DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 23 1991

From Richard P. Kusserow
Inspector General

Subject Report on the Audit of Administrative Costs Incurred by Nationwide Mutual Insurance Company Under Part B of the Health Insurance for the Aged and Disabled Program (A-05-91-00064)

To Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on October 24, 1991 of our final audit report. This report was prepared under audit contract with the certified public accounting firm, Kant Doshi and Associates, P.C. A copy is attached.

Administrative costs claimed by Nationwide Mutual Insurance Company (Nationwide) for the period October 1, 1986 through September 30, 1989 under Part B of the Health Insurance for the Aged and Disabled program contained amounts recommended for financial adjustments of $3.3 million. Financial adjustments pertained to postage charges in excess of reasonable needs of $1,453,465, unauthorized costs of $739,708, overstated charges for leasehold improvements of $269,226, overcharges for data processing costs of $251,476, unallowable fringe benefit costs of $211,422, imputed interest on excess postage of $180,649, overcharges from inappropriate accruals of $105,369, and unallowable pension, return on investment, travel, service charge and depreciation expenses of $78,.012.

We are recommending that Nationwide make appropriate financial adjustments in these amounts. We are also recommending appropriate procedural improvements in relation to financial recommendations. The auditee concurred with financial adjustments amounting to $710,523 and the procedural recommendations. Regional Health Care Financing Administration officials generally concurred with the financial and procedural recommendations.

For further information contact:
Martin D. Stanton
Regional Inspector General
for Audit Services, Region V
FTS: 353-2618

Attachment

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE AUDIT OF ADMINISTRATIVE COSTS INCURRED UNDER PART B OF THE HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM

NATIONWIDE MUTUAL INSURANCE COMPANY

FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1989, 1988 and 1987

Richard P. Kusserow
INSPECTOR GENERAL

A-05-91-00064

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION V
300 SOUTH WACKER DRIVE
CHICAGO. ILLINOIS 60606

OFFICE OF
INSPECTOR GENERAL

Our Reference: Common Identification Number A-05-91-00064

Mr. William Ramsey
Vice President, Medicare
Nationwide Mutual Insurance Company
P.O. Box 16788
Columbus, Ohio 43216

OCT 24 1991

Dear Mr. Ramsey:

Enclosed for your information and use are two copies of an Office of Inspector General audit report titled "Report on the Audit of Administrative Costs Incurred Under Part B of the Health Insurance for the Aged and Disabled Programs" for the period October 1, 1986 through September 30, 1989. The report was prepared under audit contract with the CPA firm, Kant Doshi and Associates, P.C. Your attention is invited to the audit findings and recommendations contained in the report.

Final determinations as to actions to be taken on all matters reported will be made by the HHS official named below. The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time.

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To facilitate identification, please refer to the referenced common identification number in all correspondence relating to this report.

Sincerely,

Mark D. Stern

Regional Inspector General
for Audit Services

Enclosures

Direct reply to:

Judith Stec
Asociate Regional Administrator
Division of Medicare

SUMMARY

Nationwide Mutual Insurance Company (Auditee) claimed administrative costs for Medicare, Part B, as follows:

Fiscal Year			
1989	1988	1987	Total
$39,884,363	$34,662,303	$32,259,775	$106,806,441

Of the $106,806,441 in administrative costs claimed by the Auditee during the period covered by our audit, we are recommending $3,289,327 for financial adjustment. Tne remaining $103,517,114 is recommended for acceptance.

Our findings and recommendations are summarized in the paragraphs that follow.

POSTAGE COSTS

At the end of FY 89 the Auditee had a balance of $1,788,553 in postage. This balance included: (1) $1,388,553 of postage on hand and (2) $400,000 of accrued postage expense not purchased or received. Further, we noted that the average monthly prepaid postage balances were considerably in excess of the average monthly usage during the three fiscal years audited. These excess balances cost the Federal government at least $180,649 in interest expense. We have recommended that $1,453,465 of postage costs and $180,649 of imputed interest expense be cost questioned.

UNAUTHORIZED COSTS

A total of $739,708 was claimed in FY 89 for activities outside of the normal Medicare operations that was not authorized in the approved NOBA. The Medicare Agreement provides that such costs are allowable if specifically approved in the NOBA. These costs were claimed appropriately on Line 9 of the FACP. However such costs were never approved by HCFA on Line 9. The Auditee indicated these costs would be allowable on Line 1. We determined that the total amount claimed on Line 1 was already at the maximum approved NOBA. Any additional costs identified to Line 1 would be in excess of the approved amount and would exceed the "CAP" established by HCFA.

LEASEHOLD IMPROVEMENTS

The Auditee overstated Medicare costs in FY 89 by $269,226 for leasehold improvements. Rather than capitalizing the cost of improving its computer room, such costs were expensed. The Medicare Agreement requires that items of equipment with a unit cost greater than $500 and a useful life of one year or more should be capitalized. We are recommending the Auditee depreciate the leasehold improvement and the amount in excess of current depreciation be disallowed.

DATA PROCESSING COSTS

The Auditee claimed $251,476 for data processing costs in FY 89 that represented a subcontractor's work on conversion of the Common Working File. This work was actually performed in FY 90. We are recommending the cost be questioned in FY 89.

FRINGE BENEFITS

Contrary to Federal Acquisition Regulations (FAR) the Auditee included amounts for a contingency reserve for catastrophic losses in its fringe benefit costs claimed. Medicare was charged $211,422 of the contingency costs in FY 89 that we recommend be disallowed.

ACCRUED EXPENSES

The Auditee established an accrual of $100,000 for relocation and remodeling projects and electricity charges in FY 89. However, these projects were not performed until FY 90. Also an accrual of $5,369 was established in FY 87 for legal expenses related to the Edgepark operation. Due to an oversight, this accrual was not reversed in FY 88. As a result, Medicare was overcharged in FY 88. We have cost questioned the $105,369 as unallowable.

PENSION EXPENSES

The Auditee changed its employee's retirement plan year in FY 89 from a fiscal year ended on February 28 to a calendar year. As a result of this change the Auditee inadvertently overstated Medicare's share of the pension expenses for FY 89 by a total of $27,471. This amount was applicable to FY 90. We have recommended the overstated pension expenses be disallowed.

RETURN ON INVESTMENT

Medicare costs were overstated by a net amount of $19,164. This resulted from the inappropriate computation of the ROI rate. The Auditee did not use the average net book value of assets and the cost of investments in the computations. Instead the Auditee used an adjusted quarterly net book value

and the market value of the investments. Further, the Auditee failed to credit Medicare for ROI related to a prior audit recommendation. We are recommending the $19,164 be disallowed.

UNALLOWABLE TRAVEL COSTS

During the three fiscal years audited, the Auditee claimed a total of $15,415 in travel costs related to the employee's personal use of company autos. This was unallowable in accordance with FAR. We are recommending these costs be disallowed.

SERVICB CHARGES

Medicare was overcharged $7,789 in Cafeteria and Human Resources costs during the period audited. These overcharges resulted from: (1) the use of an erroneous Medicare employee head count and (2) the inclusion of certain personnel costs that did not benefit Medicare. We have recommended these costs be disallowed.

DEPRECIATION EXPENSE

The Auditee had not followed its established policy in relation to depreciation. Normally a 10 percent salvage value was used for fixed assets. In some instances the Auditee had depreciated the asset below the 10 percent salvage value. In an attempt to correct the depreciation expense the Auditee credited a corporate account rather than Medicare. We are recommending that Medicare receive the appropriate adjustment of $8,173 in FY 88.

COMPLEMENTARY CREDITS

During the three fiscal years audited the Auditee had charged outside organizations a complementary insurance rate of $.43 per claim that was approved by HCFA. This rate was insufficient to recover the Auditee's full cost of processing a claim. We determined the Auditee had undercharged outside organizations and overcharged Medicare a total of $905,724 during the three years. Since HCFA had formally approved the $.43 complementary credit rate used by the Auditee, we have not questioned the undercharge. However we are recommending that in the future the Auditee should review the complementary credit rate at least annually to determine if the rate is adequate to cover the full cost of processing a claim. Further HCFA should be provided the results of the study.

ALLOCATION SYSTEM

The Auditee did not have a cost accounting system that provided for the identification and accumulation of costs by FACP operation line item. Instead the Auditee estimated the costs at the beginning of each fiscal year by line item and made periodic adjustments to reconcile to the NOBA. Further, the Auditee did not maintain the necessary records to support the estimates or basis of adjustments. As a result of these weaknesses, we could not determine the validity or accuracy of costs distributed to the line items. However, except as disclosed elsewhere in this report, we determined that the total costs claimed were incurred, reasonable and allowable. We are recommending certain changes to the Auditee's accounting system.

CORPORATE SUPPORT OVERHEAD

The Auditee needs to perform a study of the Corporate support overhead costs and salary base. We found that (1) unallowable costs were included in the overhead pool and (2) the salary base was understated. Further there were considerable amounts of middle management costs that were not claimed. However these middle management costs would be allowable if claimed.

UNTIMELY ALLOCATION UPDATE

The Auditee had not updated its allocation tables for the Purchasing Department charges to Medicare. Although the rates charged during this period had no adverse effect on Medicare, the Auditee should perform periodic studies (at least annually) to justify the reasonableness of such rates. We are recommending that studies be performed and documented.

AUDITEE COMMENT

Subsequent to processing the draft audit report we received additional information that resulted in adjustments in the final report. We revised the Complementary Credits and Corporate Support Overhead findings by deleting the costs questioned and recommending certain procedural changes. The Productivity Investment Sales tax finding was eliminated.

The Auditee has agreed to $710,523 of our recommended adjustments. They expressed disagreement with the remaining questioned costs. Further, they generally disagreed with our procedural findings and recommendations. Details relating to our adjustments are provided in the Findings and Recommendation section of this report. A copy of the Auditee's Comments is attached.

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INDEPENDENT AUDITOR'S REPORT

OPINION

We have audited the "Final Administrative Cost Proposals" (Form HCFA 1524) of Nationwide Mutual Insurance Company for the fiscal years ended September 30, 1989, 1988 and 1987. These financial statements are the responsibility of Nationwide Mutual Insurance Company's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards, "Government Auditing Standards," and the " Audit Guide for Review of Administrative Costs Incurred by Medicare Intermediaries and Carriers under Title XVIII of the Social Security Act." (draft interim audit instruction E-l, dated August 30, 1990). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

We have identified $3,289,327 in costs recommended for financial adjustment. The final determination as to whether such costs are allowable will be made by the United States Department of Health and Human Services.

Excluded from our audit was a review of pension segmentation and a determination of the effect of the FY 88 fully-funded pension plan on pension costs in future periods. These exclusions were requested by the Department of Health and Human Services, Office of Audit Services (OIG). According to OIG officials a separate audit will be performed of the pension segmentation at a later date. Based on the segmentation audit OIG indicated a final settlement would be made by HCFA of these pension issues.

In our opinion, with the exception of the ultimate resolution of the costs recommended for financial adjustment and the effects of such adjustments, if any, as might have been determined to be necessary for pension segmentation described

above, the "Final Administrative Cost Proposals" referred to above present fairly, in all material respects, the administrative costs applicable to Part B of the Health Insurance for the Aged and Disabled Program, claimed by Nationwide Mutual Insurance Company for the fiscal years ended September 30, 1989, 1988 and 1987 in accordance with the reimbursement principles of Part 31 of the Federal Acquisition Regulations, as contained in 48 Code of Federal Regulations (CFR) Chapter (CH) 1, interpreted and modified by the Medicare Agreements.

This report is intended solely for the use of management of Nationwide Mutual Insurance Company and the Department of Health and Human Services in regard to their agreement to administer the Medicare program and should not be used for any other purpose.

Dohi & Associates, P.C.

Kansas City, Missouri
January 24, 1991

INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act established the Health Insurance for the Aged and Disabled Program (Medicare). Part A of the program provides insurance protection against the costs of hospital and related care. The Medical Insurance Program, Part B - Supplementary Medical Insurance Benefits for the Aged and Disabled, is a voluntary program and provides protection against the cost of physicians' services and other health services not covered under Part A. The Medicare program is administered at the Federal level by the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services.

Title XVIII provides that public or private organizations, known as Intermediaries for Part A and Carriers for Part B, may assist in the administration of the Medicare program. Part A Intermediaries are nominated by provider groups. Nominations are submitted to HCFA, and agreements are entered into with approved Intermediaries. Part A Intermediaries receive funds for payments to providers for the cost of service to eligible individuals and for the Intermediaries' administrative costs in operating the program. Carriers are reimbursed for all reasonable and allowable costs incurred in administering the Part B program.

Nationwide Mutual Insurance Company (hereafter referred to as the Auditee), serves as a Part B Carrier. Benefit payments were made in the following amounts:

Fiscal Years		
1989	1988	1987
$1.363.209.969	$1,232,955,200	$1,045,423,488

SCOPE OF AUDIT

An examination was performed in accordance with the generally accepted auditing standards, "Government Auditing Standards," and the "Audit Guide for Review of Administrative Costs Incurred by Medicare Intermediaries and Carriers under Title XVIII of the Social Security Act." (draft interim audit instruction E-l, dated August 1990). We examined the administrative costs claimed by the Auditee for the period October 1, 1986 through September 30, 1989 to the extent that we considered necessary to determine if amounts claimed were in accordance with applicable Federal requirements, policies, and program instructions.

Our examination included audit procedures which were designed

to achieve the following objectives:

Determine whether the Auditee has established effective systems of internal control, accounting and reporting for administrative costs incurred under the program.

Ascertain whether the Final Administrative cost Proposals present fairly the costs of program administration allowable in accordance with Part 31 of the Federal Acquisition Regulations (FAR), as interpreted and modified by the Medicare Agreements.

Ascertain whether the Auditee has complied with contractual and administrative requirements governing specific items of costs.

Identify the underlying causes of significant errors or problems noted and make recommendations for improvements or adjustment of costs claimed as appropriate.

Our audit procedures included examination of pertinent accounting records and supporting documentations.

Our audit excluded the review of pension segmentation and the effect of the fully-funded FY 88 pension plan on future periods' pension costs. These areas were excluded at the request of OIG. A separate audit will be performed of the segmentation by OIG at a later date. Further OIG officials indicated that a final settlement of these pension issues would-be made at that time.

The audit fieldwork was performed at the offices of Nationwide Mutual Insurance Company in Columbus, Ohio during the period June 13, 1990 through January 14, 1991.

FINDINGS AND RECOMMENDATIONS

POSTAGE COSTS

We determined that the Auditee had claimed an excessive amount of postage costs in FY 89. At September 30, 1989 the Auditee had a balance of $1,788,553 in postage. This balance included (1) $1,388,553 in postage on hand and (2) $400,000 of accrued postage expense not purchased or received. By allowing the Auditee to maintain an average month's usage on hand at September 30, 1989, we consider that $1,453,465 was in excess of Medicare's needs. Maintaining the excess prepaid postage balance cost the Federal Government at least $180,649 in interest expense. We are recommending the excess balance and interest expense totalling $1,634,114 be disallowed.

The Auditee purchases postage directly from the local post office and from a subsidiary of Pitney Bowes (RKRS). The Auditee recorded postage expense on the cash basis. Therefore, the amount of postage expense claimed did not agree to the time period (fiscal year) in which the postage was actually used.

We noted that the amount of postage expense claimed increased during the audit period. For FY 86 through FY 89 costs claimed were:

FY	Costs Claimed
86	$2,302,924
87	2,696,974
88	2,958,392
89	3,126,523

Part .of the increase in the postage expense is due to the Auditee's increase in mail volume.

Also we noted that the Auditee had the following amount of postage on hand at the end of each of the fiscal years audited:

FY	Amount of Unused Postaae
87	$1,000,536
88	1,399,745
89	1,388,553

The average monthly postage claimed was:

FY	Average Monthly Postage Claimed
87	$218,914
88	246,533
89	260,544

At September 30, the Auditee had the following monthly average supply of postage on hand that had been claimed during the previous fiscal year:

FY	Number of Average Months Postage On Hand at 9/30
87	4.57
88	5.68
89	5.32

For the year ended 9/30/90 the Auditee's average monthly postage usage was $335,088.

According to 48 CFR 31.201-3, a cost is reasonable if it does not exceed an amount that would be incurred by a prudent person in the conduct of competitive business. Considering the Auditee's volume of Medicare mailings and the timely access to postage meters, we believe a one month's supply of postage on hand is reasonable. A one months reserve of postage would allow sufficient time to replenish the supply.

Based on the average monthly postage usage of $335,088 in FY 90, we determined the Auditee had overcharged Medicare a total of $1,053,465. ($1,388,553 balance on hand 9/30/89 - $335,088 average monthly postage FY 90)

In addition to the above, the Auditee made a manual accrual adjustment to the FY 89 FACP in September 1989 to claim another $400,000 of postage. The actual purchase and receipt of this postage did not occur until October 1989. We consider this $400,000 to be an unallowable cost for FY 89.

Maintaining these excess postage inventory balances has cost the Federal government at least $180,649 in imputed interest costs. For the three years audited, we calculated the interest costs based on the Auditee's ROI rate charged Medicare. The calculation was as follows:

Average	FY 87	FY 88	FY 89	Total
Month End Balance	$758,643	$1,184,129	$1,603,949	
Monthly Usage	218,914	246,533	260,544	
Excess Balance	$539,729	$937,596	$1,343,406	
ROI Rate	6%	6.5%	6.5%	
Imputed Interest	$32.384	$60.944	$87.321	$180,649

We consider these ROI rates to be reasonable for calculating the computed interest costs. Application of the Auditee's actual ROI rates for the three fiscal periods would result in total computed interest expense of $256,432. The actual ROI rates were 10.29%, 9.62% and 8.24% for FY87, FY88 and FY89, respectively.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments for the following:

	FY 89
Postage Purchased	$1,053,465
Postage Accrual	400,000
Imputed Interest	180,649
Total	$1.634.114

AUDITEE COMMENTS

The Auditee agreed that most of the postage purchased during the last six months of FY 89 was not used until FY 90. However, they disagreed with our position that only one month's supply of postage should be allowed. Also the Auditee provided details of several conditions including program changes and meter breakdowns that contributed to the large balance at FY 89 year end. Considering these conditions, they recommended that 3 months usage, or $1,005,364 be allowed as an acceptable balance at FY 89 year end. Further, they indicated that $783,289 should be repaid to HCFA.

The computed interest costs questioned were added to the report subsequent to receiving the Auditee's comments on the draft report. Consequently no official response has been received for inclusion in this report.

AUDITOR RESPONSE

We contend that one month's supply of postage on hand was adequate for the FY 89 year end. According to the Auditee's Administrative Services Department it normally took 10 to 14 days to obtain additional postage. Considering this time frame, we felt that the average monthly usage for FY 90 would be representative of the postage needs for October 1990.

The FY 90 average monthly usage of $335,088 was considerably higher than the FY 89 average usage of $260,544. The difference of $74,544 accounted for Medicare program changes that resulted in increased postage usage in FY 90.

Regarding the additional postage costs resulting from the meter breakdowns, these costs were reflected in the Auditee's ending inventory balance of $1,388,553.

September 1989 Balances

Beainninq	Purchases	Usaae	Balance on Hand
$1.225.474	$415,333	$252,254	$1.388.553

The purchases of $415,333 includes postage meter replacements. The ending balance is the net amount available for October 1990. Considering these facts, we concluded that the use of the FY 90 average monthly usage of $335,088 was an adequate adjustment in computing the excess postage costs at September 30, 1989.

We also noted that the actual amount of postage in meters at the Auditee's facilities was generally less than 20 percent of the total postage available. For the three years audited we noted the following:

Postaae Inventorv Recorded

Sept. 30	Total Postaqe	Metered at Nationwide	Available at RMRS	Percentage at Nationwide
FY 87	$1,000,536	$96,768	$903,768	9.67%
FY 88	1,399,745	280,745	1,119,000	20.05%
FY 89	1,388,553	219,554	1,168,999	15.81% *

* This does not include the $400,000 accrual adjustment.

In summary, we still contend that the excess postage at September 30, 1989 was $1,453,465. Also we believe that HCFA should cost question $180,649 of imputed interest costs.

UNAUTHORIZED COSTS

The Auditee claimed $739,708 on the FY 89 FACP that had not been approved on the NOBA. We recommend the amount be disallowed since it was not approved on the NOBA.

On the FY 89 FACP the Auditee claimed a total of $1,239,134 for various activities outside of the normal Medicare operations. These costs were claimed and included on Other line items <9-11> on the FACP for the following activities:

Activity	Cost Claimed
Moving Costs	$471,739
System Implementation	449,638
Incentive Payment	230,200
Litigation Costs	55,506
Request for Proposal	32,051
	$1.239.134

The latest approved NOBA, Supplemental Number 8 dated September 29, 1989, authorized only the Incentive Payment Activity.

The Medicare controller indicated that the Auditee notified HCFA that costs for the activities listed above would be incurred. However, funding for only one of the activities was included in the approved budget. Also the Auditee indicated that HCFA could approve these costs on Line I of the FACP as processing costs.

The Medicare Agreement contains references to the allowability of costs incurred for activities outside of normal Medicare operations.

Article XV C. states:

"In connection with the allowability of any particular item of cost, the Carrier may, from time to time, submit to the Secretary a request as to whether such item of cost is allowable. A written communication from the Secretary to the Carrier that such item of cost is allowable shall constitute a determination of allowability for purposes of this contract."

More specific guidance was provided in Section 4213.9 of the Carriers Manual relating to Lines 9, 10, and 11 on the FACP, which states:

"Use these lines only upon receiving specific authorization by HCFA."

Regarding the litigation costs claimed, Article XV E. of the Medicare Agreement provides that administrative costs:

> "... shall only be reimbursable if such settlement was entered into with the prior written approval of the Secretary."

Considering the above provision, we concluded that the Auditee needed specific approval for each of the subject items. The amounts and activities we consider unallowable are:

Activity	Costs Claimed	
Moving Costs	$202,513	*
System Implementation	449,638	
Litigation Costs	55,506	
Request for Proposal	32,051	
Total	$739,708	

* The total moving costs of $471,739 have been reduced by $269,226, representing an amount questioned under the "Leasehold Improvements" finding addressed elsewhere in this report.

Regarding approval of these costs on Line 1 of the FACP, we noted that costs claimed were already at the maximum amount approved on the latest NOBA. If the Auditee were to claim these costs on Line 1 they would exceed the maximum allowable or the CAP established by HCFA. Thus such amounts would be questionable.

RECOMMENDATION

We recommend the Auditee make the appropriate financial adjustments for the unauthorized costs claimed of $739,708 in FY 89.

AUDITEE COMMENTS

The Auditee disagreed with the finding and recommendation. They indicated that the Edgepark Litigation and Request for Proposal was approved in the FY 88 NOBA. However, the FY 88 FACP was already submitted when approval was received. In FY 89 these costs were approved but the final NOBA has not been issued. According to the Auditee, the moving costs and system implementation were included in the FY 89 Budget Request and negotiated with HCFA. Again these costs have not been approved on a final NOBA.

AUDITOR RESPONSE

We recognize that such costs were included in the various Medicare contractual documents. However, Section 4213.9 of the Carriers Manual requires the amounts claimed on Lines 9,

10 and 11 of the FACP must receive specific authorization. These costs have not received specific approval on a final NOBA for FY 89. Consequently we still contend our finding and recommendation are valid.

LEASEHOLD IMPROVEMENTS

The Auditee did not capitalize certain leasehold improvements in FY 89. This resulted in an overstatement of Medicare costs by $269,226.

During FY 89 the Auditee moved its Medicare operations to a new office building. In order to accommodate the Medicare operations, the Auditee was required to make improvements to the offices. The improvements were primarily to the computer room. The improvements consisted of:

Improvement	cost
Air Conditioning Equipment	$113,229
Power Distribution Units	55,535
Engineering and Other Fees	54,518
Raised Flooring	30,433
Card Key Readers	23,278
Balums	22,147
	$299,140

The Medicare controller had several discussions with the Corporate Office regarding the proper procedures to account for these costs. The Medicare controller requested that the cost of the leasehold improvements be amortized over 5 years. However, the Corporate Office decided that the leasehold improvements should be expensed. The Corporate Office indicated that company policy was to recoup the cost of the improvements over the term of the lease, and the Medicare Agreement was for only one year. Consequently the total cost was charged to Medicare in FY 89.

Appendix B, Section IV to the Medicare Agreement provides that all equipment having a unit cost greater than $500 and a useful life of more than one year should be depreciated.

The Medicare operations were transferred to the new location at approximately half-way through FY 89. Medicare was allocated enough space to equal the estimated need for a five year period. Allowable amortization for the six months in FY 89 would be calculated as follows:

Costs Claimed	$299,140
Allowable Amortization for 1/2 Year	29.914
Costs Recommended to be Disallowed	$269.226

RECOMMENDATION

We recommend that the Auditee:

1. Capitalize the leasehold improvements of $299,140 over five years.

2. Make the appropriate financial adjustment for the $269,226. This is the difference between the allowable amortization for FY 89 and leasehold improvement costs claimed.

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Leasehold Improvements. In addition, they indicated such costs would be claimed in FY 90 and succeeding years.

DATA PROCESSING COSTS

The Auditee overstated data processing costs by $251,476 in FY 89. This amount represents the cost of services provided by a data processing firm in FY 90 rather than in FY 89.

The Auditee contracted with a data processing firm to work on the conversion of the Common Working File. The firm was paid for its services based on the actual number of man-hours and machine hours. Accordingly, the firm billed the Auditee a total of $467,789 on two invoices dated December 29, 1989.

We tested the firm's detail man-hour and machine hour supporting documentation and found only minor differences with the total number of hours billed. However, we noted that of the $467,789 billed, $251,476 was associated with services performed after September 30, 1989. Such costs would apply to FY 90.

	Man-hours	Machine Hours	Total (Rounded)
Total Hours Billed	4,373.70	320.1433	
Hours Incurred by 9/30/89	3.019.51	17.6411	
Hours Incurred after 9/30/89	1,354.19	302.5022	
Times Hourly Billing Rate	$65.00	$497.00	
	$88,022.35	$150,343.59	
Times Factor to Add Sales Tax	1.055	1 . 055	
Costs Incurred after 9/30/89	$92.863.58	$158.612.49	$251.476

The 48 CFR 31.201-2 states:

> "That the factors to be considered in determining whether costs are allowable include . . . generally accepted accounting principles..."

Under generally accepted accounting principles, costs are incurred when services have been rendered. Because the programming services were not completed by September 30, 1989, the costs associated with services performed after that date should not be claimed in FY 89 but should be claimed in FY 90.

The Medicare controller explained that the Auditee knew that work on the Common Working File could not be completed until the new claims processing system was installed. The Auditee requested funds for the Common Working File in its FY 90 Budget Request. HCFA did not approve funding for FY 90. NOBA Supplemental Number 7, dated September 28, 1989, provided for the estimated total cost of the project for FY 89. NOBA Supplemental Number 8, dated September 29, 1989, adjusted the approved funding for FY 89 to the $467,789 claimed by the Auditee. This project was approved as a Productivity Investment.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments for the FY 89 overstated data processing costs of $251,476.

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Data Processing Costs. In addition, they indicated such costs would be claimed in FY 90.

FRINGE BENEFITS

The Auditee overcharged Medicare by a total of $211,422 in FY 89 for fringe benefits. Included in the charges for fringe benefits was an amount that represented a contingency reserve for catastrophic losses. As a self-insurer, 48 CFR 31.205-19 prohibits the Auditee from including any amount for contingencies in the rate structure.

During the period covered by audit the Auditee offered the following fringe benefits under the Nationwide Group Plan:

> Life Insurance, Accidental Death & Dismemberment (AD&D), Long-Term Disability (LTD), Major Medical, Dental and Medicare Supplement

All of these fringe benefits were considered as a package by the Auditee. Cost sharing by the Auditee and the employee varied for each type of benefit. The actual administration of the fringe benefit group plan was accomplished by the Nationwide Life Insurance Corporation.

According to the Auditee, income and expenses related to the Nationwide Group Plan were combined to determine the net gain or loss for each year. They contend that as long as the group plan was not experiencing a net loss the premiums remained fairly constant. From CY 86 through CY 89 the premiums and sharing for the employer and employee remained the same for each of the benefits. In total the Auditee had shown a net accumulative loss for CY 87 and CY 88. However, in CY 89 the group plan showed a considerable net accumulative gain.

Our review of the financial reports for the Nationwide Group Plan showed the Auditee had experienced continued losses on major medical insurance and gains in the other benefit categories. These gains were sufficient to offset the losses in medical insurance. At the end of CY 89 the Auditee's financial report showed that major medical had an accumulative loss of $36.4 million. The Auditee transferred the gains from the other benefit categories to offset the loss. Auditee officials indicated that in CY 90 each benefit will be separate and not treated as a group plan for determining gain or loss.

At the end of CY 89 the Auditee's financial report also showed the following end of the year reserve balances:

	Reserve Balance 12-31-89		
Insurance Benefit	Claim Reserve (a)	Contingency Reserve (b)	Total Funds
Life	$ 5,221,538	$ 652,351	$ 5,873,889
AD&D		52,673	52,673
WI/LTD	22,700,000	1,728,277	24,428,277
Major Medical	7,680,000	3,286,990	10,966,990
Dental	700,000	823,356	1,523,356
Medicare Supplement	1,000,000	64,299	1.064.299
Total	$37.301.538	$6,607,946	$43,909,484

(a) This amount was the reserve balance established by State statutes. The reserve amount shown for Life Insurance is overstated by $942,851 ($5,221,538-$4,278,687). This amount should be considered as part of the contingency reserve.

(b) This amount was the contingency reserve balance established for catastrophic losses.

According to 48 CFR 31.205-19(5)(c):

"Insurance provided by captive insurers (insurers owned by or under the control of the contractor) is considered self-insurance, and charges for it must comply with the self-insurance provisions of 30.416."

Further, 48 CFR 31.205-19(5)(e) of this Section provides that:

"Self-insurance charges for risks of catastrophic losses are not allowable . .."

The latter provision is further emphasized in 48 CFR 28.308(e) which states:

"Agencies shall not approve a program of self-insurance for catastrophic risks . .."

Based on the above provisions, we concluded that the Auditee's employee group plan was self-insured. Also we consider the amount identified as contingency reserves at December 31, 1989 to be unallowable. We calculated Medicare's share of the unallowable contingency reserves as follows:

Medicare Percentaue	
Medicare Premiums (CY 89)	$ 1.084.447
Total Corporation Premiums (CY 89)	$38,696,494 = 2.8%
Continuency Reserves	
Reserves	$ 6,607,946
Overstated Life Reserve	942.851
Total Contingency Reserve	$7,550,797
Medicare Share	
2.8% x $7,550,797 =	$ 211,422

The amount we calculated for Medicare should be disallowed.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments to the FY 89 FACP for the $211,422 in unallowable contingency reserves.

AUDITEE COMMENTS

The Auditee disagreed with the finding and recommendation. They contend that the reserve levels for FY 89 fringe benefits were proper and allowable. In addition, the Auditee provided a letter from the Nationwide Mutual Insurance Company Associate Group Actuary. (See attached.) The actuary indicated that the Medicare reserves were not to cover catastrophic losses. Instead these reserves are to be used to mitigate future adverse claims fluctuation and reduce the level of future rate actions. Also the actuary indicated

Medicare reserves were not in excess of statutory required reserves.

AUDITOR RESPONSE

The statutory reserve amounts are established actuarily based on State requirements. Such reserves are established to cover the estimated future losses, including anticipated fluctuations for the amount of insurance in effect at that date. Further, each plan year the insurer establishes premiums that should cover the current cost and anticipated claims fluctuations for that year. Since the statutory reserves and current premiums should cover the insurance costs, we concluded the Contingency Reserve was, in fact, established for future contingencies. Our conclusion was further supported by the Auditee's actuary letter which stated, "The positive reserve balances will mitigate future adverse claims fluctuation and reduce the level of future rate actions."

Contingencies according to 48 CFR 31.205.7 are not allowable costs under a cost type contract. Consequently we still contend our recommended disallowance is proper.

ACCRUAL EXPENSES

The Auditee overstated Medicare costs by a total of $105,369 during FY 89. These costs included expenses for: (1) the relocation and remodeling of facilities and electricity charges for Medicare purposes and (2) the consultant and professional services related to the Edgepark operation.

According to 48 CFR 31.201-2, one of the factors to be considered in determining whether costs are allowable is the application of generally accepted accounting principles. Under these principles, costs are incurred when services have been rendered.

Relocation and Remodeling

On September 15, 1989 Corporate Facilities prepared two Service Requests for the Medicare operations. Service Request number 60993 was to record costs of $52,000 for various relocation and remodeling projects. Service Request number 60994 was to record costs of $48,000 for electrical charges for the fiscal year ended September 30, 1990. A total of $100,000 was expensed in September 1989. However, such costs were not incurred until FY 90.

Medicare's billings from Corporate Facilities for the actual expenses incurred were as follows:

Relocation and Remodelinu Charues		Electrical Usaue	
Statement Date	Amount Charued	Statement Date	Amount Charued
10-26-89	$1,624	10-26-89	$ 3,157
10-31-89	4,961	11-17-89	3,157
l-25-90	6,216	12-20-89	3,125
2-23-90	3,276	l-25-90	2,778
2-28-90	795	2-26-90	2,689
3-30-90	1,843	3-30-90	2,671
4-27-90	4,701	4-27-90	2,892
5-22-90	131	5-22-90	2,803
6-26-90	13,738	6-25-90	2,904
8-27-90	3,647	7-26-90	2,778
g-28-90	11,068	8-30-90	2,910
	$52,000	8-31-90	16,136
			$48,000

Since the relocation, remodeling and electrical services were not provided until FY 90, the $52,000 and $48,000 claimed in FY 89 were unallowable.

Edgepark

The Auditee made a $5,369 accrual entry in FY 87 for consultant and professional services related to the Edgepark operation. This accrual was not reversed in FY 88, thus resulting in an overstatement of costs.

The Auditee indicated they could not find where the accrual was reversed in FY 88. However, they intended to research the records further to determine if the entry was made. At the conclusion of our audit the Auditee still had not found the reversing entry. Consequently we are recommending the $5,369 be disallowed.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustment to correct the inappropriate accruals:

	FY 88	FY 89	Total
Relocation & Remodeling		$100,000	
Equipment Accrual	5,369		
Total	$5,369	$100,000	$105,369

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Accrual Expenses. In addition, they indicated such costs would be claimed in FY 90 and succeeding years.

PENSION EXPENSES

The Auditee overstated the pension costs on Medicare in FY 89 by $27,471. This resulted from the Auditee changing its pension plan from a fiscal year to a calendar year basis.

As of March 1, 1989 the Auditee changed the year end of its retirement plan from a fiscal year end of February 28 to a calendar year end of December 31. For the fiscal year ended February 28, 1989 the Auditee's actuarial report showed that the plan was fully funded. Consequently no contributions were necessary for that period. Regarding Medicare, no pension costs were claimed in FY 89 for the five month period October 1, 1988 to February 28, 1989.

For the ten-month period March 1, 1989 through December 31, 1989 pension costs of $549,419 were charged to Medicare. Of this amount seven-tenths of the expense (March-September) or $384,593 was applicable to Medicare for FY 89. However, the Auditee claimed $412,064 for the seven months which is $27,471 greater than the allowable. The latter amount was applicable to FY 90.

It should be noted we did not review the Auditee's pension segmentation calculations. Also we did not determine the effect of the FY 88 fully-funded pension plan on future period costs.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments for the $27,471 in overstated pension costs in FY 89.

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendations related to Pension Expenses. In addition they indicated such costs would be claimed in FY 90.

RETURN ON INVESTMENT

The Auditee's method to compute the Return on Investment (ROI) was not in accordance with the Medicare Agreement. Also, the Auditee failed to give Medicare credit for the ROI associated with an error in the fixed asset records. These discrepancies resulted in overstating Medicare costs by a total of $19,164 during the three fiscal years audited.

ROI Computation Method

Appendix B, Section X of the Medicare contract provides that ROI is to be determined by multiplying the average undepreciated fixed asset balance by the actual rate of return on the investment portfolio, or a lower rate if the contractor so chooses.

We noted that the Auditee computed ROI quarterly. They used a fixed asset balance of an amount equal to one-fourth of the fixed assets' net book value on the last day of the quarter. This is not in accordance with the provisions of the Medicare contract. The average net book value should have been used.

To compute the rate of return on the investment portfolio, the Auditee used the market value of investments. This is also not in accordance with provisions of the Medicare contract. The investments should be stated at cost rather than market value. Also, specifically unallowable investments (related organizations, property held for investment and non-interest bearing accounts) were included in the Auditee's calculation.

We recalculated the rate of return and noted that the actual rate was greater than the rate used by the Auditee. Therefore, we used Auditee's rate and multiplied the rate by the average net book value for each quarter. Our computations resulted in the following:

Qtr. Ended	Calculated ROI	ROI Claimed	Difference
12-86	$13,877	$13,757	<$ 120>
3-87	12,912	13,580	668
6-87	12,644	12,655	11
9-87	13,669	12,633	< 1,036>
	$53,102	$52,625	< 477>
12-87	$14,648	$13,011	<$1,637>
3-88	15,110	16,285	1,175
6-88	14,857	14,953	96
9-88	12,822	14,762	1,940
	$57.437	$59.011	$1.574
12-88	$14,253	$14,435	$ 182
3-89	15,075	14,070	< 1,005>
6-89	14,757	13,761	< 996>
9-89	14.598	13.483	< 1,115>
	$58.683	$55.749	<$2,934>

As shown, the Auditee understated < > ROI for FY 87 and FY 89 and overstated ROI in FY 88.

Unreported Credit

The prior audit report disclosed that the Auditee overstated the value of the Medicare fixed assets by $122,804, thus inflating ROI by $24,407. After the audit report was settled, the Auditee made a correcting entry of $24,407 in FY 90. The correcting entry also reversed the ROI claimed for the period lo-l-86 through 3-31-90.

We agree that the ROI should have been reversed. However, the ROI was $21,001 for the three years audited and should have been identified to the year incurred and the respective FACPs amended accordingly. In FY 87, FY 88 and FY 89, the Auditee claimed $7,982, $7,614 and $5,405 respectively.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments as follows:

ROI	FY 87	FY 88	FY 89	Total
<Under> Overstated ROI	$< 477>	$1,574	$<2,934>	$<1,837>
Unreported Credit	7,982	7,614	5,405	21,001
	$7,505	$9,188	$ 2,471	$19,164

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Return on Investment.

UNALLOWABLE TRAVEL COSTS

The Auditee claimed total costs of $15,415 for employees' personal use of company automobiles. According to 48 CFR 31.205-46(f) such costs are unallowable.

Some of the Auditee's employees were allowed to use company automobiles for personal use. The employees were required to prepare biweekly expense reports that included the number of personal and business miles driven. At the end of the year, the payroll department would compute the employee's share of the automobile expense and add that amount to the employee's W-2 wages. However, all of the automobile expense was recorded in natural account number 63055 and charged to the employees' disbursement codes. The costs associated with personal use of the automobiles were not excluded from the costs claimed on the FACPs.

The 48 CFR 31.205-6(m)(2) states,

> "That portion of the cost of company furnished automobiles that relates to personal use by employees (including transportation to and from work) is unallowable regardless of whether the cost is reported as taxable income to the employees...."

Personnel in the Auditee's payroll and accounting departments indicated that they were unaware that these costs were unallowable. Also the Medicare controller indicated that he was not aware that these costs were included in the costs claimed on the FACPs.

Costs associated with the personal use of company automobiles charged to Medicare were $3,908, $5,904 and $5,603 for FY 87, FY 88 and FY 89, respectively.

RECOMMENDATION

We recommend that Auditee make the appropriate financial adjustments for the unallowable auto expenses as follows:

	FY 87	FY 88	FY 89	Total
Employee's Auto Expense	$3,908	$5,904	$5,603	$15,415

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Unallowable Travel Costs.

SERVICE CHARGES

The Auditee overcharged Medicare a net total of $7,789 for certain service charges based on head count. These services included Cafeteria and Human Resources Department - Personnel Services. The overcharges resulted from using an erroneous head count and service charge. We are recommending the $7,789 be cost questioned.

Details of the overcharges are discussed in the following paragraphs.

Cafeteria

The Auditee overstated the amount of cafeteria costs allocated to Medicare by $739 in FY 89. These overstated costs resulted from applying an inflated cafeteria monthly charge to an erroneous Medicare head count. However cafeteria costs were understated by $<2,829> and $<3,611> in FY 87 and FY 88 respectively.

The Auditee furnishes cafeteria services for its employees, and other tenants, located in the home office buildings in Columbus, Ohio. costs for operating the cafeteria are absorbed through customer sales and contributions from the Auditee. These contributions represent the operating losses and are allocated to all Nationwide lines of business, including Medicare. The Auditee computed a billing rate per full-time employee and allocated an amount monthly to the various lines of business based on head count.

We determined that the Auditee had not calculated the cafeteria billing rate properly and had used an erroneous head count for allocating costs to Medicare. The combination of these two factors resulted in an overstatement of costs in FY 89.

At year end the Auditee determined the cafeteria gain or loss by deducting the customer sales, and Medicare and tenant payments from the operating costs. We believe this method was improper, only the customer sales amount should have been compared to operating costs. The net amount should then be considered the Auditee's contribution and distributed to the various lines of business.

We also noted that the Auditee had included the Portsmouth, Ohio and Charleston, West Virginia sub-offices in the Medicare head count total. These sub-offices are not located in the home offices and should not share in cafeteria costs.

We recalculated Medicare's share of the cafeteria costs for each of the years audited and compared them to amounts claimed. The results of our comparison showed the following:

Fiscal Year	Amount
1987	<$2,829>
1988	< 3,611>
1989	739

The overcharge for FY 89 has been cost questioned. The undercharges for FY 87 and FY 88 have been offset against the overstated personnel charges discussed below.

Personnel Charues

During the three fiscal years audited the Auditee overcharged Medicare a total of $13,490 for Human Services costs. We found that the percentage of Human Services costs allocated to Medicare was overstated. A similar finding was reported in the prior audit report covering the three fiscal years ended September 30, 1986.

The Auditee's Human Resources Department provides personnel services to employees located in Columbus, Ohio and other

locations. costs related to these services are allocated as an overhead charge to the benefitting activities based on head count (FTE). The costs are identified by disbursement codes such as Personnel Services (110120) Benefits Admin (110130) and Personnel Relations (110610). These costs are allocated as Personnel Services or Placement Charges to Activities by FTE count.

We reviewed the Auditee's system for determining the charges for Personnel Services and Placement. During the period CY 1985 and CY 1988 the Auditee had not changed the reimbursement rate for Personnel Services. In CY 89 the Auditee calculated a new rate for use in CY 90. We noted that in disbursement codes Personnel Services (110210) and Personnel Relations (110610) the Auditee had included 100 percent of the costs in the expenses to be shared by Medicare. However, a review of each center's duties with officials in Human Resources showed the following:

110210 - One manager and secretary were allocated 100 percent to Corporate and Medicare. Only 25 percent of their efforts should have been allocated. The remaining 75 percent was direct effort.

110610 - Two counselors were allocated 100 percent to Corporate and Medicare. Only 65 percent of these efforts should have been allocated. The remaining 35 percent was direct effort.

The Auditee recalculated the CY 89 rate for Personnel Services, including adjustments for the above Disbursement Codes. The recalculated rate was approximately $.50 less per FTE than the amount charged. In our discussions with the Auditee it was agreed the $.50 reduction would apply to fiscal years 1987, 1988 and 1989. Application of the $.50 reduction to Medicare FTE count resulted in the following:

FY	Medicare FTE	x	Reduction at .50 per FTE
1987	7,166		$3,583
1988	9,699		4,850
1989	10,114		5.057
Total			$13,490

The overcharge of $13,490 is cost questioned. However underclaimed cafeteria charges for FY 87 and FY 88 were offset against these overcharges.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustments as follows:

	FY 87	FY 88	FY 89	Total
Cafeteria	$<2,829>	$<3,611>	$ 739	$<5,701>
Personnel Services	3,583	4,850	5,057	13,490
	$ 754	$1,239	$5,796	$ 7, 789

AUDITEE COMMENTS

The Auditee agreed with the finding and recommendation related to Service Charges. Also they indicated that an additional $6,440 would be claimed for the amount of cafeteria costs underclaimed in FY 87 and FY 88.

AUDITOR RESPONSE

We have revised the initial finding to deduct the undercharge for cafeteria costs in FY 87 and FY 88 from the overcharges for personnel services in these two periods.

DEPRECIATION EXPENSE

The Auditee did not give Medicare credit for an adjustment to depreciation expense in FY 88. This resulted in overstated costs of $8,173.

The Auditee's policy was to establish a 10 percent salvage value on fixed assets. During May 1988 the Auditee reviewed the Medicare fixed asset records and discovered that some of the fixed assets had been depreciated below the 10 percent salvage value. The Auditee intended to correct this error by making a debit entry of $8,173 to the fixed asset account and credit depreciation expense. However, instead of crediting a Medicare depreciation expense account, the Auditee credited a corporate account.

The Auditee's accounting personnel indicated that they were not aware that the journal entry was incorrect.

RECOMMENDATION

We recommend that the Auditee make the appropriate financial adjustment for the overstated costs of $8,173 in FY 88.

AUDITEE COMMENTS

The Auditee agreed with our finding and recommendation related to Depreciation Expense.

COMPLEMENTARY CREDITS

The Auditee's complementary credit rate (per claim) charged to outside organizations was insufficient to cover the full expense of processing and transfer costs. We found that the Medicare operating costs were overstated a total of $905,724 during the three fiscal years audited because of the undercharge. Since HCFA had formally approved the contract between the Auditee and the outside organization, we did not question the overcharge. However, we are recommending that the Auditee should perform a study at least annually to determine if the complementary credit rate is adequate to cover processing costs. Further HCFA should be provided the results of the study.

During the period covered by audit the Auditee furnished Medicare claims information to several outside organizations. HCFA had formally approved the Auditee's charge of $.43 per claim as a complementary credit. This rate was negotiated between the Auditee and HCFA and was approved on June 24, 1986.

According to Section 4601(A)2 of the Carriers Manual, the Auditee was to negotiate a charge for each unit of information released to outside organizations so that the program recovered processing and transfer costs. Further, Section 4601(C) indicates that the rate to be charged to the outside organization is to be based on a cost allocation method that distributes all costs to Medicare and the outside organization in proportion to the benefits received by both parties. The costs to be shared are any costs that are necessary to fulfill the terms of the complementary contract or the normal claims processing requirements.

Prior to May 1986 HCFA was responsible for the review and prior approval of the Auditee's methodology for computing the complementary credit rate, as well as the rate itself. This procedure applied to the release of complimentary credit information to themselves, as well as outside the organization. It was OIG's responsibility to review the methodology for reasonableness in relation to the cost of processing the claim. If the auditor noted any problems that resulted in an inequity to Medicare, such problems were reported. However, the auditor was precluded from recommending any financial adjustments resulting from the inequity.

Starting in May 1986, HCFA no longer provided prior approval of the methodology but approved a rate for subsequent application. OIG was still responsible for determining that the Auditee's methodology was appropriate and the proper credits were applied. Accordingly the auditors were required to determine whether the Auditee's method of computing complementary credits was adequate and resulted in the

reasonable absorption of processing costs related to the claims information transferred. Further, OIG was required to report the problems with the complementary credit area and recommend any resulting financial adjustments. HCFA would then negotiate settlement of any finding as part of the audit resolution process.

Although HCFA had formally approved the Auditee's application of the $.43 per claim, we determined this rate was insufficient to absorb the related processing costs. Our review showed the Auditee's experienced rate per claim for each year audited was higher than the $.43 rate. We developed the experienced rates for each fiscal period based on the Auditee's manual spreadsheet of costs by operation line item. The costs shown in line item 1 Claims Payment were adjusted for non-complementary related items. This cost was divided by the total number of claims (including complementary claims) to arrive at a rate per claim. Complementary claims share of this rate was 50 percent. Our computed rates were $.56, $.49 and $.51 for FY 87, FY 88 and FY 89, respectively.

It should be noted that the rates we developed were based on the costs as shown in the claims processing disbursement codes. As discussed in our finding titled "Allocation System," the Auditee allocated costs from various disbursement codes to operation lines based on estimates and the NOBA. These estimates may not be accurate and representative of actual costs. Consequently the costs we used to develop the complementary credit rates may be understated.

We determined that the amount of underreported credit was:

	FY 89	FY 88	FY 87	Total
Rate based on actual costs	$.51	$.49	$.56	
Rate Claimed	.43	.43	.43	
Underreported Rate	.08	.06	.13	
Number of Complementary Claims	4,828,536	3,604,977	2,331,858	
Underreported Credit	$386,283	$216,299	$303,142	$905,724

Although HCFA had approved the rate we believe studies should be performed annually to determine whether credits are adequate to cover the cost of processing a claim. Also HCFA should be provided the results of these studies.

Since HCFA had approved the $.43 per claim rate, the Auditee indicated that they did not believe studies were necessary to determine whether the rate was reasonable. Consequently no studies were performed during the period covered by audit. However, subsequent to FY 89 the Auditee agreed to apply a new rate of $.65 per claim. Auditee officials indicated that the new rate was not based entirely on a cost study but resulted from negotiations with HCFA.

RECOMMENDATION

We recommend that in the future the Auditee should periodically (at least annually) perform a study of the claims processing costs to determine whether the complementary credit rate being applied is reasonable. HCFA should be provided the results of these studies.

AUDITEE COMMENTS

The Auditee expressed total disagreement with this finding and recommendation. They indicated that HCFA had negotiated and approved the complementary credit rate of $.43 per claim. The Auditee considered the agreement a valid contract and as such charged the approved rate to outside organizations. The Auditee also indicated the auditor's assumption that all data input for Medicare was of equal value to outside organizations may not be valid.

They estimated that about 18 percent of the claims charged to outside organizations were not the liability of the complementary insurer. This estimate is based on the contention that many of the recent legislative and administrative changes to the medicare program benefit Medicare only and not the outside organization.

AUDITOR RESPONSE

Based on the responsibilities assigned the auditor in Section 4601(A)2 of the Carriers Manual, we computed the actual cost per claim for processing. Only 50 percent of the actual cost per claim was applied to complimentary credits. Our computation was based on a methodology commonly used by other Medicare carriers and intermediaries.

Apparently the rates we calculated using this methodology were generally in line with rates being charged by eight other intermediaries and carriers located in the HCFA Chicago Region. HCFA had provided the Auditee in February 1988 with a schedule of rates being charged by ten Medicare claims processors, including Nationwide. This schedule showed the average complementary credit rate charged by the ten processors was about $.55 per claim. Only two of the processors (including Nationwide) were charging $.43. The remaining eight processors' rates averaged about $.58 per claim. This schedule was used by HCFA in July 1989 as the basis to increase the Auditee's rate to $.65 per claim.

Considering the above, we still contend that our procedural recommendation is valid.

ALLOCATION SYSTEM

The Auditee's cost accounting system did not provide for the identification and accumulation of costs by FACP operation line item. Instead the Auditee estimated the costs by line item and adjusted actual costs to agree with the approved NOBA. We found that the total costs claimed were properly supported, however we could not determine the validity or accuracy of amounts claimed by line item.

Our review showed that the Auditee does not have a step-down cost accounting system. According to the Auditee, the initial budget request-procedures involved the following:

1. Budget guidelines were reviewed by the controller and Medicare Managers (disbursement codes). The budget guidelines defined the actions necessary and what cost containment measures were planned. Also work-load projections were part of these guidelines.

2. Each manager was requested to prepare a budget of resources needed to process the projected workloads and budget guidelines. This budget was in terms of salary, equipment, supplies, staffing, etc. The controller prepared the budget for non-departmental disbursement codes.

3. Each manager was required to develop allocation factors for each disbursement code under his/her management. These factors were to be based on surveys, workload mix, etc. The controller developed factors for the EDS-F codes (claims processing) based on projected workloads and for the executive disbursement codes based on summary factors for each department and non-departmental code.

4. The controller prepared various reports from data provided by the managers. This information was reviewed with the Medicare Vice President. Adjust-ments could be made if the requested amounts were inconsistent with Budget Guidelines, Productivity Goals, etc.

5. The controller established a database of allocated amounts from the information prepared by the managers and the controller. This information was used to prepare the HCFA 1524 for the initial Budget Request to HCFA.

6. The HCFA 1524 was reviewed with the Medicare Vice President and was compared to the Budget Guidelines. Adjustment could be made if allocated amounts and/or unit costs were inappropriate. After review, the

1524 Budget Request was sent to HCFA.

7. The Auditee's budget data and allocation factors were adjusted as needed to reconcile the allocated budget amounts with the initial approved NOBA. Such factors would be used to prepare the monthly IERs and final FACP.

8. During the year adjustments were made as necessary to actual expenses, workload and unit costs to ensure agreement with the NOBA.

The Medicare controller indicated that their major concern was not to exceed the total approved costs on the NOBA. Regarding the operation line item distribution, the amounts claimed were based on estimates and the approved budget.

We requested that the controller and managers provide documentation to support the reasonableness of the allocation percents. The controller provided workpapers for FY 89 that indicated that the data processing percents were based on the budgeted workload. The allocation percents for the data processing disbursement codes did not change during the year. The percents were not adjusted to actual workloads. The telephone/correspondence manager was unable to locate any documentation to support the reasonableness of the percents for the disbursement codes under her responsibility. One of the claims managers was able to locate documentation to explain how the FY 88 percents were developed. He also had some documents for FY 89, but they were incomplete. The manager could not locate documentation for FY 87. Another claims manager was unable to locate documentation for the disbursement codes under her responsibility. Generally the managers stated that they were not aware that the documentation should be retained for audit.

The Medicare controller's office retained loose-leaf binders that recorded the allocation percents for each disbursement code. The percents would be changed if the controller was notified that the functions performed in a disbursement code had changed. These changes were not based on documented studies, workload reviews, etc. Instead the controller indicated that percents would be changed to agree with the budget. We could not determine if any of the percents were adjusted to agree with the actual distribution of costs based on workloads.

We performed an analytical review of the allocation percents for the data processing, claims and telephone/correspondence disbursement codes. We compared the budget percents to the percents used on the FACP and fluctuations of the percents from year to year. The Medicare controller provided explanations for unusual fluctuations in the amount of the percents. These explanations appeared reasonable. However,

because the Auditee did not retain documentation to support the budget percents, we were unable to determine if the percents used were reasonable.

Except as discussed elsewhere in this report, we agree that the total costs claimed were incurred, reasonable and allowable. Because the Auditee did not adjust the estimated allocation percents to actual, we were unable to determine if the costs claimed by FACP operation line were valid or accurate. The controller indicated that the Auditee was concerned only that total costs claimed were less than the total NOBA. The Auditee contends that costs by individual FACP operation lines should not be an issue.

According to Section 4213 of the Carrier's Manual, specific activities should be included in each operation. Accordingly, the FACP should reflect the actual costs incurred for each of these activities by operation line item. Further, the Carrier's Manual allows for shifting budgeted amounts between lines up to 5% but it does not allow shifting actual costs incurred.

Since the Auditee does not have the detailed accounting system necessary to identify actual costs by operation line item, they need to establish an adequate system of estimation, allocation and review to properly support the costs claimed. Once the initial budget is developed, the Auditee's system will need to provide for monthly comparisons of actual effort to estimated by disbursement code and operation line items. Revisions will be needed to reflect over or under estimates. All documents used in the Auditee's review process should be retained to support the costs claimed.

RECOMMENDATION

We recommend that the Auditee:

1. Retain documentation to support the budgeted allocation percents.

2. Design and implement a system that provides for identification and accumulation of actual costs by operation line item.

AUDITEE COMMENTS

The Auditee disagreed with our finding and recommendation. They indicated that Nationwide's cost allocation system satisfied the contract requirements. Further, they do not plan to develop a new system or to modify the existing system. However, in the future they will retain the necessary documentation to support the budget and any allocation percents.

AUDITOR RESPONSE

We still contend that the Auditee's system does not provide for identification and accumulation of costs by FACP operation line item. Unless the Auditee designs a new system or modifies the existing system, this deficiency will continue to exist.

CORPORATE SUPPORT OVERHEAD

Our review showed that corporate support overhead costs were overstated. We noted that unallowable items were included in the overhead pool and the salary base of distribution was understated. In addition there were middle management costs that had not been included in the overhead costs. These costs would be allowable if claimed. We believe the allowable amount of unclaimed middle management costs would be sufficient to offset the overstated amount. In the future the Auditee will need to perform an indepth study of the corporate support overhead expense pool and the salary base.

The Auditee's corporate support overhead costs allocated to Medicare include fifteen different categories of expenses related to support functions. For example, some of the major categories are payment for time not worked, Health & Welfare, rent and executive and secretarial salaries. Such costs are allocated to Medicare based on salary dollars. The Auditee computes a rate for each category of support expense at the end of the calendar year to determine a composite support overhead rate for the next year. The latter rate is applied to the Medicare salary dollars.

We reviewed each of the fifteen categories of expenses included in the support overhead allocation to Medicare. Based on this review, we found that the following adjustments were needed:

Executive Supervision

The Auditee identified certain executives and their secretarial staff who indirectly or periodically provide services to Medicare. The salaries of these individuals and related overhead charges were included in the support overhead costs for allocations to Medicare.

Our review of the executive positions included in this support overhead pool showed that certain of these positions were unallowable for allocation to Medicare. Some of the unallowable executive positions we noted were:

v. P. Positions: Marketing, Taxation, Nationwide Health Care Corporation, Chief Medical Director, Claims, Industry Relations, Variable Life, Puerto Rico, Personal Lines, Life & Health Sales, Advertising Marketing-Information and Education, Property and Casualty, Insurance & International Functions, Underwriting, Pension Sales, etc.

In addition, these V.P. positions had secretarial and other expenses identified.

According to 48 CFR 31.201-4, a cost is allocable to the Government contract if it benefits both the contract and other work. The above V.P. positions benefit the Auditee's commercial and private activities but not Medicare. As a result we have eliminated the applicable costs from the executive expense pool for each fiscal year.

The effect of this adjustment was to reduce Medicare's share as follows:

FY	Amount
87	$3,100
88	3,751
89	5,199
Total	$12,050

Depreciation

The Auditee, as of January 1, 1988 was buying equipment and selling the items to a bank with leaseback provisions. Under this system no depreciation would be claimed, only the lease payments. The Auditee did not eliminate the depreciation from the support overhead computation. We have eliminated the depreciation from the overhead rate computation. The effect of this adjustment was to reduce the costs allocated to Medicare by the following:

FY	Amount
88	s 90
89	507
Total	$597

Leual Expenses

The Auditee had included the legal expenses for Distribution Code 001900. Included in this code was expenses for case settlements, anti-trust lawsuits, legal fees (not related to employees), and agent lawsuits. Also included were costs for a law firm whose owner is an employee of Nationwide.

Regarding these legal expenses, we consider them unallowable since there was no benefit to the Federal government. The Auditee was not aware that certain legal fees were

unallowable. Further, the Auditee did not furnish the necessary information to support the fees. The effect of these adjustments was to reduce Medicare by the following:

FY	Amount
87	s 44
88	198
89	474
Total	$716

Reuional Rent

The Auditee included the regional rent expense in the "Rent" percent calculation. We found that regional offices all lease their buildings and generally pay a higher rate per square foot. Since the regional offices are exclusively commercial and do not benefit Medicare, we eliminated the salaries and rent costs from the CY 88 calculation. This reduced the amount allocated to Medicare by the following:

FY	Amount
87	$< 201>
88	439
89	1.514
Total	$ 1,752

Real Estate salaries

The Auditee's support overhead included factors for sick leave, vacation, holidays, and excused absences. The initial calculation used by the Auditee was to determine the average salary cost per day. This cost was computed by dividing the corporate salary dollars, including Real Estate and Accrual salaries into the year end full-time equivalent work days. The resultant cost was applied to the number of days recorded for sick leave, vacation, holidays and excused absences to establish the total cost related to such time. The next step was to divide the total cost of sick leave and other paid absences by the corporate salary base to arrive at a rate per salary dollar.

Our review showed that the Auditee had overstated the rate by excluding the real estate and accrual salary dollars in the calculation to determine the percentage per salary dollar. We recalculated the percentage per salary dollar and computed Medicare's share. This adjustment resulted in the following:

FY	Sick Leave	Other Time not Worked	Total
87	$ 153	S 736	$ 889
88	441	2,046	2,047
89	395	1,755	2,150
	$ 989	$ 4,537	$5,526

Reassiuned Salaries

The Auditee applied the incorrect composite support overhead rate for reassigned salaries in CY 88. A composite support overhead rate was calculated manually by the Auditee at the end of CY 86 for application in CY 87. This same rate was applied in CY 88. The composite rate for CY 86 was .5561 versus the CY 88 actual rate of .5327. We applied the proper rate for CY 88 resulting in' the following adjustment in Medicare for FY 88and FY 89:

FY	Overstated Amount
88	$ 506
89	418
Total	$ 924

Individual Life and Health Oneration

During the three fiscal years audited, the Auditee applied a negotiated standard monthly charge for Individual Life and Health Operation (IL&H) support. This charge related to the executive, and personnel, secretaries and other salaries, as well as support costs of the IL&H operations in disbursement codes 311110 and 311130 respectively.

We noted that the Auditee did not charge Medicare the negotiated standard rate. Instead they applied the support overhead rate applicable to corporate activities. We recalculated the amount of IL&H operation costs applicable to Medicare using the negotiated standard monthly charge. The effect of this recalculation was as follows:

IL&H Disbursement Codes

FY	311110 Executives	311130 Personnel & Support	Total
87	$ 1,826	$ 3,206	$ 5,032
88	1,852	3,690	5,542
89	<2,131>	<7,019>	<9,150>
	$ 1,547	$<123>	$ 1,424

The total net effect of the above support overhead adjustments was to overstate Medicare by a total of $22,989.

Generally the Auditee was conservative in allocating support overhead to Medicare. There were certain other support overhead costs that the Auditee incurred but did not claim. The Auditee identified middle managers' salaries and support costs as one of the overhead expenses incurred but not claimed. They provided us with a schedule which showed the following amounts of middle managers' salaries and support costs related to Medicare:

FY	Amount
87	$27,151
88	$26,641
89	$25,813

Although the middle management costs would be an allowable overhead charge, the Auditee did not claim such costs. We believe the allowable amount of overhead middle management costs would be sufficient to offset the overstated amount of $22,989. Consequently the overstated amount was not questioned.

RECOMMENDATION

We recommend that the Auditee perform a study of its corporate support overhead to eliminate unallowable items and to identify the appropriate salary base. Also in the future, the Auditee will need to conduct a study to determine which middle managers benefit Medicare. This is especially important since there are middle managers assigned full-time to a direct function that do not benefit Medicare. Further, there may be other managers that have divided responsibilities benefiting a direct function as well as overhead functions. In both cases the Auditee would need documented time studies to support the distribution of the middle managers' costs.

AUDITEE COMMENTS

Except for the Executive Supervision and Regional Rent Costs questioned, the Auditee agrees with the recommended disallowance. The Auditee contends that developing a "true" overhead rate requires that all costs of an operation be included in the overhead expenses. Excluding certain costs or selectively including only a part of these costs understates the true cost of overhead. Thus including the officers' salaries and regional rent in the overhead rate does not mean that Medicare is being charged a portion of these salaries or rent.

In addition the Auditee felt that the Middle Management Costs of $79,605 not allocated to Medicare should be allowed. This amount was cited in the report.

AUDITOR RESPONSE

We do not agree with the Auditee's position on including all overhead costs, Executive Salaries and Regional Rent in the overhead rate calcution. There are four key factors to be considered in determing the allowability of a direct or indirect cost charged to a Federal contract. The cost must: (1) be reasonable, (2) be allowable in accordance with the applicable, CFR cost principles and special contract terms, (3) be allocable, and (4) have received consistent accounting

treatment. We questioned the Executive Supervision and Regional Rent Costs because these functions relate to the Auditee's private and commercial lines of business and not Medicare. Unless there is an identifiable benefit to Medicare, the cost does not meet the allocability factor. Thus the cost is unallowable for allocation to Medicare.

Of the $79,605 in middle management costs not claimed, We offset $22,989 against the overstated amount. As a result no costs were questioned.

UNTIMELY ALLOCATION UPDATE

During the three years audited the Auditee charged Medicare $460 per month for services provided by the Purchasing Department. Services provided included purchasing and contracting activities and operation of the leased automobile program. The Auditee had not performed a study to determine whether the rates charged were reasonable.

According to the Auditee, a rate study had not been made for several years. They agreed to perform a study for each of the years under audit. The Auditee's study showed that the experienced monthly rates were higher than the rates charged to Medicare during the three fiscal years audited. Experienced rates as developed by the Auditee were:

	FY 87	FY 88	FY 89
Experienced Monthly Rate	$584	$648	$694

Although there was no adverse effect on Medicare as a result of applying the $460 per month, the Auditee should perform periodic studies to justify the rates charged. Further, the documentation used in these studies should be maintained as justification for the rates applied.

RECOMMENDATION

We recommend that the Auditee perform annual rate studies to support the rates charged to Medicare. The results of these studies should be retained for subsequent review.

AUDITEE COMMENTS

The Auditee indicated that overhead rates were calculated and applied each year. Also, they recalculated the Purchasing Department's rates for the three fiscal years audited. The recalculation showed that the Auditee had underclaimed in each year. They propose to offset the $6,552 underclaim against costs questioned under other findings in this report.

AUDITOR RESPONSE

We do not agree that overhead rates were calculated and applied each year. If this was a fact, then the underclaim would not exist. Regarding the underclaim, we do not have authority to offset these costs against other questioned costs.

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Managers:
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COMMENTS ON EVALUATION OF INTERNAL CONTROL STRUCTURE

We have audited the Medicare Part B Statements of Administrative Costs of Nationwide Mutual Insurance Company (the Auditee) for the fiscal years ended September 30, 1989, 1988 and 1987 and have issued our report thereon dated January 24, 1991.

We conducted our audit in accordance with generally accepted auditing standards and the standards for financial audits contained in Government Auditinu Standards issued by the Comptroller General of the United States.

In planning and performing our Audit of the Auditee, we considered its internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control structure.

For the purpose of this report, we have classified the significant internal control structure, policies and procedures in the following categories:

-Property and Equipment
-Cash Receipts
-Cash Disbursements
-Purchasing and Receiving
-Accounts Payable and Accrued Expenses
-Payroll

For all of the control categories listed above, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation. We also assessed control risk.

Our consideration of the internal control structure would not necessarily disclose al.1 matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a condition in which the design or operation of a specific internal control structure element does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

However, we noted no matters involving the internal control structure and its operations that we consider to be material weaknesses as defined above.

The management of the Auditee is responsible for establishing and maintaining a system of internal accounting control. In fulfilling this responsibility, estimates and judgements by management are required to assess the expected benefits and related costs of control procedures. The objectives of a system are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles.

Because of inherent limitations in any system of internal accounting control, errors or irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of the system to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the degree of compliance with the procedures may deteriorate.

This report is intended solely for the use of management of Nationwide Mutual Insurance Company and the Department of Health and Human Services in regard to their agreement to administer the Medicare program and should not be used for any other purpose.

Deloitte & Associates, P.C.

Kansas City, Missouri
January 24, 1991

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COMMENTS ON COMPLIANCE WITH PERTINENT REGULATORY REQUIREMENTS

We have audited the "Final Administrative Cost Proposals" (Form HCFA and 1524) of Nationwide Mutual Insurance Company for the fiscal years ended September 30, 1989, 1988 and 1987, and have issued our report thereon dated January 24, 1991.

We conducted our audit in accordance with generally accepted auditing standards, "Government Auditing Standards," and the "Audit Guide for the Review of Administrative Cost Incurred by Medicare Intermediaries and Carriers Under Title XVIII of the Social Security Act" (draft interim audit instruction E-l dated August 1990). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

Compliance with laws, regulations, contracts, grants, and binding policies and procedures applicable to Nationwide Mutual Insurance Company is the responsibility of Nationwide Mutual Insurance Company's management. As part of our audit, we performed tests of Nationwide Mutual Insurance Company's compliance with certain provisions of laws, regulations, contracts, grants, and binding policies and procedures. However, it should be noted that we performed those test of compliance as part of obtaining reasonable assurance about whether the financial statements are free of material misstatement: our objective was not to provide an opinion on compliance with such provisions.

Our testing of transactions and records selected from Federal programs disclosed instances of noncompliance with those laws and regulations. All instances of noncompliance that we found and the programs to which they relate are identified in the Findings and Recommendations Section of this report.

Except as described above, the results of our tests indicate that with respect to items tested, Nationwide Mutual Insurance Company complied, in all material respects, with the provisions referred to in the third paragraph of this report. With respect to items not tested, nothing came to our attention that caused us to believe that Nationwide Mutual Insurance Company had not complied, in all material respects, with those provisions.

This report is intended solely for the use of management of Nationwide Mutual Insurance Company and the Department of Health and Human Services in regard to their agreement to administer the Medicare program and should not be used for any other purpose.

Dohi & Associates P.C.

Kansas City Missouri
January 24, 1991

NATIONWIDE MUTUAL INSURANCE COMPANY

Part B

INTERIM EXPENDITURE REPORTS

The audit guide issued by the Department of Health and Human Services requested that comments be included in the audit report concerning the accuracy of the Auditee's interim expenditure reports (IERs).

In order to determine the accuracy of these reports, we performed various tests for clerical accuracy and reliability of allocation methods and examined supporting cost reports which verified actual costs as reported on the IERs chosen for test work.

Our audit disclosed that the Auditee had not established a cost accounting system that provided for identification and accumulation of costs by FACP operation line item. Essentially the Auditee estimated costs by line item and adjusted actual costs to agree with the approved NOBA. We found that the total costs claimed were properly supported but could not determine the validity or accuracy of amounts claimed by line item. (See our finding Allocation System). Although these weaknesses were disclosed, we still believe that on the whole the IERs are materially accurate.

NATIONWIDE MUTUAL INSURANCE COMPANY
Analytical Review of Reported Costs - Part B
For the Years Ended September 30, 1989 and 1988

Operation	Administrative Costs Claimed 1989	1988	Increase <Decrease> Amount	%	Ref.
Claims Payment	$23,583,672	$21,346,229	$2,237,443	10.48	
Reviews and Hearings	2,961,167	3,504,901	< 543,734>	< 15.51>	1
Beneficiary/ Physician Inquiry	2,942,771	4,010,056	<1,067,285>	< 26.62>	2
Professional Relations	161,104	-	161,104	100.00	
Medical Review & Utilization Review	5,320,338	2,929,980	2,390,358	81.58	3
Medicare Secondary Payer	1,042,370	1,161,784	< 119,414>	< 10.28>	
Participating Physician	766,696	822,548	< 55,852>	< 6.79>	
Productivity Investments	1,867,111	550,268	1,316,843	239.31	4
Other	32,051	84,581	< 52,530>	< 62.11>	5
Other	54,342	213,700	< 159,358>	< 74.57>	5
Other	1.152.741	38,256	1.114.485	29.13	5
	$39.884.363	$34.662.303	$5.222.060	15.07	

Explanations of variances > 15% and $250,000

1. **Reviews and Hearinus (Line 2)**

There was no official total workload reported for Line 2 in FY **1988, but the HCFA-1524C shows detail workload that totals to 549,538. The workload for FY 1989 was 580,249, a 5.6 percent increase.**

Reopenings were moved from line 2 to Line 1 per Budget Guidelines. This was $587,516 in FY 1988 and is slightly higher than the decrease in Line 2 costs for FY 1989.

2. **Beneficiary/Pysician Inquiries (Line 3)**

There was a 3.5 percent increase in workload. However, there was a decrease of 20.7 percent decrease in productive hours to process the increased workload. The reduced costs are a direct result of productivity improvements initiated from the ACE contract.

3. MR/UR (Line 5)

Claims volume increased 9.2 percent and this increases Line 5 workload. There were additional requirements mandated by HCFA in prepay procedures and screens. There was a mandated increase of greater than 50 percent to postpay activities. Level of work increased for both prepay and postpay. The NOBA for this line exceeded the Budget Request and remained at $5,349,200 for the entire year.

4. PI (Line 8)

Projects funded by HCFA for FY 1989 increased primarily for two reasons:

1. Implementation of MCS was a $1,190,000 payment to EDS-F.

2. Conversion to CWF was a $467,789 payment to EDS-F.

These both were directed by HCFA and total $1,657,789 compared to a total increase of $1.3 million for Line 8.

5. Other (Lines 9. 10 and 11)

There were two major projects in FY 1989 that resulted in the $902,597 increase in these lines.

1. The move from Plaza I to Plaza III was $471,739.

2. Implementation of MCS also had Nationwide costs for training, testing, documentation, etc. of $449,638.

Costs of both projects was $921,377.

6. Summary

Total unit cost decreased slightly from $1.84 to $1.81 after the four major projects for Lines 8-11 were deleted, Workload increased 9.2 percent.

NATIONWIDE MUTUAL INSURANCE COMPANY
Analytical Review of Reported Costs - Part B
For the Years Ended September 30, 1988 and 1987

Operation	Administrative costs Claimed 1988	1987	Increase <Decrease> Amount	%	Ref.
Claims Payment	$21,346,229	$20,211,013	$1,135,216	5.62	
Reviews and Hearings	3,504,901	3,337,898	167,003	5.00	
Beneficiary/ Physician Inquiry	4,010,056	4,154,569	< 144,513>	< 3.48>	
Medical Review & Utilization Review	2,929,980	2,298,238	631,742	27.49	1
Medicare Secondary Payer	1,161,784	915,999	245,785	26.83	2
Participating Physician	822,548		822,548	100.00	3
Physician Fee Freeze		299,597	< 299,597>	<100.00>	4
Productivity Investments	550,268	727,533	< 177,265>	< 24.36>	
Other	213,700	91,828	121,872	131.72	
Other	38,256	75,000	< 36,744>	< 48.99>	
Other	84,581	148,100	< 63,519>	< 42.89>	
	$34,662,303	$32.259.775	$2.402.528	7.45	

Explanations of variances > 15% and $250,000

1. MR/UR (Line 51

There was an increase of 17.4 percent in claims processed. This has a direct impact on Line 5 workload. Line 5 funding was 11.4 percent of Line 1 funding. The Line 5 funding increased slightly to 13.7 percent in FY 1988. This is due to increased workload and the additional screens and protocols initiated in FY 1987. The final costs were well within the guidelines of 12-15 percent of Line 1 costs. A specific new requirement was Development of unassigned claims before denial for medical necessity.

2. MSP (Line 6)

The 17.4 percent increase in claims processed resulted in additional work in the MSP area. More claims are suspended and must be worked. Savings increased from $13,773,385 to $17,493,312 or 27.0 percent. This mirrors exactly the

increase of 26.8 percent in costs.

3. Participating Physician (Line 7)

HCFA defined specific requirements for Line 7 starting with the Budget Guidelines for FY 1988. The initial NOBA for these tasks was $650,800 or more than double that in FY 1987. HCFA converted PI 8809, OBRA 404 1 to line 7 in mid 1988. The increase from FY 1987 to FY 1988 for Line 7 is a result of HCFA defined requirements and converting a PI to Line 7 costs.

4. Physician Fee Freeze (Line 7)

This was renamed to Participating Physician from FY 1987 to FY 1988.

5. Summary

Total unit costs decreased from $2.01 in FY 1987 to $1.84 in FY 1988 while workload increased 17.4 percent.

NATIONWIDE MUTUAL INSURANCE COMPANY
Analytical Review of Reported Costs - Part B
For the Years Ended September 30, 1987 and 1986

Operation	Administrative Costs Claimed 1987	1986	Increase <Decrease> Amount	%	Ref.
Claims Payment	$20,211,013	$20,369,489	$< 158,476>	< 0.78>	
Reviews and Hearings	3,337,898	2,289,249	1,048,649	45.81	1
Beneficiary/ Physician Inquiry	4,154,569	2,492,715	1,661,854	66.67	2
Medical Review & Utilization Review	2,298,238	1,938,977	359,261	18.53	3
Medicare Secondary Payer	915,999	657,162	258,837	39.39	4
Physician Fee Freeze	299,597	237,000	62,597	26.41	
Productivity Investments	727,533	936,103	< 208,570>	<22.28>	
Other	91,828	426,897	< 111,969>	<26.23>	
Other	75,000				
Other	148,100				
	$32.259.775	$29.347.592	$2.912.183	9.92	

Explanations of variances > 15% and $250,000

1. Reviews of Hearinas (Line 2)

Workload in FY 1986 was 312,529. Workload in FY 1987 was 494,728. This is a 58.3 percent increase in workload. the unit cost decreased 4.4 percent. The change in workload accounts for the increase in costs reported on Line 2.

2. Beneficiary/Pysician Incfuiries (Line 3)

Workload in FY 1986 was 789,550. Workload in FY 1987 was 836,449. This is a 5.9 percent increase in workload. The unit cost increased from $3.16 to $4.97 or 57.3 percent.

The increase in unit cost is due to a change in HCFA standard for measuring telephone service. The standard was for "percentage of time all trunks are busy." Additional staffing and equipment were needed including more WATS lines, local line and special software.

3. MR/UR (Line 5)

Workload was 1,499,929 in FY 1986. Workload was 2,512,548 in FY 1987. This is a 67.8 percent increase. The unit cost decreased from $1.29 to $0.91 or 29.5 percent. There were additional screens and protocols mandated by HCFA. The majority of the additional workload was handled with existing resources, the increased workload resulted in the small increase in total costs.

4. MSP (Line 6)

The savings achieved in FY 1986 was $7,573,163. The savings achieved in FY 1987 was $13,773,385. This is a 81.9 percent increase. More claims were received and processed (12.7 percent increase over FY 1986) and thus more claims are reviewed for MSP. There were HCFA directed changes in MSP that resulted in increased suspense and workload per claim.

5. Summary

Total unit cost decreased from $2.06 to $2.01 while workload increased 12.7 percent.

EXIT CONFERENCE

An exit conference was conducted at the offices of NATIONWIDE MUTUAL INSURANCE COMPANY on January 24, 1991. Those in attendance were:

William Ramsey	Vice-President of Medicare	Nationwide Mutual Insurance Company
Mike Miller	Director - Corporate Accounting	Nationwide Mutual Insurance Company
Leslie Gutter	Director - Property Services	Nationwide Mutual Insurance Company
Ronald Harmon	Medicare Controller	Nationwide Mutual Insurance Company
Mark White	Manager - Cost Standards and Accounting	Nationwide Mutual Insurance Company
Kant D. Doshi	Principal	Doshi & Associates, P.C.
William J. Anderson	Manager	Doshi & Associates, P.C.
Louis E. Davis	Supervisor	Doshi & Associates, P.C.
Mary M. Duff	Supervisor	Doshi & Associates, P.C.

The Findings and Recommendations as reported in this audit report were discussed.

Exhibit A

NATIONWIDE MUTUAL INSURANCE COMPANY
FINAL ADMINISTRATIVE COST PROPOSAL COSTS
CLAIMED BY OPERATION - PART B
FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 1989

Operation	Administrative Costs Claimed
Claims Payment	$23,583,672
Reviews and Hearings	2,961,167
Beneficiary/Physician Inquiry	2,942,771
Professional Relations	161,104
Medical Review & Utilization Review	5,320,338
Medicare Secondary Payer	1,042,370
Participating Physician	766,696
Productivity Investments	1,867,111
Other	32,051
Other	54,342
Other	1.152.741
FACP Costs Claimed	39.884.363
Recommended Adjustments:	
1. Postage Costs	1,453,465
2. Imputed Interest	180,649
3. Unauthorized Costs	739,708
4. Leasehold Improvements	269,226
5. Data Processing	251,476
6. Fringe Benefits	211,422
7. Accrued Expenses	100,000
8. Pension Expense	27,471
9. Return on Investment	2,471
10. Unallowable Travel	5,603
11. Service Charges	5,796
Total Adjustments	3.247.287
Costs Recommended for Acceptance	$36.637.076

Note: Explanation of each adjustment is provided in the "Findings and Recommendations" section of this report.

Exhibit B

NATIONWIDE MUTUAL INSURANCE COMPANY
FINAL ADMINISTRATIVE COST PROPOSAL COSTS
CLAIMED BY OPERATION - PART B
FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 1988

Operation	Administrative Costs Claimed
Claims Payment	$21,346,229
Reviews and Hearings	3,504,901
Beneficiary/Physician Inquiry	4,010,056
Medical Review & Utilization Review	2,929,980
Medicare Secondary Payer	1,161,784
Participating Physician	822,548
Productivity Investments	550,268
Other	84,581
Other	213,700
Other	38,256
FACP Costs Claimed	34.662.303
Recommended Adjustments:	
1. Accrued Expenses	5,369
2. Return on Investment	9,188
3. Unallowable Travel Costs	5,904
4. Service Costs	1,239
5. Depreciation Expense	8,173
Total adjustments	29.873
Costs Recommended for Acceptance	$34,632,430

Note:. Explanation of each adjustment is provided in the "Findings and Recommendations" section of this report.

Exhibit C

NATIONWIDE MUTUAL INSURANCE COMPANY
FINAL ADMINISTRATIVE COST PROPOSAL COSTS
CLAIMED BY OPERATION - PART B
FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 1987

Operation	Administrative Costs Claimed
Claims Payment	$20,211,013
Reviews and Hearings	3,337,898
Beneficiary/Physician Inquiry	4,154,569
Medical Review & Utilization Review	2,298,238
Medicare Secondary Payer	915,999
Physician Fee Freeze	299,597
Productivity Investments	727,533
Other	91,828
Other	75,000
Other	148,100
FACP Costs Claimed	32.259.775
Recommended Adjustments:	
1. Return on Investment	7,505
2. Unallowable Travel Costs	3,908
3. Service Charges	754
Total Adjustments	12,167
Costs Recommended for Acceptance	$32.247.608

Note: Explanation of each adjustment is provided in the "Findings and Recommendations" section of this report.

APPENDIX

MEDICARE

NATIONWIDE MUTUAL INSURANCE COMPANY
MEDICARE OPERATIONS
P O BOX 16788 • COLUMBUS, OHIO 43216

NATIONWIDE INSURANCE
Nationwide is on your side

May 10, 1991

Mr. William J. Anderson
Senior Manager
Doshi & Associates, P.C.
Accountants and Management Consultants
4520 Madison, Suite 105
Kansas City, MO 64111

Re: Draft Audit Report of Administrative Expenses for Fiscal Years 1987, 1988 and 1989

Dear Mr. Anderson:

We have reviewed the proposed audit adjustments. Our comments to each proposed adjustment have been provided in the attachment.

Would it be advantageous to have a meeting to discuss several of the findings where we have provided additional information and have disagreed with the finding?

Sincerely,

William P. Ramsey
Vice President
Medicare Operations

WPR/RLH/ka

Attachment

cc: Mr. Paul P. Swanson, HHS-OIG Chicago
Ms. Judith D. Stec, HCFA Chicago

Discussion of Audit Adjustments

We agree the following findings are unallowable in FY 87-89:

1.	Leasehold Improvements	$269,226*
2.	Data Processing Costs	251,476*
3.	Accrued Expenses	100,000* 5,369
4.	Pension Expenses	27,471*
5.	Return on Investment	19,164
6.	Unallowable Travel Costs	15,415
7.	Service Charges	14,229**
8.	Depreciation Expense	8,173
9.	Untimely Allocation Update (procedural)	**
	Subtotal	$710,523
	Additional claims by Nationwide	(14,341)
	Total	696,182

* These costs have been audited and found to be allowable if claimed in FY 1990 and succeeding years.

**Nationwide claims additional costs for the three audit years.

We disagree with the following findings:

1.	Postage Costs	$1,453,465*
2.	Complimentary Credits	905,724
3.	Unauthorized Costs	739,708
4.	Fringe Benefits	211,422
5.	Productivity Investments Sales tax	65,450
6.	Corporate Support Overhead	22,989*
7.	Allocation System (procedural)	
	Total	$3,398,758

*We agree with some portions of these findings, but do not agree with the monetary adjustment.

The following are the reasons for disagreeing with the seven monetary and one procedural findings.

1. Postage Costs

Nationwide agrees that most of the postage purchases during the last six months of FY 1989 were not actually used in the five mailing machines until FY 1990. However, Nationwide disagrees with the finding that only one month's supply of postage should be allowed in FY 1989.

There were several conditions that existed in the last half of FY 1989 that contributed to the large balance on hand at the end of the year.

- Implementation of the new Multi-carrier System (MCS) and conversion to the Common Working File (CWF) environments was originally scheduled for April, 1989 but was delayed several times.

  Claims Receipts were increasing more than 13 percent per day over the same period in FY 1988 and more than 7 percent per day over the first six months of FY 1989.

  Extra efforts were being made to process the increasing workload so that Pending would be at the lowest level possible when we went to MCS and CWF. Postage usage increased more than 20 percent from July to August. Based on the increased usage, increasing receipts and changing to MCS/CWF, additional postage needs were projected for September and October.

- In August two of the five postal meters broke with a total of $153,108.93 on the meters. A third meter broke in September 1989 with $91,684.51. These were the first breakdowns in more than a year. The postage on the meters is sent as a credit to Nationwide, but is not available for loading to another meter.

  Nationwide must initiate a postage purchase request to replenish the account with RMRS. Within a 30 day period, $244,793.44 was involved in meter breakdowns. Additional postage was purchased in case of additional breakdowns.

- Anticipated funding for the first quarter of FY 1990 was inadequate and excess funds were available in FY 1989. The new inexperienced Controller initiated four requests for postage ($1,150,000) in August and September to insure the account with RMRS had sufficient postage to load to the five postal meters. The need for postage was increasing as receipts were up, pending had to be decreased and the three meters had broken for the first time in more than a year. A fourth meter broke in October with $82,731.83 on it.

- Additional funding for implementing more sections of OBRA 89 was received in early July 1990. Physician Payment Reform (PPR) was one of the major items in this funding. Additional postage was ordered for the anticipated special mailings and newsletters, but were not completed in FY 1990.

Increasing receipts, new MCS/CWF environment, Physician Payment Reform activities, equipment breakdowns and uncertain funding were significant factors in the purchase of additional postage. Nationwide agrees in retrospect that some postage purchases should have been delayed into FY 1990. Nationwide recommends that $1,005,364 (3 months usage) be allowed in FY 1989 and that $783,289 be repaid to HCFA as unallowable costs in FY 1989. The $783,289 is an allowable in FY 1990 and will be claimed in a revised FACP.

2. Complementary Credits

Nationwide disagrees completely with the finding. As stated in the draft report, Nationwide had negotiated a rate with HCFA in mid-1986 and the rate was approved in a letter dated July 24, 1986 (copy was provided to Audit Team). Subsequently, Nationwide entered into contracts with outside organizations; no data was provided to another Nationwide organization. Both parties fulfilled all aspects of these contracts: the data was provided and invoiced, the invoices were paid.

There are several conditions that could be included in calculating the "total cost" of providing the data to outside organizations. Claims data was sent to these organizations based on eligibility files provided to Nationwide. All claims data for policyholders on these eligibility files were sent to the outside organization. This included claims for which they had no liability. Nationwide used no edits to screen these claims. These claims include those that were 100 percent paid by Medicare, Duplicate claims, Replicate claims, MSP denials, HMO denials, and denials due to no response to development. Based on data provided by one outside organization and confirmed by analysis of Medicare files by EDS-F, nearly 18 percent of all claims sent to the outside organizations were unneeded, yet they paid 43 cents for each of these claims. By recalculating the amounts that should have been charged, Nationwide overcharged for 17.9 percent of the claims it provided during the audit years.

FY 1989	$371,652
FY 1988	277,475
FY 1987	179,483
	$828,610

Although this $828,610 does not fully account for the audit finding of $905,724, the assumption that all data input for Medicare processing was of equal value to the outside organizations may not be valid. So many requirements have been mandated in the past several years by legislative and administrative means that it is difficult to identify what is processed for Medicare's benefit only and is of no value to the complementary insurers in meeting their obligations to their policyholders.

In summary, Nationwide disagrees with this finding. Nationwide had valid contracts with outside organizations for a negotiated rate approved by HCFA. Within this rate, Nationwide charged for nearly 18 percent of the claims for which there was no liability on the part of the complementary insurer.

3. Unauthorized Costs

Nationwide disagrees with this finding. NOBA approval was provided for Edgepark Litigation and Request for Proposal (RFP) in FY 1988. This approval was received in the final NOBA issued by HCFA in January 1989 after the FACP had been submitted. The final NOBA has not been issued for FY 1989.

The Audit Team has verified that the costs were indeed incurred and allowable, but had not been specifically authorized to be reported on Lines 9-11. Some of these costs were included in the FY 1989 Budget Request and were included in the budget negotiations.

The Variance Analysis for October/May included explanations of the four activities in this finding. HCFA has been involved with these activities and indeed approved the move to Plaza III, implementation of MCS, Edgepark litigation and the RFP. A final NOBA should be issued approving these costs.

4. **Fringe Benefits**

Nationwide disagrees with the finding. Based on the information provided in the preliminary finding, Nationwide sent a letter, dated March 14, 1991, to Mr. Anderson. Upon review of the Draft report, Nationwide continues to affirm that the reserve's are proper and are allowable. A copy of the letter is attached and remains the basis for Nationwide's disagreement with this finding.

5. **Productivity Investment Sales Tax**

Nationwide disagrees with this finding. Based on several Ohio Supreme Court cases, Nationwide has been paying sales tax on computer services provided by EDS-F. The audit finding does not disagree with the payment of sales tax, thus sales tax is an allowable cost. There was a contractual arrangement with EDS-F to reimburse a maximum of $1,190,000 for the computer services needed to implement MCS. The sales tax is paid to implement MCS. The sales tax is paid to the State of Ohio, thus the contractual amount paid to EDS-F was not exceeded.

The sales tax amount of $65,450 is an allowable amount, the issue is one of where is it authorized to be claimed on the FACP. By allocating to Lines 1,2,3,5 and 6, Nationwide is consistent in allocating sales tax paid for computer services. Sales tax is charged to one account in one cost center; this is how the amount was booked.

The final NOBA for FY 1990 could be issued to increase the amount of the PI or HCFA can affirm the consistency of allocating sales tax on computer services to Lines 1,2,3,5 and 6.

6. **Corporate Support Overhead**

Nationwide agrees with five of the seven issues to this finding.

a. **Executive Supervision**

Nationwide disagrees with this issue and believes that it is appropriate to include all costs in developing a "true" overhead rate. Developing an overhead rate requires that one include all costs of operations in the overhead expenses.

These total costs are then divided by the total salary dollars to develop an overhead rate. Excluding certain costs or selectively including only a part of the costs, understates the true cost of overhead. This results in a "cost" to the Nationwide Insurance Companies that would belong to Medicare.

Including these officers salaries in the overhead rate does not mean that Medicare is being charged a portion of these salaries. The overhead rate is a factor that is applied to salaries that are chargeable to Medicare. The overhead factor would contain a portion that represents the "management overhead" for a particular area.

Nationwide believes that the Executive Supervision portions of the overhead rate is being calculated properly by including all costs. Nationwide does not agree that $12,050 should be repaid for the three audit years.

b. Depreciation

Nationwide agrees that $597 should be repaid for the three audit years.

c. Legal Expenses

Nationwide agrees that $716 should be repaid for the three audit years.

d. Regional Rent

Nationwide disagrees with this issue and believes that all costs should be included in the calculation of the overhead rate. The majority of our regions own their buildings. The purpose of calculating the overhead rate is to estimate total administrative cost of an employee. Excluding selected costs or units makes the rate calculation less representative of the administrative costs of an average employee.

Nationwide believes that the Regional Rent portion of the overhead rate is being calculated properly because most of the regions own, not lease their buildings. Nationwide does not agree that $1,752 should be repaid for the three audit years.

e. -Real Estate Salaries

Nationwide agrees that $5,526 should be repaid for the three audit years.

f. Reassigned Salaries

Nationwide agrees that $924 should be repaid for the three audit years.

g. Individual Life and Health Operations

Nationwide agrees that $1,424 should be repaid for the three audit years.

In summary, Nationwide agrees that $9,187 should be repaid for the three audit years. Nationwide believes that all costs, including all Executive Supervision salaries and Regional Rent expenses, should be included in the calculation of the overhead rate that is to be applied to the salaries that are chargeable to Medicare. Thus, Nationwide does not agree that $13,802 should be repaid for the three audit years.

Nationwide has generally been conservative in allocating overhead charges to the Medicare Operations. The Audit report identified middle managers' salaries and support costs as an overhead cost that has been incurred, but not claimed.- Based on studies completed by the Cost Accounting Division of Corporate Accounting, Nationwide claims additional costs of $27,151.25 for FY 1989, $26,641.15 for FY 1988, $25,813.24 for FY 1987 for a total of $79,605.64 during the three audit years-.

The preliminary audit findings identified possible unallowable costs of $141,282.56 for excessive rent charges during the three audit years.. The initial finding was that Nationwide charged Medicare Operations a higher rate than it charged itself internally. Appendix B, Paragraph X.A. of the Medicare Contract states:

> To the extent that land and tangible depreciable assets, such as buildings, equipment and leasehold improvements, owned by the contractor are used for Medicare purposes, the cost of investment will be determined by multiplying the average undepreciated balance of such assets for the contract period by the actual rate of return of the contractor's investment portfolio for the contact period, or a lower rate if the contractor so chooses.

Nationwide had chosen the conservative approach and had not charged actual expenses and actual rate of return of our investment portfolio. Nationwide recalculated the rental rates that could be charged per usable square foot and the actual rate was $22.25 compared to $18.15 that had been claimed in CY 1989. For CY 1988, the actual rate was $16.32 compared to the $14.80 rate that was claimed.

Although the preliminary finding was not included in the Draft Report, Nationwide claims reimbursement for additional costs of $92,683.52 for calendar year 1988 in FY 1989. Actual costs and rate of return on investment are not available until the Annual Statement for Nationwide Mutual Insurance Company is filed in February each year. The difference between projected and actual rent costs for CY 1989 is $327,971.30 and will be claimed in the revised FY 1990 FACP.

The Audit Team has reviewed the source data and the spreadsheet calculations for calendar years 1988 and 1989.

7. Allocation System

Nationwide disagrees with this finding. The procedures for accumulating, allocating and reporting costs has been consistent for more than twenty (20) years and have received the highest evaluation each year during the Contractor Performance Evaluation Program (CPEP) evaluation and there were no comments during previou audits. Each year, allocation factors are calculated for each disbursement code and are based on actual work studies, surveys, production reports, staffing patterns as well as the projected workloads and performance requirements directed by HCFA.

Throughout the year, managers receive daily feedback from productio reports of various types on actual performance. The allocation factors are changed when there have been changes in requirements, workloads or functions. Nationwide has maintained efficient, but relatively simple procedures for allocating of costs and has been one of the most cost efficient contractors.

Nationwide has consistently met the requirements for sound Fiscal Administration as required by the MCM, Part 1 and contract provisic with the existing procedures. It does not plan to develop a new cost accounting system nor to modify the existing system. However, Nationwide does agree that documentation should be retained and has reviewed the workload, performance, staffing and requirements after the first quarter of FY 1991. The results of the review are being retained in the Controller's office for inspection during future audits.

7. Service Charges

Nationwide agrees that $13,490 should be repaid for unallowable Personnel Charges during the three audit years. Nationwide also agrees that $739 should be repaid for Cafeteria Charges for FY 1989. However, Nationwide also claims additional costs of $2,829.25 for FY 1987 and $3,611.08 for FY 1988 as described in the Draft report. This will result in a net repayment of $7,789 by Nationwide.

9. Untimely Allocation Update

This was a procedural finding that Nationwide had not updated the rate charged Medicare for services provided by the Purchasing Department. Overhead rates are based on actual expenses incurred in the previous calendar year and can only be calculated after all expenses have been allocated corporately. This is usually done in May each year. The revised rates are applied retroactively to the previous calendar year's activities.

The Purchasing Department's rate has been recalculated. The revised rates are $584.42 for CY 1986: $648.07 for CY 1987 and $693.50 for CY 1988. The differences between the existing rate, $460.00, and the revised rates are applied retroactively for each month, but are claimed in the following fiscal year.

Fiscal Year	Difference	Counterclaim
1987	$124.42	$1,493.04
1988	188.07	2,256.84
1989	233.50	2,802.00
Total Counterclaim		$6,551.88

NATIONWIDE MUTUAL INSURANCE COMPANY
HOME OFFICE: ONE NATIONWIDE PLAZA • COLUMBUS, OHIO 43216

NATIONWIDE INSURANCE
Nationwide is on your side

March 13, 1991

Received
MAR 14 1991
Fiscal

Mr. William Anderson, C.3.A.
Kant E. Doshi
Certified Public Accountants
4520 Madison, Suite 105
Kansas City, MO 64111

Re: Response to Preliminary Medicare Audit Findings

Dear Mr. Anderson:

On behalf of Nationwide's Medicare Operations ("Medicare") I would like to respond to Mary Duff's recent preliminary audit findings. In her *working* papers Ms. Duff stated that:

> "Auditee is maintaining fringe benefit reserves in excess of statutory *required* reserves to cover possible future catastrophic losses."

In support of this finding, Ms. Duff cites Federal Acquisition Regulation ("FAR") Section 31.205-19(e). This section states: "Self-insurance changes for risks of catastrophic losses are not allowable, (see 28.308(e))."

Medicare's reserves are proper and are not used to cover possible future catastrophic losses. Section 31.205-19(e) references Section *28.308(e), Self Insurance. Paragraph (a)* states:

> "Agencies shall not approve a program of self-insurance for catastrophic risks (e.g., Sec. 50.403, special procedures for unusually hazardous or nuclear risks). Should performance of Government contracts create the risks *of* catastrophic losses, the Government may, to the extent authorized *by* law, agree to indemnify the contractor or recognize an appropriate share of premiums for purchased insurance or both."

Section SO.403 deals with special procedures for unusually hazardous or nuclear risks.

The Medicare reserves *are* not *maintained* to cover *possible* catastrophic losses, *(unusually hazardous* or nuclear *risks).* The reserves are a result of the inherent instability and fluctuation present in the underlying normal claims experience. The positive reserve balances will mitigate future adverse claims fluctuation and reduce the level of future rate actions. No part of the

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reserve is used to cover unusually hazardous or nuclear risks. Medicare's reserves are not in excess of statutory required reserves and do not appear to be prohibited by FAR Section 31.205-19(e).

Should you have any questions or comments regarding this matter, please let me know. My direct dial number is (614) 249-8766.

Very truly yours,

James E. Spencer

James E. Spencer, FSA, MAAA
Associate Group Actuary

JES/ko

cc: Ronald Harmon