

Department of Health and Human Services
Office of Inspector General



Office of Audit Services

August 2025 | OAS-25-07-052

CGS Administrators, LLC, Did Not Claim Some Allowable Medicare Excess Plan Costs Through Its Incurred Cost Proposals

REPORT HIGHLIGHTS



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Why OIG Did This Audit

- CMS reimburses Medicare contractors for a portion of their nonqualified plan costs. A nonqualified plan is a type of tax-deferred, employer-sponsored retirement plan.
- HHS, OIG, Office of Audit Services, reviews the cost elements related to qualified defined-benefit, postretirement benefit, and any other pension-related cost elements claimed by Medicare contractors through Incurred Cost Proposals (ICPs).
- Previous OIG audits found that Medicare contractors did not always comply with Federal requirements when claiming nonqualified plan costs for Medicare reimbursement.
- This audit examined whether the calendar years (CYs) 2017 through 2021 Excess Plan costs that CGS claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

What OIG Found

- CGS claimed Excess Plan costs of \$624,843 for Medicare reimbursement, through its ICPs, for CYs 2017 through 2021; however, we determined that the allowable Excess Plan costs during this period were \$861,970. The difference, \$237,127, represented allowable Medicare Excess Plan costs that CGS did not claim on its ICPs for CYs 2017 through 2021.
- CGS did not claim these allowable Medicare Excess Plan costs primarily because it used incorrect indirect cost rates when claiming those costs for Medicare reimbursement.

What OIG Recommends

We recommend that CGS work with CMS to ensure that its final settlement of contract costs reflects an increase in Medicare Excess Plan costs of \$237,127 for CYs 2017 through 2021.

CGS concurred with our finding but did not specifically indicate concurrence or nonconcurrence with our recommendation. CGS said that it would work with CMS to ensure the final settlement and collection of contract costs.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) reimburses a portion of its contractors' nonqualified plan costs.¹ In claiming nonqualified plan costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation (FAR), the Cost Accounting Standards (CAS), and the Medicare contracts. Previous Office of Inspector General (OIG) audits found that Medicare contractors did not always comply with Federal requirements when claiming nonqualified plan costs for Medicare reimbursement.

At CMS's request, the Department of Health and Human Services, OIG, Office of Audit Services, reviews the cost elements related to qualified defined-benefit, nonqualified defined-benefit, postretirement benefit (PRB), and any other pension-related cost elements claimed by Medicare administrative contractors (MACs) and other CAS-covered and Federal Acquisition Regulation (FAR)-covered contracts through Incurred Cost Proposals (ICPs).

For this audit of CGS Administrators, LLC (CGS), a Medicare contractor, we examined the Blue Cross Blue Shield of South Carolina (BCBS South Carolina) Excess Plan (Excess Plan) Partial Medicare segment costs that CGS claimed for Medicare reimbursement and reported on its ICPs.

OBJECTIVE

Our objective was to determine whether the calendar years (CYs) 2017 through 2021 Excess Plan costs that CGS claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

BACKGROUND

CGS Administrators, LLC, and Medicare

During our audit period, CGS was a subsidiary of BCBS South Carolina, whose home office is in Columbia, South Carolina. CGS performed Medicare work upon being awarded the MAC contracts for Medicare Durable Medical Equipment (DME) Jurisdiction C and Medicare Parts A and B Jurisdiction 15 (including home health and hospice services), effective August 31, 2012,

¹ A nonqualified plan is a tax-deferred, employer-sponsored retirement plan that does not meet the standards of the Employee Retirement Income Security Act of 1974, P.L. No 93-406 (Sept. 2, 1974).

and September 17, 2015, respectively.^{2, 3} CGS continues to perform Medicare work for DME Jurisdiction C (re-awarded August 20, 2020) and Medicare Parts A and B Jurisdiction 15 (re-awarded November 30, 2023).

During our audit period, BCBS South Carolina had three Medicare segments that participated in its Excess Plan: (1) Palmetto Government Benefits Administrator, LLC, (Palmetto); (2) Companion Data Services, LLC (CDS); and (3) Partial Medicare.⁴ This report addresses CGS's compliance with the provisions of the Federal requirements and its Medicare contract in claiming Excess Plan costs. We are addressing the Excess Plan costs claimed for Palmetto, and the CDS Medicare segments, in separate audits.

The disclosure statement that CGS submits to CMS states that CGS uses pooled cost accounting. Medicare contractors use pooled cost accounting to calculate the indirect cost rates (whose computations include pension, PRB, Supplemental Executive Retirement Plan III, and Excess Plan costs) that they submit on their ICPs. Medicare contractors use the indirect cost rates to calculate the contract costs that they report on their ICPs. In turn, CMS uses these indirect cost rates in determining the final indirect cost rates for each contract.⁵

Blue Cross Blue Shield of South Carolina Excess Plan

BCBS South Carolina sponsors the Excess Plan. The purpose of the Excess Plan is to provide benefits in excess of the limits imposed by the Employee Retirement Income Security Act of 1974 (footnote 1) for participants in the qualified defined-benefit plan.

Accounting Methodologies

The Medicare contracts require CGS to calculate the Excess Plan costs in accordance with the FAR and CAS 412 and 413. The FAR and the CAS require that the costs for nonqualified plans be measured under either the accrual method or the pay-as-you-go method. Under the accrual method, the allowable costs are based on the annual contributions that the employer deposits into its trust fund. For nonqualified plans that are not funded through the use of a funding

² Medicare DME Jurisdiction C consists of the States of Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia and the U.S. Territories of Puerto Rico and the U.S. Virgin Islands.

³ Medicare Parts A and B Jurisdiction 15 consists of the States of Kentucky and Ohio. Jurisdiction 15 also includes home health and hospice services provided in the States of Colorado, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming, and in the District of Columbia.

⁴ The Partial Medicare segment allocates costs to three Medicare segments: (1) Palmetto, (2) CDS, and (3) CGS.

⁵ For each CY, each Medicare contractor submits to CMS an ICP that reports the Medicare direct and indirect costs that the contractor incurred during that year. The ICP and supporting data provide the basis for the CMS Contracting Officer and the Medicare contractor to determine the final billing rates for allowable Medicare costs.

agency, costs are to be accounted for under the pay-as-you-go method. This method is based on the actual benefits paid to participants, which are comprised of lump-sum payments and annuity payments. CGS claimed Excess Plan costs on an accrual basis.

Incurred Cost Proposal Audits

At CMS's request, CohnReznick, LLP (CohnReznick), and Kearney & Company, P.C. (Kearney), performed audits of the ICPs that CGS submitted for CYs 2017 through 2021. The objectives of these ICP audits were to determine whether costs were allowable in accordance with applicable Federal regulations.

For our current audit, we relied on the CohnReznick and Kearney ICP audit findings and recommendations when computing the allowable Excess Plan costs discussed in this report.

We incorporated the results of the CohnReznick and Kearney ICP audits into our computations of the audited indirect cost rates, and ultimately the Excess Plan costs claimed, for the contracts subject to the FAR. CMS will use our report on allowable Excess Plan costs, as well as the CohnReznick and Kearney ICP audit reports, to determine the final indirect cost rates and the total allowable contract costs for CGS for CYs 2017 through 2021. The cognizant Contracting officer will perform a final settlement with the contractor to determine the final indirect cost rates. These rates ultimately determine the final costs of each contract.⁶

HOW WE CONDUCTED THIS AUDIT

We reviewed \$624,843 of Excess Plan costs that CGS claimed for Medicare reimbursement on its ICPs for CYs 2017 through 2021.

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

Appendix A contains details of our audit scope and methodology.

FINDING

CGS claimed Excess Plan costs of \$624,843 for Medicare reimbursement, through its ICPs, for CYs 2017 through 2021; however, we determined that the allowable Excess Plan costs during

⁶ In accordance with FAR 42.705-1(b)(5)(ii) and FAR 42.705-1(b)(5)(iii)(B), the cognizant Contracting Officer shall "[p]repare a written indirect cost rate agreement conforming to the requirements of the contracts" and perform a "[r]econciliation of all costs questioned, with identification of items and amounts allowable or disallowed in the final settlement," respectively.

this period were \$861,970.⁷ The difference, \$237,127, represented allowable Medicare Excess Plan costs that CGS did not claim on its ICPs for CYs 2017 through 2021. CGS did not claim these allowable Medicare Excess Plan costs primarily because it used incorrect indirect cost rates when claiming those costs for Medicare reimbursement.

ALLOCABLE EXCESS PLAN PARTIAL MEDICARE SEGMENT COSTS UNDERSTATED

During this audit, we calculated the allocable Excess Plan Partial Medicare segment costs for CYs 2017 through 2021 in accordance with Federal requirements.⁸ We determined that the allocable Excess Plan Partial Medicare segment costs for CYs 2017 through 2021 totaled \$11,475,801. CGS reported that its allocable Excess Plan Partial Medicare segment costs, as identified in its actuarial computations, totaled \$8,324,797. Therefore, CGS understated the allocable Excess Plan Partial Medicare segment costs by \$3,151,004. This understatement occurred because of differences in the calculations of the assignable Excess Plan costs. More specifically, differences in the amortization calculations resulted in different assignable Excess Plan costs.

Table 1 shows the differences between the allocable Excess Plan Partial Medicare segment costs that we determined for CYs 2017 through 2021 and the allocable Excess Plan Partial Medicare segment costs that CGS calculated for the same time period.

Table 1: Allocable Excess Plan Partial Medicare Segment Costs

Calendar Year	Allocable Per Audit	Per Partial Medicare	Difference
2017	\$1,924,857	\$1,534,185	\$390,672
2018	2,035,410	1,599,532	435,878
2019	2,263,929	1,287,764	976,165
2020	2,616,271	1,742,632	873,639
2021	2,635,334	2,160,684	474,650
Total	\$11,475,801	\$8,324,797	\$3,151,004

CALCULATION OF ALLOWABLE EXCESS PLAN COSTS

We used the allocable Excess Plan costs for the Partial Medicare segment (Appendix C) to adjust the indirect cost rates (i.e., the fringe benefit and general and administrative rates) to

⁷ These claimed and allowable Excess Plan costs were associated with the cost reimbursement and variable time and material portions of the contract.

⁸ The Partial Medicare segment allocates costs to all three BCBS South Carolina subsidiaries: Palmetto, CDS, and CGS (footnote 4). The Excess Plan Partial Medicare segment cost identified here is the total before allocations are made to the subsidiaries. These allocable costs are used in the determination of the indirect cost rates and ultimately the Excess Plan costs claimed by CGS.

determine the allowable Excess Plan costs for Medicare reimbursement for CYs 2017 through 2021.

CGS claimed Medicare Excess Plan costs of \$624,843 on its ICPs for CYs 2017 through 2021. After incorporating the results of the CohnReznick and Kearney ICP audits and our adjustments to the indirect cost rates, we determined that the allowable Medicare Excess Plan costs for CYs 2017 through 2021 were \$861,970. Thus, CGS did not claim \$237,127 of allowable Medicare Excess Plan costs on its ICPs for CYs 2017 through 2021. This underclaim occurred specifically because CGS based its claim for Medicare reimbursement on incorrect allocable Excess Plan costs, and ultimately used incorrect indirect cost rates on the ICPs it used to calculate the CGS segment allowable Excess Plan costs.

We calculated the allowable Medicare Excess Plan costs based on separately computed CAS-based Excess Plan costs in accordance with CAS 412 and 413. For details on the Federal requirements, see Appendix B.

Table 2 compares the Medicare Excess Plan costs that we calculated (using our adjusted indirect cost rates) to the Medicare Excess Plan costs that CGS claimed for Medicare reimbursement for CYs 2017 through 2021.

Table 2: Comparison of Allowable Excess Plan Costs and Claimed Excess Plan Costs⁹

Calendar Year	Allowable Per Audit	Per CGS	Difference
2017	\$168,948	\$134,642	\$34,306
2018	161,666	127,099	34,567
2019	178,083	101,312	76,771
2020	181,699	121,133	60,566
2021	171,574	140,657	30,917
Total	\$861,970	\$624,843	\$237,127

RECOMMENDATION

We recommend that CGS Administrators, LLC, work with CMS to ensure that its final settlement of contract costs reflects an increase in Medicare Excess Plan costs of \$237,127 for CYs 2017 through 2021.

AUDITEE COMMENTS

In written comments on our draft report, CGS, through its parent company, BCBS South Carolina, concurred with our finding but did not specifically indicate concurrence or

⁹ Our calculation of allowable costs does not appear in this report because those indirect cost rate computations that CGS used in its ICPs, and to which we referred as part of our audit, are proprietary information.

nonconcurrence with our recommendation. CGS said that it would work with CMS to ensure the final settlement and collection of contract costs.

CGS's comments appear in their entirety as Appendix D.¹⁰

¹⁰ Although BCBS South Carolina, of which CGS is a subsidiary, provided written comments on this draft report, for consistency we associate these comments with CGS.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$624,843 of Excess Plan costs that CGS claimed for Medicare reimbursement on its ICPs for CYs 2017 through 2021.

Achieving our objective did not require that we review CGS's overall internal control structures. We reviewed the internal controls related to the Excess Plan costs that were included in CGS's ICPs and ultimately used as the basis for Medicare reimbursement, to ensure that these costs were allocable in accordance with the CAS and allowable in accordance with the FAR.

We performed our audit work from August 2023 to June 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed the portions of the FAR, CAS, and Medicare contracts applicable to this audit;
- reviewed information provided by CGS to identify the amounts of Excess Plan costs used in CGS's calculation of indirect cost rates for CYs 2017 through 2021;
- used information that CGS's actuarial consulting firms provided, including information on the Excess Plan's assets, liabilities, normal costs, contributions, benefit payments, investment earnings, and administrative expenses;
- examined CGS's accounting records, Excess Plan documents, and annual actuarial valuation reports;
- determined the extent to which CGS funded CAS-based Excess Plan costs with contributions to the trust and accumulated prepayment credits;
- reviewed the results of the CohnReznick and Kearney ICP audits and incorporated those results into our calculations of allowable Excess Plan costs;
- engaged the CMS Office of the Actuary, which provides technical actuarial advice, to calculate the allocable Excess Plan Medicare costs based on the CAS;
- reviewed and verified the CMS actuaries' methodology and calculations and used this information to calculate the Excess Plan costs for the CGS Medicare segment for CYs 2017 through 2021; and

- provided the results of our audit to CGS officials.

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

- *CGS Administrators, LLC, Claimed Some Unallowable Medicare Supplemental Executive Retirement Plan III Costs Through Its Incurred Cost Proposals* (OAS-25-07-049); and
- *CGS Administrators, LLC, Did Not Claim Some Allowable Medicare Pension Costs Through Its Incurred Cost Proposals* (OAS-25-07-051).

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

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

FEDERAL REGULATIONS

Federal regulations (FAR 31.205-6(j)) require Medicare contractors to measure, assign, and allocate the costs of all defined-benefit pension plans in accordance with CAS 412 and 413.

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

Federal regulations (CAS 412) (as amended) address the determination and measurement of pension cost components. These regulations also address the assignment of pension costs to appropriate accounting periods.

Federal regulations (CAS 413) (as amended) address the valuation of pension assets, allocation of pension costs to segments of an organization, adjustment of pension costs for actuarial gains and losses, and assignment of gains and losses to cost accounting periods.

MEDICARE CONTRACTS

The Medicare contracts require CGS to submit invoices in accordance with FAR 52.216-7, "Allowable Cost & Payment." (See our citation to FAR 52.216-7(a)(1) in "Federal Regulations" above.)

**APPENDIX C: ALLOCABLE MEDICARE EXCESS PLAN COSTS FOR CGS ADMINISTRATORS, LLC,
FOR CALENDAR YEARS 2017 THROUGH 2021**

Date	Description		Total Company	Other Segment	Palmetto Segment	CDS Segment	Partial Medicare Segment	Non Medicare Segment
2017	Contributions <u>1/</u>		\$3,069,116	\$3,069,116	\$0	\$0	\$0	\$0
	Discount for Interest <u>2/</u>		(\$101,265)	(\$101,265)	\$0	\$0	\$0	\$0
January 1, 2017	Present Value Contributions <u>3/</u>		\$2,967,851	\$2,967,851	\$0	\$0	\$0	\$0
	Prepayment Credit Applied <u>4/</u>		\$12,506,042	\$5,776,700	\$310,031	\$130,308	\$1,924,857	\$4,364,146
	Present Value of Funding <u>5/</u>		\$15,473,893	\$8,744,551	\$310,031	\$130,308	\$1,924,857	\$4,364,146
January 1, 2017	CAS Funding Target <u>6/</u>		\$12,506,042	\$5,776,700	\$310,031	\$130,308	\$1,924,857	\$4,364,146
	Percentage Funded <u>7/</u>			100.00%	100.00%	100.00%	100.00%	100.00%
	Funded Pension Cost <u>8/</u>			\$5,776,700	\$310,031	\$130,308	\$1,924,857	\$4,364,146
	Allowable Interest <u>9/</u>			\$0	\$0	\$0	\$0	\$0
2017	CY Allocable Pension Cost <u>10/</u>			\$5,776,700	\$310,031	\$130,308	\$1,924,857	\$4,364,146

Date	Description		Total Company	Other Segment	Palmetto Segment	CDS Segment	Partial Medicare Segment	Non Medicare Segment
2018	Contributions		\$47,010,084	\$47,010,084	\$0	\$0	\$0	\$0
	Discount for Interest		(\$2,039,057)	(\$2,039,057)	\$0	\$0	\$0	\$0
January 1, 2018	Present Value Contributions		\$44,971,027	\$44,971,027	\$0	\$0	\$0	\$0
	Prepayment Credit Applied		\$12,922,357	\$5,642,137	\$369,709	\$155,153	\$2,035,410	\$4,719,948
	Present Value of Funding		\$57,893,384	\$50,613,164	\$369,709	\$155,153	\$2,035,410	\$4,719,948
January 1, 2018	CAS Funding Target		\$12,922,357	\$5,642,137	\$369,709	\$155,153	\$2,035,410	\$4,719,948
	Percentage Funded			100.00%	100.00%	100.00%	100.00%	100.00%
	Funded Pension Cost			\$5,642,137	\$369,709	\$155,153	\$2,035,410	\$4,719,948
	Allowable Interest			\$0	\$0	\$0	\$0	\$0
2018	CY Allocable Pension Cost			\$5,642,137	\$369,709	\$155,153	\$2,035,410	\$4,719,948

Date	Description	Total Company	Other Segment	Palmetto Segment	CDS Segment	Partial Medicare Segment	Non Medicare Segment
2019	Contributions	\$4,278,702	\$4,278,702	\$0	\$0	\$0	\$0
	Discount for Interest	(\$141,174)	(\$141,174)	\$0	\$0	\$0	\$0
January 1, 2019	Present Value Contributions	\$4,137,528	\$4,137,528	\$0	\$0	\$0	\$0
	Prepayment Credit Applied	\$13,437,492	\$5,483,362	\$423,550	\$124,032	\$2,263,929	\$5,142,619
	Present Value of Funding	\$17,575,020	\$9,620,890	\$423,550	\$124,032	\$2,263,929	\$5,142,619
January 1, 2019	CAS Funding Target	\$13,437,492	\$5,483,362	\$423,550	\$124,032	\$2,263,929	\$5,142,619
	Percentage Funded		100.00%	100.00%	100.00%	100.00%	100.00%
	Funded Pension Cost		\$5,483,362	\$423,550	\$124,032	\$2,263,929	\$5,142,619
	Allowable Interest		\$0	\$0	\$0	\$0	\$0
2019	CY Allocable Pension Cost		\$5,483,362	\$423,550	\$124,032	\$2,263,929	\$5,142,619

Date	Description	Total Company	Other Segment	Palmetto Segment	CDS Segment	Partial Medicare Segment	Non Medicare Segment
2020	Contributions	\$10,027,431	\$10,027,431	\$0	\$0	\$0	\$0
	Discount for Interest	(\$380,911)	(\$380,911)	\$0	\$0	\$0	\$0
January 1, 2020	Present Value Contributions	\$9,646,520	\$9,646,520	\$0	\$0	\$0	\$0
	Prepayment Credit Applied	\$15,978,064	\$6,802,818	\$482,802	\$139,525	\$2,616,271	\$5,936,648
	Present Value of Funding	\$25,624,584	\$16,449,338	\$482,802	\$139,525	\$2,616,271	\$5,936,648
January 1, 2020	CAS Funding Target	\$15,978,064	\$6,802,818	\$482,802	\$139,525	\$2,616,271	\$5,936,648
	Percentage Funded		100.00%	100.00%	100.00%	100.00%	100.00%
	Funded Pension Cost		\$6,802,818	\$482,802	\$139,525	\$2,616,271	\$5,936,648
	Allowable Interest		\$0	\$0	\$0	\$0	\$0
2020	CY Allocable Pension Cost		\$6,802,818	\$482,802	\$139,525	\$2,616,271	\$5,936,648

Date	Description	Total Company	Other Segment	Palmetto Segment	CDS Segment	Partial Medicare Segment	Non Medicare Segment
2021	Contributions	\$16,460,433	\$16,460,433	\$0	\$0	\$0	\$0
	Discount for Interest	(\$652,927)	(\$652,927)	\$0	\$0	\$0	\$0
January 1, 2021	Present Value Contributions	\$15,807,506	\$15,807,506	\$0	\$0	\$0	\$0
	Prepayment Credit Applied	\$15,570,922	\$6,699,839	\$438,365	\$176,884	\$2,635,334	\$5,620,500
	Present Value of Funding	\$31,378,428	\$22,507,345	\$438,365	\$176,884	\$2,635,334	\$5,620,500
January 1, 2021	CAS Funding Target	\$15,570,922	\$6,699,839	\$438,365	\$176,884	\$2,635,334	\$5,620,500
	Percentage Funded		100.00%	100.00%	100.00%	100.00%	100.00%
	Funded Pension Cost		\$6,699,839	\$438,365	\$176,884	\$2,635,334	\$5,620,500
	Allowable Interest		\$0	\$0	\$0	\$0	\$0
2021	CY Allocable Pension Cost		\$6,699,839	\$438,365	\$176,884	\$2,635,334	\$5,620,500

ENDNOTES

- 1/ We obtained these Total Company contribution amounts and dates of deposit from the Excess Plan trust statements. These contributions include deposits made during the CY. We determined the contributions allocated to the Medicare segment during the pension segmentation reviews (OAS-25-07-026, OAS-25-07-027, and OAS-25-07-028). The amounts shown for the Other segment represent the difference between the Total Company and Medicare segments.
- 2/ We subtracted the interest that was included in the contributions deposited after the beginning of the valuation year to discount the contributions back to their beginning-of-the-year value. For purposes of this Appendix, we computed the interest as the difference between the present value of contributions (at the CAS valuation interest rate) and actual contribution amounts.
- 3/ The present value of contributions is the value of the contributions discounted from the date of deposit back to the first day of the CY.
- 4/ A prepayment credit represents the accumulated value of premature funding from the previous year(s). A prepayment credit is created when contributions, plus interest, exceed the end-of-year CAS funding target. A prepayment credit is carried forward, with interest, to fund future CAS pension costs.
- 5/ The present value of funding represents the present value of contributions plus prepayment credits. This is the amount of funding that is available to cover the CAS funding target measured at the first day of the CY.
- 6/ The CAS funding target must be funded by contributions made during the current accounting period or prepaid contributions to satisfy the funding requirement of the FAR 31.205-6(j)(2)(i).

7/ The percentage of costs funded is a measure of the portion of the CAS funding target that was funded during the CY. Because any funding in excess of the CAS funding target is accounted for as a prepayment in accordance with CAS 412.50(c)(1), the funded ratio may not exceed 100 percent. We computed the percentage funded as the present value of funding divided by the CAS funding target. For purposes of illustration, the percentage funded has been rounded to four decimal places.

8/ We computed the funded CAS-based pension cost as the CAS funding target multiplied by the percent funded.

9/ We assumed that interest on the funded CAS-based pension cost, less the prepayment credit, accrues in the same proportion as the interest on contributions bears to the present value of contributions. However, we limited the interest in accordance with FAR 31.205-6(j)(2)(iii), which does not permit the allowable interest to exceed the interest that would accrue if the CAS funding target, less the prepayment credit, were funded in four equal installments deposited within 30 days after the end of the quarter.

10/ The CY allocable CAS pension cost is the amount of pension cost that may be allocated for contract cost purposes.



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July 8, 2025

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Report Numbers:

A-07-23-00638	OAS-25-07-020	OAS-25-07-022
OAS-25-07-023	OAS-25-07-026	OAS-25-07-027
OAS-25-07-028	OAS-25-07-046	OAS-25-07-047
OAS-25-07-052	OAS-25-07-051	

Dear Mr. Korn:

We are responding to the U.S. Department of Health and Human Services, Office of Inspector General, draft reports referenced above which pertain to the BlueCross BlueShield South Carolina sponsored qualified-defined benefit pension plan and excess plan.

We concur with findings in each report, we will work with our actuarial firm to ensure we implement the recommendations prospectively beginning with calendar year 2025, consistent with the timing of receipt of reports referenced above. The findings collectively resulted in underbilling costs for each of our companies for calendar years 2017-2021. We will work with CMS to ensure final settlement and collection of these costs.

We appreciate the opportunity to comment on the recommendations. Please let me know if you have any questions or need additional information regarding our response.

Sincerely,

/Jennifer Capell/

Jennifer Capell
 Vice President, Corporate Controller
 BlueCross BlueShield South Carolina

Cc: Bruce Hughes, Celerian Group
 Lori Hair, BlueCross BlueShield South Carolina
 Jamie Keller, Companion Data Services, LLC
 Michael Logan, CGS Administrators, LLC
 Nancy Lybrand, Palmetto GBA, LLC

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Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. [Learn more about complaints OIG investigates.](#)

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of [whistleblowing](#) or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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