DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

JUL 0 3 2006

Report Number: A-07-05-00191

Mr. Kent Marquardt, Chief Financial Officer
Premera Blue Cross
7001 220th SW, MS 349
Mountlake Terrace, Washington 98043

Dear Mr. Marquardt:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Review of Pension Segmentation Requirements at Premera Blue Cross, a Terminated Medicare Contractor." A copy of this report will be forwarded to the HHS action official noted on the next page for his review and any action deemed necessary.

The HHS action official will make final determination regarding actions taken on all matters in the report. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to the public to the extent information contained therein is not subject to exemptions of the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, extension 274, or contact Jenenne Tambke, Audit Manager, at (573) 893-8338, extension 21, or through email at Jenenne.Tambke@oig.hhs.gov. Please refer to report number A-07-05-00191 in all correspondence.

Sincerely yours,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. RJ Ruff
Regional Administrator, Region X
Centers for Medicare & Medicaid Services
2201 Sixth Avenue, MS 40
Seattle, Washington 98121

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PENSION SEGMENTATION REQUIREMENTS AT PREMERA BLUE CROSS, A TERMINATED MEDICARE CONTRACTOR

Daniel R. Levinson
Inspector General

July 2006
A-07-05-00191

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Premera Blue Cross (Premera) administered Medicare Part A operations under cost reimbursement contracts with the Centers for Medicare & Medicaid Services (CMS) until the contractual relationship was terminated September 30, 2004. The effective closing date for the Medicare segment was December 31, 2004.

Starting with fiscal year 1988, CMS incorporated segmentation requirements into Medicare contracts. The Medicare contract defines a segment and specifies the methodology for the identification and initial allocation of pension assets to the segment. Additionally, the contract requires Medicare segment assets to be updated for each year after the initial allocation in accordance with Cost Accounting Standards (CAS) 412 and 413. Furthermore, in situations such as contract terminations, the Medicare contract requires contractors to identify excess Medicare pension liabilities in accordance with CAS 413.

OBJECTIVES

Our objectives were to determine if Premera complied with the Medicare contract's pension segmentation requirements:

- while updating Medicare segment assets from January 1, 1995, to December 31, 2004, and

- in determining Medicare's share of excess liabilities as a result of the termination of the Medicare contract.

SUMMARY OF FINDINGS

Premera did not comply with the Medicare contract's pension segmentation requirements while updating the Medicare segment's assets from January 1, 1995, to December 31, 2004. As a result, Premera understated the Medicare segment assets by $481,681. The understatement occurred primarily because Premera did not allocate net investment earnings to the Medicare segment in accordance with the CAS requirements.

In addition, Premera did not comply with the Medicare contract in determining Medicare's share of the segment's excess liabilities as of December 31, 2004. Premera calculated excess Medicare segment pension liabilities of $1,047,159, which is an $856,522 overstatement. The overstatement occurred because Premera understated the segment's assets, as noted above, and overstated the segment's final liabilities. The segment's liabilities were overstated because Premera did not calculate them in accordance with the CAS requirements. Medicare's share of the segment's excess liabilities should have been $190,637.

RECOMMENDATION

We recommend that Premera decrease Medicare's portion of the Medicare segment's excess pension liabilities by $856,522, and therefore recognize $190,637 as Medicare's portion.

AUDITEE'S COMMENTS

Premera partially concurred with our findings. Premera agreed that the final segment assets were understated by $481,681. However, Premera did not agree that the segment's accrued benefit liability was overstated by $369,752. Premera asserted that the guidance in the CAS "… as to which actuarial assumptions to use to determine the accrued liability is not germane" to its type of pension plan. Instead, Premera stated that the appropriate measure of the accrued benefit liability is the lump sum benefit determined by its pension plan benefit formula. Premera claims that using a different approach would result in a loss, which contradicts terms of the Medicare contract and general principles of government contract law.

Premera revised their proposed calculations and presented $599,686 as Medicare's portion of the segment's excess liabilities. Premera's comments are presented in their entirety in Appendix C.

OIG RESPONSE

Premera's assertion regarding the applicability of the CAS to its type of plan is incorrect. According to the CMS Office of the Actuary, the CAS makes no distinction regarding a defined benefit plan's form of payment but relies on the contractor's established practice in determining a segment's termination liability.

In addition, Premera's assertion that a loss will occur by applying the CAS requirements is based upon a probability that all terminated vested participants will elect to receive a lump sum benefit. However, CAS 413-50(c)(12)(i) requires that the actuarial assumptions stated in the valuation report be used when computing the segment's termination liability. As stated by the CMS Office of the Actuary, "Actuaries create assumptions to balance the gains and losses inherent in valuing plan liabilities; that is, gains are expected to be just as likely as losses." The benefit assumption for Premera's pension plan, which was developed by Premera's consulting actuary, is "50% of the terminated vested participants who are eligible to do so are assumed to elect a lump sum and 50% are assumed to elect a deferred annuity." In accordance with the CAS, our calculations are based upon the actuarial assumptions established by Premera's actuary.

Therefore, we still recommend that Premera decrease Medicare's portion of the Medicare segment's excess pension liabilities by $856,522, and therefore recognize $190,637 as Medicare's resulting portion.

The CMS Office of the Actuary's comments on Premera's response are presented in their entirety in Appendix D.

TABLE OF CONTENTS

Glossary of Abbreviations and Acronyms

CAS	Cost Accounting Standards
CMS	Centers for Medicare & Medicaid Services
OIG	Office of Inspector General
Premera	Premera Blue Cross

INTRODUCTION

BACKGROUND

Premera's Medicare Contract

Premera Blue Cross (Premera) administered Medicare Part A operations under cost reimbursement contracts with the Centers for Medicare & Medicaid Services (CMS) until the contractual relationship was terminated September 30, 2004. The effective closing date for the Medicare segment was December 31, 2004.

Segmentation Requirements

CMS incorporated segmentation requirements into Medicare contracts starting in fiscal year 1988. The Medicare contract defines a segment and specifies the methodology for the identification and initial allocation of pension assets to the segment. Furthermore, the contract requires Medicare segment assets to be updated for each year after the initial allocation in accordance with Cost Accounting Standards (CAS) 412 and 413. Finally, in claiming costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulations, CAS, and Medicare contract.

Regulations

The CAS 412 regulates the determination and measurement of pension cost components. It also regulates the assignment of pension costs to appropriate accounting periods.

The CAS 413 regulates the valuation of pension assets, allocation of pension costs to segments of an organization, adjustment of pension costs for actuarial gains and losses, and assignment of gains and losses to cost accounting periods.

The CAS 413 also regulates the determination of segment liabilities in the event of contract terminations and segment closings.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine if Premera complied with the Medicare contract's pension segmentation requirements:

- while updating Medicare segment assets from January 1, 1995, to December 31, 2004, and

- in determining Medicare's share of excess liabilities as a result of the termination of the Medicare contract.

Scope

We reviewed Premera's identification of its Medicare segment and update of Medicare segment assets from January 1, 1995, to December 31, 2004. Premera's Medicare contract was terminated on September 30, 2004. We agreed with Premera to use December 31, 2004, as the appropriate settlement date for the segment closing.

Achieving our objectives did not require us to review Premera's overall internal control structure. However, we did review controls relating to the identification of the Medicare segment, the update of the segment's assets, and the determination of the final segment liabilities to ensure adherence to the Medicare contract, CAS 412, and CAS 413.

We performed fieldwork at Premera's office in Mountlake Terrace, WA, during December 2004 and June 2005.

Methodology

In performing this review, we used information provided by Premera's actuarial consulting firm. The information included assets, liabilities, normal costs, contributions, benefit payments, investment earnings, and administrative expenses. We reviewed Premera's accounting records, pension plan documents, annual actuarial valuation reports, and Department of Labor/Internal Revenue Service Form 5500s. The CMS Office of the Actuary staff used the documents to calculate Medicare segment assets as of December 31, 2004. We reviewed the methodology and calculations.

We performed this review in conjunction with our audit of the pension costs claimed for Medicare reimbursement (A-07-05-00192). The information obtained and reviewed during the audit also was used in performing this review.

Details of the Medicare segment's updated pension assets from January 1, 1995, to December 31, 2004, are presented on Appendix A.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATION

Premera did not comply with the Medicare contract's pension segmentation requirements while updating the Medicare segment's assets from January 1, 1995, to December 31, 2004. In addition, Premera did not comply with the Medicare contract in determining Medicare's share of the segment's excess liabilities as of December 31, 2004.

When Premera's Medicare segment closed, Medicare's share of the excess pension liabilities was $190,637. We are recommending that Premera identify $190,637 as Medicare's share of the excess pension liabilities. To determine Medicare's share, it was necessary to (1) update the segment's assets to December 31, 2004, (2) calculate the segment's actuarial liability for the accrued benefits, and (3) compute the difference between the segment's assets and liabilities.

UPDATE OF MEDICARE SEGMENT ASSETS

Cost Accounting Standards

The Medicare contract states that: ". . . the pension assets allocated to each Medicare Segment shall be adjusted in accordance with CAS 413.50(c)(7)." The CAS 413.50(c)(7) requires that the asset base be adjusted by contributions, permitted unfunded accruals, income, benefit payments, and expenses. In addition, CAS 413.50(c)(8) requires an adjustment to be made for transfers (participants who enter or leave the segment) if the transfers materially affect the segment's ratio of pension plan assets to actuarial accrued liabilities.

Furthermore, the CAS 412.50(c)(1) states: "Amounts funded in excess of the pension cost computed for a cost accounting period pursuant to the provisions of this Standard shall be accounted for as a prepayment credit and carried forward to future accounting periods."

Medicare Segment Assets as of January 1, 1995, Updated to December 31, 2004

Premera did not comply with the Medicare contract's pension segmentation requirements while updating its Medicare segment assets from January 1, 1995, to December 31, 2004. Premera did not implement our prior audit recommendation[1] to increase the Medicare segment assets or properly account for contributions and prepayments, and it used an inappropriate method to allocate earnings and expenses. We identified Medicare segment assets of $2,718,938 as of December 31, 2004; however, Premera identified Medicare segment assets of $2,237,257. Therefore, Premera understated the Medicare segment assets by $481,681. The understatements are summarized in Table 1.

Table 1: Summary of Asset Adjustments	
Prior Audit Recommendation	$96,740
Contributions and Prepayment Transfers	128,182
Earnings and Expenses	256,759
(Over)/Understatement	**$481,681**

Prior Audit Recommendation

Premera did not implement our prior audit recommendation to increase the Medicare segment assets as of January 1, 1995. As a result, the beginning Medicare segment asset value was understated by $96,740.

Contributions and Prepayment Transfers Understated

Premera did not properly account for contributions and prepayments. Premera's update methodology did not equitably assign pension contributions to the Medicare segment. As a

[1]We previously reviewed Premera's updates of segment assets from January 1, 1986, to January 1, 1995 (A-07-96-01189).

result, Premera understated segment assets by $128,182. The understatement primarily occurred because Premera did not assign any of the 2004 total company contribution to the segment.

For years 1995, 1997, and 1999 through 2004, Premera's contributions exceeded the required funding of the CAS pension costs. According to the CAS, amounts funded in excess of pension costs (or prepayments) shall be carried forward with interest to fund future CAS pension costs. In our audited update, we accounted for the excess contributions and made prepayment adjustments to fund CAS pension costs of the Medicare segment.

The audited update of Medicare segment assets assigned contributions to the Medicare segment using the pension costs as calculated by the CMS Office of the Actuary. The segment assets increased by $128,182 in the audited update due to differences in assigned contributions and prepayment transfers.

Earnings and Expenses Understated

Premera used an inappropriate allocation method after the effective date of the revised CAS; therefore, it understated the segment's investment earnings, less administrative expenses, by $256,759. Premera allocated investment earnings and administrative expenses to the Medicare segment based on a ratio of beginning of year segment assets to total company assets. For plan years beginning after March 30, 1995, the CAS requires investment income and expenses to be allocated among segments based on the ratio of the segment's weighted average value (WAV) of assets to total company WAV of assets. In our audited update, we allocated earnings and expenses based upon the applicable CAS requirements.

MEDICARE SEGMENT'S ACTUARIAL LIABILITY FOR ACCRUED BENEFITS

Cost Accounting Standards

Contract terminations and segment closings are addressed by CAS 413-50(c)(12), which states:

> If a segment is closed, . . . the contractor shall determine the difference between the actuarial accrued liability for the segment and the market value of the assets allocated to the segment, irrespective of whether or not the pension plan is terminated. The difference between the market value of the assets and the actuarial accrued liability for the segment represents an adjustment of previously-determined pension costs.
>
> (i) The determination of the actuarial accrued liability shall be made using the accrued benefit cost method. The actuarial assumptions employed shall be consistent with the current and prior long term assumptions used in the measurement of pension costs . . . .
>
> (iii) The calculation of the difference between the market value of the assets and the actuarial accrued liability shall be made as of the date of the event (e.g., contract termination, plan amendment, plant closure) that caused the closing of the segment, ... If such a date is not readily determinable, or if its use can result in an inequitable calculation, the contracting parties shall agree on an appropriate date.

Determining the Federal Government's share of the excess segment assets is addressed by CAS 413.50(c)(12)(vi), which states:

> The Government's share of the adjustment amount determined for a segment shall be the product of the adjustment amount and a fraction . . . . The numerator of such fraction shall be the sum of the pension plan costs allocated to all contracts and subcontracts (including Foreign Military Sales) subject to this Standard during a period of years representative of the Government's participation in the pension plan. The denominator of such fraction shall be the total pension costs assigned to cost accounting periods during those same years . . . .

Medicare Segment Accrued Benefit Liabilities as of December 31, 2004

Premera did not calculate the segment's final termination liabilities in accordance with the CAS. Premera's approach did not compute the accrued benefit liability using the actuarial assumptions stated in its valuation reports. As of December 31, 2004, we identified Medicare segment closing liabilities of $2,914,664. Premera identified Medicare segment closing liabilities of $3,284,416. Therefore, Premera overstated the Medicare segment's pension liabilities by $369,752. The misstatements are summarized in Table 2.

Table 2: Summary of Medicare Segment Liability Adjustments	
Active Participants	($170,223)
Termintated Vested Participants	(249,745)
Terminated Vested Participants with Lump Sum Payments	50,216
(Over)/Understatement	**($369,752)**

Active and Terminated Vested Participants – Liabilities Overstated

Premera overstated the final liabilities for active and terminated vested participants at the segment closing date. Premera's methodology did not comply with the CAS requirements. Premera did not compute an accrued benefit liability using the plan's actuarial assumptions for active and terminated vested participants. Premera overstated the active participant's liabilities by $170,223 and the terminated vested participant's liabilities by $249,745.

Terminated Vested Participants with Lump Sum Payments – Liabilities Understated

Premera's methodology understated the final liabilities for terminated vested participants who received a lump sum payout in 2005. We discounted actual lump sum payments from the date of payment back to December 31, 2004, the segment closing date. Premera understated the liabilities for this group by $50,216.

MEDICARE'S SHARE OF EXCESS PENSION LIABILITIES

Premera did not comply with the Medicare contract in determining Medicare's share of the segment's excess liabilities as of December 31, 2004. Premera understated the segment's assets

and overstated the segment's pension liabilities. We computed $190,637 as Medicare's portion of excess segment pension liabilities whereas Premera computed $1,047,159 as Medicare's share. Therefore, Premera overstated Medicare's share of excess pension liabilities by $856,522. The differences are summarized in Table 3.

Table 3: Adjustments to Medicare's Share of Excess Liabilities	
Segment Asset Adjustment	($481,681)
Segment Liability Adjustment	(369,752)
Application of Aggregate LOB Percentage[2]	(5,089)
(Over)/Understatement	**($856,522)**

Premera's Medicare segment performed non-Medicare operations. Therefore, only a portion of the segment's excess liabilities is attributable to Medicare. We calculated the segment's aggregate Medicare percentage and applied it to the segment's total excess liabilities to determine Medicare's share of the excess liabilities. We computed the segment's aggregate Medicare percentage as an average of the segment's Medicare line-of-business percentage. Each year's line-of-business percentage was developed using a ratio of the segment's Medicare salary dollars to the segment's total salary dollars. The resulting aggregate Medicare percentage was 97.40 (see Appendix B).

In accordance with the CAS, we applied the aggregate Medicare percentage to the excess segment liabilities of $195,726 ($2,718,938 of assets less $2,914,664 of liabilities). We determined that $190,637 ($195,726 multiplied by 97.40 percent) is Medicare's portion of the excess pension liabilities.

RECOMMENDATION

We recommend that Premera decrease Medicare's portion of the Medicare segment's excess pension liabilities by $856,522, and therefore recognize $190,637 as Medicare's portion.

AUDITEE'S COMMENTS

Premera partially concurred with our findings. Premera agreed that the final segment assets were understated by $481,681. However, Premera did not agree that the segment's accrued benefit liability was overstated by $369,752. Premera asserted that the guidance in the CAS "… as to which actuarial assumptions to use to determine the accrued liability is not germane" to its type of pension plan. Instead, Premera stated that the appropriate measure of the accrued benefit liability is the lump sum benefit determined by its pension plan benefit formula. Premera claims that using a different approach would result in a loss, which contradicts terms of the Medicare contract and general principles of government contract law.

Premera revised their proposed calculations and presented $599,686 as Medicare's portion of the segment's excess liabilities. Premera's comments are presented in their entirety in Appendix C.

[2] Segment excess liabilities of $195,726 less Medicare's share of $190,637.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Premera's assertion regarding the applicability of the CAS to its type of plan is incorrect. According to the CMS Office of the Actuary, the CAS makes no distinction regarding a defined benefit plan's form of payment but relies on the contractor's established practice in determining a segment's termination liability.

In addition, Premera's assertion that a loss will occur by applying the CAS requirements is based upon a probability that all terminated vested participants will elect to receive a lump sum benefit. However, CAS 413-50(c)(12)(i) requires that the actuarial assumptions stated in the valuation report be used when computing the segment's termination liability. As stated by the CMS Office of the Actuary, "Actuaries create assumptions to balance the gains and losses inherent in valuing plan liabilities; that is, gains are expected to be just as likely as losses." The benefit assumption for Premera's pension plan, which was developed by Premera's consulting actuary, is "50% of the terminated vested participants who are eligible to do so are assumed to elect a lump sum and 50% are assumed to elect a deferred annuity." In accordance with the CAS, our calculations are based upon the actuarial assumptions established by Premera's actuary.

Therefore, we still recommend that Premera decrease Medicare's portion of the Medicare segment's excess pension liabilities by $856,522, and therefore recognize $190,637 as Medicare's resulting portion.

The CMS Office of the Actuary's comments on Premera's response are presented in their entirety in Appendix D.

APPENDIXES

Premera Blue Cross
Statement of Medicare Pension Assets
For the Period
January 1, 1995, to December 31, 2004

Description		Total Company	Other Segment	Medicare Segment
Assets January 1, 1995	1/	$26,817,553	$25,564,310	$1,253,243
Prepayment Transfer		0	0	0
Contributions	2/	1,443,986	1,414,882	29,104
Other Transactions		0	0	0
Earnings	3/	7,766,408	7,403,467	362,941
Benefit Payments	4/	(1,115,101)	(1,115,101)	0
Expenses	5/	(169,532)	(161,609)	(7,923)
Transfers	6/	0	175,617	(175,617)
Assets January 1, 1996		34,743,314	33,281,566	1,461,748
Prepayment Transfer		0	0	0
Contributions		0	0	0
Other Transactions		0	0	0
Earnings		5,379,839	5,153,118	226,721
Benefit Payments		(922,236)	(888,227)	(34,009)
Expenses		(207,093)	(198,366)	(8,727)
Transfers		0	(135,814)	135,814
Assets January 1, 1997		38,993,824	37,212,277	1,781,547
Prepayment Transfer		0	0	0
Contributions		320,000	320,000	0
Other Transactions	7/	6,102,590	6,102,590	0
Earnings		8,255,544	7,872,198	383,346
Benefit Payments		(1,516,670)	(1,516,670)	0
Expenses		(235,005)	(224,093)	(10,912)
Transfers		0	115,365	(115,365)
Assets January 1, 1998		51,920,283	49,881,667	2,038,616
Prepayment Transfer		0	0	0
Contributions		945,031	945,031	0
Other Transactions		0	0	0
Earnings		7,485,283	7,180,782	304,501
Benefit Payments		(4,076,803)	(4,057,962)	(18,841)
Expenses		(318,093)	(305,153)	(12,940)
Transfers		0	0	0
Assets January 1, 1999		55,955,701	53,644,365	2,311,336

Premera Blue Cross
Statement of Medicare Pension Assets
For the Period
January 1, 1995, to December 31, 2004

Description		Total Company	Other Segment	Medicare Segment
Assets January 1, 1999		55,955,701	53,644,365	2,311,336
Prepayment Transfer		0	0	0
Contributions		5,240,471	5,240,471	0
Other Transactions		0	0	0
Earnings		6,769,076	6,497,435	271,641
Benefit Payments		(6,384,207)	(5,996,309)	(387,898)
Expenses		(392,625)	(376,869)	(15,756)
Transfers		0	0	0
Assets January 1, 2000		61,188,416	59,009,093	2,179,323
Prepayment Transfer		0	0	0
Contributions		6,515,669	6,515,669	0
Other Transactions		0	0	0
Earnings		235,651	227,205	8,446
Benefit Payments		(3,711,279)	(3,621,591)	(89,688)
Expenses		(455,156)	(438,843)	(16,313)
Transfers		0	(88,817)	88,817
Assets January 1, 2001		63,773,301	61,602,716	2,170,585
Prepayment Transfer	8/	0	(6,658)	6,658
Contributions		4,640,084	4,640,084	0
Other Transactions		0	0	0
Earnings		(1,139,021)	(1,099,728)	(39,293)
Benefit Payments		(4,620,821)	(4,510,294)	(110,527)
Expenses		(369,420)	(356,676)	(12,744)
Transfers		0	48,848	(48,848)
Assets January 1, 2002		62,284,123	60,318,292	1,965,831
Prepayment Transfer		0	(136,830)	136,830
Contributions		29,800,000	29,774,467	25,533
Other Transactions		0	0	0
Earnings		(5,488,488)	(5,316,136)	(172,352)
Benefit Payments		(3,855,756)	(3,699,432)	(156,324)
Expenses		(466,877)	(452,216)	(14,661)
Transfers		0	25,169	(25,169)
Assets January 1, 2003		82,273,002	80,513,314	1,759,688

Premera Blue Cross
Statement of Medicare Pension Assets
For the Period
January 1, 1995, to December 31, 2004

Description		Total Company	Other Segment	Medicare Segment
Assets January 1, 2003		82,273,002	80,513,314	1,759,688
Prepayment Transfer		0	(230,604)	230,604
Contributions		11,100,000	11,100,000	0
Other Transactions		0	0	0
Earnings		18,401,353	17,943,490	457,863
Benefit Payments		(8,439,549)	(8,353,928)	(85,621)
Expenses		(514,222)	(501,427)	(12,795)
Transfers		0	(82,654)	82,654
Assets January 1, 2004		102,820,584	100,388,191	2,432,393
Prepayment Transfer		0	(225,563)	225,563
Contributions		7,500,000	7,500,000	0
Other Transactions		0	0	0
Earnings		11,206,296	10,926,288	280,008
Benefit Payments		(5,490,323)	(5,179,639)	(310,684)
Expenses		(547,223)	(533,550)	(13,673)
Transfers	9/	0	(105,331)	105,331
Assets December 31, 2004		115,489,334	112,770,396	2,718,938
Per Premera	10/	115,489,334	113,252,077	2,237,257
Asset Variance	11/	0	(481,681)	481,681

Premera Blue Cross
Statement of Medicare Pension Assets
For the Period
January 1, 1995, to December 31, 2004

FOOTNOTES

1/ We determined the Medicare segment assets as of January 1, 1995, in our prior review of Premera's pension segmentation (A-07-96-01189). The amounts shown for the other segment represent the difference between the total company and the Medicare segment. All pension assets are shown at market value.

2/ We obtained total company contribution amounts from the actuarial valuation reports and Department of Labor/Internal Revenue Service Form 5500s. We allocated total company contributions to the Medicare segment based on the ratio of the Medicare segment's funding target divided by the total company funding target. Contributions in excess of the funding targets were treated as prepayment credits and accounted for in the other segment until needed to fund pension cost in the future.

3/ We obtained investment earnings from actuarial valuation reports. We allocated investment earnings based on the market value of Medicare assets at the beginning of the plan year after adjustment for transfers. For years starting with 1996, we allocated investment earnings based on the ratio of the segment's Weighted Average Value (WAV) of assets to total company WAV of assets as required by the Cost Accounting Standards.

4/ We accepted Premera's benefit payments to Medicare segment retirees.

5/ We allocated administrative expenses to the Medicare segment in proportion to investment income.

6/ Premera made adjustments for participant transfers between segments. We accepted their calculations.

7/ We obtained other transaction information from the actuarial valuation reports. Other transactions represent plan merger activities.

8/ Prepayment credits represent funds available to satisfy future funding requirements and are applied to future funding requirements before current year contributions in order to reduce interest costs to the Federal Government. Prepayment credits are transferred to the Medicare segment as needed to cover funding requirements.

9/ Transfer adjustments for 2004 are not related to the Medicare segment closing.

10/ We obtained asset amounts as of December 31, 2004, from documents provided by Premera's consulting actuary.

11/ The asset variance represents the difference between our calculation of Medicare segment assets and Premera's market value of assets.

Premera Blue Cross **APPENDIX B**
Calculation of the Aggregate Medicare Percentage
for the Medicare Segment

MEDICARE SEGMENT LINE OF BUSINESS PERCENTAGES	
Fiscal Year	**% Medicare***
1987	88.49%
1988	96.40%
1989	96.29%
1990	98.48%
1991	99.74%
1992	99.98%
1993	99.77%
1994	98.29%
1995	94.36%
1996	95.23%
1997	94.15%
1998	96.04%
1999	96.75%
2000	99.18%
2001	100.00%
2002	100.00%
2003	100.00%
2004	100.00%
Medicare Segment Aggregate LOB	**97.40%**

* The Medicare line of business (LOB) percentages are based on information provided by Premera Blue Cross. The information for 1987 - 1994 was obtained during our prior audits (A-07-96-01189 and A-07-97-01205); however, the information for 1986 was not available. The information for 1995 - 2004 was obtained during the current review.

POWELL GOLDSTEIN LLP

Atlanta • Washington

RESIDENT IN WASHINGTON OFFICE
DIRECT DIAL: (202) 624-7227
[illegible]

April 28, 2006

VIA OVERNIGHT MAIL

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, MO 64106

Re: Response to draft report entitled "Review of Pension Segmentation Requirements at Premera Blue Cross, a Terminated Medicare Contractor" (Report Number A-07-05-00191)

Dear Mr. Cogley:

On behalf of Premera Blue Cross ("Premera"), Powell Goldstein LLP as its outside counsel hereby submits Premera's response to the above-referenced report ("Draft Report"). Premera accepts the OIG's conclusion that Premera understated the Medicare segment assets by $481,681. Premera disagrees with the OIG's conclusion that Premera overstated the Medicare segment's pension liabilities by $369,752.[1] Premera agrees with the OIG's conclusion that 97.40 is the appropriate aggregate Medicare percentage to utilize to determine the portion of the segment's excess liabilities attributable to Medicare. Therefore, Premera disagrees with the OIG's conclusion that $190,637 is Medicare's portion of the excess pension liabilities. Premera's position is that $599,686 is Medicare's portion of the excess pension liabilities. The following chart provides a comparison of the OIG's and Premera's positions.

[1] The "Aggregate Medicare LOB%" of $5,089 calculated by the OIG in Table 3 at page 6 of the Draft Report appears to be the difference between the total excess segment liabilities of $195,725 and Medicare's share of excess liabilities of $190,637, but does not appear to have an impact on the OIG's calculation of Medicare's share of excess liabilities. Therefore, this does not appear to be an adjustment. Premera does not understand the purpose of the identification of this amount in the Draft Report.

Third Floor • 901 New York Avenue, NW • Washington, DC 20001-4413
Tel: 202.347.0066 • Fax: 202.624.7222
www.pogolaw.com

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services
April 28, 2006

Medicare's Share of Excess Segment Liabilities
Detailed Comparison of OIG's and Premera's Positions

	OIG's Position			Premera's Position		Difference
	Assets, Liabilities & Adjustments	Calculation of Total Excess Segment Liabilities	OIG's Recommended Adjustments to Premera's Assets and Liabilities	Assets, Liabilities & Adjustments	Calculation of Total Excess Segment Liabilities	
Assets						
Assets as of 12/31/04	2,718,938			2,237,257		
Adjustment-Understatement of Medicare assets	0		481,681	481,681		
Total Assets as of 12/31/04	2,718,938	2,718,938		2,718,938	2,718,938	0
Liabilities						
Liabilities as of 12/31/04	2,914,664			3,284,416		
Adjustment-Active Participants Liability Overstated	0		(170,223)	0		
Adjustment-Terminated Vested Participants Liability Overstated	0		(249,745)	0		
Adjustment-Terminated Vested Participants with Lump Sum Payments, Liabilities Understated	0		50,216	50,216		
Total Liabilities as of 12/31/04	2,914,664	2,914,664		3,334,632	3,334,632	
Total Excess Segment Liabilities		195,726			615,694	
Aggregate Medicare LOB%		97.40%			97.40%	
Medicare's Share of Excess Pension Liabilities		190,637			599,686	(409,049)

Premera's position regarding each of the OIG's recommended adjustments is set out below.

I. UPDATE OF MEDICARE SEGMENT ASSETS

In the above-referenced draft report, the OIG asserts that Premera did not comply with the contract's pension segmentation requirements while updating the Medicare segment assets from January 1, 1995 to December 31, 2004. (Draft Report at 3) As a result, Premera understated the Medicare segment assets by $481,681. (Draft Report at 3) Premera accepts the OIG's conclusion that Premera understated the Medicare segment assets by $481,681. (Draft Report at 3) Therefore, Premera's position is that Medicare segment assets are $2,781,938 ($2,237,257 plus $481,681).

II. MEDICARE SEGMENT'S ACTUARIAL LIABILITY FOR ACCRUED BENEFITS

A. Summary

The OIG asserts that Premera did not calculate the segment's final termination liabilities in accordance with CAS. (Draft Report at 5) Specifically, the OIG asserts that Premera's approach did not compute the accrued benefit liability using the actuarial assumptions stated in its valuation reports. (Draft Report at 5) Therefore, the OIG asserts that Premera overstated the final liabilities for active and terminated vested participants at the segment closing date, thereby resulting in the overstatement of active participants' liabilities by $170,223, and the overstatement of terminated vested participants' liabilities by $249,745. (Draft Report at 5) Premera disagrees with the OIG's assertion that the accrued benefit liability should be computed using the actuarial assumptions stated in its valuation reports. Therefore, Premera disagrees with the OIG's assertion that it overstated the active participants' liabilities by $170,223 and the terminated vested participants' liabilities by $249,745.

B. Treatment of Terminated Vested Participants

Premera disagrees with the OIG's assertion that the liability for terminated vested participants should be determined using the plan's actuarial assumptions, *i.e.* the same assumptions that the actuaries used in determining the actuarial liability associated with these participants in past annual actuarial valuations. It is Premera's position, based on the opinion of its actuarial firm, Watson Wyatt, that the appropriate measure for the accrued liability for each of these terminees is their pension equity plan ("PEP") lump sum benefit because the lump sum value of this benefit is directly determinable from the PEP benefit formula. There are no actuarial assumptions needed to determine this value, and therefore, there is no need to turn to the CAS for guidance regarding how to determine the actual liability at the Medicare segment closing date. In addition, the lump sum value is the appropriate measure of the accrued liability for terminated vested participants because each terminee can elect to receive that benefit immediately in a lump sum payment. Premera's position is discussed in detail in section D., below.

C. **Treatment of Active Participants**

Premera disagrees with the OIG's assertion that the liability for active participants should be determined using the plan's actuarial assumptions, *i.e.* the same assumptions that the actuaries used in determining the actuarial liability associated with these participants in past annual actuarial valuations. (Draft Report at 5) Premera's position as to the accrued liability for active participants is the same as its position for the terminated vested participants—the accrued liability should be the lump sum benefit that had been earned by these individuals at the segment closing date as calculated by the PEP's own formula.

The same arguments apply with equal force to the calculation of the accrued liability for active participants. That is, as of the Medicare segment's closing date, one can determine the value of the benefit earned by each active participant directly from the PEP benefit formula. The only difference between the situation for an active participant and that of a vested terminated participant is that an active participant would not yet be eligible to actually receive his lump sum benefit, since he is still employed by Premera. But, the fact remains that the current value of the benefit earned by each active participant is known at the Medicare segment closing date. There are no actuarial assumptions needed to determine this value, and therefore, there is no need to turn to the CAS for guidance regarding how to determine the actual liability at the Medicare segment closing date. Consequently, Premera's position is that the lump sum liability of the active participants as calculated by the PEP's own formula should be accepted as the accrued liability amount.

D. **Termination Principles**

Premera has previously communicated its position regarding the treatment of accrued benefit liabilities to the Government by letter from its outside counsel, W. Bruce Shirk of Powell Goldstein LLP, to Jamie Insley, Office of General Counsel, United States Department of Health and Human Services, dated September 26, 2005. (Exhibit A) Attached to that letter is a letter from Mr. James L. R. Isbell of Watson Wyatt to Mr. Steve Garrison of the United States Department of Health and Human Services dated September 6, 2005, setting out the Watson Wyatt opinion. (Exhibit A) We restate Premera's position contained in the September 26, 2005 letter below.

In summary, Premera believes that the appropriate measure of the accrued benefit liability for both active and terminated vested participants is the lump sum liability calculated by the PEP's own formula, not the accrued liability calculated by the use of actuarial assumptions. The use of the liability as calculated by the PEP is appropriate and correct because the PEP is designed to calculate an individual's accrued benefit liability directly; therefore, the guidance in CAS 9904.413-50(c)(12)(i), as to which actuarial assumptions to use to determine the accrued liability is not germane. When a plan (or contract) is being terminated, no actuarial assumptions need to be made in order to determine the accrued benefit liability when a plan is a PEP.

Further, Premera's Medicare contract and general principles of government contract law dictate that Premera not suffer a loss in the performance of the contract. Strict adherence to accounting rules is inappropriate if it would result in a loss. Business judgment, as opposed to adherence to strict accounting principles, should be used in reaching a settlement with a terminated contractor.

1. Premera Should Not Suffer a Loss in the Performance of the Contract

a. The CAS Regulations Do Not Appropriately Contemplate Non-traditional Pension Plans Such as Premera's PEP

The CAS regulations do not provide guidance on how to determine the accrued benefit liability for vested terminees in the Premera PEP. Paragraph 9904.413-50(c)(12)(i) of those regulations states that, in determining the accrued liability when a segment is closed, "the actuarial assumptions employed shall be consistent with the current and prior long-term assumptions used in the measurement of pension costs." However, the CAS regulations were drafted at a time when today's "hybrid" pension plans (e.g., cash balance and pension equity plans) were very rare, and the regulations contemplate a "traditional" pension plan in which the benefit determined by the plan's formula is a monthly annuity benefit payable starting at one's retirement eligibility age. For a vested terminee who has not yet reached retirement eligibility when a segment in a traditional pension plan is closing once and for all, there is a need to convert that monthly stream of future benefit payments into its present value today. Under those circumstances, the CAS regulations say that the accrued liability for vested terminees is determined using the same actuarial assumptions as are used in the regular annual valuations to determine pension cost.

In the pension equity plan sponsored by Premera, however, the benefit formula produces a lump sum benefit liability amount directly for each participant. For one who terminates employment with a vested benefit, the vested terminee has the right to immediately receive the lump sum benefit that is produced by the PEP formula, or to receive the lump sum including an interest adjustment at a later date. Alternatively, the vested terminee can elect to receive a monthly annuity, either immediately or starting at some point in the future, in which case the lump sum benefit amount is converted using annuity conversion factors into the appropriate monthly benefit. So, this process is the reverse of what would happen in calculating the accrued liability in a traditional pension plan, where the monthly annuity benefit must be converted into a lump sum present value using appropriate annuity conversion factors.

The Premera PEP produces a lump sum benefit value directly, and a terminating participant can elect to receive that lump sum benefit immediately following termination of employment. Therefore, it is not appropriate to make use of any actuarial assumptions to produce the accrued liability for a vested terminee. That accrued liability is simply the PEP

lump sum amount. Accordingly, application of CAS 9904.413-50(c)(12)(9) is unreasonable and inappropriate.

b. The Lump Sum Benefit Amount Is Premera's Actual Liability

As you are aware, CMS is obligated by contract, statute and regulation to ensure that Premera is fairly compensated and to ensure that Premera does not suffer a loss in the performance of the contract. Further, the regulations specifically direct the use of business judgment, as opposed to strict accounting principles, in reaching a settlement with a terminated contractor. Sound business judgment requires CMS to recognize that using actuarial assumptions appropriate during contact performance will not capture Premera's actual liability after termination and will in fact result in a contractually inappropriate loss to the company. Therefore, the lump sum benefit amount should be used as the accrued liability amount for each of these 21 vested terminees.

In Premera's PEP, an individual who terminates employment with a vested benefit has the right to immediately receive the lump sum benefit that is produced by the PEP formula for that individual. Alternatively, such an employee can elect to receive a monthly annuity, either immediately or starting at some point in the future, in which case the lump sum benefit amount is converted into the appropriate monthly benefit using annuity conversion factors. In either case, the accrued liability is known at the time of the employee's termination and the terminee can demand payment at any time following termination. Stated otherwise, under the terms of the PEP each of the 21 vested terminees can demand a lump sum payment today or at any time in the future. Therefore the only way to ensure that Premera is reimbursed by CMS for its actual liability is to calculate the liability by reflecting the fact that each of the 21 vested terminees may demand immediate payment of the lump sum amount. Reflecting the lump sum benefit for all of these terminees is required because after closing of Premera's Intermediary contract no contractual vehicle will exist through which Premera can request reimbursement on a pay-as-you-go basis; therefore, any other method of calculating the liability will result in a loss to Premera as to any employee who requests and is paid a lump sum benefit.

c. The Medicare Contract Requires that Premera Not Suffer a Loss

A guiding principle of the Medicare Contract is that CMS ensure that the contractor is made whole as to its costs of contract performance. This obligation is embodied in Federal statute. 42 U.S.C.A. §1395h(c) provides, in part: "An agreement with any agency or organization under this section...shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement." This requirement is incorporated in Article XII, Paragraphs A and B of the Medicare Intermediary Contract. Paragraph A clearly states that the Intermediary is *not to suffer a loss*:

> It is the intent of this agreement that the Intermediary, in performing its functions under this agreement, shall be paid its costs of administration under the principle of neither profit nor loss to the Intermediary.

(Medicare Intermediary Contract, Article XII, Paragraph A.)

Paragraph B clearly states that allowable costs shall be determined according to Part 31 of the FAR:

> The Secretary shall pay to the Intermediary the total amount of allowable costs of the Intermediary incurred in the performance of this agreement subject to the provisions of Article XIII. In determining the costs allowable under this agreement, the Secretary shall take into account the amount which is reasonable and adequate to meet the cost which must be incurred by an efficiently and economically operated Intermediary in carrying out the terms of this agreement. The types of costs allowable and allocable under this agreement shall be determined in accordance with the provision of Part 31 of the FAR, as interpreted and modified by Appendix B to this agreement.

(Medicare Intermediary Contract, Article XII, Paragraph B.) Thus, CMS is obligated by both statute and contract to allow Premera to value the liability of the 21 vested terminees on a lump sum basis as to act otherwise would impermissibly cause Premera to suffer a loss in allowable costs incurred and paid for the benefit of the Medicare program.

2. CMS Is Required To Exercise Business Judgment, As Opposed To Strict Accounting Principles, in Reaching a Settlement with a Terminated Contractor

The Federal Acquisition Regulation ("FAR") contains general principles for the settlement of terminated contracts. (See FAR Subpart 49.1.) The general principles state that the cost principles of Part 31 and the general principles of Part 49.201 apply to the determination of "costs relevant to termination settlements." (FAR 49.113) FAR 49.201 specifically provides that business judgment should govern the settlement of terminations.

> (a) A settlement should compensate the contractor fairly for the work done and the preparations made for the terminated portions of the contract, including reasonable allowance for profit. *Fair compensation is a matter of judgment and cannot be measured exactly.* In a given case, various methods may be

> equally appropriate for arriving at fair compensation. *The use of business judgment, as distinguished from strict accounting principles, is the heart of a settlement.*
>
> (b) The primary objective is to negotiate a settlement by agreement. The parties may agree upon a total amount to be paid the contractor without agreeing on or segregating the particular elements of cots or profit comprising this amount.
>
> (c) Costs and accounting data may provide guides, but are not rigid measures, for ascertaining fair compensation. In appropriate cases, costs may be estimated, differences compromised, and doubtful questions settled by agreement. Other types of data, criteria, or standards may furnish equally reliable guides to fair compensation. The amount of recordkeeping, reporting, and accounting related to the settlement of terminated contracts should be kept to a minimum compatible with the reasonable protection of the public interests.

(FAR 49.201 (emphasis added).)

The FAR not only states the general proposition that business judgment is the governing principle of termination settlements, it specifically subjects the cost principles of FAR Part 31 themselves to that governing principle:

> 49.113 Cost Principles:
>
> The cost principles and procedures in the applicable subpart of Part 31 shall, *subject to the general principles in 49.201*—
>
> (a) be used in asserting, negotiating, or determining costs relevant to termination settlements under contracts with other than educational institutions . . .

(FAR 49.113 (emphasis added).)

3. The Contract Specifically Incorporates FAR Part 31, 49.103, 49.113 and 49.201

Premera's Medicare Part A Contract specifically incorporates FAR Part 31, 49.103, 49.113 and 49.201 in several provisions relating to termination of the contract. These are Article XXVI, Termination of Contract; Article XII, Types of Costs Allowable for Administration of this Contract; Appendix B, paragraph B; and Appendix B, Article XIV, Termination Costs.

Article XXVI, paragraph D, states that if the contract is terminated or non-renewed, the reimbursable costs due to either the government or the contractor shall be determined in accordance with paragraph B of Article XII.

Paragraph B of Article XII states that Part 31 of the Federal Acquisition Regulation ("FAR"), as interpreted and modified by Appendix B, is to be used to determine allowable and allocable costs:

> "The types of cost allowable and allocable under this agreement shall be determined in accordance with the provisions of Part 31 of the FAR, as interpreted and modified by Appendix B, to this agreement."

FAR Subpart 31.103(b) states that the cost principles and procedures in FAR Subpart 31.2 are the basis for proposing, negotiating or determining costs under terminated contracts. In regard to termination, the subpart refers specifically to FAR 49.103 and 49.113:

> (b) In addition, the contracting officer shall incorporate the cost principles and procedures in Subpart 31.2 and agency supplements by reference in contracts with commercial organizations as the basis for— . . .
>
> (3) Proposing, negotiating, or determining costs under terminated contracts (see 49.103 and 49.113).

48 C.F.R. 31.103(b).

FAR 49.103 describes the methods by which the "settlement of terminated cost-reimbursement contracts" may be made. The listed methods include negotiation, which is the method Premera believes appropriate for use in the present case.

Finally, FAR 49.113 specifies that the principles of FAR Part 31 shall be subject to the general principles of FAR 49.201. As discussed above FAR 49.201 states that "[t]he use of business judgment, as distinguished from strict accounting principles, is the heart of a settlement." (48 C.F.R. 49.201.).

The Government must give effect to the specific reference to FAR 49.103 and 49.113 in the contract. Fundamental principles of contract interpretation require that effect be given to every part of a contract. Restatement (Second) of Contracts, § 203(a) and cmt. b. (1981). Since an agreement is interpreted as a whole, it is assumed that no part of it is superfluous. Id. No part should be read so that it is either unreasonable or of no effect. Id. at cmt. c. In this case, giving the specified provisions effect is consistent with a reasonable reading of the contract.

CMS drafted this contract. Its terms will therefore be construed against CMS in connection with any dispute. Restatement (Second) of Contracts § 207 and cmt. a. (1981). Any question as to whether the Government intended to incorporate FAR 49.103, 49.113, and 49.201 when it specifically incorporated FAR Part 31 will be decided in Premera's favor.

4. FAR 49.103, 49.113 and 49.201 Apply to the Settlement of Amounts Due to Premera Regardless of the Manner in which the Contract Was Terminated

As you are aware, the contract may be non-renewed if either the government or the contractor gives the other party notice at least 90 days before the end of the current period of intent not to renew. (See Article XXVI, paragraph A.) The contract also may be terminated at any time by mutual consent of the parties, and may be terminated by the government for cause, such as performance failure. (See Article XXVI.) The contract specifically provides in Article XXVI, paragraph D, however, that in either case, the amount due the contractor shall be determined in accordance with paragraph B of Article XII.

> If this agreement is terminated or nonrenewed by the Secretary and/or the Intermediary *in any manner provided in this agreement*. . . any funds determined to be due . . . the Intermediary after the application of Article XIII shall be paid to such party. . . . In determining the amount due to either party, reimbursable costs shall be determined in accordance with paragraph B of Article XII.

(Article XXVI, paragraph D.) The contract thus provides that, for purposes of determining the reimbursement of contractor costs after the contract has ended, termination and non-renewal are equivalent. In both cases, the contractor's reimbursement is to be determined in accordance with Paragraph B of Article XII; paragraph B states that the costs are to be determined in accordance with the provisions of FAR Part 31. As mentioned above, FAR 31.103(b) specifically references FAR 49.103 and 49.113, and 49.113 specifically references FAR 49.201, which specifically provides that business judgment is the heart of a settlement.

Any attempt by the Government to create a distinction and limit the applicability of FAR 49.103, 49.113, and 49.201 as referenced in Part 31 to terminations for convenience and default is without merit. [2]

[2] Reading the contract to mean that FAR 49.103, 49.113, and 49.201 apply only to contracts terminated for default, but not to contracts terminated or non-renewed by a Medicare contractor in accordance with the terms of the contract, would produce an odd outcome. Contractors who are terminated for default for problems such as performance failure or wrongdoing would be entitled to application of the principles described in FAR 49.201—including fair compensation, reasonable allowance for profit, the use of business judgment in arriving at a settlement, the goal of negotiating a settlement by agreement, and guidance that cost and accounting data are not the

5. **Conclusion**

It is the obligation of CMS to ensure that Premera is fairly compensated, to ensure that Premera does not suffer a loss, and to utilize business judgment, as opposed to strict accounting principles, in reaching those goals. Specifically as to treatment of the liability associated with the 21 terminees who have not yet requested payment of their benefits, sound business judgment requires CMS to recognize that using actuarial assumptions appropriate during contract performance will not capture Premera's potential actual liability after termination and will in fact result in a contractually inappropriate loss to the company. Premera submits that, in light of these facts, the proper measure of the liability for the 21 terminees is the sum of the amounts of their individual lump sum benefits.

E. Terminated Vested Participants with Lump Sum Payments – Liabilities Understated

The OIG asserts that Premera's methodology understated the final liabilities for terminated vested participants who received a lump sum payout in 2005. (Draft Report at 5) The OIG recommends increasing the final liabilities for these terminated vested participants by $50,216. Premera agrees with the OIG's recommendation.

III. MEDICARE'S SHARE OF EXCESS PENSION LIABILITIES

Premera disagrees with the OIG's conclusion that Medicare's portion of excess segment pension liabilities is $190,637. (Draft Report at 6) Premera's position is that Medicare's portion of excess segment pension liabilities is $599,686, as explained below.

Premera did not overstate Medicare liabilities for active participants by $170,223 and for terminated vested participants by $249,745. Premera has explained in detail in section II. above why these amounts, which are the lump sum liabilities for these participants, should be included in the Medicare segment liabilities. Premera agrees with the OIG's recommendation that Premera increase the final liabilities for terminated vested participants who received a lump sum payout in 2005 by $50,216. Therefore, Premera's position is that the Medicare segment liabilities are $3,334,632.

---

only basis on which fair compensation may be determined—but Medicare contractors who do not have such performance problems and who terminate or non-renew as permitted by the terms of the contract would not. It would be unreasonable to interpret the contract in a way that places a defaulted contractor in a better position than one who non-renews or terminates as permitted by the terms of the contract. This equitable view is consistent with the holding of the Armed Services Board of Contract Appeals in Metropolitan Life Insurance Co., ASBCA No. 27161, 85-2 BCA 17,973 (Costs claimed pursuant to contractor's "nonrenewal" right *"are not truly 'termination' costs as commonly understood [but] they are, nevertheless, to be measured for allowability as if they were."* 85-2 BCA at 90,153).

Premera does not understand the purpose of the adjustment of $5,089 in Table 3 of the Draft Report for "Application of Aggregate LOB Percentage." (Draft Report at 6) It does not appear to have an impact on the calculation of Medicare's share of excess pension liabilities.

The OIG concluded that 97.40 is the appropriate aggregate Medicare percentage to utilize to determine the portion of the segment's excess liabilities attributable to Medicare. (Draft Report at 6) Premera agrees with the OIG's percentage.

Therefore, Premera's position is that Medicare segment assets are $2,718,938 ($2,237,257 plus $481,681) and Medicare segment liabilities are $3,334,632 ($3,284,416 plus $50,216), resulting in excess Medicare segment pension liabilities of $615,694. Medicare's portion of the excess pension liabilities is $599,686 ($615,694 multiplied by 97.40 percent).

IV. CONCLUSION

For the foregoing reasons, Premera requests that the OIG revise its draft report to recommend that the Federal Government remit $599,686 to Premera.

Sincerely,

W. Bruce Shirk

W. Bruce Shirk

For POWELL GOLDSTEIN, LLP
Counsel to Premera Blue Cross

cc: Jamie Insley, Esq.
Office of General Counsel
U.S. Department of Health and Human Services
7500 Security Boulevard
C2-03-24
Baltimore, MD 21244

::ODMA\PCDOCS\WSH\386369\1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Actuary
7500 Security Blvd, N3-01-21
Baltimore, MD 21244-1850
Phone 410-786-6396
FAX: 410-786-1295
E-Mail Russell.Weatherholtz@cms.hhs.gov

MEMORANDUM

To: Jenenne Tambke, Audit Manager

CC: Eric Shipley, Senior Pension Actuary

From: Russ Weatherholtz, Pension Actuary

Date: June 19, 2006

Subject: Premera Excess Medicare Assets for PEP

This memo is in response to the letter written by Mr. W. Bruce Shirk of Powell Goldstein, LLP to Mr. Patrick J. Cogley on April 28, 2006, concerning the results of the "Review of the Pension Segmentation Requirements at Premera Blue Cross, a Terminated Medicare Contractor" (Report number A-07-05-00191.)

In his letter, Mr. Shirk claims that no actuarial assumptions are needed in determining the termination liability for Premera's pension participants who have not retired. The basis for his claim is the nature of Premera's pension equity plan (PEP), which determines a lump sum directly from the plan formula. His logic is incorrect. A PEP benefit formula develops an account balance which can be used as the lump sum option. According to section 5.03 of the Premera Pension Equity Plan and Trust Agreement, in order to compute the Normal Form of Benefit, Premera must take this account balance and "calculate the actuarial equivalent benefit as a straight life annuity." The lump sum is merely another option for which plan participants can choose. Although they normally will, PEPs do not have to offer lump sum options. Because they are defined benefit plans, PEPs must offer annuity options, **and consequently the plan liability cannot be determined by the lump sum entitlements.**

The plan formula does not dictate what form of benefit participants will elect to receive. The benefit options from which they have to choose are the same in a PEP as they are in a traditional plan. Premera's valuation assumptions project that on average 50% of terminated employees and future terminations choose to receive a lump sum at or before their retirement and 50% will choose an annuity upon retirement. The Premera plan actuaries at Watson Wyatt Worldwide

(Wyatt) derived this assumption from the actual historical experience of Premera PEP participants.

Paragraph 9904.413-50(c)(12)(i) of the CAS regulations states that "the actuarial assumptions employed shall be consistent with the current and prior long-term assumptions used in the measurement of pension costs." According to Mr. Shirk, this does not apply to non-traditional pension plans, such as Premera's PEP. This is wrong. The CAS makes no distinction about the basic or optional forms of payment available under a defined benefit plan but relies on the contractor's established practice. For ERISA, Wyatt utilizes a set of assumptions to value the PEP liabilities, just as they would for a traditional plan. For FASB, Wyatt utilizes a set of assumptions to value the PEP liabilities, just like they would for a traditional plan. And during the years that Premera was performing the Medicare contract, its actuary used a set of assumptions to measure the liability and normal cost of the plan. Therefore, for CAS 413 purposes, we used the set of assumptions that Wyatt had been using to value the plan.

Mr. Shirk also claims that Premera's Medicare contract dictates that Premera "not suffer a loss in the performance of the contract." He says that if all of the employees in question were to actually elect lump sums, a loss would be incurred. This only paints half of the picture. The contract also states that Premera should not profit as a result of being reimbursed for more than the costs pertaining to the contract. If we assume that all participants will elect lumps sums immediately but only half of the participants actually do, a profit is incurred by Premera, which is not allowed by the contract.

Actuaries create assumptions to balance the gains and losses inherent in valuing plan liabilities; that is, gains are expected to be just as likely as losses. The CAS requires that these assumptions be used when computing termination liability in accordance with CAS 413-50(c)(12)(i):

> "The determination of the actuarial accrued liability shall be made using the accrued benefit cost method. The actuarial assumptions employed shall be consistent with the current and prior long term assumptions used in the measurement of pension costs."

Wyatt drew on the experience of the plan when they created the assumptions for the Premera PEP. Specifically the form of benefit assumption is that "50% of the terminated vested participants who are eligible to do so are assumed to elect a lump sum and 50% are assumed to elect a deferred annuity." This is not an arbitrary assumption. It holds up very well. When we look at the participants who terminated as a result of this segment closing, less than half of them have chosen to receive their lump sum at this time. Moreover, this assumption is only applied to the liability for terminated participants who did not make an election to receive a lump sum. And there is no evidence that these employees will take a lump sum prior to retirement. We only have a probability of this action, for which Wyatt has established a reasonable assumption. Mr. Shirk's insistence that the termination liability be calculated using immediate lump sum values is not only incorrect in theory, but also inaccurate as shown by actual experience.