is allocated on the basis of payroll, Medicare is being charged a disproportionate amount for this benefit. Segmenting would correct this inequity.

Age distribution is another important characteristic of a plan population that has a significant effect on pension cost. The importance of age distribution on pension costs is reflected by the fact that CAS 413.50(c)(2) singles it out as the only demographic criterion which would, by itself, require segment accounting.

A materially different age distribution was noted at one of the contractors. Contractor A's plan population characteristics for the 5-year period 1978 through 1982 showed the following differences. The Medicare workforce had a higher percentage of employees in each of the age groups up to age 40, while over 40, the reverse was true. Participants under age 40 represented 69.8 percent of the Medicare population whereas only 56.1 percent of total company participants were under age 40.

Pension costs for younger plan participants are less than for older participants because their chances of surviving in service to retirement are significantly less. Also, the discount period is much greater. This is the period during which current contributions will earn interest until the retirement benefit is to be paid. Therefore, an inequity arises when the age distribution is not similar throughout the plan population and pension costs are allocated on some basis such as salary dollars. This inequity would be eliminated by calculating pension costs separately for segments with different age distributions.

Actuarial Assumptions

The first step in computing pension costs is to make an estimate of the present value of future benefits that will have to be paid to participants upon retirement. This estimate is made once each year in a process known as an actuarial valuation. In producing a valuation, an actuary must select assumptions believed to be appropriate.

Two of the more important actuarial assumptions involved in estimating future benefits are (1) determining the extent to which the salaries of the participants will increase up to the date of retirement and (2) predicting the rate of employee turnover (withdrawal). When salary projections are low and/or estimated employee turnover is high, the total present value of benefits, and thus the annual contribution, is lower than when the opposite is true.

CAS 413 recognized the possibility that the projections of future salaries, referred to as salary scale, and turnover could produce different results, due to differences in the characteristics of the workforce, when applied to different segments within the same company. As a result, the present value of future benefits and the corresponding annual cost would vary. And, if one or more of the segments had Government contracts, inequities would be created because the methods used to allocate pension costs would not recognize these differences.

Consequently, CAS 413 contains the requirement that when certain actuarial assumptions, including those relating to salary scale and turnover, are materially different for the Government segment, separate pension costs must be computed for that segment. This provision is intended to assure that the Government is not charged for pension costs which, because of actuarial differences in the workforce, properly or equitably relate only to non-Government segments.

Two of the contractors used an actuarial cost method of the type that would create inequities between plan segments if there were material differences in either salary increases or turnover between plan segments. These two contractors (A and B) used the frozen entry age normal (aggregate) actuarial cost method.

Both contractors have a salary based pension plan; that is, pension benefits are related to the salaries at or near the time of retirement. Therefore, estimating future salaries accurately in the actuarial valuation is important.

Contractor A The actuary assumed that the annual salaries of all participants would increase at an annual rate of 4.5 percent, without a distinction for age. Analysis of average annual salaries for both Medicare and the total company workforce during the 5-year period, 1978 through 1982, showed that the average rate of salary increase was 9.8 percent for both Medicare and the total company.

Although the rate of salary increase was identical, annual salaries were not. Medicare participants received significantly lower annual salaries than the total company. During the 5-year period, Medicare salaries average 21 percent less than company-wide salaries, $13,922 versus $17,708.

Contractor B The actuary assumed that the annual salary increases of employees would vary according to age. Assumed annual rates of increases were:

SALARY SCALE ACTUARIAL ASSUMPTION

Age at Nearest Birthday	Rate (Male and Female) (Through 12-31-81)	Rate (Male and Female) (Effective 1-01-82)
25	10.00%	11.50%
30	6.75%	10.50%
40	3.75%	7.50%
50	3.75%	5.50%
60	3.00%	4.00%

It was noted, however, that for each age group, Medicare employees had a significantly lower salary. For example, the average Medicare salary was $14,129 while the average company-wide salary was $16,454. Consequently, when the salaries were projected using Contractor B's estimated annual rates of increase, the present value of future benefits, as well as the annual pension cost, would be significantly lower for Medicare employees in each age group than for total company employees. By segmenting, the cost to Medicare would equitably reflect this situation.

Both Contractors A and B had higher turnover assumptions for females and proportionately more females in their Medicare workforce than in the total company workforce. Due to this fact, projected benefits for the Medicare workforce -- and the resulting annual pension cost -- would have been lower had Medicare been treated as a segment.

Contractor A The actuary, in computing the present value of future benefits, used the following assumptions to estimate employee turnover.

TURNOVER RATE ACTUARIAL ASSUMPTION

Age	Male	Female
20-24	20%	30%
25-29	13%	20%
30-34	9%	13%
35-39	6%	9%
40-44	4%	6%
45-49	3%	4%
50-54	2%	3%
55-59	1%	2%
60-64	0%	1%

As shown, Contractor A assumed that females would terminate their employment at a 50 percent greater rate than males and that the rates of termination for both sexes would decrease with age.

We analyzed the make-up of Contractor A's workforce for the 5-year period, 1978 through 1982, by age and sex, for all participants as well as for only those in the Medicare workforce. This analysis showed that females made up 81 percent of the Medicare workforce and only 60 percent of the total company workforce. Furthermore, the percent of females in the Medicare workforce was not only greater than the percent of females in the total company workforce but the percent was higher in each age bracket with the exception of the older age brackets, 50 and over.

Contractor B The actuary, in computing the present value of future benefits, used the following assumptions to estimate employee turnover.

TURNOVER RATE ACTUARIAL ASSUMPTION

Age	Male	Female
30	8.00%	22.80%
40	2.75%	8.30%
50	1.15%	4.30%

As shown, it was assumed that females would terminate their employment at a far greater rate than males and that the rates of termination for both sexes would decrease with age.

We analyzed the age and sex composition of the workforce, both the total company and Medicare, for the 6-year period, 1977 through 1982. This analysis showed that females made up 80.6 percent of the total Medicare workforce and only 67.2 percent of the total company workforce. The percent of females in the Medicare workforce was not only greater than the percent of females in the total company workforce, the percent was also higher in each age bracket.

Lump Sum Settlements

One contractor paid lump sum settlements to all plan participants at retirement. Lump sum settlements, given in lieu of paying monthly benefits, generated losses to the pension fund which were disproportionately allocated to the Medicare program.

Actuaries tend to be conservative in their estimate of investment yield due to the long term over which they are estimating future events. Therefore, assumed interest rates tend to be lower than actual yields. Settlement amounts based on the assumed earnings rate were, therefore, greater than necessary to provide monthly benefits at the level specified by the plan. A smaller lump sum settlement with the greater yield of actual earnings would have provided the required level of benefits.

By removing assets from the fund equal to the entire actuarial liability for each retiree, actuarial gains due to differences between earnings at the actual versus assumed rates were no longer realized. Had retirement benefits been paid in the form of a monthly annuity, the major share of assets associated with each retiree would have remained in the fund to earn a return at actual rates, thus generating further gains for the fund.

In order to determine the loss realized by the fund, we calculated what the assets of the pension fund would have been if monthly benefits had been paid instead of lump sum payments, using both the actual investment earnings of the fund and the assumed earnings. Investment yields and total lump sum payments were available back to the plan year ending March 31, 1972. Our calculations produced an estimated asset amount as of April 1, 1982, of $29,658,685 using actual investment yields. Using the assumed interest rates, which are used to convert each participant's monthly retirement benefit to a lump sum payment, produced an estimate of $27,453,906.

The $2,204,779 difference represents an actuarial loss to the pension plan which is being paid off, along with other components of the unfunded actuarial liability, as part of the annual contribution each year. We estimate that $733,710 of this amount has already been charged to the Medicare program.

Almost all of the loss due to lump sum settlements was attributable to non-Medicare participants, yet Medicare was charged at its average sharing rate. We analyzed retirements that occurred during the 8 years ending March 31, 1982. This comparison showed that for 8 years, Medicare retirees received only 2.63 percent of the total lump sum payments, whereas Medicare's average share of total pension costs was 32.15 percent. If the fund were segmented, these losses would be equitably applied to the proper segments.

EXTENT OF OVERCONTRIBUTION

As stated previously, Contractors A and B used the frozen entry age normal actuarial cost method in developing annual pension contributions. Under this method, the total actuarial liability is carried forward from its initial (frozen) amount year by year, recognizing both contributions (amortization payments) made against it, and any increases (enhancements) made thereto, rather than being computed on each valuation date. The true current actuarial liability therefore never emerges and, as a result, a determination cannot be made under this method as to whether the pension fund is overfunded.

Because of this, CAS 412 requires that an entry age normal (non-frozen) calculation also be performed at each actuarial valuation date to ensure that the plan is not overfunded. Both A and B's actuaries were asked to perform such a calculation as of January 1, 1982.

The results follow:

	ACTUARIAL VALUATION-JANUARY 1, 1982	
	A	B
Frozen Entry Age Normal Method:		
Actuarial Liability	$712,091,545	$699,354,208
Less: Assets (Plan Value)	527,242,862	692,869,478
Unfunded Actuarial Liability	$184,848,683	$ 6,484,730
Non-Frozen Entry Age Normal Method:		
Actuarial Liability	$869,403,018	$803,088,000
Less: Assets (Plan Value)	527,242,862	692,869,478
Unfunded Actuarial Liability	$342,160,156	$110,218,522

As shown, the pension plans of both contractors were not overfunded since the actuarial liability exceeded cumulative assets. If the overall plans had been overfunded, there would not have been an unfunded actuarial liability.

Contractor's C and D both used the entry age normal method for calculating pension costs. This method resulted in a true presentation of the actuarial liability including gains and losses as follows:

	Contractor C Valuation April 1, 1982	Contractor D Valuation January 1, 1983
Actuarial Liability	$30,870,913	$27,955,581
Less: Assets (Plan Value)	20,822,066	26,373,261
Unfunded Actuarial Liability	$10,048,847	$ 1,582,320

Again, neither of the two plans were overfunded since the actuarial liability in both instances exceeded cumulative assets. However, had Contractor D's assets been adjusted to market value ($29,303,623), the overall plan would have been overfunded by $1,348,042. Such an adjustment was not necessary per CAS 413.50(b)(2) since the actuarial value of assets-$26,373,261-was within the corridor of 80 to 120 percent of market value, $23,442,901 to $35,164,348.

Notwithstanding the above, the conditions previously discussed suggested the possibility that the Medicare segment at each contractor was overfunded. It was, therefore, requested that all four contractors prepare separate actuarial valuations for direct Medicare participants.

Contractors A and B would not prepare a separate actuarial valuation for the Medicare segment. Therefore, we prepared one with the help of the HCFA pension actuary. The methodology and calculations are shown on Appendix A (Contractor A) and Appendix B (Contractor B). Contractors C and D both complied with our request and furnished Medicare's actuarial liability.

Medicare's actuarial liability for direct participants at each of the four contractors was as follows:

Contractors			
A	B	C	D
1-1-82	1-1-82	4-1-82	1-1-83
$10,478,341	$11,075,627	$4,860,561	$6,564,287

To determine whether the actuarial liability attributable to Medicare was overfunded, Medicare's share of the pension fund assets was computed as of each valuation date shown above. This was done by identifying annual Medicare pension cost contributions, adding a proportinate share of the interest earned, and deducting the applicable administrative expenses and benefit payments.

Since gross Medicare contributions were used in the calculations, the total assets represented contributions made on behalf of all Medicare employees, not just direct Medicare employees. Therefore, assets associated with indirect employees had to be eliminated so that the actuarial liability could be compared with assets relating to only direct Medicare employees.

	Contractors			
	A	B	C	D
Medicare Assets	$16,680,336	$19,529,827	$10,306,464	$11,620,135
Less: Assets of Indirect Employees 1/	3,336,067	2,929,474	2,061,293	2,556,430
Assets of Direct Employees	$13,344,269	$16,600,353	$8,245,171	$9,063,705

1/ The amount of assets reduced for indirect employees was based on the percentage of total costs allocated to Medicare that originated from indirect cost centers. Percentages for each contractor were 20%, 15%, 20%, and 22%, respectively.

By comparing Medicare's share of pension fund assets with the actuarial liability attributable to Medicare employees, we concluded that Medicare's share of the four pension plans was overfunded by a total of $14.3 million.

The extent to which each individual contractor was overfunded follows:

	OVERFUNDING Contractors				
	A	B	C	D	Total
Assets	$13,344,269	$16,600,353	$8,245,171	$9,063,705	$47,253,498
Less: Actuarial Liability	10,478,341	11,075,627	4,860,561	6,564,287	32,978,816
Over-Funding	$2,865,928	$5,524,726	$3,384,610	$2,499,418	$14,274,682

Furthermore, past Medicare contributions had been disproportionate in relation to total company contributions because Medicare's actuarial liability is fully funded and the overall company's actuarial liability is not. Had Medicare contributed at the same rate as the total company rate, Medicare assets would be less than the actuarial liability. This represents additional overcontributions of $7.6 million.

Calculations by contractor follow:

	ADDITIONAL OVERCONTRIBUTIONS Contractors				
	A	B	C	D	Total
Medicare Actuarial Liability	$10,478,341	$11,075,627	$4,860,561	$6,564,287	$32,978,816
Less: Proportionate Assets 1/	6,391,788	9,525,039	3,256,576	6,170,430	25,343,833
Additional Over-Contribution	$4,086,553	$1,550,588	$1,603,985	$393,857	$7,634,983

1/ The percentage of total company assets to total company actuarial liability. Percentages for each contractor were 61%, 86%, 67% and 94%, respectively.

In summary, the total extent of overcontributions at the four contractors by Medicare was $21.9 million -- overfunding of $14.3 million plus addtiional overcontributions of $7.6 million.

EFFECT OF SEGMENT ACCOUNTING

Segment accounting would have eliminated most of the problems discussed above. That is, pension costs relating to the Medicare workforce would have been identified directly to Medicare regardless of the actuarial cost method or assumptions used.

Each of the four contractors reviewed could have calculated pension costs on a direct basis since each contractor's Medicare operation was identifiable as a separate segment of their business. In fact, some of the contractors had physically separated Medicare from their other lines of business.

Direct costing, or segmenting would require some reformatting of the pension valuation data furnished to each contractor's actuary. However, extracting Medicare employee data for the purpose of making a separate actuarial valuation would not result in any significant additional cost to the Medicare contracts. And, direct costing would not increase the contractor's overall pension costs. Rather, it would shift some costs reimbursed by Medicare to the contractor's other private lines of business.

In addition to the above, direct costing would provide greater administrative control over future Medicare pension contributions. For example, HCFA could readily determine whether annual Medicare contributions to the pension plan are equitable in relation to Medicare's pension liability. Also, direct costing would provide HCFA the status of Medicare's claim to pension assets when terminations or other contract changes occur.

SUMMARY

Pension costs were charged to the Medicare program without regard to the benefits Medicare employees would ultimately receive. Furthermore, credits which applied primarily to Medicare employees accrued to the total pension fund reducing overall pension costs, not just Medicare's share. As discussed above, these conditions generated significant overcharges to the Medicare program for pension costs.

Inherent in all cost accounting principles is the concept that costs should be charged to final cost objectives in reasonable proportion to the benefits received. This means that when costs or credits can be specifically identified with a final cost objective or contract, they should be charged or credited directly to that objective or contract. Only when costs are incurred or credits are realized for common or joint objectives should they be charged or credited indirectly, or allocated, to final cost objectives. This concept is designed to assure that costs are charged <u>equitably</u> and <u>consistently</u> to cost objectives or contracts.

The treatment of pension costs by the four contractors reviewed did not comply with this concept. Pension costs were allocated as an indirect cost. This treatment was inequitable because it ignored material differences between participating segments. It is just this type of situation which CAS 413 rectifies by requiring separate costs to be calculated for different segments.

RECOMMENDATIONS

We recommend that HCFA:

1. Make segment accounting a requirement in contracts awarded to Medicare intermediaries and carriers.

2. Require all intermediaries and carriers to refund the amounts by which the pension funds of the Medicare segments are overfunded.

3. Suspend future Medicare pension contributions until each contractor's ratio of Medicare assets to actuarial liability is comparable to the company-wide ratio of pension assets to actuarial liability.

HCFA COMMENTS

HCFA agreed with our recommendation that Medicare contractors be required to use segment accounting in claiming pension costs. They are of the opinion that segment accounting would result in more equitable direct charging of pension cost to the Program as contrasted to the overall indirect method of allocation that is presently being used by Medicare contractors.

HCFA intends to issue an instruction that will require Medicare contractors to use segment accounting unless they can prove that Medicare is not a separate segment of their operations. The complete text of HCFA's comments on our draft report is included as Appendix D.

ACTUARIAL VALUATION OF CONTRACTOR A's MEDICARE SEGMENT

In making an actuarial valuation of the Medicare segment, we used average data for 1981 active participants such as average age, average length of service, and average salary. To the extent possible, those factors employed by the contractor's actuary were also used.

The results of our valuation are as follows:

	OFFICE OF AUDIT VALUATION	
	TOTAL COMPANY	MEDICARE
Actuarial Liability (As of January 1, 1982)	$424,745,886	$6,578,918
Plus: Actuarial Liability for Retired Participants Applicable to Medicare	225,027,359	801,097 2/
Actuarial Liability Per Office of Audit	$649,773,245	$7,380,015

The contractor's actuarial valuation for the total company was also included. From this valuation, we made an estimate of Medicare's actuarial liability using percentage relationships developed from the valuation shown above.

Our estimate is as follows:

	CONTRACTOR A VALUATION TOTAL COMPANY	OFFICE OF AUDIT MEDICARE ESTIMATE
Actuarial Liability (As of January 1, 1982)	$ 869,403,018	
Less: Actuarial Liability for Retired Participants	(245,064,722)	
Actuarial Liability for Active Participants	$ 624,338,296	$ 9,677,244 1/
Plus: Actuarial Liability for Retired Participants Applicable to Medicare	225,027,359	801,097 2/
Actuarial Liability Per Contractor A	$ 849,365,665	$10,478,341

1/ Medicare's actuarial liability was computed by applying 1.55 percent to Contractor A's total company actuarial liability. This percentage represents the relationship of our computed Medicare actuarial liability to our computed total company actuarial liability ($6,578,918 ÷ $424,745,886).

2/ Medicare's actuarial liability for retired participants was computed by applying 0.356 percent to the total actuarial liability for retired participants less plan enhancements that were not applicable to Medicare ($245,064,722 - $20,037,363 = $225,027,359). This percentage was based on the relationship of Medicare benefit payments to total benefit payments during 1981 ($85,376 ÷ $23,978,036 = 0.356%).

As shown, the actuarial liability we computed for the total company was about $200 million, or 30.7 percent, less than the liability computed by the contractor's actuary. Consequently, the portion of the liability attributable to Medicare employees based on the contractor's valuation is about $3.4 million higher than the liability we computed. We did not attempt to identify the reasons for the differences between our estimate of the actuarial liability and the liability computed by the contractor. However, we believe the actual Medicare liability is somewhere between $7,380,015 and $10,478,341. To be conservative in the calculation of Medicare overfunding, we used the higher amount of $10,478,341 as the estimate of the actuarial liability for the Medicare workforce.

ACTUARIAL VALUATION OF CONTRACTOR B's MEDICARE SEGMENT

In making an actuarial valuation of the Medicare segment, we used average data for 1981 active participants such as average age, average length of service, and average salary. To the extent possible, we also used those factors employed by the contractor's actuary.

The results of our valuation are as follows:

	OFFICE OF AUDIT VALUATION	
	TOTAL COMPANY	MEDICARE
Actuarial Liability (As of January 1, 1982)	$530,157,180	$ 9,392,446
Plus: Actuarial Liability for Retired Participants Applicable to Medicare	196,189,280	1,043,727 2/
Actuarial Liability Per Office of Audit	$726,346,460	$10,436,173

The contractor's actuarial valuation for the total company was also included. From Contractor B's valuation, we made an estimate of Medicare's actuarial liability using percentage relationships developed from our valuation shown above.

Our estimate is as follows:

	CONTRACTOR B'S VALUATION TOTAL COMPANY	OFFICE OF AUDIT MEDICARE ESTIMATE
Actuarial Liability (As of January 1, 1982)	$ 803,088,000	
Less: Actuarial Liability for Retired Participants	(236,314,000)	
Actuarial Liability for Active Participants	$ 566,774,000	$10,031,900 1/
Plus: Actuarial Liability for Retired Participants Applicable to Medicare	196,189,280	1,043,727 2/
Actuarial Liability Per Contractor B	$ 762,963,280	$11,075,627

1/ Medicare's actuarial liability was computed by applying 1.77 percent to Contractor's B total company actuarial liability. This percentage represents the relationship of our computed Medicare actuarial liability to our computed total company actuarial liability ($9,392,446 ÷ $530,157,180).

2/ Medicare's actuarial liability for retired participants was computed by applying .532 percent to the total actuarial liability for retired participants less plan enhancements that were not applicable to Medicare ($236,314,000 - $40,124,720 = $196,189,280). This percentage was based on the relationship of Medicare benefit payments to total benefit payments during 1981 ($118,592 ÷ $22,276,927 = .532%).

As shown, the actuarial liability we computed for the total company was about $36.6 million, or 6.5 percent, less than the liability computed by Contractor B's actuary. Consequently, the portion of the liability attributable to Medicare employees based on Contractor B's valuation is $639,454 higher than the liability we computed. We did not attempt to identify the reasons for the differences between our estimate of the actuarial liability and the liability computed by the contractor. Rather, to be conservative, we used the higher amount, or $11,075,627, as the estimate of the actuarial liability for the Medicare workforce.

SUMMARY OF CONTRACTOR OVERCONTRIBUTIONS AND ESTIMATE OF NATIONAL IMPACT

Contractors	Amount Overfunded (Million) 1/	Additional Overcontributions (Million) 2/	Total (Million)
A	$ 2.86	$4.09	$ 6.95
B	5.52	1.55	7.07
C	3.38	1.60	4.98
D	2.50	.39	2.89
Total	$14.26	$7.63	$21.89 3/

1/ Amount by which Medicare assets exceed the actuarial liability of the Medicare workforce. This amount to be refunded to Medicare.

2/ Amount by which Medicare assets in relation to Medicare's actuarial liability is disproportionate to the ratio of total plan assets to the total plan actuarial liability. This difference to be offset against future Medicare contributions until the two ratios are equal.

3/ The average overcontribution per contractor of $5.47 million ($21.89 - 4) multiplied by the 93 current contractors would result in a possible overcontribution of $508.7 million. However, since these are four of the larger Medicare contractors, a more realistic estimate of total overcontributions would be about $200 to $230 million, or 40 to 45 percent of $508.7 million.

APPENDIX D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUL 18 1985

From Carolyne K. Davis, Ph. D.
Administrator
Health Care Financing Administration

Subject OIG Draft Audit Report — Medicare Intermediaries and Carriers Should Be Required to Use Segment Accounting for Claiming Pension Costs (ACN 07-52013)

To The Inspector General
Office of the Secretary

We have reviewed the subject draft report and we agree with the recommendation that Medicare contractors should be required to use segmented accounting procedures for claiming pension costs. We are of the opinion that this method results in a more equitable direct charge of pension costs to Medicare as contrasted to the overall indirect method of allocation which is presently being used by our contractors.

It is our intention to issue an instruction requiring our contractors to use this method of accounting unless they can convincingly prove to us that Medicare is not a separate, recognizable segment of their operations. We believe that this course of action coupled with the language in our contract will remedy the situation.