Section III: Financial Section

FY 2006 Performance and Accountability Report

Message From the Chief Financial Officer

OFFICE OF THE SECRETARY OF
HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Charles E. Johnson

As the Chief Financial Officer of HHS, I recognize that our Department is accountable to our ultimate stakeholders – the American Public. We are vigilant to use taxpayer resources wisely to carry out the Department's mission to enhance the health and well-being of Americans. With net outlays in excess of $600 billion in FY 2006, we are one of the largest, most complex financial organizations in the world. Incorporating the tenets of the President's Management Agenda (PMA) into our daily routines is central to our success in accomplishing ambitious goals and delivering on the promise of the PMA.

The Department's work revolves around eight strategic goals. This report includes information on our accomplishments in the past year in support of these important goals. We present in the program performance section, by strategic goal, highlights of our FY 2006 performance results. In addition, we discuss the challenges ahead and how we will address those challenges.

There is perhaps no better measure of our performance in FY 2006 than the successful implementation of the new Medicare Prescription Drug Program (or Part D). This is the most far-reaching benefit to be added to the Medicare program in nearly 40 years.

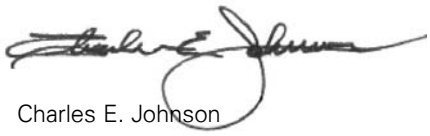
This report also contains our audited financial statements. For the eighth year in a row, the independent auditors have issued an unqualified or "clean" opinion. This is particularly significant in that we included in FY 2006 a new basic financial statement – the Statement of Social Insurance – as required by Federal accounting standards, which was subjected to audit for the first time in 2006. This new statement, which includes actuarially-determined projections of future Medicare costs of approximately $50 trillion, is likely the largest financial statement ever audited. The statement is intended to help citizens assess the financial position of the Medicare trust funds, as well as the adequacy of future budgetary resources for its programs, including Part D described above.

During 2006, the Department successfully implemented revised OMB Circular A-123, *Management's Responsibility for Internal Control,* which calls for a more rigorous assessment of internal control similar to the private sector requirements of the Sarbanes-Oxley Act of 2002. The Secretary's annual Statement of Assurance reflecting the results of our assessment is presented in Section I of this report. The Department created in FY 2006 the Risk Management and Financial Oversight Board (RMFOB), which functions similar to a corporate audit committee. The RMFOB is responsible for overseeing A-123 implementation as well as the financial statement audit process. During 2007, the RMFOB will be actively involved in overseeing corrective actions to resolve our internal control weaknesses.

The independent auditors' report identifies material weaknesses that must be corrected relating to: (1) financial management systems and reporting, and (2) information systems controls. The primary catalyst for addressing our financial systems deficiencies is the Unified Financial Management System (UFMS), which is being deployed in phases – two agencies in April 2005; HHS headquarters and seven agencies in October 2006; and two agencies by October 2007. In addition to implementing UFMS, the Department continues a program to implement FFMIA-compliant systems at Medicare contractors by 2010. Significant financial reporting process improvements will be needed also to resolve this weakness.

Information system control weaknesses are also identified as a material weakness relating to electronic data processing vulnerabilities identified at Medicare contractors along with other Departmental information technology control weaknesses. The Department recognizes the importance of effective internal control and is committed to resolving this material weakness promptly. The RMFOB will closely monitor remediation efforts in this area.

Finally, I want to thank our employees and partners – who work each day to achieve our Nation's noblest human aspirations for safety, compassion, and trust. This report – and the accomplishments it describes – is a reflection of their extraordinary dedication to our mission. Together we look forward to tackling our ambitious agenda for the future in 2007.



Charles E. Johnson

NOV 15 2006

Independent Auditor's Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 15 2006

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2006 (A-17-06-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2006 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting (CPA) firm of PricewaterhouseCoopers, LLP (PwC), to audit the HHS consolidated balance sheet as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 06-03, Audit Requirements for Federal Financial Statements.

The financial statements of HHS as of September 30, 2005, and for the year then ended were audited by the CPA firm of Ernst & Young, LLP, whose report dated November 11, 2005, expressed an unqualified opinion on those statements.

Results of Independent Audit

Based on its audit, PwC found that the FY 2006 HHS financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, PwC noted two matters involving internal controls over financial reporting that were considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants:

- *Financial Management Systems and Reporting.* As in prior years, HHS continued to have serious internal control weaknesses in its financial management systems and processes for producing timely and reliable financial statements. Substantial manual procedures, significant adjustments to balances, and numerous accounting entries recorded outside HHS's general ledger system were necessary.

- *Departmental Information Systems Controls.* For several systems, PwC reported numerous issues in the areas of access to data and controls over changes to edits. In addition, weaknesses continued in the Entitywide Security Program and Service Continuity Planning and Testing, and some slippage occurred in systems software controls since the FY 2005 audit.

PwC also noted instances in which HHS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 06-03, we reviewed PwC's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;

- reviewing the approach and planning of the audit;

- attending key meetings with auditors and HHS officials;

- monitoring the progress of the audit;

- examining audit documentation related to the review of internal controls over financial reporting;

- reviewing the auditors' reports; and

- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached reports dated November 14, 2006, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no

instances in which PwC did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-06-00001.

Daniel R. Levinson

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Resources and Technology

Sheila Conley
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

To the Secretary of the Department of Health of Human Services and the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) and its components as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006. These financial statements are the responsibility of HHS's management. Our responsibility is to express an opinion on these financial statements based on our audit.

The financial statements of HHS as of and for the year ended September 30, 2005 were audited by other auditors whose report thereon dated November 11, 2005 expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements*. Those 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.

In our opinion, based on our audit, the consolidated and combined financial statements referred to above and the statement of social insurance, present fairly, in all material respects, the financial position of HHS and its components as of September 30, 2006, and their net cost of operations, changes in net position, budgetary resources and reconciliation of net cost to budgetary obligations for the year then ended, and the financial condition of its social insurance program as of January 1, 2006, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted HHS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, HHS is exempted from reporting recoveries of prior year obligations on the statement of budgetary resources.

As discussed in Note 1 to the financial statements, HHS adopted Statement of Federal Financial Accounting Standard (SFFAS) No. 27, *Earmarked Funds*, beginning October 1, 2005. This standard does not permit the restatement of prior periods.

As discussed in Note 31 to the financial statements, HHS adopted SFFAS No. 25, *Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessment*, requiring that the statement of social insurance (SOSI) be presented as basic financial statements beginning in fiscal year 2006. The SOSI presents the projected 75-year actuarial present value of the income and expenditures of HHS's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds, designed to illustrate the long-term sustainability of this social insurance program. In preparing the SOSI, management considers and selects assumptions and data that it believes provides a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the SOSI and the fact that such assumptions are inherently subject to substantial uncertainty, arising from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events, significant uncertainties and contingencies, many that cannot be reliably anticipated and most of which are beyond HHS's control particularly over more distant timeframes such as the 75-year projection period used for the SOSI, actual future expenditures are likely to differ significantly from the projections, and those differences may be material and could affect the long-term sustainability of this social insurance program. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program experience upon which to base the estimates.

As discussed in Note 32 to the financial statements, the projected SMI Part B expenditure growth reflected in the accompanying SOSI is likely understated due to the structure of physician payment updates, which under current law would result in multiple years of significant reductions in physician payments, totaling an estimated 37 percent over the next nine years. Since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. However, in practice it is not possible to anticipate what actions Congress might take, either in the near or long term, to alter the physician payment updates. For example, Congress has overridden scheduled reductions in physician payments for each of the last four years. The potential magnitude of the understatement of Part B expenditures, due to the physician payment updates can differ materially from the amount presented in the SOSI. In Note 32, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the SOSI, the projected 75-

year present value of future Part B expenditures is $17.6 trillion. In management's hypothetical examples, if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.3 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $24.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

The Management's Discussion and Analysis (MD&A), Required Supplementary Information (RSI) and Required Supplementary Stewardship Information (RSSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements.* We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSI and RSSI. However, we did not audit the information and express no opinion on it.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of HHS and its components taken as a whole. The additional information presented on the statement of social insurance is not a required part of the statement and is presented for purposes of additional analysis. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards,* we have also issued reports dated November 15, 2006 on our consideration of HHS's internal control and on its compliance and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

PricewaterhouseCoopers LLP

November 15, 2006

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Report of Independent Auditors on Compliance and Other Matters

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) and its components as of September 30, 2006 and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and have issued a report thereon dated November 15, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements.*

The management of HHS is responsible for compliance with laws and regulations. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 06-03, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). Under FFMIA, we are required to report whether the HHS financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to HHS. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion.

The results of our tests of HHS's compliance with laws and regulations, described in the preceding paragraph, exclusive of FFMIA or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 06- 03, resulted in one instance of non-compliance as described below.

HHS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although HHS has not complied with IPIA, HHS currently measures payment accuracy rates for several of its high-risk programs and has plans in place to measure payment accuracy rates for the remaining high-risk programs.

In the accompanying Performance and Accountability report, HHS has reported the discovery of internal control weaknesses in a program managed by one of its component entities, which resulted in probable violations of the Anti-Deficiency Act (ADA). HHS reported that these weaknesses occurred over a period of several prior fiscal years and any amounts which could be involved would not be material to any year's financial statements and that management is investigating these weaknesses and is committed to promptly resolving the internal control weaknesses in this program, and complying with all aspects of the ADA.

We were unable to fully test consolidated performance reporting requirements of the Government Performance and Results Act (GPRA) (Public Law 103-62), OMB Circular A-11, and OMB Circular A-136, *Financial Reporting Requirement*. In a letter dated August 30, 2006, OMB said that for FY 2006 performance reporting, HHS should present a key set of measures that HHS management has identified as representing HHS's key priorities for FY 2006 in the Management Discussion and Analysis (MD&A) with reference to individual operating division plans. Because the issuance of the operating divisions' plans will be subsequent to the completion of our fieldwork, we were unable to fully assess compliance with GPRA, OMB Circular A-11, and OMB Circular A-136 as they relate to consolidated performance reporting requirements. In addition, HHS has not met all of the reporting requirements related to these measures as required by OMB Circular A-136 in their presentation in the MD&A.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. The results of our tests disclosed instances, noted below, where HHS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

In our report on internal control dated November 15, 2006, we reported two material weaknesses related to Financial Management Systems and Reporting and Information Systems Controls and reportable conditions related to the Managed Care Benefit Payment Cycles (Part C and D) and Program Analysis and Oversight. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to HHS in our report on internal control dated November 15, 2006.

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This report is intended solely for the information and use of the management of the HHS, the Office of the Inspector General of HHS, the OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

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November 15, 2006

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Report of Independent Auditors on Internal Control

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health of and Human Services and its components (HHS) as of September 30, 2006 and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and have issued a report thereon dated November 15, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements.*

In planning and performing our audit, we considered HHS's internal control over financial reporting by obtaining an understanding of HHS's internal control, determined whether internal controls had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated and combined financial statements and not to provide an opinion on the internal controls. We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements and Required Supplementary Stewardship Information (RSSI) in accordance with accounting principles generally accepted in the United States of America, and to safeguard assets against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in accordance with laws governing the use of budget authority and any other laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 06-03 that could have a direct and material effect on the consolidated and combined financial statements or RSSI ; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982. Our purpose was not to provide an opinion on HHS's internal control. Accordingly, we do not express an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. Under standards issued by the American Institute of Certified Public Accountants (AICPA) and OMB, reportable conditions are matters coming to our attention, that in our judgment, should be communicated because they represent significant deficiencies in the design or operation of the internal control that could adversely affect the HHS's ability to meet the internal control objectives related to the reliability of financial reporting, compliance with laws and regulations, and the reliability of performance reporting previously noted. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that errors, fraud or noncompliance in amounts that would be material in relation to the consolidated and combined financial statements being audited, or material to a performance measure or aggregation of related performance measures, may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted five matters, discussed below, involving the internal control and its operation that we consider to be reportable conditions (of which two are considered material weaknesses).

Material Weakness I

Financial Management Systems and Reporting (Repeat Condition)

Overview

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. HHS relies on a decentralized processes and complex systems to accumulate data for financial reporting. An integrated financial system, sufficient number of properly trained personnel and a strong oversight function are needed to ensure that periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Within HHS, the Centers for Medicare and Medicaid Services (CMS) and the National Institutes of Health (NIH) have stand alone financial management and accounting systems, Financial Accounting and Control Systems (FACS) and NIH Business System (NBS), respectively. The Centers for Disease Control and Prevention (CDC), Agency for Toxic Substances and Disease Registry (ATSDR), and the Food and Drug Administration (FDA) have implemented the Unified Financial Management System (UFMS) eliminating their separate financial management systems. The remaining eight components utilize the Program Support Center’s (PSC) Division of Financial Operations (DFO) CORE accounting system.

Financial Management System Control Weaknesses

HHS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems, compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards.

The lack of an integrated financial management system, non-compliance with the USSGL at the transaction level and weaknesses in internal controls impair HHS's ability to efficiently and effectively support and analyze accounts, as well as, prepare timely and reliable financial statements. Substantial "work-arounds," cumbersome reconciliation and consolidation processes, and significant adjustments to reconcile subsidiary records to reported balances have been necessary under the existing systems. The following matters illustrate the challenges presented by the existing systems:

- In the NBS system, which supports net outlays of more than $27 billion, more than 900 nonstandard accounting entries with an approximate value of $1.4 billion to adjust budgetary and proprietary accounts were recorded for financial reporting purposes. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. During our testing we noted that transaction codes for direct, reimbursable, and sponsored travel required manual intervention to assign an identifier, either direct or reimbursable, to the transaction within the NBS.

- The CORE accounting system, which supports net outlays of more than $93 billion, is a legacy accounting system and does not support all functionality required by USSGL and JFMIP standards. Accordingly, it does not capture all transactions properly and does not facilitate the timely preparation of financial statements. The necessary data has to be downloaded from CORE, with numerous adjusting entries processed throughout the year before compiling the statements. In fiscal year FY 2006, approximately 100 miscellaneous journal vouchers were posted into CORE, each representing multiple accounting transactions with an approximate value of $107 billion to reconcile the general ledger to subsidiary ledgers, perform data clean-up in preparation of conversion to UFMS, and record accounting entries that are not supported through standard transaction codes.

- Currently, UFMS supports net outlays of $7.9 billion. HHS continues to experience significant challenges in resolving issues related to the UFMS conversion and implementation. This is evidenced by the following:

    - Despite the implementation of UFMS, HHS recorded more than 1,000 manual entries during the year totaling in excess of $10 billion to correct conversion balances, correct opening balances, and record financial transactions in order to complete the financial reporting process.

    - HHS has not completed the implementation of the UFMS reports module. Ad-hoc extracts from UFMS and reports generated from the legacy systems continue to be used to support monthly reconciliations and the interim and year-end financial statements.

In addition, as related to Medicare program financial information, HHS currently relies on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to HHS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because HHS, and its Medicare contractors, do not have a JFMIP compliant financial management system, the preparation of the 750 and 751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to HHS. Likewise the reporting mechanism used by the Medicare contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, is heavily dependent on inefficient, labor intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to HHS.

The financial management systems issues prevent the timely use and reliance on this information by both operations and financial reporting personnel. For example, HHS is not able to report all information required for the completion of quarterly financial statements, such as the Entitlement Benefits Due and Payable accrual, in accordance with OMB timelines and provides only minimal information at year end which supports the completion of the financial statements. Just as important, these reporting deficiencies do not provide sufficient data for oversight and management.

Financial Statement Preparation

HHS compiles its financial statements through a multi-step process using a combination of manual and automated procedures. Due to system limitations, many components record numerous entries outside the general ledger systems and employ manually intensive procedures using Excel spreadsheets and database queries to prepare the financial statements. These processes increase the risk that errors may occur in the HHS financial statements. The following issues were identified during the financial statement preparation process:

- To prepare financial statements, more than 200 journal vouchers representing multiple transactions with a value of more than $143 billion were recorded outside the CORE accounting system. Many of these accounting entries were made to record year-end accruals, adjust between governmental and nongovernmental accounts, record expenditures not posted to the general ledger prior to the month-end close, adjust proprietary to budgetary accounts, post reconciliation adjustments, and correct for the CORE accounting systems posting logic errors that are non-USSGL compliant. In addition, the prior quarter journal entries must be manually re-recorded into Access databases used to create the financial statements since they are not posted to the general ledger.

- We noted numerous errors in supporting spreadsheets, calculations, and journal vouchers used to produce the financial statements that were brought to management's attention, to include the following:

    - An incorrect journal voucher with a value of approximately $1 billion was recorded. This entry was made to balance an edit check and caused the Undelivered Orders balance to be understated and Unapportioned Authority to be overstated. This error made it appear monies were available for obligation which were not. This error was subsequently corrected.

    - Multiple errors where the accounting entries made through a journal voucher were not properly posted to the financial statements. This resulted from HHS's inability to process this transaction through the system, therefore, it had to be manually mapped to the affected line items on the Statement of Budgetary Resources (SBR). These errors resulted in revisions to the SBR and Statement of Financing (SOF) requiring the SF133s to be updated during the FACTS II revision period.

    - A $1.8 billion error was found in the SBR related to funds permanently not-available. The error was the result of an inconsistent application of the HHS accounting policy.

    - More than 118 errors in the spreadsheets and databases that were used to compile the financial statements. These errors included incorrect formulas, instances of amounts input incorrectly and failure to include all accounts. This resulted in errors on the financial statements in excess of $6.8 billion. Significant errors were corrected while those of a clearly inconsequential amount were not.

- Our review identified over 100 instances with an approximate value of over $3 billion general ledger accounts and crosswalks were not used consistently or in compliance with the Treasury guidance. For example, when certain changes and corrections are

posted in the CORE system, activity is erroneously posted to the upward and downward adjustments accounts. In order to compensate for these postings and prevent abnormal balances on the SBR, HHS must net all amounts in these accounts in order to produce the financial statements. These accounts are then inconsistently mapped to the recoveries or the obligations line item on the SBR.

- Despite the implementation of UFMS, the process for compiling the financial statements requires significant manual intervention to record numerous accounting entries and precipitate the use of spreadsheets. In fiscal year 2006, there were 40 adjusting entries with an approximate value of $2.5 billion posted at year end.

Overall, HHS does not maintain a uniform financial statement crosswalk to facilitate the financial reporting process. This results in significant manual "work arounds" and delays in financial reporting. We received multiple cross-walks which are inconsistent and non-compliant with the USSGL. While the errors, unexplained differences, and unsupported entries noted were not material to the Department-level financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually-intensive financial statement preparation process, as well as the need for strengthening of the HHS's financial statement preparation, review, and approval processes.

Financial Reporting Analysis and Reconciliations

The U.S. Government Accountability Office (GAO)'s *Standards for Internal Control in the Federal Government* states that internal control activities help ensure that management's directives are carried out. The control activities should be effective and efficient in accomplishing the organization's control objectives. Examples of control activities include: top-level reviews, reviews by management at the functional or activity level, segregation of duties, proper execution of transactions and events, accurate and timely recording of transactions and events, and appropriate documentation of transactions and internal control.

Because weaknesses exist in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of weaknesses that impact HHS's ability to report accurate financial information. During FY 2006, we found that certain processes were not adequately performed to ensure that differences were properly identified, researched and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- On a monthly basis, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2006, the general ledger and Treasury's records differ by an approximate value of $300 million in the Fund

Balance with Treasury account. Management could not explain the variance. Furthermore, we noted:

- HHS is not performing a reconciliation of the suspense account related to fund balance with treasury with a total balance of $219 million at year end.

- HHS policy and procedures do not provide thresholds that personnel are required to follow in determining whether a difference with Treasury has to be investigated. This permits individual staff members to determine threshold amounts that may be inconsistent with managements needs and may allow for invalid disbursements to occur from Treasury.

- Reconciliations are not being performed within the time frame established by HHS policies.

- Management's grant monitoring report identified more than 64,000 grants, with remaining total net obligation balance of $1.6 billion, that are eligible for close out. For 75% of the grants identified as eligible for closeout by management, the project period had expired more than 2 years ago. HHS lacks sufficient reconciliation and tracking processes to ensure that obligation and expenditure activity within the Payment Management System, which tracks draws and expenditures for grants, are consistent with activity within the component general ledgers.

- HHS components are not completing a detailed review of non-grant open obligations. We noted that over 14% of our non-grant obligation testing contained errors related to open undelivered orders. These errors consisted of obligations remaining open for more then two years, final de-obligation transactions not being used to remove completed orders, and the inability to provide documentation for outstanding obligations. In some instances we noted open undelivered orders were outstanding for almost five years.

- HHS components are not following departmental policy and performing reconciliations between FACTS II and the SBR. In addition, a large number of the journal vouchers that are recorded outside the general ledger system are not posted at an appropriation / fiscal year level and therefore are not submitted in the FACTS II reporting process. Even at components that perform reconciliations they are at the general ledger account level and not the line item level. PwC identified more than $10 billion in differences between the 4th quarter FACTS II submission and the SBR in aggregate at the component level

The control processes in place to ensure the accuracy of the HHS Performance and Accountability Report are not working as intended by management. We noted numerous deficiencies as noted below:

- The initial draft of the Statement of Changes in Net Position provided was not completed in accordance with OMB Circular No. A-136.

- Information in the financial statements related to contingencies was inconsistent with the legal representation letters received from the Office of General Counsel at interim. Subsequently, it was determined that the financial statements contained an erroneous contingent liability of approximately $550 million which was corrected.

- The information in the MD&A did not meet the requirements of OMB Circular No. A-136 due to the lack of trend data, forward looking information, and performance highlights.

- Information related to the Obligations not covered by Budgetary Resources for the Medicaid program was incorrectly classified in the footnotes and the balance sheet.

- Inconsistencies between the CMS financial report and the HHS PAR were identified by the auditors and ultimately corrected.

- A $1.8 billion error on the SBR went undetected when management failed to investigate the variance from the prior year as required under current policies and procedures.

- Ending balances from the prior year financial statements did not agree to the opening balances for FY 2006.

- The current review checklists in use are not adequate for a reviewer to ensure the information provided is compliant with applicable OMB guidance and generally accepted accounting standards.

PAR Reporting and Communication

HHS lacks a coordinated end-to-end process among cross-functional teams of financial and program management, information technology, actuarial, and operations personnel to monitor business activities and identify those situations where accounting evaluation or decision-making may be necessary. Further, upon the identification of issues with an accounting impact, no standardized, documented process exists to ensure timely resolution of accounting and reporting questions with the appropriate personnel. For example:

- A formal communication process is not in place to track and account for necessary accruals for the Part C managed care program and the Part D prescription drug program. The lack of a formal process to provide financial accounting personnel with the detailed information to support the need for an accrual of payments due to and from individual managed care and prescription drug program contractors can lead to the misstatement of assets and/or liabilities. We noted that the final accrual

methodology was not finalized until October 2006, subsequent to fiscal year end. Clearly, the inability to provide a detailed accrual subsequent to year end indicates the misstatement of quarterly financial statements.

- With respect to the Statement of Social Insurance (SOSI), a new basic financial statement requirement for FY 06, we did not note evidence of proactive involvement of the HHS financial reporting function personnel in designing or executing internal control for the SOSI financial reporting process. While the underlying SOSI assumptions, computations and processes are driven by the HHS actuarial function personnel, the ultimate financial statement is an integral part of the HHS-wide financial statement package. Accordingly, there should be standardized, documented policies and procedures that explain the role and responsibility of the financial reporting function personnel in the SOSI financial reporting process.

HHS's current financial reporting process lacks the framework needed to effectively and efficiently implement changes to their financial statements. Procedures do not exist to ensure changes/updates to HHS's accounting and financial reporting policies are properly vetted and approved in writing. Furthermore, HHS does not have sufficient policies and procedures in place to ensure that changes/updates or the preparation of the financial statements are supported by generally accepted accounting principles or department and OMB guidance. For example:

- The agency has not completed a formalized process for implementing changes related to the requirements introduced by OMB Circular A-136. This was evidenced by the fact that a written approved "white paper" had not been completed prior to the requests by auditors and the completion of interim financial statements. In particular, we noted HHS did not have departmental policies and procedures related to the breakout of earmarked funds.

- In relation to the other accounting matters, HHS had not completed agency-wide policies to ensure the consistent application of generally accepted accounting principles related to accounting for leases, application of FASAB interpretation No. 6, documentation of the basis for the grant accrual, advance charging algorithm (which is the key process in allocating cash draws to advances) and the Commissioned Corps Pension Liability prior to the auditors identification and request for department-wide policy and procedures.

The MD&A met some but not all of the requirements outlined in the OMB Circular A-136. Section II.2.6 of OMB Circular A-136 states that the MD&A should include highlights of performance goals and results for the applicable year related to and consistent with major goals and objectives in the entity's strategic and performance plans, including trend data where applicable. However, based on our review, we noted the following weaknesses:

- While HHS presents strategic goal highlights, much of the discussion does not correlate to HHS's strategic goals and objectives.

- HHS presents a performance scorecard in the MD&A that summarizes its performance results. However, the scorecard does not explain the department's programs, performance targets, measures, or trends, thereby making it difficult for the reader to understand the meaning and significance of its performance data and results.

- HHS only reports FY 2006 results for only about half of the limited number of performance measures presented as result of data limitations.

- The performance measures show little about the department's FY 2006 contributions toward outcome-oriented goals. For example, less than half of the measures reported under each strategic goal are outcomes.

- The Circular also encourages entities to provide information in the PAR to help the reader to assess the relative efficiency and effectiveness of entity programs and operations. However, the MD&A does not link its goals and results to cost information to show the "cost effectiveness" of the programs.

Recommendations

We recommend that HHS management:

- Enhance the documentation related polices and procedures for the preparation of financial statements and ensure compliance through a monitoring process.

- Ensure that the components (1) develop formal procedures to conduct periodic, detailed reviews and analyses of transactions within the subsidiary ledgers and (2) establish controls to identify, research, and resolve significant accounting anomalies in a timely manner.

- Establish appropriate policies, procedures and protocols to address situations or transactions that require cross-functional involvement to determine the appropriate accounting treatment. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting policies.

- Continue to establish an integrated financial management system for use by HHS to promote consistency and reliability in recording and reporting financial information.

- Develop formal written procedures to consider and approve policy changes. This would include a process to prepare a "white paper" to support any significant

changes/updates to the financial statements. These papers should include references to the applicable guidance that supports the changes/updates, and HHS's conclusion/opinion for making the changes/updates. The white papers should be approved by the Chief Financial Officer.

- Re-design the current procedures used to prepare its Performance and Accountability Report. This process should include the use of a cross-functional team representing all components that are responsible for information which is included in the PAR. This group should be led by the finance office to ensure that all information is accurate and supported by the responsible functional areas. This group should be responsible for the reviews of the financial statements to ensure internal consistency and accuracy. The following should be considered in this re-design:

    - All information prepared and supporting documentation prepared by components for use and review by the department in the preparation of the PAR.

    - Analytical procedures should be enhanced to ensure logical relationships between various financial statement amounts. Variances from expected results should be thoroughly researched and resolved.

    - Develop and implement standard methodologies and formats for completing supporting schedules and reports across all components. To ensure the accuracy and completeness of work performed, supervisory reviews need to be critical as opposed to cursory.

    - A review should be conducted by someone independent of the financial statements to ensure that amounts within the PAR are internally consistent.

- Receive, review, and maintain a copy of all documentation used to support the information in the PAR.

- HHS should implement policies and procedures to expand the current reconciliations performed around undelivered orders to ensure that stale and outdated orders are removed and require supporting documentation be retained.

Material Weakness

II. Departmental Information Systems Controls

Many of the business processes that generate information for the financial statements are supported by information systems. Adequate internal controls over these systems are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensure the reliability, confidentiality, and availability of financial information.

Medicare Electronic Data Processing

Overview

Management relies on extensive information systems operations to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

Our internal control testing for the audit covered both general and application controls. General controls involve organizational security plans, referred to as entity-wide security plans (EWSP), access controls (physical and logical), application software development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data. Our audit included various general controls testing for thirty contractors and site visits to fourteen data centers supporting Medicare claims processing. We also reviewed application controls for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF),Financial Accounting Control System (FACS), Contractor Administrative Budget and Financial Management System (CAFM), Retiree Drug Subsidy System (RDS), Health Plan Management System (HPMS), Medicare Advantage prescription Drug System (MARx), HIGLAS and MBES/CBES.

We conducted vulnerability reviews of network controls at nine data centers sites and headquarters. Further, desktop based audit procedures were conducted to review the high level management controls regarding platform security settings at all data centers supporting Medicare claims processing. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at nine sites, and internal penetration testing at headquarters.

Our audit noted numerous issues in the areas of direct update access to Medicare claims data and that controls over changes to edits and proper edit settings for the FISS, VMS and MCS systems were not is use during most of the audit period. We also noted no significant improvements regarding prior year weaknesses noted in the areas of Entity-wide Security Program, and Service Continuity Planning and Testing and a worsening of controls in the area of Systems Software when compared to the prior year.

During FY 2006, management continued their program to review, analyze and thoroughly discuss the proposed corrective action plans of contractors and at headquarters. This process included extensive discussions both on-site at headquarters, with contractor management in attendance, and remotely with contractor management. Management deserves great credit for this undertaking. Further, management solicited help from the contractors and formed key working groups to address the control of edits within the FISS, VMS and MCS systems. However, the results of the work from these groups and implementation of suggested changes was not accomplished during the audit period. The completion of this effort should help greatly to resolve issues noted regarding the control of edits for the key front-end Medicare claims processing systems.

During FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, management issued a new change request (CR 3862) which provides guidance on the control of edits for the FISS, MCS and VMS systems. Furthermore, management launched a project to determine contractor readiness regarding compliance with CR 3862. Initial results of the testing during September and October of 2005 clearly indicated improved policies and procedures for the control of front end edits for these three systems and enhancements within all three systems which allow automated logging and tracking of edit changes for review, analysis and follow-up. We support management's efforts in this area and believe that these procedures when combined with the actual implementation of the workgroup recommendations to control edits should provide the foundation to correcting the edits weaknesses noted.

During FY 2004 management launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. This program was continued for FY 2005 and FY

2006 and we believe that the evaluations obtained as a result of this effort have served and continue to serve management greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors testing as a consequence of the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the reportable conditions, management continues its programs to review the contractors through Statement on Auditing Standard (SAS) 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, management continues to request and receive system security plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

Efforts to address the findings noted in our review have been and will continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to management, the modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. Management is also in the process of its contractor reform initiative, including data center consolidation, which should reduce the number of contractors and data centers. This process has already begun and should, when completed, further reduce the number of IT security weaknesses noted as a result of testing.

Logical Access Controls

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Our audit noted numerous findings regarding logical access during our controls testing. We noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed. We consistently noted employees who did not require direct access to data and application software programs to perform their job responsibilities, but who nevertheless had been granted inappropriate standing update access to Medicare data and application software programs.

We also noted that many contractors had not performed procedures to recertify access granted to employees on an annual basis as required. As a result, we noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites. Although this issue was also noted during the FY 2005 audit, our audit noted many more instances where employees who did not require direct access to data and application software programs to perform their job responsibilities had been granted inappropriate standing update access to Medicare data and application software programs without mitigating controls such as logging and review of the use of this access.

Application Security, Development and Program Change Control

Application security, development and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. A key element of system changes is the proper use and control of edits within the FISS, VMS and MCS applications which process Medicare claims.

We noted that although HHS and contractor management have created workgroups to determine edits within FISS, VMS and MCS that should be turned on to prevent improper processing, the completion of the suggested changes to edits for the VMS and MCS systems and the implementation of the changes were still in process as of August 2006. Additionally, for the FISS system, the process of determining edits that should be turned on in the system and the implementation of these edits was still ongoing at September 30, 2006.

Control of edits represents a very important area of concern because the edits are a key control in the prevention of improper processing of Medicare claims. The volume of claims processed requires strong automated preventative controls to ensure proper claims processing. Claims volume is far too great to rely on non-automated controls.

We also noted that automated program code used to process claims did not always provide a proper audit trail to allow review of changes to the program code used to process claims or to review actual changes made by the code to claims data. We also noted that application changes were, in some cases, being implemented without documented testing and approval and that application change control procedures were not followed at all sites tested. Finally, we noted numerous contractor sites at which application programmers had the ability to directly update production data and/or source program code for applications thereby allowing then to bypass application change controls.

During our application review, we noted a number of problems with access controls within the applications at the contractors and at headquarters, which included both inappropriate or unsubstantiated access as well as segregation of duties weaknesses. Security violation reports were not being reviewed for many of the applications. Further, we were unable to obtain evidence of change control procedures for the MARx application and, as such, we could not determine whether or not the application was functioning appropriately.

Systems Software

Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. We noted that most of the contractor sites audited showed no measurable improvement in this area when compared to the FY 2005 audit and that for two sites, significant issues existed regarding the control of systems software. Further, we noted numerous instances across the fourteen data centers audited, where security settings for

platforms were not consistent with NIST standards and failed to provide sufficient security settings for computer platforms.

Entity-wide Security Program (EWSP)

These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. We noted no significant improvements in the entity-wide security programs reviewed during the FY 2006 audit when compared to the FY 2005 programs reviews.

Service Continuity Planning and Testing

Service continuity relates to the readiness of a site in the case of a system outage or event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and timely. We noted no significant improvements in the continuity plans and testing of the plans when compared to the FY 2005 audit.

Recommendations

During FY 2006, many contractors, upon realizing they would not continue to process Medicare claims and/or act as data centers under future contracts, did not apply the same vigor to ensuring controls and their effectiveness. We recommend management begin now to address this issue for future years. Management must work to create clear methods to gain cooperation from their contractors. Without a direct intervention by management, we believe that the trend noted during the FY 2006 audit will worsen and may gain momentum in the coming years.

Additionally, we recommend management should:

- Target contractor access control policies and procedures to ensure their sufficiency and enforcement, including recertification of access annually and assurance of proper segregation of duties for application and systems programmers specifically limiting update access to Medicare data and/or programs.
- Complete the workgroup efforts to determine edits that should be turned on within the FISS, VMS and headquarters systems and ensure implementation of the workgroup recommendations promptly.
- Continue the process to assess the enforcement of CR 3862, especially with regard to the approval of changes to shared system coded edits and the use of the newly developed audit trails in the FISS, MCS and VMS systems to analyze the effect of edit modifications on Medicare claims processing and approval. The analysis of edit modifications from the system audit trails should be used to match the results to error trends resulting from contractor claims processed during periods when edits

are turned off and include specific matching of error types to contractors from which the errors emanated.

- Work with their contractors and maintainers of the FISS, VMS and headquarter systems to ensure add on programs such as SuperOps and SCF maintain complete audit trails and that changes to program code associated with these systems follow the rules outlined in CR 3011 for testing and approval.
- Provide more specific guidance to the contractors regarding procedures to formally assess and reduce risk on an ongoing basis by identifying and matching controls to mitigate risks noted in their systems security plans and by requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness.
- Continue to enhance processes to monitor and track compliance with the security configuration models for all platforms maintained within, the contractor sites, the maintainer sites and central office. Management should greatly encourage the use of automated tools to monitor, detect and report to the Information Security Office, all noncompliance with contractor, maintainer or headquarter platform security configuration standards for distributed servers including WINDOWS, UNIX, router, switches, Web server and Oracle database servers on a quarterly basis.

Other Components and Programs

Although HHS has made efforts to strengthen controls over its systems, our testing noted general controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

- Entity-wide security program,
- Access controls (physical and logical),
- Application development and program change controls, and
- Systems software.

Of particular concern, we noted the lack of pervasive IT security standards for areas such as IT security settings on platforms and policies regarding the control and use of passwords, for HHS at the department level. Our testing consistently noted that management of the various component entities within HHS either had developed their own IT security standards or simply stated that they do not follow HHS standards.

Because of the pervasive nature of general controls, the cumulative effect of these weaknesses represents significant deficiencies in the overall design and operation of internal controls. Detailed descriptions of control weaknesses may be found in SAS 70 reports and the management letters issued on information technology general controls and applications audited. The following discusses the summary results by review area.

Entity-wide security programs: These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated,

relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- **Information System Platform and Database Security Controls:** HHS lacks accepted and used standards for information system platform security settings that are consistent with NIST standards for securing information system platforms and databases.
- **Information System Platform and Database Security Control Monitoring:** HHS lacks processes to monitor security settings ongoing to ensure they remain effective.
- **Security Plans:** Security plans for some of the systems have not been updated, finalized, approved, and communicated.
- **Certification & Accreditation:** Required certification and accreditation statements for some of the major financial applications and general support systems have expired or have not been reviewed or updated recently.
- **Security Training:** Relevant security and security awareness training was not provided to all employees and contractors.

Access controls (logical and physical): Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help to ensure that only authorized users and computer processes can access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Our procedures identified the following issues:

- Access Authorizations: For some of the systems, the approval of access requests was not or inadequately documented.
- Access Revalidations: For some of the systems, the periodic revalidation of user accounts is either not performed or inadequately documented.
- Password Controls: The password controls applied to some of the systems do not provide an adequate level of authentication controls.
- Access Assignments: Access assignments were excessive for some systems and did not provide an adequate segregation of duties.

Systems software: Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related

equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

- Configuration Controls: Systems settings for selected databases and operating systems are not optimized to provide a secure computing environment.
- Patch Management: The controls over timely and consistent application of system patches are not effective for all of the systems.
- Change Management: Change management procedures were insufficient to ensure only properly authorized changes were implemented into some production systems.

Application software development and change controls: A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs or changes to existing programs are applied to the production environment. Additionally, the process facilitates that new or changed programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures identified the following issues:

- Change Controls: For some applications, there is no formal and consistently applied change control process.

Additionally, we noted the following weaknesses within the Division of Financial Operations, the Centers for Information Technology, Division of Payment Management, and the Human Resource Services operation, based on SAS 70 Reviews.

- Change Management: Evidence to support that change management procedures and processes were followed, was not provided.
- Access Controls: Periodic reviews of user access permissions were not conducted and/or not documented. Procedures to approve access assignments and to control terminated and transferred employees were either non-existent or not followed.
- Application Controls: Output reports were not properly reviewed and used to correct any issues that would be noted and to ensure the accuracy of information stored on systems.
- Configuration Controls: Password controls and system lockouts for incorrect password attempts were not sufficient to provide effective security. Platform security configuration settings were also insufficient to provide effective security.

Recommendations

To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should:

- Develop overall HHS platform configuration security standards for all operating platforms and databases, following the guidance issued by NIST, for all components.
- Ensure the acceptance and implementation of the platform configuration security standards by all components.
- Develop and implement effective tools, policies and procedures to review platform security settings for all components, on an ongoing basis.
- Develop an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum.
- Enhance policies and procedures to ensure that system administrators perform periodic reviews of access authorizations for all applications and that a process exists for communicating terminated employees to administrators for their timely removal.
- Revalidate access rights on a periodic basis to limit systems access on a need-to have basis.
- Complete certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.
- Maintain system security plans to provide security and controls commensurate with risk changes associated with systems.
- Train all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.
- Maintain effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

Reportable Conditions

I. Managed Care (Part C) and Prescription Drug (Part D) Benefits Payment Cycle

HHS lacks a comprehensive control environment related to the managed care and prescription drug benefits payment cycle, and the oversight of managed care contractors which include Medicare Advantage Organizations (MAO). The existence of a payment process outside of the CMS Office of Financial Management (OFM) and lack of integration of accounting processes within operating procedures related to managed care organizations and prescription drug plans establishes an environment where the risk of inaccurate payments is not sufficiently mitigated.

Overview

The Medicare benefits expense is composed of two major components, fee-for-service and managed care. Fee-for-service expenditures are processed and paid for by Medicare contractors, while managed care and prescription drug expenditures are processed and paid by

the Central Office. In January 2006, HHS completed a system conversion to the Medicare Advantage Prescription Drug System (MARx) for payments to the managed care organizations and prescription drug plans for both Part C and Part D.

The MARx payment errors have been identified and are in the process of being corrected or accrued for at the plan level, during fiscal year 2006, policies and procedures were not sufficient to adequately reduce the risk of benefit payment errors occurring and not being corrected in a timely manner. System errors have gone uncorrected for more then seven months.

Inadequate Procedures to Review and Process Managed Care and Prescription Drug Payments (Part C and Part D)

Managed care organizations are paid using two methodologies: (1) a risk-based methodology in which multiple demographic and health factors are used to determine the reimbursement rate for a beneficiary which represents 95% of all Managed Care Payments and (2) a cost-based methodology in which a plan is reimbursed a predetermined amount per beneficiary which is then adjusted to actual cost incurred during the year through the cost settlement process. PwC noted instances of inadequate policies and documentation for risk-based payments as evidenced by the following:

- During the monthly payment validation process management noted that various payments made to the managed care and prescription drug providers were in error. These errors are being tracked and a detailed analysis is performed, but the errors are not corrected in a timely manner. In one instance an error noted with the Working Aged adjustment in the January payment has yet to be corrected. In addition, CMS identified cases where the amount of Part D Low Income Premium Subsidy included in the Monthly Membership Report was incorrect. These items remain as systems errors and are accounted for via an accrual.

- Management has not performed a timely reconciliation of beneficiary level payments that are calculated and authorized to the actual payment request sent to Treasury. The reconciliation for the first quarter of the year was not performed until September 2006. Once the reconciliations were completed and differences were identified no explanations were provided. Differences were noted between the detail calculation of payments and the payments made at the Plan level, as well as, the actual payments made by Treasury and the approved payments.

- Management did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan level payments. In addition, the monthly review binders are not created timely and documentation supporting the payment approval is not retained.

- For risk based plans, management processed manual adjustments for managed care payments without calculating or adjusting the amount at the beneficiary level which is the basis of the transaction (for example, in August 2006 HHS processed approximately $1 billion in manual adjustments). This methodology may lead to inaccurate payments.

Lack of Documentation and Procedures to Determine Eligibility of Organizations

- Management was unable to provide adequate documentation of organizations that were approved during the fiscal year as either new managed care providers and or prescription drug providers. Exceptions were noted in the following areas where documentation did not meet requirements.
  - Business Organization Reviews for Part D applications were not provided for fourteen sample items out of forty-five selected. In addition, we noted one instance where the review tool was incomplete and an additional instance was noted where the reviewer did not sign the business organization review tool.
  - Part C transitional applications were approved with no formal review performed when transitioning from a demonstration plan into a managed care provider.
  - No application review tools were provided for the review and acceptance of new managed care providers. PwC noted that twelve sample items out of forty-five were not provided.
  - No documentation was provided for four out of the forty-five items selected for the testing of new managed care provider applications.
  - Management was unable to provide comprehensive documentation of new managed care organizations that were approved during the fiscal year. We noted exceptions in thirteen of the forty-five contracts reviewed, where documentation did not meet requirements. Examples of the missing documentation included: review tools, incomplete recommendation reports, site visit letters, and state licensures.

Inadequate Oversight of Managed Care Organizations

The Health Plan Monitoring System (HPMS) used by the management to monitor the execution and status of managed care organization oversight contains inaccurate information. This system lies at the core of the monitoring process for Medicare Advantage Organizations (MAOs). Inaccurate information within HPMS weakens the monitoring of MAOs and may cause HHS to pay plans that are ineligible. The following inaccuracies were noted during the audit which included selecting a sample of forty-five monitoring reviews:

- The HPMS monitoring review module does not contain all of the managed care organizations receiving payment. One of the managed care organizations included in our sample selected for testing was not included in HPMS. Incomplete information in the system may result in missed reviews and the payment of ineligible plans.

- The HPMS monitoring review module was not updated in accordance with the policy for the results of audits conducted during the current fiscal year. The lack of information for management to rely upon in making determinations related to an organization's ability to meet contractual requirements may result in ineligible plans receiving payment.

- Management was unable to provide sufficient documentation to support the on-going monitoring of managed care organizations by the Regional Offices in accordance with policies and procedures. We identified inconsistencies in the documentation that was available for review. The documentation maintained by the Regional Offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews. In addition, we found instances where the corrective action plans were not received, released, and/or approved within the prescribed time frame. In some instances the review report was issued after the forty-five day time frame.

- Regional Offices did not retain documentation to support exception items noted in the reviews of the managed care organizations. We noted three instances where the documentation noting exceptions were not retained in HMPS.

- HHS lacks comprehensive policies and procedures for monitoring reviews related to demonstration projects. These are specialized health care programs/services established to address the needs of specific beneficiary populations.

Recommendation

We recommend that HHS develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare managed care activity.

Specifically, HHS should:

- Ensure that relevant data are updated on a timely basis to provide information allowing for adequate management oversight.

- Ensure that established policies address standard documentation and retention requirements for regional office monitoring reviews of the managed care organizations.

- Establish policies for regional office monitoring of demonstration projects that include tailored procedures to address the unique requirements or risks of each demonstration project.

- Perform extensive beneficiary data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. This analysis should evaluate information such as: (1) demographic makeup of the plan's population as compared to the coverage area's population and (2) enrollment fluctuations as compared to other plans and enrollment in the overall Medicare managed care program.

- Due to the importance of the payment function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we recommend that management perform a timely reconciliation of authorized payments made by Treasury. They should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.

- Develop a process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.

Management has established strong controls for monitoring fee-for service contractors in many areas listed in this reportable condition and should consider implementing many of those requirements for the managed care and prescription drug programs. In particular, implementing the data analysis methodologies employed by Medicare Contractors and Program Safeguard Contractors should provide the Center for Beneficiary Choices (CBC) with a foundation for improving internal control within the managed care benefits payment cycle.

II. Medicaid and Other Health Programs Oversight

Overview

The CMS Health Program's Regional Office oversight of the States is a monitoring control designed to detect potential errors within State-submitted financial information related to Medicaid, SCHIP and other health programs. CMS-64, the Quarterly Medicaid Statement of Expenditures, is a key submission from the States in which Medicaid program expenditures

are reported to CMS. CMSO issued financial review guides to assist the Regional Office analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process yet Region Office adherence to the guides is sporadic.

During FY 2006, CMSO achieved the following accomplishments: (1) conducted initial testing of the automated initial grant award that will use the MBES; (2) revised the Regional Office Review Guides for forms CMS-64, 37, 21, and 21b to include updated statutory and regulatory citations and to capture the all review steps for the ROs; (3) developed the MBES waiver initiative to capture emergency initiatives such as the Disaster Waiver initiatives involving both Hurricanes Katrina and Rita; (4) developed methodologies to calculate the Medicaid and SCHIP IBNR accruals; and (5) placed the Medicaid and SCHIP IBNR surveys on the MBES platform.

While progress has been made during the current year, we noted control weaknesses regarding Medicaid program oversight and reporting as follows:

Lack of Regional Office Oversight

Within the Regional Offices, analysts are not required to follow the Financial Review Guide to assess each State's budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted that the Regional Offices did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used, the reasons that steps were not performed were not always documented. Additionally, we noted that documentation for certain line items on the CMS-64 supporting the analysts' review was lacking. The line items affected included those relating to adjustments and other expenditures for varying amounts.

An analysis of changes in quarterly budget and expenditure submissions is a major consideration in the Regional Office's recommendation to award a grant or validate expenditures. Furthermore, it is a significant step in the CMS Financial Review Guide. During our visit to the Regional Offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain States, although evidence of trend analysis was available, the scope of the items selected for review was not documented in the workpapers nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that reviewers gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

The Regional Offices obtain and review the Medicaid and Other Health Program findings identified in the State Single Audit and Office of Inspector General Audit reports. These reports are entered in the Audit Tracking and Reporting System (ATARS) by each regional office as it relates to the particular state within their region. Currently, the agency does not have a central oversight function to ensure that all reports that should be entered in ATARS have been actually entered. In addition, we noted during our testing that the status annotated

in the system ("Closed versus Open") was not always correct. Also, we identified several reports in ATARS that were dated with fiscal years prior to 2005 and no action has been taken to follow up on the issues noted.

State Plan Amendments (SPA) and State Plan Waivers (SPW) are processed at the Regional Offices throughout the year. The Regional Offices were provided guidance for processing state plan amendments and waivers in a memorandum from CMSO issued March 19, 2004. During our review, we noted that acknowledgement letters were missing from the files along with other source documents, such as the Form CMS-179. In addition, we noted that approval letters were signed by someone other than the Associate Regional Administrator. In addition, there is no formal guidance regarding how State Plan Amendments should be reviewed and approved.

The Regional Offices process Medicaid and SCHIP deferrals and disallowances. These deferrals and disallowances are entered into the agency's FACS for reporting purposes. We noted the following observations as a result of our testing: Medicaid and SCHIP deferrals were not consistently being entered into FACS on a timely basis nor were they being consistently captured in the Financial Issues Report (FIR). In addition, disallowance letters could not be made readily available to support approved disallowances.

Lack of Central Office Oversight

HHS uses its Payment Management System (PMS) to process and manage Medicaid payments to the States. Management does not have policies and procedures in place to review the SAS 70 review conducted at DPM to assess the impact of exceptions and findings on the financial statements.

In addition, HHS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation and expenditure activity within PMS, which tracks draws for State grants, are consistent with activity within the general ledger. Currently, the States use the CMS 64 to report accrued expenditures while submitting a PMS 272 to report expenditures on a cash basis to PMS resulting in inconsistent expenditure activity between the two systems for the same grant. Although component personnel close out grants in the General Ledger once obligations and expenditures match, the obligations are not always de-obligated within PMS, leaving unexpended balances available for draws by the States. As of September 30, 2006 over $1 billion in grants eligible for close out were not closed. In addition, management does not perform a detailed review of the information retained within PMS.

HHS does not have formal policies that require periodic reconciliation of State cash draws to the quarterly expenditure reports. During our testing, we noted that management is currently not reconciling State cash draws to the State expenditure reports. During our review of State expenditures, we noted states that exhibited significant variances from the prior year to the current year. We requested an explanation from the management, but they could not readily provide a response. Periodic reviews are submitted by the Regional Offices; however, an analysis of the results is not documented.

The Regional Offices are not performing a timely review, within 30 days of submission, and approval of State expenditure and budget submissions, primarily because of late submissions by the States. In many cases, grants are approved when prior expenditures reports have been outstanding for six months (two quarters). In addition, the Regional Offices lack formal documented policies identifying alternative analyses that should be performed to support an approval when routine information is not available. We also noted that the Regional Offices do not have polices and procedures that require documenting follow-up communication with the grantee on late expenditure and budget submissions.

Lack of Controls over the Medicaid Accruals

Approved state plans are the basis for claims that are eligible for federal matching in the Medicaid program. Plans are subject to amendment throughout the year, these amendments are effective on the date of submission not the date of approval and may have a payment impact on the financial reimbursement the state receives. CMS lacks formalized policies and procedures to track and calculate accruals for the Medicaid program related to the impact of retroactive state plan amendments. Currently the impact of these waivers is tracked on a spreadsheet maintained by CMSO and is not subject to any type of formalized internal control review.

Recommendations

As a result of not consistently adhering to the CMS Financial Review Guide to assist in monitoring and providing oversight of State Operations, deficiencies in internal control may allow significant misstatements to occur without being identified. HHS should require the Regional Offices analysts to follow the Financial Review Guide to assess each State's budget requests, quarterly expenditure reports, and other State activities related to SCHIP and Medicaid funding. In addition, standard documentation policies should be established to ensure consistency among regions.

HHS should revise its procedures to provide a mechanism for Central and Regional Offices to monitor states' activities and enforce compliance with HHS financial management procedures by:

- Provide specific guidance in the use and preparation of the Financial Review Guides to ensure that the Regional Offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.

- Develop a specific scope to be used to identify areas for review and that this scope, or any deviations from the scope, is documented within the trend analysis work paper(s) along with explanations.

- Management should enhance employee training initiatives on records retention and deferral and disallowance reporting. In addition, task responsibilities should be clearly assigned to employees to ensure proper performance.

HHS should enhance their current policies and procedures to ensure that the ATARS is complete and accurate. In addition, these policies and procedures should include steps to closely monitor the findings and ensure that they are resolved within a specified timeframe.

The oversight of SPA and SPW should be improved to ensure Regional Offices are retaining evidential matter to support their reviews and approvals. Similar to State Plan Waivers, (3.3 Instructions), the agency should develop and provide guidance on how to review and approve each type of State Plan Waiver.

III. Statement of Social Insurance Preparation Processes

Overview

The Statement of Social Insurance (SOSI) is a long-term projection of the present value of income to be received from or on behalf of existing and future participants of social insurance programs, the present value of the benefits to be paid to those same individuals, and the difference between the income and benefits. In prior years this information was presented as required supplemental information, therefore not subject to a detailed review of internal controls. During our review we noted several areas where controls were not effective.

Lack of Change Controls

During our review of the models used in the SOSI projection process we noted a lack of controls associated with change management. The following items were identified:

- Changes subject to change management policy and procedures are not clearly defined. In fact, OACT implemented significant changes to the projection process during the current year that did not go through their established change control process.
- The current change management process does not require formal tracking of the status of authorized changes which are in progress.
- The current change management process does not require that the person who requests the change be different from the authorizer.
- Outdated worksheets are kept in the working directory with the updated worksheets, so outdated worksheets could be used in error.

Inadequate change controls may lead to unauthorized changes to the models/spreadsheets which may cause a misstatement in the projection.

Lack of Access Controls

We identified a lack of controls around the access to models and spreadsheets used to calculate the amounts reported on the SOSI. Specifically, quarterly review of user access rights needs to be strengthened and procedures have not been established to terminate user access immediately when the user's employment is terminated for cause. In addition, the addition or deletion of user access to working or final directories is not formally documented, and some production directories do not have associated working directories.

Inadequate access controls may allow unintentional and/or intentional errors to be introduced to the models/spreadsheets.

Lack of Formalized Policies and Procedures over Input and Processing Controls

OACT policies and procedures in place over inputs and processing controls are not consistently implemented. The following items where noted:

- Inappropriate controls in place to ensure final assumptions used in the projection are appropriately reviewed, led to instances where assumptions documented and approved by the Chief Actuary did not agree to the assumptions used within the models/spreadsheets. HHS asserts that the correct assumptions were ultimately used in the projection.

- During our review of 123 OACT models/spreadsheet used in the projection process, we noted 184 instances of cells with referencing issues, where the cells reference an invalid location. In addition, we noted 42 instances were formulas are dividing by zero (or black cells) or were the formulas are referencing cells that contain erroneous values. Although the anomalies noted did not cause an error in the projection, inaccurate formulas or unused information in the models/spreadsheets could pose a risk to the projection.

Lack of Appropriate Documentation

During our testing of the Statement of Social Insurance the following documentation issues were noted:

- Inconsistencies and errors in the model/spreadsheet inventory exist. The lack of completeness of the list resulted in models/spreadsheets being used during the projection process that were not validated by OACT. In one instance, the lack of appropriate validation of all spreadsheets involved in the projection process resulted in a formula error affecting the projection.

- Inconsistencies and a lack of proper Model/Spreadsheet documentation regarding the use of outputs (i.e. how and where the output is subsequently used including file, sheet, column etc.) may lead to errors in the projection process.
- A standard file naming convention is not used which may result in version control failures.
- Internally developed sources of significant models/spreadsheets are not always maintained. The lack of retention of source file limits management's ability to validate the accuracy and completeness of data introduced into their models.
- OACT did not appropriately document controls in place to ensure the reasonableness of data developed by other HHS departments or by other agencies/outside sources. For example, communications with outside data sources regarding errors or discrepancies are not documented and, as such there is no record of actions taken by OACT to mitigate the risk of errors in their calculations due to inaccurate data sources.
- OACT did not appropriately document or maintain evidence of input controls. We noted that specific steps taken to ensure the accuracy and completeness of data input to the models/spreadsheets were not documented. Lack of appropriate documentation of controls, limits OACT's ability to ensure controls are performed as intended.

Recommendations

HHS should enhance its controls over the Statement of Social Insurance through the implementation of formal polices and procedures related to change, access, input and processing controls, and in the formulization of documentation through the following:

- Establish an appropriate change control policy and ensure its consistent application.
- Enhance access controls procedures in order to ensure that only authorized individuals have access to OACT directories including production, working directories, and final directories.
- Ensure appropriate controls and documentation exists over approved assumptions, methods and/or techniques.
- Ensure models/spreadsheets used in the projection process are free of formula anomalies, and only contain information used during the current year's projection.
- Create a complete inventory of models used for the projection process, in order to ensure appropriate controls are in place.
- Appropriately document the use of outputs from spreadsheets that serve as inputs to subsequent spreadsheets.
- Implement a standard file naming convention.
- Implement policies and procedures requiring the retention of all source information used in the preparation of the statement.

- Appropriately document and maintain evidence of input controls in place, including controls in place to ensure the reasonableness of data obtained from sources outside of OACT.

* * * * * * * * * * * * *

Internal Control Related to Key Performance Indicators and RSSI

With respect to internal control relevant to data that support reported performance measures included in the MD&A, we obtained an understanding of the design of significant internal control relating to the existence and completeness assertions, as required by OMB Bulletin No. 06-03. Our procedures were not designed to provide assurance on the internal control over reported performance measures and, accordingly, we do not express an opinion on such control. In addition, we considered HHS's internal control over RSSI by obtaining an understanding of HHS's internal control, determined whether these internal controls had been place in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 06-03 and not to provide assurance on these controls. Accordingly, we do not provide an opinion on such controls.

We also identified other less significant matters that will be reported to HHS's management in a separate letter. This report is intended solely for the information and use of the management the Department of Health and Human Services, the Office of the Inspector General of the Department of Health and Human Services, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 15, 2006

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

Mr. Daniel R. Levinson
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W., Room 5250
Washington, D.C. 20201

NOV 15 2006

Dear Mr. Levinson:

This letter responds to the audit report submitted by the Office of Inspector General in connection with the Department of Health and Human Services' fiscal year 2006 financial statement audit. We concur with the findings and recommendations presented to us.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, the audit was completed on-time, which is significant in that the Statement of Social Insurance was audited for the first time in 2006.

We acknowledge that we have material weaknesses in internal controls relating to financial systems and processes, and information technology (IT) controls. The Department's long-term strategic plan to resolve the financial systems and processes weakness is to replace the existing accounting systems and certain other financial systems within the Department with the Unified Financial Management System (UFMS) and strengthen the Department's financial reporting processes and controls. The UFMS has been implemented at two Departmental Operating Divisions and, in October 2006, the Program Support Center successfully deployed UFMS thus increasing the number of other Departmental Operating Divisions supported by UFMS. We are working towards complying with the requirements of the Federal Financial Management Improvement Act by October 2007 for UFMS.

The Department will be formulating short-term and long-term goals for correcting IT weaknesses in logical access controls; application security, development and program change control; and systems software. The Centers for Medicare and Medicaid Services will be working to strengthen the internal controls related to Medicare electronic data processing operations at its central office and Medicare contractor sites as well.

I would like to extend my appreciation to you and your staff for the professionalism that was demonstrated in working with us through this particularly challenging year.

Sincerely,

Charles E. Johnson
Assistant Secretary for Resources
and Technology

Financial Statements

U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEETS
As of September 30, 2006 and 2005
(In Millions)

	2006	2005
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 159,921	$ 99,638
Investments, Net (Note 5)	341,976	300,664
Accounts Receivable, Net (Note 6)	726	738
Anticipated Congressional Appropriations (Note 7)	-	14,272
Other (Note 10)	132	169
Total Intragovernmental	502,755	415,481
Accounts Receivable, Net (Note 6)	3,207	2,103
Cash and Other Monetary Assets (Note 4)	145	204
Inventory and Related Property, Net (Note 8)	2,322	1,614
General Property, Plant & Equipment, Net (Note 9)	4,971	4,557
Other (Note 10)	509	4,528
Total Assets	**$ 513,909**	**$ 428,487**
Stewardship PP&E (Note 33)		
Liabilities (Note 11)		
Intragovernmental		
Accounts Payable	$ 620	$ 365
Accrued Payroll and Benefits	88	69
Other (Note 15)	955	992
Total Intragovernmental	1,663	1,426
Accounts Payable	562	732
Entitlement Benefits Due and Payable (Note 12)	61,164	53,754
Accrued Grant Liability (Note 14)	3,833	3,783
Federal Employee & Veterans' Benefits (Note 13)	7,532	7,183
Accrued Payroll & Benefits	804	785
Other (Note 15)	2,867	3,296
Total Liabilities	**$ 78,425**	**$ 70,959**
Net Position		
Unexpended Appropriations - Earmarked Funds	$ 27,665	$ 6,877
Unexpended Appropriations - Other Funds	102,832	80,473
Unexpended Appropriations, Total	130,497	87,350
Cumulative Results of Operations - Earmarked Funds	304,465	271,485
Cumulative Results of Operations - Other Funds	522	(1,307)
Cumulative Results of Operations, Total	304,987	270,178
Total Net Position	**$ 435,484**	**$ 357,528**
Total Liabilities & Net Position	**$ 513,909**	**$ 428,487**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U. S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006	2005
Responsibility Segments		
Administration for Children and Families (ACF)	$ 47,165	$ 46,722
Administration on Aging (AoA)	1,386	1,400
Agency for Healthcare Research and Quality (AHRQ)	(280)	(297)
Centers for Disease Control and Prevention (CDC)	6,152	5,242
Centers for Medicare & Medicaid Services (CMS)	524,398	483,645
Food & Drug Administration (FDA)	1,599	1,449
Health Resources & Services Administration (HRSA)	6,180	6,787
Indian Health Service (IHS)	3,275	3,157
National Institutes of Health (NIH)	28,450	27,875
Office of the Secretary (OS)	2,183	2,159
Program Support Center (PSC)	261	(18)
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,168	3,199
Net Cost of Operations	**$ 623,937**	**$ 581,320**

ccompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF CHANGES IN NET POSITION
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006				2005
	Earmarked Funds	All Other Funds	Eliminations	Consolidated Total	Consolidated Total
Cumulative Results of Operations:					
Beginning Balances	$ 271,485	$ (1,307)	$ -	$ 270,178	$ 254,881
Adjustments (+/-) (Note 19)					
Correction of Errors (+/-)	-	-	-	-	178
Beginning balances, as adjusted	271,485	(1,307)	-	270,178	255,059
Budgetary Financing Sources:					
Other Adjustments	-	369	-	369	(5)
Appropriations Used	173,571	287,273	-	460,844	410,373
Nonexchange Revenue	198,114	247	116	198,477	186,136
Donations and Forfeitures of Cash and Cash Equivalents	32	4	-	36	56
Transfers-in/out without Reimbursement	(2,105)	861	-	(1,244)	(418)
Other Financing Sources (Non-Exchange):					
Donations and forfeitures of property	-	4	-	4	3
Transfers-in/out without reimbursement (+/-)	(1)	(26)	(2)	(29)	(46)
Imputed financing	25	406	(118)	313	342
Other (+/-)	-	(24)	-	(24)	(2)
Total Financing Sources	369,636	289,114	(4)	658,746	596,439
Net Cost of Operations (+/-)	336,656	287,285	(4)	623,937	581,320
Net Change	32,980	1,829	-	34,809	15,119
Cumulative Results of Operations	**304,465**	**522**	**-**	**304,987**	**270,178**
Unexpended Appropriations					
Beginning Balance	6,877	80,473	-	87,350	82,052
Adjustments:					
Corrections of errors	-	-	-	-	(210)
Beginning Balance, as adjusted	6,877	80,473	-	87,350	81,842
Budgetary Financing Sources					
Appropriations Received	201,231	323,104	-	524,335	420,644
Appropriations transferred in/out	-	(121)	-	(121)	241
Other Adjustments	(6,872)	(13,351)	-	(20,223)	(5,004)
Appropriations Used	(173,571)	(287,273)	-	(460,844)	(410,373)
Total Budgetary Financing Sources	20,788	22,359	-	43,147	5,508
Total Unexpended Appropriations	**27,665**	**102,832**	**-**	**130,497**	**87,350**
Net Position	**$ 332,130**	**$ 103,354**	**$ -**	**$ 435,484**	**$ 357,528**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006		2005	
	Budgetary	Non-Budgetary Credit Program Financing Accounts	Budgetary	Non-Budgetary Credit Program Financing Accounts
Budgetary Resources:				
Unobligated Balance, Brought Forward, October 1:	$ 18,001	$ 206	$ 18,908	$ 253
Recoveries of Prior Year Unpaid Obligations				
Actual	14,481	-	11,672	-
Budget Authority				
Appropriation	948,366	4	773,208	-
Spending Authority from Offsetting Collections				
Earned				
Collected	6,741	172	6,806	27
Change in Receivables from Federal sources	(77)	-	204	-
Change in unfilled customer orders				
Advance received	37	-	1	-
Without advance from Federal sources	1,903	-	1,160	-
Expenditure Transfers from trust funds				
Actual	3,328	-	2,945	-
Subtotal	960,298	176	784,324	27
Nonexpenditure transfers, net, anticipated and actual	59	-	(87)	-
Temporarily not available pursuant to Public Law	(34,551)	-	(11,470)	-
Permanently not available (-)	(5,847)	-	(9,785)	-
Total Budgetary Resources	$ 952,441	$ 382	$ 793,562	$ 280
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 877,128	$ 4	$768,771	$ -
Reimbursable	7,587	184	6,790	74
Subtotal	884,715	188	775,561	74
Unobligated Balances – Available				
Apportioned	60,075	106	12,078	206
Exempt from apportionment	73	-	78	-
Subtotal	60,148	106	12,156	206
Unobligated Balances - Not Available	7,578	88	5,845	-
Total Status of Budgetary Resources	$ 952,441	$ 382	$ 793,562	$ 280
Change in Obligated Balance:				
Obligated Balance, Net				
Unpaid obligations, brought forward, October 1	$ 123,768	$ -	$ 117,575	$ -
Less: Uncollected customer payments from Federal sources, brought forward, October 1	5,700	-	4,007	-
Total unpaid obligated balance, net	118,068	-	113,568	-
Obligations incurred net (+/-)	884,715	188	775,561	74
Less: Gross outlays	851,874	185	757,988	74
Less: Recoveries of prior year unpaid obligations, actual	14,481	-	11,672	-
Change in uncollected customer payments from Federal sources (+/-)	1,739	-	1,299	-
Obligated Balance, Net, End of Period				
Unpaid Obligations	142,161	3	123,768	-
Less: Uncollected customer payments from Federal sources	7,327	-	5,700	-
Total, unpaid obligated balance, net, end of period	134,834	3	118,068	-
Net Outlays				
Net Outlays:				
Gross outlays	851,874	185	757,988	74
Less: Offsetting collections (-)	(10,338)	(172)	(9,715)	(27)
Less: Distributed Offsetting receipts	226,844	31	166,971	55
Net Outlays	**$ 614,692**	**$ (18)**	**$ 581,302**	**$ (8)**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF FINANCING
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006	2005
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$ 884,903	$ 775,635
Less: Spending Authority from Offsetting Collections and Recoveries	26,585	22,815
Obligations Net of Offsetting Collections and Recoveries	$ 858,318	$ 752,820
Less: Offsetting Receipts	226,875	167,026
Net Obligations	$ 631,443	$ 585,794
Other Resources		
Donations and Forfeitures of Property	$ 4	$ 3
Non-Budgetary Transfers in/out Without Reimbursement	(29)	(46)
Imputed Financing From Costs Absorbed by Others	313	342
Other Non-Budgetary Resources	(24)	(2)
Net Non-Budgetary Resources Used to Finance Activities	$ 264	$ 297
Total Resources Used to Finance Activities	$ 631,707	$ 586,091
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ (4,249)	$ 4,092
Resources That Fund Expenses Recognized in Prior Periods	15,278	15,802
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations:		
Credit Program Collections That Increase Liabilities for Loans Guarantees or Allowances for Subsidy	90	24
Other	(242)	(241)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,296	1,540
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	(3,352)	(1,232)
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	$ 8,821	$ 19,985
Total Resources Used to Finance the Net Cost of Operations	$ 622,886	$ 566,106
COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD		
Components Requiring or Generating Resources in Future Periods:		
Increase in Annual Leave Liability	$ 18	$ 31
Increase in Environmental and Disposal Liability	4	2
Upward/downward Reestimates of Credit Subsidy Expense	(56)	(40)
Increase in Exchange Revenue Receivable from the Public	(342)	679
Other	369	4,954
Accrued Entitlement Benefit Costs	-	9,470
Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods	$ (7)	$ 15,096
Components Not Requiring or Generating Resources:		
Depreciation and Amortization	$ 376	$ 218
Losses or (Gains) from Revaluation of Assets and Liabilities	13	11
Other	669	(111)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources	$ 1,058	$ 118
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	1,051	15,214
NET COST OF OPERATIONS	**$ 623,937**	**$ 581,320**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2006 and Prior Base Years
(in billions)

		Estimates from Prior Years			
	2006	**2005** unaudited	**2004** unaudited	**2003** unaudited	**2002** unaudited
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 31 and 32)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	$5,685	$5,064	$4,820	$4,510	$4,408
SMI Part B	12,446	11,477	10,505	8,796	7,423
SMI Part D	7,366	7,895	7,545	0	0
Have attained eligibility age (age 65 and over)					
HI	192	162	148	128	125
SMI Part B	1,606	1,436	1,310	1,160	1,008
SMI Part D	750	817	713	0	0
Those expected to become participants (under age 15)					
HI	4,767	4,209	4,009	3,773	3,753
SMI Part B	3,562	3,658	3,514	2,817	2,402
SMI Part D	2,134	2,522	2,511	0	0
All current and future participants:					
HI	10,644	9,435	8,976	8,411	8,286
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of:					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	15,633	12,668	12,054	10,028	9,195
SMI Part B	12,433	11,541	10,577	8,845	7,463
SMI Part D	7,338	7,913	7,566	0	0
Have attained eligibility age (age 65 and over)					
HI	2,397	2,179	2,168	1,897	1,747
SMI Part B	1,773	1,622	1,475	1,306	1,132
SMI Part D	792	880	773	0	0
Those expected to become participants (under age 15)					
HI	3,904	3,417	3,246	2,653	2,470
SMI Part B	3,407	3,408	3,277	2,622	2,238
SMI Part D	2,121	2,440	2,431	0	0
All current and future participants:					
HI	21,934	18,264	17,468	14,577	13,412
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 31 and 32)					
HI	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)	$ (5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Additional Information					
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 31 and 32)					
HI	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)	$ (5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust fund assets at start of period					
HI	285	268	256	235	209
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0
Actuarial present value for the 75-year projection of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over cost (Note 31 and 32)					
HI	$ (11,006)	$ (8,561)	$ (8,236)	$ (5,931)	$ (4,917)
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0

Note: Totals do not necessarily equal the sums of rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

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U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

Note 1. Summary of Significant Accounting Policies

Reporting Entity

The Department of Health and Human Services (HHS) is a Cabinet-level agency of the Executive Branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), officially came into existence on April 11, 1953. In 1979, the Department of Education Organization Act of 1979 (*Public Law 96-88*) was signed into law, providing for a separate Department of Education. HEW officially became HHS on May 4, 1980. The Department is responsible for protecting the health of all Americans and providing essential human services.

Organization and Structure of HHS

The HHS is comprised of 11 Operating Divisions (OPDIVs) with diverse missions and programs. Each OPDIV is considered a responsibility segment representing a component that is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. Although it is part of the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other OPDIVs and Federal agencies. The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control and Prevention for financial reporting purposes; therefore, these footnotes will refer to them as one responsibility segment. The managers of the responsibility segments report to the entity's top management directly, and its resources and results of operations can be clearly distinguished from those of other responsibility segments of the entity. The 12 responsibility segments are:

1. Administration for Children and Families
2. Administration on Aging
3. Agency for Healthcare Research and Quality
4. Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry
5. Centers for Medicare & Medicaid Services
6. Food & Drug Administration
7. Health Resources & Services Administration
8. Indian Health Service
9. National Institutes of Health
10. Office of the Secretary–excluding Program Support Center
11. Program Support Center
12. Substance Abuse & Mental Health Services Administration

Basis of Accounting and Presentation

The HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P. L. 101-576), as amended by the Government

U. S. Department of Health and Human Services
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Management Reform Act of 1994, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular No. A-136 (Revised), *Financial Reporting Requirements* which, effective fiscal year (FY) 2006, supersedes OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*. These statements have been prepared from the Department's financial records using an accrual basis in conformity with accounting principles generally accepted in the United States. The generally accepted accounting principles (GAAP) for Federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as Federal GAAP. These statements are, therefore, different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control HHS' use of budgetary resources.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned, and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles, on the other hand, are designed to recognize the obligation of funds according to legal requirements, which in many cases is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of Federal funds. The HHS OPDIVs use the cash basis of accounting for some programs with an accrual adjustment made by recording year-end estimates of unpaid liabilities.

The financial statements consolidate the balances of approximately 160 appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts, and general government functions. Transactions and balances among HHS OPDIVs have been eliminated in the presentation of the Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statements of Changes in Net Position, and the Consolidated Statements of Financing. The Combined Statements of Budgetary Resources are presented on a combined basis, therefore, intra-HHS and intra-OPDIV transactions and balances have not been eliminated from these statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

Unified Financial Management System

The HHS continues to streamline and integrate its financial management systems through a phased development of the Unified Financial Management System (UFMS). HHS' overarching financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that HHS resources are used appropriately, efficiently, and effectively. With UFMS, HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. The Centers for Disease Control and Prevention and the Food and Drug Administration went live with UFMS

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in April 2005. Efforts continue with the scheduled implementation for the PSC and its customer OPDIVs in October 2006. Final deployment for the Indian Health Service is scheduled for October 2007.

Transition of Payroll System to Defense Finance and Accounting Service
The HHS successfully completed its payroll conversion for civilian payroll, except for Public Health Service Commissioned Corps, from the HHS legacy payroll system to the Defense Finance and Accounting Service (DFAS) on April 17, 2005. HHS is the single largest civilian agency payroll conversion ever completed by the DFAS.

Use of Estimates in Preparing Financial Statements
Preparation of financial statements in accordance with accounting principles generally accepted in the U.S. requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities as of the date of the financial statements. Estimates and assumptions also affect the revenues and expenses accrued and reported in the financial statements. Actual results may differ from those estimates.

Entity and Non-Entity Assets
Entity assets are assets that the reporting entity has authority to use in its operations, i.e., management has the authority to decide how the funds are used, or management is legally obligated to use the funds to meet entity obligations.

Non-entity assets are those assets that are held by the reporting entity, but are not available for use by the entity. An example of a non-entity asset is the interest accrued on overpayments and cost settlements reported by the Medicare contractors.

Entity and non-entity assets are combined into one line on the face of the balance sheet as required by OMB Circular No. A-136. The detail for non-entity assets is presented in Note 2, Non-Entity Assets.

Fund Balance with Treasury
The HHS maintains its available funds with the Department of the Treasury (Treasury) except for the Medicare Benefit accounts maintained at commercial banks – see Note 4, Cash and Other Monetary Assets. The Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by Treasury, and HHS' records are reconciled with those of Treasury on a regular basis.

Note 3, Fund Balance with Treasury, provides additional information.

Investments
Investments consist of Treasury securities including the Centers for Medicare and Medicaid Services' par value securities that represent the majority of the HHS earmarked funds carried at face value, and other securities carried at amortized cost. Section 1817 for Hospital Insurance Trust Fund (HI) and Section 1841 for Supplementary Medical Insurance Trust

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Fund (SMI) of the Social Security Act require that trust investments not necessary to meet current expenditures be invested in interest-bearing obligations of the U.S. Government, or in obligations guaranteed as to both principal and interest by the U.S. Government. Treasury securities are issued to the earmarked fund as evidence of earmarked receipts and provide the fund with the authority to draw upon the U.S. Treasury for future authorized expenditures (although for some funds, this is subject to future appropriation). No provision is made for unrealized gains or losses on these securities since it is the Department's intent to hold investments to maturity. Interest income is compounded semiannually in June and December and is adjusted to include an accrual for interest earned from July 1 to September 30. The FASAB Statement of Federal Financial Accounting Standard, No. 27, prescribes certain disclosures concerning earmarked investments, such as the fact that cash generated from earmarked funds is used by the U.S. Treasury for general Government purposes and that upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures. Treasury securities held by an earmarked fund are an asset of the fund and a liability of the U.S. Treasury, so they are eliminated in consolidation for the U.S. Government-wide financial statements.

Note 5, Investments, Net, provides additional information on investments.

Accounts Receivable, Net
Accounts receivable consist of the amounts owed to HHS by other Federal agencies and the public as the result of the provision of goods and services. Intragovernmental accounts receivable arise generally from the provision of reimbursable work to other Federal agencies and no allowance for uncollectible accounts is established as they are considered to be fully collectible. Accounts receivable also includes interest due to HHS that is directly attributable to delinquent accounts receivable.

Accounts receivable from the public typically result from overpayments to Medicare providers and beneficiaries, amounts due from cost disallowance for Medicaid, and amounts due from organizations for civil monetary penalties not yet remitted to the Department of Justice. They are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is determined based on past collection experience and an analysis of outstanding balances.

Note 6, Accounts Receivable, Net, provides additional information on accounts receivable.

Direct Loans and Loan Guarantee Receivables and Liabilities
Direct Loans:
The Health Care Infrastructure Improvement Program was enacted into law as part of the Medicare Modernization Act of 2003. This loan program provides loans to hospitals or entities that are engaged in research in the causes, prevention, and treatment of cancer; and are designated as cancer centers by the National Cancer Institute, or are designated by the State legislature as the official cancer institute of the State, and such designation by the State legislature occurred prior to December 8, 2003, for payment of the capital costs of eligible

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projects. HHS reasonably expects any loans made under this program to be forgiven as it is anticipated that the borrowers will meet the requirements for forgiveness.

Loan Guarantees:
HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loans (HEAL) programs. Loans receivable represent defaulted guaranteed loans, which have been paid to lenders under this program. Loans receivable also include interest due to HHS on the defaulted loans. The loans guarantee liabilities are valued at the present value of the cash outflows from HHS less the present value of related inflows.

As required under the Federal Credit Reform Act (FCRA) of 1990, for loan guarantees committed on or after October 1, 1991, guaranteed loans are reduced by an allowance for subsidy representing the present value of the amounts not expected to be recovered and thus having to be subsidized by the government for loan guarantees. The FCRA also requires that the subsidy cost estimate be based on the net present value of the specified cash flows discounted at the interest rate of marketable Treasury securities of similar maturities. The liability for loan guarantees committed on or after October 1, 1991, is reported at present value.

For loan guarantees committed prior to October 1, 1991, loan guarantee principal and interest receivable are reduced by an allowance for estimated uncollectible amounts. The allowance is estimated based on past experience and an analysis of outstanding balances. The liability for loan guarantees committed prior to October 1, 1991, is established based upon an average default rate. The liability is adjusted each year for the change in default rates.

Advances to Grantees/Accrued Grant Liability
HHS awards grants to various grantees and provides advance payments to grantees to meet their cash needs to carry out their programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the "Advances to Grantees" account. An accrued grant liability occurs when the accrued grant expenses exceed the outstanding advances to grantees, resulting in a negative balance in the "Advances to Grantees" account. HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." Progress payments on work in process are not included in grants.

Grants Not Subject to Grant Expense Accrual: These grants represent formula grants (also referred to as "block grants") under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded as the grantees draw funds. These grants are funded on an allocation basis determined by budgets and agreements approved by the sponsoring OPDIV as opposed to a reimbursable basis. Therefore, they are not subject to grant expense accrual.

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Grants Subject to Grant Expense Accrual: For grants subject to grant expense accrual, commonly referred to as "non-block grants," grantees draw funds (recorded as Advances to Grantees) based on their estimated cash needs. As grantees report their actual disbursements (quarterly), the amounts are recorded as expenses, and their advance balance is reduced. At year-end, the OPDIVs report both actual payments made through the third quarter and an unreported grant expenditures estimate for the fourth quarter based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimate of fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash being drawn down.

Exceptions to the definition of "block" or "non-block" grants for reporting purposes are the Temporary Assistance for Needy Families program and the Child Care Development Fund program. These two programs are referred to as "block" grants but since the programs report expenses to HHS, they are treated as "non-block" grants for the estimate of the grant accrual.

HHS reports advances other than grant advances in Note 10, Other Assets and Note 14, Accrued Grant Liability, which provides additional information on the accrued grant liability.

Inventory and Related Property, Net
Inventory and Related Property primarily consist of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Fund for sale to HHS components and other Federal entities. Inventories held for sale are valued at historical cost using the "first-in, first-out" (FIFO) cost flow assumption with the exception of the National Institutes of Health, which uses the moving average cost flow assumption method.

Operating Materials and Supplies consist of pharmaceuticals, biological products, and other medical supplies used in providing medical services and conducting medical research. Operating materials and supplies are recorded as assets when purchased, and are expensed when they are consumed. Operating materials and supplies are valued at historical cost using the FIFO cost flow assumption.

As required by the Project BioShield Act of 2004, the Department of Homeland Security transferred Strategic National Stockpile materials to HHS in FY 2004. These materials are held in reserve to respond to local and national emergencies. In addition, the Centers for Disease Control and Prevention (CDC) maintain a stockpile of vaccines to meet unanticipated needs in the case of a national emergency. The Strategic National Stockpile materials are valued at historical cost using the FIFO cost flow assumption and the CDC's stockpile is valued at historical cost using a specific identification cost flow assumption.

Note 8, Inventory and Related Property, Net, provides additional information.

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General Property, Plant and Equipment, Net

General Property, Plant and Equipment (PP&E) consists of buildings, structures, and facilities used for general operations; land acquired for general operating purposes; equipment; assets under capital lease; leasehold improvements; construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, which includes all costs incurred to bring the PP&E to a form and location suitable for its intended use. The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. The cost of PP&E acquired through donation is the estimated fair market value when acquired. The cost of PP&E transferred from other Federal entities is the net book value of the transferring entity. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more are capitalized, except for internal use software discussed below.

The PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

Statement of Federal Financial Accounting Standards (SFFAS) No.10, *Accounting for Internal Use Software*, requires that the capitalization of internally-developed, contractor-developed and commercial off-the-shelf (COTS) software begin in the software development phase. In FY 2004, HHS incurred development costs for the Unified Financial Management System (UFMS), a COTS software package, and began capitalizing the cost. In FY 2001, the Centers for Medicare and Medicaid Services (CMS) began the Healthcare Integrated General Ledger Accounting System (HIGLAS) project to replace the Medicare contractors' and CMS' current accounting systems with a single, unified system. The HIGLAS will eventually replace the different systems now in use by contractors that process and pay claims, in addition to CMS' current mainframe-based administrative accounting financial system. The estimated useful life for internal use software was determined to be seven to ten years for amortization purposes.

The SFFAS No.10 also requires that amortization begin when the asset is placed in use. In April 2005, UFMS was implemented at the CDC and the Food and Drug Administration (FDA). In FY 2005, CMS began amortizing HIGLAS over ten years using the straight-line method in accordance with HHS policy for UFMS. In addition, CMS has other capitalized internal use software that is currently being amortized over a useful life of five years.

The capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the capitalization threshold for revolving funds is $500,000. Costs below the threshold levels are expensed. The software is depreciated for a period of time consistent with the estimated useful life used for planning and acquisition purposes.

Additional information is provided in Note 9, General Property, Plant and Equipment, Net.

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Stewardship PP&E
Stewardship PP&E consist of heritage assets and stewardship land whose physical properties resemble those of general PP&E that are traditionally capitalized in financial statements. The valuation of these assets is difficult and matching costs for a period of time is meaningless. On July 7, 2005, SFFAS No. 29, Heritage Assets and Stewardship Land was issued. This standard requires that the balance sheet reference a note that discloses information but not an amount for Stewardship PP&E.

Note 33, Stewardship PP&E has additional information.

Liabilities
Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing Federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare Health Insurance Trust Fund, since liabilities are only those items that are present obligations of the Government. The Department's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

Liabilities Covered by Budgetary Resources: Available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of expired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriations or borrowing authority.

Liabilities Not Covered by Budgetary Resources: Sometimes funding has not yet been made available through Congressional appropriations or current earnings. The major liabilities in this category include employee annual leave earned but not taken, and amounts billed by the Department of Labor (DOL) for Federal Employees' Compensation Act (FECA) disability payments, and for portions of the Entitlement Benefits Due and Payable liability (discussed below) for which no obligations have been incurred. Also, included in this category is the actuarial FECA liability determined by DOL but not yet billed. For HHS revolving funds, all liabilities are funded as they occur.

Liabilities Covered by Budgetary Resources and Liabilities Not Covered by Budgetary Resources are combined on the balance sheet. The breakout of these resources is presented in Note 11, Liabilities Not Covered by Budgetary Resources; Note 12, Entitlement Benefits Due and Payable; Note 13, Federal Employee and Veterans' Benefits; and Note 15, Other Liabilities.

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Accounts Payable
Accounts Payable primarily consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Accrued Payroll and Benefits
Accrued Payroll and Benefits consist of salaries, wages, leave and benefits earned by employees, but not disbursed as of September 30. Liability for annual and other vested compensatory leave is accrued when earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since this leave will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken.

Entitlement Benefits Due and Payable
Entitlement Benefits Due and Payable represent the liability for Medicare and Medicaid for medical services incurred but not reported as of the balance sheet date. The abbreviation IBNR is periodically used in these statements in place of "incurred but not reported."

Medicare
The Medicare liability is developed by the Office of the Actuary of the Centers for Medicare and Medicaid Services and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in FY 2006 but paid in FY 2007, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers. The Medicare Advantage liability includes amounts incurred related to risk adjustments and other estimates.

Medicaid
The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. The September 30, 2006, estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Note 12, Entitlement Benefits Due and Payable, provides additional information.

Federal Employee and Veterans' Benefits
Most HHS employees participate in either the Civil Service Retirement System (CSRS) – a defined benefit plan, or the Federal Employees Retirement System (FERS) – a defined benefit and contribution plan. For employees covered under CSRS, the Department

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contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. A primary feature of FERS is that it offers a Thrift Savings Plan (TSP) into which the Department automatically contributes one percent of employee pay and matches employee contributions up to an additional four percent of pay.

The U.S. Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS or FERS assets, accumulated plan benefits, or unfunded liabilities applicable to Federal employees. Therefore, HHS does not recognize any liability on its balance sheet for pensions, other retirement benefits, and other post-employment benefits with the exception of Commissioned Corps (see below). HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position.

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System, a defined noncontributory benefit plan, for its active duty officers and retiree annuitants or survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay as you go basis by Congressional appropriations. HHS records the actuarial liability based on the present value of accumulated pension plan benefits and the post-retirement health benefits.

The liability for Federal employee and veterans' benefits also includes a liability for actual and estimated future payments for workers' compensation pursuant to the Federal Employees Compensation Act (FECA). FECA provides income and medical cost protection (1) to Federal employees who were injured on the job or who have sustained a work-related occupational disease and (2) to beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the Department of Labor (DOL), which pays valid claims and subsequently bills the employing Federal agency. The FECA liability consists of two components – the actual claims paid by DOL but not yet disbursed, and the estimated liability for future benefit payments as a result of past events, such as death, disability, and medical costs.

Note 13, Federal Employee and Veterans' Benefits, provides additional information.

Revenue and Financing Sources

The Department receives the majority of funding needed to support its programs through Congressional appropriation and through reimbursement for the provision of goods or services to other Federal agencies. The United States Constitution prescribes that no money may be expended by a Federal agency unless and until funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by the Department.

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Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations. The Department receives annual, multi-year, and no year appropriations that may be used within statutory limits. For example, funds for general operations are generally made available for one fiscal year; funds for long-term projects such as major construction will be available for the expected life of the project; and funds used to establish revolving fund operations are generally available indefinitely (i.e., no year funds). The Statement of Budgetary Resources presents information about the resources appropriated to the Department.

Exchange and Non-Exchange Revenue. HHS classifies revenues as either exchange revenue or non-exchange revenue. Exchange revenues are recognized when earned, i.e., when goods have been delivered or services have been rendered. These revenues reduce the cost of operations borne by the taxpayer.

Non-exchange revenues result from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable. Non-exchange revenues are not considered to reduce the cost of the Department's operations and are reported in the Statement of Changes in Net Position.

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employee wages and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the Hospital Insurance (HI) trust fund. The Social Security Act requires the transfer of these contributions from the General Fund of the Treasury to the HI trust fund based on the amount of wages certified by the Social Security Administration (SSA) from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers and self-employed individuals to the Internal Revenue Service as the basis for conducting quarterly certification of regular wages.

With minor exceptions, all receipts of revenues by Federal agencies are processed through Treasury's central accounting system. Regardless of whether they derive from exchange or non-exchange transactions, all receipts that are not earmarked by Congressional appropriation for immediate departmental use are deposited in the general or special funds of the Treasury. Amounts not retained for use by HHS are reported as transfers to other government agencies on the HHS Statement of Changes in Net Position.

Imputed Financing Sources. In certain instances, operating costs of HHS are paid out of funds appropriated to other Federal agencies. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management, and certain legal judgments against HHS are paid from the Judgment Fund maintained by Treasury. When

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costs that are identifiable to HHS and directly attributable to the Department's operations are paid by other agencies, the Department recognizes these amounts as imputed costs of HHS, and at the same time, this amount is recognized as an imputed financing source on the Consolidated Statement of Changes in Net Position.

Other Financing Sources. Medicare's HI program, or Medicare Part A, is financed through the HI trust fund, whose revenues come primarily from the Medicare portion of payroll and from self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and under the Self-Employment Contribution Act (SECA). The Medicare payroll tax rate is 2.9 percent of annual wages. Contribution rates are discussed under Exchange and Non-Exchange Revenue. Medicare's Supplemental Medical Insurance (SMI) program, or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. Premium payments from Medicare beneficiaries are matched approximately three to one by Congressional appropriations.

Aggregate non-exchange revenues consist primarily of FICA taxes of $168,564 million and $157,702 million, SECA taxes of $11,829 million and $11,252 million, and Trust Fund investment interest of $17,142 million and $16,484 million for FY 2006 and FY 2005, respectively.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the Department. The uncertainty should ultimately be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. Statement of Federal Financial Accounting Standards (SFFAS) No. 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS No. 12, *Recognition of Contingent Liabilities from Litigation*, contain the criteria for recognition and disclosure of contingent liabilities. With the exception of pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur, and the related future outflow or sacrifice of resources is measurable.

Note 22, Contingencies, provides additional information.

Reclassifications

Certain reclassifications were made to the presentation of the September 30, 2005 financial statements and footnotes to improve their comparability with the September 30, 2006 statements and footnotes. These reclassifications were made in compliance with the form and content prescribed by the OMB Circular No. A-136.

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Intragovernmental Relationships and Transactions
In the course of its operations, HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are the Social Security Administration (SSA) and the Department of the Treasury. The SSA determines eligibility for Medicare programs and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. At the government-wide level, the assets related to the trust funds on HHS' financial statements and the corresponding liabilities on the Treasury's financial statements would be eliminated.

Earmarked Funds
Effective FY 2006, FASAB SFFAS No. 27, *Identifying and Reporting Earmarked Funds*, defines earmarked funds and requires that they be shown separately from all other funds on the Statement of Changes in Net Position, as well as in the Net Position section of the Balance Sheet. The HHS adopted FASAB SFFAS No. 27 effective October 1, 2005. Earmarked funds are defined as those financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time; are required by statute to be used for designated activities, benefits or purposes; and must be accounted for separately from the Government's general revenues. "Fund" in this statement's definition of earmarked funds refers to a "fiscal and accounting entity with a self-balancing set of accounts recording cash and other financial resources, together with all related liabilities and residual equities or balances, and changes therein, which are segregated for the purpose of carrying on specific activities or attaining certain objectives in accordance with special regulations, restrictions, or limitations." Whether the appropriation is provided by authorizing legislation or annual appropriations acts, the cumulative results of operations arising from earmarked funds is reserved or restricted to the designated activity, benefit or purpose. The SFFAS 27 does not allow restating of the FY 2005 reported amounts. The standard also requires that condensed information on assets, liabilities and costs for earmarked funds be disclosed (see Note 30). An earmarked fund may be classified in the unified budget as a trust, special or public enterprise fund. Examples of HHS earmarked funds include the HI trust fund that is used to process claims associated with Part A benefits and the SMI trust fund that is used to process claims associated with Part B benefits.

Note 30, Earmarked Funds provides additional information.

Medicare Hospital Insurance (HI) Trust Fund
The Medicare Hospital Insurance Trust Fund is authorized by Title XVIII of the Social Security Act. Medicare contractors are paid by HHS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as any related administrative costs are charged to the HI trust fund. The HHS payments to managed care plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Treasury. This trust fund has permanent indefinite budgetary authority.

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Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The HI is financed primarily by these payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held by the HI Trust Fund, and invested in U. S. Treasury securities.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

The Medicare Supplementary Medical Insurance Trust Fund is authorized by Title XVIII of the Social Security Act. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment providers, rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The HHS payments to managed care plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite budgetary authority. The SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. Funds not currently needed to pay benefits and related expenses are held by the SMI Trust Fund, and invested in U. S. Treasury securities.

Medicare Prescription Drug Benefit – Part D

The Medicare Prescription Drug Benefit – Part D, established by the Medicare Modernization Act of 2003, became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Plans, and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards as well as helps those with limited income and resources. Under demonstration authority, Medicare will reimburse States who paid prescription drug costs for dual eligibles who had difficulty accessing Part D benefits at the very outset of the Part D program. Since FY 2004, the Transitional Assistance and Drug Discount Card Programs have provided credits and discounts toward prescription drug coverage for certain eligible beneficiaries; however, with the implementation of Medicare Part D, these programs were phased out in FY 2006. The

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Part D is considered part of the SMI trust fund and is reported in the Medicare column of financial statements where required.

Medicare and Medicaid Integrity Program (MIP)
The Health Insurance Portability and Accountability Act (*Public Law 104-191*) established the MIP and codified the program integrity activities previously known as "payment safeguards." This account is also referred to as the Health Care Fraud and Abuse Control program or simply "Fraud and Abuse." To safeguard the Medicare system, the HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI trust fund.

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) which represents a substantial milestone in HHS' strategy to detect and prevent Medicaid fraud and abuse in the program's history. The Medicaid MIP is also funded by the HI trust fund.

Medicaid
Medicaid, the health care program for low-income Americans, is administered by HHS in partnership with the states. Grant awards limit the funds that can be drawn by the states to cover current expenses. The grant awards, which are prepared at the beginning of each quarter and are amended as necessary, are an estimate of the HHS share of states' Medicaid costs. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HHS for the difference between approved expenses reported for the period and grant awards previously issued. Medicaid is financed by general funds and is not classified as "earmarked."

State Children's Health Insurance Program (SCHIP)
The SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The grant award to the individual State is prepared before the end of the fiscal year in an amount equal to the annual allotment. Under Section 2104 of the Act, allotments are available for 3 fiscal years, referred to as the "period of availability." At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HHS for the difference between approved expenses reported for the period and the grant awards previously issued.

Statement of Social Insurance
The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program

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participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions. This projected potential future income and expenditures under current law is not included in the accompanying Balance Sheets, Statements of Net Cost, Changes in Net Position, Budgetary Resources, or Financing.

The Medicare financial projections are developed based on numerous assumptions and are inherently subject to substantial uncertainty. This uncertainty arises from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events and contingencies that cannot be reliably anticipated, particularly over more distant timeframes such as the 75-year projection period used for the SOSI. Most of these future conditions and events are beyond our control. Future income and expenditures under current law will be affected by variation in demographic trends (birth rates, mortality rates, and immigration), general economic trends (wage growth, inflation, interest rates, labor force participation, and unemployment), and health-specific trends (growth in the utilization and intensity of health care services, and increases in medical care prices). Recent historical trends in health care have often varied dramatically; consequently, such projections can only indicate the level of expenditures that would occur under current law based on trend assumptions that are considered reasonable from today's viewpoint. Actual future expenditures are likely to differ significantly from the projections shown in the SOSI. Further, it is likely that Congress will pass legislation from time to time modifying the provisions of the Medicare program. Such legislation could also result in differences between actual future income and expenditures from those amounts projected under current law in the accompanying SOSI.

The additional information on the SOSI of actuarial present values of estimated future income (excluding interest) less expenditures plus assets at the start of the period is presented for purposes of additional analysis and is not a required part of the financial statements.

Notes 31 and 32, Statement of Social Insurance Disclosures provides additional information.

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Note 2. Non-Entity Assets

Non-entity assets at September 30, 2006, and 2005, consisted of the following:

(Dollars in Millions)	2006	2005
Intragovernmental:		
Fund Balance with Treasury	$ 26	$ 23
Accounts receivable	-	-
Other	-	-
Total Intragovernmental	26	23
Accounts receivable	14	14
Cash and other monetary assets	-	-
Other	-	-
Total Non-Entity Assets	40	37
Total Entity Assets	513,869	428,450
Total Assets	$ 513,909	$ 428,487

The $26 million non-entity asset Fund Balance with Treasury includes: $15 million of Federal tax refunds collected by the Internal Revenue Service for delinquent child support payments that were transferred to ACF for distribution to the states; $9 million in NIH collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act; and $2 million representing CDC withholdings for state payroll deductions, collections of interest, and other miscellaneous receipts. The $14 million accounts receivable represents CMS' receivables for interest and penalties.

Note 3. Fund Balance with Treasury

The Fund Balance with Treasury (FBWT) and the status of the fund balance as of September 30, 2006, and 2005, are listed below by fund type.

(Dollars in Millions)	2006	2005
Fund Balance with Treasury		
Trust Funds	$ 28,985	$ 1,964
Revolving Funds	896	757
Appropriated Funds	129,292	96,315
Other Funds	748	602
Total	$ 159,921	$ 99,638

Status of Fund Balance with Treasury

Unobligated Balance	2006	2005
Available	$ 60,254	$ 12,362
Unavailable	7,666	5,845
Obligated Balance not yet Disbursed	134,837	117,876
Non-Budgetary FBWT	(42,836)	(36,445)
Total	$ 159,921	$ 99,638

Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts.

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The Unobligated Balance includes $2.2 billion for September 30, 2006 and $2.1 billion for September 30, 2005, which is restricted for future use and is not apportioned for current use. The $2.2 billion and the $2.1 billion reported for September 30, 2006 and September 30, 2005 respectively, include restricted amounts for the ACF Contingency Fund for State Welfare Programs, the CMS Program Management and State Grants and Demonstrations, the HRSA Federal Interest Subsidies for Medical Facilities Guarantee and Loan Fund, and the PSC Service and Supply Funds.

The Non-Budgetary FBWT negative balances reported for September 30, 2006 and 2005 are due primarily to CMS Medicare trust funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist primarily of the time account balances at the Medicare contractors' commercial banks. CMS uses the "Checks Paid Letter-of-Credit" method for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against Medicare Benefits Accounts maintained at commercial banks. To compensate the commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest bearing time accounts. The interest foregone by CMS on these time accounts is used to reimburse the commercial banks for the service. The account balances as of September 30, 2006 and 2005 were $145 million and $204 million, respectively.

Note 5. Investments, Net

HHS' investments as of September 30, 2006 and 2005, are summarized below:

	2006			
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 29	$ -	$ 29	$ 29
Non-Marketable: Par Value	335,247	-	335,247	335,247
Non-Marketable: Market-based	2,383	7	2,390	2,390
Subtotal	337,659	7	337,666	337,666
Accrued Interest	4,310	-	4,310	4,310
Total, Intragovernmental	$ 341,969	$ 7	$ 341,976	$ 341,976

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	2005			
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 18	$ -	$ 18	$ 18
Non-Marketable: Par Value	294,471	-	294,471	294,471
Non-Marketable: Market-based	2,169	21	2,190	2,190
Subtotal	296,658	21	296,679	296,679
Accrued Interest	3,985	-	3,985	3,985
Total, Intragovernmental	$ 300,643	$ 21	$ 300,664	$ 300,664

HHS invests entity trust fund balances in excess of current needs in U.S. Treasury securities. The majority of HHS investments in securities are redeemed at maturity and no provision is made for unrealized gains or losses. The Department of Treasury acts as the fiscal agent for the U.S. Government's investments in securities. HHS securities purchased and redeemed include Marketable, Non-Marketable (Par Value), and Non-Marketable Market-based (MK) securities.

The HHS cash receipts collected for the invested funds, consisting primarily of Hospital Insurance and Supplementary Medical Insurance trust funds (earmarked funds), are deposited into the Treasury. Treasury securities are issued to the earmarked fund as evidence of earmarked receipts and provide the fund with the authority to draw upon the U.S. Treasury for future authorized expenditures (although for some funds, this is subject to future appropriation). When the earmarked fund redeems its Treasury securities to make expenditures, the U.S. Treasury will finance those expenditures in the same manner that it finances all other expenditures. Treasury securities held by earmarked funds are an asset of the fund and a liability of the U.S. Treasury, so they are eliminated for the consolidated U.S. Government-wide financial statements. The Treasury does not set aside assets to pay future expenditures for earmarked funds. When the securities are redeemed to make expenditures, Treasury will finance the expenditures out of accumulated cash balances raised by taxes or other receipts, by issuing public securities, by repaying less debt, or by curtailing other expenditures.

Par value securities purchased by the CMS are recorded at cost; interest is earned based on a statutory formula; and securities are redeemed at face value. CMS invests in U.S. Treasury Special Issue bonds (Par Value securities) that are special public obligations for exclusive purchase by the Medicare trust funds. Sections 1817 (for Hospital Insurance) and 1841 (for Supplemental Medical Insurance) of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury.

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Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The Medicare bonds paid from 3.5 percent to 7.375 percent from October 1, 2005, to September 30, 2006, and 3.5 percent to 8.125 percent from October 1, 2004, to September 30, 2005. The One Day Certificates are short-term and paid between 4.75 percent and 5.25 percent from October 1 to September 30 in 2006 and 4.125 percent from October 1 to September 30 in 2005.

The HRSA invests in One Day Certificates, Market- Based Notes and Market-Based Bills. MK securities purchased by HRSA mirror marketable securities terms that are not traded on any securities exchange; these include Non-Marketable, MK, and One Day Certificates. MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund. Discounts and premiums are recorded and amortized on a straight-line basis. Currently, securities held by the VICP will mature in fiscal years 2007 through 2011. The Market-Based Notes paid from 3.00 percent to 6.25 percent from October 1, 2005 to September 30, 2006, and from 1.625 percent to 6.25 percent from October 1, 2004 to September 30, 2005. One Day Certificates paid from 3.36 percent to 5.34 percent from October 1, 2005 to September 30, 2006 and from 1.71 percent to 3.17 percent from October 1, 2004 to September 30 2005.

Marketable securities purchased by the National Institutes of Health gift funds are recorded at cost based on market terms and are invested in interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

Note 6. Accounts Receivable, Net

HHS' accounts receivable as of September 30, 2006 and 2005 are summarized below:

	2006							
(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 978	$ -	$ -	$ 978	$ -	$ 978	$ (252)	$ 726
Non-Entity	-	-	-	-	-	-	-	-
Total, Intragovernmental	$ 978	$ -	$ -	$ 978	$ -	$ 978	$ (252)	$ 726
With the Public								
Entity								
Medicare	$ 4,784	$ -	$ -	$ 4,784	$ (1,919)	$ 2,865	$ -	$ 2,865
Other	590	2	1	593	(265)	328	-	328
Non-Entity	9	43	-	52	(38)	14	-	14
Total, With the Public	$ 5,383	$ 45	$ 1	$ 5,429	$ (2,222)	$ 3,207	$ -	$ 3,207

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(Dollars in Millions)	2005 Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 970	$ -	$ -	$ 970	$ -	$ 970	$ (232)	$ 738
Non-Entity	-	-	-	-	-	-	-	-
Total, Intragovernmental	$ 970	$ -	$ -	$ 970	$ -	$ 970	$ (232)	$ 738
With the Public								
Entity								
Medicare	$ 3,322	$ -	$ -	$ 3,322	$ (1,508)	$ 1,814	$ -	$ 1,814
Other	465	-	69	534	(259)	275	-	275
Non-Entity	12	44	-	56	(42)	14	-	14
Total, With the Public	$ 3,799	$ 44	$ 69	$ 3,912	$ (1,809)	$ 2,103	$ -	$ 2,103

The Hospital Insurance (HI) Trust Fund accrues a receivable from the Railroad Retirement Board (RRB) for amounts transferred through a financial interchange between the HI Trust Fund and RRB. The financial interchange is intended to place the HI trust fund in the same position it would have been had railroad employment been covered by the Federal Insurance Contributions Act. Of the Intragovernmental Accounts Receivable, net as of September 30, 2006 and 2005, $473 million and $454 million were owed by the RRB, respectively.

The Department's accounts receivable with the public is primarily composed of Medicare receivables resulting from overpayments to Medicare providers, beneficiaries, physicians and suppliers, as well as repayments owed on claims where Medicare should have been the secondary payer. The remainder represents receivables arising from Medicaid cost disallowances.

For Medicare receivables, the CMS calculates the allowance for uncollectible accounts receivable based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable amount based on historic analysis of actual recoveries and the rate of disallowances found in favor of the states.

Non-entity accounts receivable consist of receivables for interest and penalties that cannot be used by the Department once collected. Such collections are transferred to the General Fund of the Treasury.

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Note 7. Anticipated Congressional Appropriation

In FY 2006, Congress provided the CMS with sufficient appropriation amounts to cover the entire Medicaid IBNR liability and the matching of SMI premiums from the general fund. Therefore, no Anticipated Congressional Appropriation exists for FY 2006.

As of September 30, 2005, the HHS recorded $14,272 million in anticipated Congressional appropriations to cover liabilities incurred by the Medicaid program and the Payments to the Health Care Trust Funds, as discussed below:

Medicaid

Beginning in FY 1996, HHS accrued an expense and liability for Medicaid IBNR as of September 30. In FY 2005, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $9,099 million. A review of appropriation language by the Office of General Counsel resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, HHS recorded a $9,099 million anticipated appropriation in FY 2005 for IBNR claims that exceeded the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable and deposited in the Trust Fund. Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by the Office of the Actuary (OACT) and can be insufficient in any particular fiscal year. In FY 2005, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30, approximately $5,107 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $65 million in interest on the unmatched amount, leaving a cumulative liability of about $5,173 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, HHS recorded a $5,173 million anticipated appropriation in FY 2005 for the amount of the unmatched SMI premiums. Although the actual transfer of funds occurred in FY 2006, HHS reported the $5,173 million as revenues earned in FY 2005.

In addition, the $5,173 million in unmatched SMI premiums is reported as a liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

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Note 8. Inventory and Related Property, Net

HHS' inventory and related property, net at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions)	2006	2005
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 19	$ 19
Inventory Held for Repair	-	-
Total Inventory Held for Sale	19	19
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	4	5
Operating Materials and Supplies Reserved for Future Use	-	-
Total Operating Materials and Supplies	4	5
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	2,299	1,590
Total Stockpile Materials	2,299	1,590
Inventory and Related Property, Gross	2,322	1,614
Less: Allowance for Loss/Obsolescence/Spoilage	-	-
Inventory and Related Property, Net	$ 2,322	$ 1,614

On August 13, 2004, the Department of Homeland Security transferred Strategic National Stockpile (SNS) materials to HHS as required by the Project BioShield Act of 2004. These materials are not available for sale and are maintained to respond to local and national emergencies. The stockpile materials maintained are primarily SNS and are valued at $2,029 million as of September 30, 2006.

Note 9. General Property, Plant and Equipment, Net

Major categories of HHS General Property, Plant and Equipment (PP&E) at September 30, 2006 and 2005 are listed below:

			2006			2005
(Dollars in Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Land & Land Rights	-	-	$ 48	$ -	$ 48	$ 48
Construction in Progress	-	-	718	-	718	723
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,179	(1,458)	2,721	2,472
Equipment	Straight Line	3-20 Yrs	1,281	(620)	661	679
Internal Use Software	Straight Line	5-10 Yrs	863	(179)	684	487
Assets Under Capital Lease	Straight Line	1-20 Yrs	141	(38)	103	110
Leasehold Improvements	Straight Line	*Life of Lease	43	(7)	36	38
Totals			$ 7,273	$ (2,302)	$ 4,971	$ 4,557

*7 to 15 years or the life of the lease.

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Included in the September 30, 2006 and 2005, Net Book Value for Internal Use Software are Unified Financial Management System capitalized costs totaling approximately $10 million for FY 2006 and $13 million for FY 2005.

Note 10. Other Assets

Other assets as of September 30, 2006 and 2005 are comprised of the following, all of which are considered entity assets:

(Dollars in Millions)	2006	2005
Intragovernmental		
Advances to Other Federal Entities	$ 499	$ 538
Prepayments & Deferred Charges	-	-
Other	1	1
OPDIV Combined, Intragovernmental	500	539
Less: Intra-OPDIV Eliminations	(365)	(366)
OPDIV Consolidated, Intragovernmental	135	173
Less: Inter-OPDIV Eliminations	(3)	(4)
HHS Consolidated, Intragovernmental	$ 132	$ 169
With the Public		
Prepayments and Deferred Charges	$ -	$ 4,044
Travel Advances & Emergency Employee Salary Advances	139	5
Other	370	479
HHS Consolidated, With the Public	$ 509	$ 4,528

Advances to other Federal entities is largely comprised of advances from the NIH to the NIH Service and Supply Fund and the Management Fund for financing the NIH Business System and the NIH Clinical Center, as well as advances from the CDC and the Office of the Secretary to the Department of Veterans Affairs for Strategic National Stockpile items.

As of September 30, 2006, the Centers for Medicare and Medicaid Services had $124 million ($102 million in FY 2005) in Other Assets representing advances made to various contractors and vendors. Medicare Advantage plans were issued an advance payment on September 30, 2005, in the amount of $4,099 million for services that were provided in October 2005. No such advance payment was necessary for FY 2006.

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Note 11. Liabilities Not Covered by Budgetary Resources

HHS' liabilities not covered by budgetary resources at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions)	2006	2005
Intragovernmental		
Accounts Payable	$ -	$ -
Accrued Payroll and Benefits	27	21
Other	526	169
Total Intragovernmental	553	190
Entitlement Benefits Due and Payable	-	9,470
Federal Employees and Veterans' Benefits	7,532	7,183
Accrued Payroll and Benefits	458	453
Other	1,889	2,581
Total Liabilities Not Covered by Budgetary Resources	10,432	19,877
Total Liabilities Covered by Budgetary Resources	67,993	51,082
Total Liabilities	$ 78,425	$ 70,959

Note 12. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represent benefits due and payable to the Public at year-end from entitlement programs enacted by law. The Medicare and Medicaid programs are the largest entitlement programs in HHS and comprise all of the HHS Entitlement Benefits Due and Payable.

Entitlement Benefits Due and Payable at September 30, 2006 and 2005, are summarized in the following schedule:

	2006			2005		
(Dollars in Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Medicare	$ 40,824	$ -	$ 40,824	$ 33,399	$ -	$ 33,399
Medicaid	19,182	-	19,182	10,635	9,470	20,105
Other	1,158	-	1,158	250	-	250
Totals	$ 61,164	$ -	$ 61,164	$ 44,284	$ 9,470	$ 53,754

Medicare benefits payable consists of a $36,628 million estimate ($32,884 million in FY 2005) by the Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2006. The liability represents (a) an estimate of claims incurred that may or

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may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2006 that were paid in 2007 and (e) an estimate of retroactive settlements of cost reports.

The Retiree Drug Subsidy (RDS) consists of a $2,377 million estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2006. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $1,683 million estimate for amounts owed to plans relating to risk and other payment related adjustments. Under the Medicare Modernization Act, certain Medicare payments to private Part D insurance plans are ultimately based on the individual claims experiences for each plan enrollee. In particular, Medicare reinsurance amounts are payable if an enrollee's total "true out-of-pocket costs" exceed $3,600 in 2006. Similarly, beneficiaries who have additional assistance through the Medicare low-income subsidy program qualify for payment of much of their Part D cost-sharing liability; the ultimate amount of such assistance will depend on each such beneficiary's individual cost experience.

For administrative practicality, Part D plans are paid an estimated average monthly amount per enrollee for reinsurance and a corresponding estimated average amount per LIS enrollee for cost sharing. These monthly payments are based on the plans' estimates of such costs, as included in their actuarial bid submissions to CMS. The bids are prepared by a qualified and credentialed actuary and reviewed by the OACT for reasonableness prior to the start of the plan year. Following the end of the plan year, when complete data on enrollees' use of prescription drugs are available, Medicare and the Part D plans will reconcile the estimated monthly payments with the actual experience, and a payment adjustment will be made—either from the program to the plan or vice-versa, as necessary to balance each account.

In practice, it is probable that some plans will have underestimated the average reinsurance and/or LIS cost-sharing amounts, and other plans will have overestimated these amounts. From an actuarial standpoint, it is reasonable to expect that the plans' expectations would be about right on average, with the overpayments to some plans tending to offset the underpayments to others. In the absence of actual plan data for the complete year, however, there is no way to reasonably estimate the aggregate amount of overpayments and the aggregate amount of underpayments for either the reinsurance or the LIS cost-sharing subsidies. In practice, each such aggregate amount could be substantial, and the net difference between them could also be very significant.

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Thus, because this is the initial year of the prescription drug program and actual data have not been received and reviewed, at this time HHS cannot reasonably estimate financial statement accrual amounts for Part D reinsurance and low-income cost sharing that it will ultimately owe plans. Nor can HHS reasonably estimate such amounts that other Part D plans will owe HHS. These amounts can only be determined with any degree of certainty when the final reconciliations of the 2006 plan year data are performed, which will take place in 2007.

Moreover, because the aggregate amounts payable or receivable at calendar year-end cannot be reasonably estimated, it is not possible to estimate a reliable accrual for the end of the fiscal year. The monthly payments of estimated reinsurance and LIS cost-sharing liabilities are determined as simple averages of the annual amounts. It is reasonable to expect that the cumulative payments at any point during the calendar year would not exactly match the cumulative actual incurred amounts, because the timing of the latter is not uniform throughout the year. However, since the ultimate annual amount cannot be reasonably estimated at this time, it is similarly not possible to reasonably estimate September 30th (or other intermediate) accruals.

A potential gain contingency in the Medicare Advantage and Prescription Drug Program consists of amounts due to HHS resulting from risk and other payment related adjustments. However, these amounts have not been finalized as of year end.

Undocumented aliens consist of a $170 million estimate ($250 million in FY 2005) of emergency health services furnished by providers to eligible aliens but not paid as of September 30, 2006. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act related to undocumented aliens.

The HHS implemented the State to Plan Reconciliation Demonstration project under the authority of Section 402 of the Social Security Amendments of 1967 in order to ensure appropriate care continuation for dual eligibles and other low-income subsidy entitled beneficiaries. The liability of $136 million relating to the demonstration project represents estimated amounts to be paid to States for costs incurred in assisting dual eligible beneficiaries to transition to the Medicare Part D Prescription Drug Benefit. A potential gain contingency exists relating to the State to Plan Reconciliation Demonstration project that represents amounts expected to be recovered from the Part D plans for Medicaid and State Pharmaceutical Assistance Program (SPAP) claims. The actual amount of the expected recoveries will not be known until the reconciliation process is completed. The anticipated outcome of the reconciliation is that CMS anticipates the recovery of funds from the Part D plans.

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Medicaid benefits payable of $19,182 million ($19,786 million in FY 2005) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to HHS as of September 30, 2006. An estimated SCHIP benefits payable of $284 million has been recorded for the net Federal share of expenses that have been incurred by the States but not yet reported to HHS as of September 30, 2006. No such SCHIP accrual was recorded at September 30, 2005 because management deemed the estimate immaterial.

The liability for Katrina relief waivers of $704 million consists of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid, as of September 30, 2006. HHS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

Medicaid audit and program disallowances of $319 million in FY 2005 were contingent liabilities established as a result of Medicaid audit and program disallowances that were being appealed by the States. In all cases, the funds were returned to HHS. The HHS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment are deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There were also outstanding reviews of the State expenditures in which a final determination was not made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid & State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMSO. The outcome of these reviews is that HHS could be owed funds.

Note 13. Federal Employee and Veterans' Benefits

HHS' Federal Employee and Veterans' Benefits at September 30, 2006 and 2005, are summarized below. These liabilities are not covered by budgetary resources.

(Dollars in Millions)	2006	2005
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$6,583	$6,287
PHS Commissioned Corp Post-retirement Health Benefits	680	627
Workers' Compensation Benefits (Actuarial FECA Liability)	269	269
Total, Federal Employee and Veterans' Benefits	$7,532	$7,183

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Public Health Service Commissioned Corps: HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System for approximately 5,908 active duty officers and 5,275 retiree annuitants and survivors. Authorized by *Public Law 78-410*, it is a defined noncontributory benefit plan. The plan does not have accumulated assets; funding is provided entirely on a pay as you go basis by Congressional appropriations. Administrative costs are borne by the plan. The plan provides pension payments and medical benefits to eligible retirees. At September 30, 2006, the actuarial present value of accumulated plan pension benefits was $6,583 million, of which $616 million was not vested, and the liability for medical benefits was actuarially determined to be $680 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2006, were as follows:

Interest on Federal securities	6.25 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. HHS applies the aggregate entry age normal actuarial cost method to both programs to determine its liabilities.

The following shows key valuation results as of September 30, 2006 and 2005, in conformance with the actuarial reporting standards set forth in the Statement of Federal Financial Accounting Standards No. 5, *Accounting for Liabilities of the Federal Government*.

(Dollars in Millions)	2006	2005
SFFAS 5 Expense		
(a) Normal Cost	$ 156	$ 154
(b) Interest Cost	425	423
(c) Ongoing Cost (a & b)	581	577
(d) Prior Service Cost & (Gains)/Losses	34	(294)
(e) Total Expense	$ 615	$ 283

Workers' Compensation Benefits: The actuarial liability for future workers' compensation benefits include the expected liability for death, disability, medical, and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims.

The liability utilizes historical benefit payment patterns related to a specific incurred period to predict the ultimate payment related to that period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's

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economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2006 and 2005 appear below.

FY 2006	FY 2005
5.170% in Year 1	4.528% in Year 1
5.313% in Year 2 and thereafter	5.020% in Year 2 and thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (cost of living adjustments (COLAs)) and medical inflation factors (consumer price index medical (CPIMs)) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLAs and CPIMs used in projections are:

FY	COLA	CPIM
2006	3.50%	4.00%
2007	3.13%	4.01%
2008	2.40%	4.01%
2009	2.40%	4.01%
2010+	2.43%	4.09%

Note 14. Accrued Grant Liability

Grant advances are liquidated upon the grantees' reporting of expenditures on the quarterly Federal Cash Transaction Report (SF-272). In many cases, HHS receives these reports several months after the grantee incurs the expense, resulting in an understated grant expense in the financial statements. To mitigate this, HHS developed departmental procedures to estimate and accrue amounts due grantees for their unreported expenses through September 30.

At September 30, the OPDIVs record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective OPDIV advances outstanding exceeds the amount of the collective estimated expenses, HHS reports the difference as "Advances to Grantees." If the amount of the estimated expenses exceeds the amount of the collective advances outstanding, HHS reports the difference as "Accrued Grant Liability."

HHS' net grant advances (liability) at September 30, 2006 and 2005, are summarized below:

	2006	2005
Grant Advances Outstanding (before year-end grant accrual)	$ 15,590	$ 15,491
Less: Estimated Accrual for Amounts Due to Grantees	(19,423)	(19,274)
Net Grant Liability	$ (3,833)	$ (3,783)

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Note 15. Other Liabilities

HHS' other liabilities at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions) 2006	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ -	$ -	$ -
Deferred Revenue	480	-	480	746	-	746
Contingent Liabilities	-	34	34	-	1,601	1,601
Capital Lease Liability	-	83	83	27	9	36
Custodial Liabilities	-	409	409	-	10	10
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	1	36	37
Other	471		471	204	12	216
Combined OPDIV Totals	951	526	1,477	978	1,889	2,867
Less: Intra-OPDIV Eliminations	(365)	-	(365)	-	-	-
Consolidated OPDIV Totals	586	526	1,112	978	1,889	2,867
Less: Inter-OPDIV Eliminations	(157)	-	(157)	-	-	-
Consolidated HHS Totals	$ 429	$ 526	$ 955	$ 978	$ 1,889	$ 2,867

(Dollars in Millions) 2005	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ 15	$ -	$ 15
Deferred Revenue	475	-	475	552	-	552
Contingent Liabilities	-	-	-	-	2,266	2,266
Capital Lease Liability	-	86	86	31	5	36
Custodial Liabilities	-	84	84	-	5	5
Vaccine Injury Compensation Program	-	-	-	-	265	265
Environmental and Disposal Costs	-	-	-	2	31	33
Other	806	(1)	805	115	9	124
Combined OPDIV Totals	1,281	169	1,450	715	2,581	3,296
Less: Intra-OPDIV Eliminations	(366)	-	(366)	-	-	-
Consolidated OPDIV Totals	915	169	1,084	715	2,581	3,296
Less: Inter-OPDIV Eliminations	(92)	-	(92)	-	-	-
Consolidated HHS Totals	$ 823	$ 169	$ 992	$ 715	$ 2,581	$ 3,296

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The majority of the other liabilities include Deferred Revenue, Contingent Liabilities, and the Vaccine Injury Compensation Program, and Other Intragovernmental Liabilities.

Deferred Revenue:
The Centers for Medicare and Medicaid Services routinely receive premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill. CMS accounts for $364 million of the deferred revenue with the public.

In addition, the Food and Drug Administration collects fees in relation to its various user fee appropriations. FDA accounts for $241 million of the deferred revenue with the public for the portion of the fees collected during current fiscal year that should be applied to the next fiscal year. The Indian Health Service accounts for $169 million of the intragovernmental deferred revenue for construction-in-process projects primarily under the Contribution, Indian Health Facilities fund, and $89 million of the deferred revenue with the public for the Tribal Buybacks. The Substance Abuse and Mental Health Services Administration accounts for $139 million intragovernmental deferred revenue for interagency agreement with another Federal agency to award and administer the Drug Free Communities program grants. The Vaccine Injury Compensation Program administered by the Health Resources and Services Administration accounts for $29 million in intragovernmental deferred revenue arising from the provision of goods and services by the program. The National Institutes of Health accounts for $104 million of the intragovernmental deferred revenue and $51 million deferred revenue with the public for unearned Cooperative Research and Development Agreement (CRADA) revenue.

Other Intragovernmental Liabilities:
Other Intragovernmental Liabilities of $955 million are comprised of $434 million, of which CMS owes to other Federal entities, primarily to the Department of the Treasury ($333 million at September 30, 2006). The CMS' payable to Treasury is a result of the receivables from the beneficiaries and Medicare contractors. The CMS owes other Federal entities $100 million for services performed through interagency agreements.

Environmental and Disposal Costs:
The Comprehensive Environmental Response Compensation and Liability Act, the Comprehensive Environmental Cleanup and Responsibility Act, the Superfund Amendments and Reauthorization Act of 1986, and the Conservation Recovery Act of 1976 are several laws and regulations which require HHS to remove, contain, and/or dispose of hazardous waste. Environmental and disposal costs are the costs of removing, containing, and/or disposing of (1) hazardous waste from property, or (2) material and or property that consists of hazardous waste at a permanent or temporary closure or shutdown of associated property, plant, or equipment. The majority of the environmental and disposal costs consist of Indian Health Service's liabilities associated with surveying, testing, and remediating contaminated

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sites and the National Institutes of Health ground water remediation project in accordance with applicable laws and regulations.

Note 16. Leases

Capital Leases:

HHS has entered into various capital leases with Native American and Alaskan Native tribes and with the General Services Administration (GSA) for office and warehouse space. Lease terms vary from 1 to 20 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments.

Operating Leases:

HHS has commitments under various operating leases with private entities and GSA for office, laboratory spaces, and land. Leases with private entities have initial or remaining noncancelable lease terms from 1 to 20 years. GSA leases in general are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

In FY 2005, the National Institutes of Health identified certain operating leases that do not have cancellation clauses and the obligation for the full term of the lease was not recorded. GSA issued a policy clarification for delegations of lease acquisition authority dated July 7, 2006, stating that leases meeting the criteria for operating leases were required to cover the annual lease payments only with budget authority.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2006 and 2005 is presented in the schedules that follow:

(Dollars in Millions)	2006	2005
Summary of Net Assets Under Capital Lease		
Land and Building	$ 140	$ 140
Machinery and Equipment	1	2
Other	-	-
Subtotal	$ 141	$ 142
Less: Accumulated Amortization	(38)	(32)
Assets Under Capital Lease	$ 103	$ 110

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(Dollars in Millions)	2006 Capital Leases	2006 Operating Lease	2005 Capital Leases	2005 Operating Lease
Future Minimum Lease Payments				
2007	$ 12	$ 319	$ 12	$ 322
2008	12	333	12	342
2009	13	333	12	348
2010	13	285	13	355
2011	11	253	13	340
Later Years	137	859	149	1,064
Total Minimum Lease Payments	$ 198	$ 2,382	$ 211	$ 2,771
Less: Imputed Interest	(79)		(89)	
Total Capital Lease Liability	$ 119		$ 122	

Note 17. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

Intragovernmental transactions are between Federal entities meaning both the buyer and seller are Federal. Exchange revenue with the public is a transaction when the buyer of the goods or services is a non-Federal entity and the seller is Federal.

If a Federal entity purchases goods or services from another Federal entity and sells them to the public, the exchange revenue would be classified as "with the public" but the related costs would be classified as "intragovernmental." The purpose of the classifications is to enable the Federal Government to provide consolidated financial statements, and not to match public and intragovernmental revenue with costs that are incurred to produce public and intragovernmental revenue. HHS' consolidated gross cost and exchange revenue by budget functional classification for the years ended September 30, 2006 and 2005 are summarized below:

	2006							2005
(Dollars in Millions)	Education Training and Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	HHS Consolidated Totals
Intragovernmental								
Gross Cost	$ 166	$ 4,146	$ 695	$ 26	$ 5,033	$ (1,713)	$ 3,320	$ 3,535
Less: Earned Revenue	(21)	(2,773)	(8)	(8)	(2,810)	1,709	(1,101)	(1,085)
Net Cost, Intragovernmental	$ 145	$ 1,373	$ 687	$ 18	$ 2,223	$ (4)	$ 2,219	$ 2,450
With the Public								
Gross Cost	$ 12,068	$238,604	$ 386,229	$ 36,269	$ 673,170	$ -	$ 673,170	$ 618,463
Less: Earned Revenue	-	(1,505)	(49,947)	-	(51,452)	-	(51,452)	(39,593)
Net Cost, With the Public	$ 12,068	$ 237,099	$336,282	$36,269	$ 621,718	$ -	$ 621,718	$ 578,870
Totals								
Gross Cost	$ 12,234	$ 242,750	$386,924	$36,295	$ 678,203	$ (1,713)	$ 676,490	$ 621,998
Less: Earned Revenue	(21)	(4,278)	(49,955)	(8)	(54,262)	1,709	(52,553)	(40,678)
Net Cost of Operations	$ 12,213	$ 238,472	$ 336,969	$36,287	$ 623,941	$ (4)	$ 623,937	$ 581,320

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Note 18. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $53 billion and $41 billion for the years ended September 30, 2006, and 2005, respectively. The HHS' exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

Premiums collected are used to finance Supplemental Medical Insurance benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal Government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

HHS' pricing policy under the reimbursable agreements is to recover full cost and to incur no profit or loss. Most OPDIVs either charge full cost or are implementing procedures to do so. In addition to revenues related to reimbursable agreements, HHS collects various user fees to finance its programs. Certain fees charged by HHS are based on an amount set by law or regulations and may not represent full cost.

Note 19. Prior Period Adjustments

In FY 2005, prior period adjustments of $32 million were reported to correct errors and accounting changes with retroactive effect. HHS included prior period adjustments in the calculation of the net change in cumulative results of operations and unexpended appropriations. The FY 2005 adjustments were related to IHS' accrued unfunded payroll, the NIH's royalty activity, and the Office of the Secretary's stockpile transfer.

Note 20. Custodial Activity

The Administration for Children and Families receives monies from the Internal Revenue Service for outlay to the States for child support. These monies represent delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to HHS appropriation 75X6234 to cover outlays. During FY 2006, receipts amounted to $1,571 million ($1,573 million for FY 2005) and outlays amounted to $1,556 million ($1,562 million for FY 2005).

The FDA custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal feeds and drug products. Total CMP collections in FY 2006 were $24.8 million ($4.7 million for FY 2005). CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

The Centers for Disease Control and Prevention custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total

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custodial liabilities for FY 2006 and FY 2005 were $3.6 million and $84 thousand, respectively. CDC custodial collections are also forwarded to the Department of the Treasury and cannot be used for CDC operations.

Note 21. Federal Matching Contribution

Supplemental Medical Insurance benefits and administrative expenses are financed by monthly premiums which are paid by Medicare beneficiaries and which are matched by the Federal Government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected and outlines both the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $78.20 from October 2005 through December 2005 and $88.50 from January 2006 through September 2006. Premiums collected from beneficiaries totaled $41.6 billion in FY 2006 ($35.9 billion in FY 2005) and were matched by $129.1 billion ($113.5 billion in FY 2005) contribution from the Federal Government.

Note 22. Contingencies

The Department and its components are parties to various administrative proceedings, legal actions, and claims brought by or against it. These contingencies arise in the normal course of operations and their ultimate disposition is unknown. To the extent that a past transaction or event has occurred, a future outflow or other sacrifice of resources is probable, and the related future outflow or sacrifice of resources is measurable, a contingent liability will be accrued and reported in Note 15, Other Liabilities. With respect to all other contingencies, management, in consultation with legal counsel, has determined that it is reasonably possible that certain claims may result in an adverse outcome to the Department. However, an estimate of the range of possible liability cannot be determined. It is management's opinion that the expected outcome of these matters, individually or in the aggregate, will not have a material adverse effect on the financial statements of the Department.

Obligations Related to Cancelled Appropriations:

Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled pursuant to the National Defense Authorization Act of FY 1991 (*Public Law 101-150*). The total payments related to cancelled appropriations are estimated at $1,009 million and $1,136 million as of September 30, 2006 and 2005, respectively.

Contingent Liabilities:

The HHS is an agency in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. The HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined.

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The Medicaid amount for $1,126 million consists of Medicaid audit and program disallowances of $419 million and $707 million for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMSO. The outcome of these reviews is that CMS could be owed funds.

The following contingent liability for which a loss has been determined to be reasonably possible has not been accrued in the Department's financial statements:

The CMS expects that as of September 30, 2006, it is reasonably possible that a contingent liability could be owed to States in an estimated amount as much as $1,641 million ($1,648 million in FY 2005), for unasserted claims arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2005, CMS believed this contingent liability was probable, and therefore, recorded it as a liability in the financial statements. However, because no states have filed any claims since CMS first disclosed this issue, no liability has been recorded for FY 2006.

Vaccine Injury Compensation Program (VICP):
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $221 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2006.

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2005, there were 5,737 PRRB cases (5,580 in FY 2005) under appeal. A total of 2,422 new cases (2,301 in FY 2005) were filed in FY 2006. The PRRB rendered decisions on 85 cases (72 in FY 2005) in FY 2006 and 2,188 additional cases (2,072 in FY 2005) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 85 cases that were decided in FY 2006, a reasonable liability estimate cannot be projected for the value of the 5,886 (5,737 in FY 2005) cases remaining on appeal as of September 30, 2006. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

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Note 23. Apportionment Categories of Obligations Incurred

Obligations incurred by apportionment categories at September 30, 2006 and 2005, are summarized below:

	2006		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 125,641	$ 7,340	$ 132,981
Category B	388,707	431	389,138
Exempt from Apportionment	362,784	-	362,784
Total Obligations Incurred	$ 877,132	$ 7,771	$ 884,903

	2005		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 89,605	$ 5,466	$ 95,071
Category B	332,565	1,398	333,963
Exempt from Apportionment	346,601	-	346,601
Total Obligations Incurred	$ 768,771	$ 6,864	$ 775,635

Obligations incurred consist of expended authority and the change in undelivered orders. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. The OMB has exempted CMS from the Circular No. A-11 requirement to report the refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as offsetting receipts beginning in FY 2005.

Note 24. Legal Arrangements Affecting Use of Unobligated Balances

Unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for new obligations in the year the appropriation was received and for adjustments to valid obligations for 5 subsequent years. Revolving funds are no-year funds available until expended. The National Institutes of Health Management Fund is available for 2 fiscal years. The trust funds are also no-year funds without time limits. The CRADA funds are available for the performance of the contractual agreement.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available Pursuant to Public Law in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and

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currently become available for obligation as needed. The entire trust fund balances in the amount of $292,426 million as of September 30, 2006 ($258,025 million in FY 2005) are included in Investments on the Balance Sheet.

The FDA received $168 million in funding in FY 2002 to remain available until expended, to support counter-terrorism projects that recognize the important role FDA plays in protecting the public health. The attacks of September 11, 2001, and subsequent national events resulted in an accelerated and intensified need for attention to activities related to counter-terrorism. The amount obligated for counter-terrorism projects through FY 2006 was approximately $167.7 million.

Note 25. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The SFFAS No. 7, *Accounting for Revenue and Other Financing Sources*, requires explanations for material differences between the information required by paragraph 77 (of SFFAS No. 7) and the amounts described as "Actual" in the *Budget of the United States Government,* also referred to as the *President's Budget*. Paragraph 77 of the SFFAS No. 7 requires the presentation of total budgetary resources available to a reporting entity, the status of those resources, and any outlays of the reporting entity. This information is provided in the Department's Statement of Budgetary Resources.

Chapter 11, Title 31, U.S. Code requires: "On or after the first Monday in January but not later than the first Monday in February of each year, the President shall submit a budget of the United States Government for the following fiscal year." The FY 2008 *President's Budget*, with actual amounts for FY 2006, has not yet been published, and, therefore, no comparisons can be made between FY 2006 amounts presented in the SBR with amounts reported in the "Actual" column of the *President's Budget*. The FY 2008 *President's Budget* is expected to be released in February 2007, and may be obtained from the Office of Management and Budget website http://www.whitehouse.gov/omb/budget or the Government Printing Office.

The *Budget of the United States Government, FY 2007 – Appendix* was used as the reference for the HHS total budgetary resources amount. Information in the "Federal Programs by Agency and Account" in the FY 2007 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (less offsetting receipts) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2005.

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The prior year September 30, 2005, reconciliation is disclosed in the following schedule:

	2005			
(Dollars in Millions)	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$ 793,842	$ 775,635	$ 167,026	$ 581,294
Unobligated Balances – Not Available	(5,845)	-	-	-
Other	1,249	(261)	4	285
Budget of the U.S. Government	$ 789,246	$ 775,374	$ 167,030	$ 581,579

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not in the *President's Budget* is the budgetary resources that were not available. The unobligated balances – not available line in the above schedule includes expired authority, recoveries, and other amounts included in the SBR that are not included in the *President's Budget*. The "Other" line in the schedule includes gift and donations, offsetting collections, reimbursable items and timing differences between the SBR and the *President's Budget*.

The Other Adjustments Line for Budgetary Resources included an increase of $1,920 million for the amounts reported in the President's Budget for the CMS to fund the Vaccines for Children program; these funds were subsequently transferred to the CDC and the Department of Treasury (Treasury). The CMS reported a decrease of $69 million for offsetting receipts. CDC reported offsetting receipts of $1.2 million and gifts and donations of $8 million.

The Other Adjustments Line for Obligations Incurred included an increase by CMS of $1,864 million for the obligations for the Vaccines for Children program reported in the President's Budget, offset by amounts reported by CDC and Treasury. The CMS also reported a decrease of $85 million for expired accounts.

The Other Adjustments Line for Net Outlays included an increase to net outlays for CMS in the amount of $1,659 million for the amounts reported in the President's Budget for CMS for the Vaccines for Children program subsequently reported by the CDC and Treasury. The CDC's outlays for the Vaccines for Children program were $1,302 million.

Note 26. Explanation of Differences between Liabilities Not Covered by Budgetary Resources and Components Requiring or Generating Resources in Future Periods

The components requiring resources in future periods include increases in certain liability accounts, such as accrued annual leave, that are also included in the category "Not Covered by Budgetary Resources." In this instance, the expense is recorded for the period when the leave is earned and is included as a current period cost on the Statement of Net Cost.

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The Balance Sheet uses proprietary accounts to present the balances for "Liabilities Not Covered by Budgetary Resources." An increase in the annual leave liability increases the unfunded liability on the Balance Sheet and the expenses on the Statement of Net Cost. The increase is not included in the Statement of Budgetary Resources since the liability will be paid from future resources. As a result, the Statement of Financing reports "Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods" which includes items such as accrued annual leave to reconcile budgetary resources to net cost.

Note 27. Permanent Indefinite Appropriations

The HHS permanent indefinite appropriations are open-ended; that is, the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

The list below includes the Treasury Fund Symbols that meet the criteria stated above and are considered permanent indefinite appropriations. The list also includes the period of availability (fiscal year or no-year) and the titles of the accounts.

75 0170 (fiscal year) HHS Accrual Contribution to the Uniformed Services Retiree Health Care Fund, Office of the Assistant Secretary for Health
75 0340 (fiscal year) Health Education Assistance Loans Program
75X0350 (no year) Health Centers Loan Program, HRSA
75X0513 (no year) Payments for Credits Against Health Care Contributions
75X0585 (no year) Taxation on Old-Age, Survivors, and Disability Insurance Benefits
75 1552 (fiscal year) Temporary Assistance for Needy Families
75 1553 (fiscal year) Children's Research and Technical Assistance
75X1553 (no year) Children's Research and Technical Assistance
75X4305 (no year) Health Prof. Grad. Student Loan Insurance Fund, Liquidating Account
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8247 (no year) FDA Unconditional Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8249 (no year) Unconditional Gift Fund, HRSA
75X8250 (no year) Gifts and Donations, CDC
75X8253 (no year) NIH Conditional Gift Fund
75X8254 (no year) Conditional Gift Fund, HRSA
75X8307 (no year) Transitional Drug Assistance, CMS
75X8308 (no year) Medicare Prescription Drug Account, CMS
75X8510 (no year) Administration on Aging Gift Fund
75X8511 (no year) Indian Health Service Gift Fund
75X8512 (no year) AHRQ Gift Fund

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75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) OS Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X8889 (no year) Patients Benefit Fund, HRSA
7520X8004 (no year) Federal Supplementary Medical Insurance Trust Fund, CMS
7520X8005 (no year) Federal Hospital Insurance Trust Fund, CMS
7520X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA

Note 28. Adjustments to Beginning Balance of Budgetary Resources
In FY 2005, $164 million was reported as a beginning balance adjustment to properly reflect drug industry fees collected in advance by the Food and Drug Administration at the end of FY 2004.

Note 29. Undelivered Orders at the End of the Period
At the end of the period, HHS reported $76,429 million of budgetary resources obligated for undelivered orders for FY 2006 and $74,329 million for FY 2005.

Note 30. Earmarked Funds
Medicare is the largest earmarked fund group managed by the Department; therefore, Medicare financial data is presented on an individual basis with a separate column in the schedule below.

The HHS has designated as earmarked funds the Medicare HI and SMI trust funds, which also include the Payments to the Health Care Trust Funds appropriation and the Health Care Fraud and Abuse Control Account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds.

The Medicare programs include: (a) Medicare Hospital Insurance (HI) Trust Fund, (b) Medicare Supplementary Medical Insurance (SMI) Trust Fund, (c) Medicare Prescription Drug Benefit – Part D, and (d) Medicare Integrity Program (MIP). See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the fund.

The Social Security Act provides for payments to the HI and SMI trust funds (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The Medicare Modernization Act of 2003 prescribes that funds covering the Medicare Prescription Drug Benefit, retiree drug coverage, reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to SMI. A transfer of general funds to the HI trust fund is made in amounts equal to Self-Employment Contribution Act tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries.

There were no legislative changes that significantly changed the purpose of or redirected a significant portion of an earmarked fund during this reporting period.

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Earmarked Funds (In Millions)	Medicare Earmarked Fund	Other Earmarked Funds	Eliminations	Total Earmarked Funds
Balance Sheet as of September 30, 2006				
Assets				
Fund balance with Treasury	$ 28,726	$ 820	$ -	$ 29,546
Investments	339,545	2,431	-	341,976
Other Assets	46,484	42	(42,637)	3,889
Total Assets	$ 414,755	$ 3,293	$ (42,637)	$ 375,411
Entitlement Benefits Due and Payable	$ 40,824	$ -	$ -	$ 40,824
Other Liabilities	44,420	674	(42,637)	2,457
Total Liabilities	$ 85,244	$ 674	$ (42,637)	$ 43,281
Unexpended Appropriations	$ 27,658	$ 7	$ -	$ 27,665
Cumulative Results of Operations	301,853	2,612	-	304,465
Total Liabilities and Net Position	$ 414,755	$ 3,293	$ (42,637)	$ 375,411
Statement of Net Cost For the Period Ended September 30, 2006				
Gross Program Costs	$ 386,924	$ 199	$ -	$ 387,123
Less: Earned Revenues	49,955	512	-	50,467
Net Cost of Operations	$ 336,969	$ (313)	$ -	$ 336,656
Statement of Changes in Net Position For the Period Ended September 30, 2006				
Net Position Beginning of Period	$ 276,020	$ 2,342	$ -	$ 278,362
Non-Exchange Revenue	197,843	155	116	198,114
All Other Financing Sources	192,617	(191)	(116)	192,310
Net Cost of Operations	(336,969)	313	-	(336,656)
Change in Net Position	53,491	277	-	53,768
Net Position End of Period	$ 329,511	$ 2,619	$ -	$ 332,130

The list below includes the Treasury fund symbols that are “Other Earmarked Funds”:

75X8510 (no year) Administration on Aging Gift Fund
75X8512 (no year) Agency for Healthcare Research and Quality Gift Fund
75X0943 (no year) Disease Control, Rsrch, & Trning, CDC (partial – user fee portion only)
75 0943 (fiscal year) Disease Control, Rsrch, & Trning, CDC (partial – multi-year royalties)
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X8250 (no year) Gifts and Donations, CDC
20X8145 (no year) Allocation Transfer from EPA Hazardous Superfund CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8247 (no year) Food and Drug Administration Unconditional Gift Fund
75X0600 (no year) User Fee Act(s), FDA
75X4309 (no year) Revolving Fund for Certification and Other Services, FDA

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75X8249 (no year) Unconditional Gift Fund, HRSA
75X8254 (no year) Conditional Gift Fund, HRSA
75X8889 (no year) Patients Benefit Fund, HRSA
20X8175 (no year) Vaccine Injury Compensation Trust Fund HRSA
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8511 (no year) IHS Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8253 (no year) NIH Conditional Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75 3966 (fiscal year) Royalties, NIH
75X8513 (fiscal year) SAMHSA Gift Fund
75X8514 (no year) Office of the Secretary Gift Fund

Note 31. Statement of Social Insurance Disclosures

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions.

Actuarial present values are computed for the year shown and over the 75-year projection period beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future cost are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, or those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or

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both. Since the projection period consists of 75 years, it covers virtually all of the current participants' working and retirement years.

The SOSI sets forth, for each of these three groups, the projected actuarial present value of all future HI (Part A) and SMI (Parts B and D) expenditures and all future non-interest income for the next 75 years. The SOSI also presents the net present value of future net cash flows for each fund, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of a large actuarial deficit for the HI trust fund indicates that, under these assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.

In addition to the actuarial present value of estimated future excess of income (excluding interest) over cost, shown in the basic statement, for the open group of participants, it is possible to make an analogous calculation for the "closed group" of participants. The "closed group" of participants consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained age 15 through 64. In order to calculate the actuarial net present value of the excess of future income over future costs for the closed group, one could subtract the actuarial present value of estimated future costs for or on behalf of current participants from the actuarial present value of future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in the treatment of medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors, and such changes are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under current law. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

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The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included on the table below. The assumptions underlying the SOSI actuarial projections, and the projections themselves, are drawn from the Social Security and Medicare Trustees Reports for 2006. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions.

Medicare and Economic and Demographic Assumptions

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2006	2.03	1,075,000	848.9	1.2	4.1	2.9	3.4	4.7	8.6	—	1.4
2010	2.03	1,000,000	829.2	1.5	4.3	2.8	2.6	4.7	4.1	7.9	3.1
2020	2.01	950,000	767.1	0.9	3.7	2.8	2.1	4.4	4.5	6.6	2.9
2030	2.00	900,000	707.4	1.1	3.9	2.8	1.9	5.8	5.6	5.3	2.9
2040	2.00	900,000	654.5	1.1	3.9	2.8	2.0	5.8	5.3	5.2	2.9
2050	2.00	900,000	608.0	1.1	3.9	2.8	2.0	4.9	4.8	4.9	2.9
2060	2.00	900,000	566.9	1.1	3.9	2.8	1.9	4.6	4.7	4.6	2.9
2070	2.00	900,000	530.3	1.1	3.9	2.8	2.0	4.5	4.4	4.4	2.9
2080	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that populations were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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Part D Projections
In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is new (having begun operations in January 2006), and very little actual program data is available. The actual 2006 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, has been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Note 32. SMI Part B Physician Update Factor
The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 37 percent over the next 9 years. Reductions of this magnitude are not feasible and such reductions are very unlikely to occur fully in practice. For example, Congress has overridden scheduled negative updates for each of the last 4 years. However, since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. Consequently, the projected actuarial present values of Part B expenditure shown in the accompanying SOSI is likely understated.

The potential magnitude of the understatement of Part B expenditures due to the physician payment mechanism, can be illustrated using two hypothetical examples of changes to current law. These examples were developed by management for illustrative purposes only; the calculations have not been audited; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation on physician payments under Medicare and of the broad range of uncertainty associated with such impacts. Under current law, the projected 75-year present value of future Part B expenditures is $17.6 trillion. If Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.3 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $24.4 trillion.

The extent to which actual future Part B costs could exceed the projected current-law amounts due to physician payments, depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example, in the Deficit Reduction Act). As noted, these examples only reflect hypothetical changes to physician payments. It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these would likely be designed to reduce costs in an effort to make the program

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more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

Note 33. Stewardship PP&E

The HHS assets regardless of their status are used to support the day-to-day operations of providing healthcare to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist. For stewardship reporting purposes, the HHS identifies two types of assets: Heritage and Indian Trust Lands.

Heritage assets are PP&E that are historically, architecturally, or culturally significant. This category includes:

- Buildings Located in a Historic District or Included with a National Landmark
- Buildings Determined to be Historic in Nature
- Building Submitted to Tribal Historic Preservation /State Historic Preservation Office for Determination
- Buildings Having Some Potential Historic Eligibility Criteria

Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than that acquired for or used in connection with general (capitalized) PP&E), but have always been held by the U. S. Government as separate and distinct, because of the Government's long-term trust responsibility. The U. S. Government holds Indian land in trust upon which the Indian Health Service has built health care facilities. All Trust lands, when no longer needed by IHS in connection with its general use PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs, for continuing trust responsibilities and oversight.

Currently, HHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. Indian Trust land balances are removed from the IHS FY 2006 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

The Required Supplementary Information (RSI) provides additional information for Stewardship PP&E.

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Required Supplementary Stewardship Information

U.S. Department of Health and Human Services
Investment in Human Capital
For the Year Ended September 30, 2006
(In Millions)

Responsibility Segment Program	2006	2005	2004	2003	2002
ACF					
Administration on Developmental Disabilities	$ 7	$ 8	$ 9	$ 10	$ 6
NIH					
Research Training and Career Development	1,747	1,699	1,696	1,405	1,248
Totals	**$1,754**	**$1,707**	**$1,705**	**$1,415**	**$1,254**

"Investments in Human Capital" are expenses incurred by Federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Two operating divisions of the Department conduct education and training programs under this category: Administration for Children and Families, and the National Institutes of Health.

Administration for Children and Families (ACF)

ACF is able to estimate investment in human capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 40 grants have been awarded for Projects of National Significance (PNS). PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. Monies also support the development of national and state policy to serve this community. Grants awarded total $7 million in FY 2006.

National Institutes of Health (NIH)

The NIH Research Training and Career Development Program address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the Nation's health. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

U.S. Department of Health and Human Services
Investment in Research and Development
For the Year Ended September 30, 2006
(In Millions)

Responsibility Segments	2006				2005 Total	2004 Total	2003 Total	2002 Total	Grand Total
	Basic	Applied	Develop-Mental	Total					
ACF	$ -	$39	$ -	$39	$21	$21	$24	$29	$134
AHRQ	175	-	-	175	162	170	163	150	820
CDC	-	478	-	478	521	549	557	533	2,638
FDA *	33	-	4	37	31	28	31	29	156
HRSA	-	28	-	28	23	16	16	16	99
NIH	15,468	10,312	-	25,780	25,320	23,700	21,359	19,058	115,217
Totals	**$15,676**	**$10,857**	**$4**	**$26,537**	**$26,078**	**$24,484**	**$22,150**	**$19,815**	**$119,064**

*FDA restated its FY 2003 amount by $1 million as compared to their FY 2003 statements.

The many research and development programs in HHS include the following:

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision-making processes.

The OPD Program was established by the Orphan Drug Act (Public Law 97-414, as amended) with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device, or medical food that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the United States.)

The FDA Research Grants Program is a grants program which is listed as No. 93-103 under the Catalog of Federal Domestic Assistance, whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

Infectious Diseases, Occupational Safety and Health, Health Promotion, and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested.

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational and population-based

U.S. Department of Health and Human Services
Investment in Research and Development
For the Year Ended September 30, 2006
(In Millions)

research, behavioral research, and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches; and health services research. The NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

The ACF, HRSA and AHRQ oversee research and development programs that contribute to a better understanding of how to improve the economic and social well being of families and children so that they lead more healthy and productive lives.

Required Supplementary Information

U.S. Department of Health and Human Services
Combining Statement of Budgetary Resources
For the Year Ended September 30, 2006
(In Millions)

	CMS				
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Totals
Budgetary Resources:					
1. Unobligated balance, brought forward, October 1	$ -	$ -	$ 317	$ 17,890	$ 18,207
2. Recoveries of prior year unpaid obligations	14	20	12,196	2,251	14,481
3. Budget Authority	211,227	176,663	215,736	356,848	960,474
4. Nonexpenditure transfers, net, anticipated & actual	44	84	(1,895)	1,826	59
5. Temporarily not available pursuant to Public Law	(22,091)	(12,434)	-	(26)	(34,551)
6. Permanently not available (-)	-	(5)	-	(5,842)	(5,847)
7. Total Budgetary Resources	$ 189,194	$ 164,328	$ 226,354	$ 372,947	$ 952,823
Status of Budgetary Resources:					
8. Obligations Incurred	$ 189,194	$ 164,328	$ 199,868	$ 331,513	$ 884,903
9. Unobligated Balances - Available	-	-	25,844	34,410	60,254
10. Unobligated Balances - Not Available	-	-	642	7,024	7,666
11. Total Status of Budgetary Resources	$ 189,194	$ 164,328	$ 226,354	$ 372,947	$952,823
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net	$ 17,733	$ 17,580	$ 10,635	$ 72,120	$ 118,068
13. Obligations incurred, Net (+/-)	189,194	164,328	199,868	331,513	884,903
14. Less: Gross outlays	185,872	162,393	179,124	324,670	852,059
15. Obligated balance transferred, Net	-	-	-	-	-
16. Less: Recoveries of prior year unpaid obligations	14	20	12,196	2,251	14,481
17. Change in uncollected customer payments	-	-	-	1,739	1,739
18. Obligated balance, Net, end of period	21,041	19,495	19,183	75,118	134,837
19. Net Outlays	$ 169,992	$ (47,408)	$ 178,860	$ 313,230	$ 614,674

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 52,789	$ 52,789	$ 45,858
AoA	1,383	1,383	1,378
AHRQ	371	371	(3)
CDC	8,987	8,987	6,458
CMS	250,292	250,292	213,748
FDA	2,115	2,115	1,528
HRSA	7,175	7,175	6,575
IHS	4,840	4,840	3,494
NIH	31,929	31,929	27,835
OS	8,259	8,259	2,786
PSC	1,161	1,161	334
SAMHSA	3,646	3,646	3,239
	$ 372,947	$ 372,947	$ 313,230

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the eleven HHS Agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid.

U.S. Department of Health and Human Services
Deferred Maintenance
For the Years Ended September 30, 2006 and 2005
(In Millions)

Deferred maintenance is maintenance that was not performed when it should have been, was scheduled and not performed, or was delayed for a future period. Maintenance is the act of keeping fixed assets in acceptable condition, to include preventive maintenance, normal repairs, replacement of parts and structural components and other similar activities needed to preserve the asset to assure acceptable services and achieves its expected life. Maintenance does not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance expenses are recognized as incurred. Every year, the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and the Indian Health Service all conduct a Facilities Condition Assessment to evaluate the condition of all classes of property. The deferred maintenance requirement is updated annually as well:

Category of Asset	Condition	Cost to Return to Acceptable Condition	
		2006	2005
General PP&E			
Buildings	1 - 4	$ 925	$ 961
Equipment	4	8	8
Other Structures	1 - 4	22	25
Total		$ 955	$ 994

Asset Condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A “fair” or 3 rating is considered acceptable operating condition. Although PP&E categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of “fair” or above may still report necessary costs to return them to acceptable condition.

U.S. Department of Health and Human Services
Stewardship Property, Plant, and Equipment
For the Year Ended September 30, 2006

The HHS has two types of property, plant, and equipment (PP&E) for stewardship reporting: Heritage Assets, and Indian Trust Lands.

Heritage Assets are PP&E of historical, natural, cultural, educational, or artistic significance. Heritage Assets are generally expected to be preserved indefinitely. This category includes buildings on the National Historic Register, cemetery sites, etc.

Indian Trust Lands are those lands that do not meet the definition of Stewardship Land, but are held by the U. S. Government as separate and distinct, because of the Federal Government's long-term trust responsibility. The U. S. Government holds Indian land in trust upon which the Indian Health Service has built health care facilities. All Indian Trust lands, when no longer needed by IHS in connection with its General PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs for continuing trust responsibility and oversight. The IHS separately reports Indian Trust land parcels by site and installation numbers, and Indian Trust Lands from General PP&E situated thereon.

IHS Stewardship Classes and Trust Land

Asset Descriptions	Number of Sites	Total Square Footage	Federal Hectares	Total Hectares
Heritage Assets	1	2,295		
Indian Trust Lands	79	N/A	424.9 (1,049 acres)	424.9 (1,049acres)

Distribution of Stewardship Assets by Type and Area

	Heritage Assets		**Indian Trust Lands**	
	Number of Sites	Square Footage	Number Of Sites	Total Hectares
Aberdeen			9	75
Albuquerque			4	4
Bemidji			2	9
Billings			7	48
Navajo			35	255
Oklahoma City			1	2
Phoenix	1	2,295	13	19
Portland			3	1
Tucson			5	12
Total IHS	1	2,295	79	425

U.S. Department of Health and Human Services
Social Insurance
For the Year Ended September 30, 2006

Medicare, the largest health insurance program in the country, has helped fund medical care for the Nation's aged and disabled for slightly over four decades. The recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a new prescription drug benefit. A separate Part D account within the Supplementary Medical Insurance (SMI) trust fund handles the transactions for this new coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI) (Part A) trust fund and the SMI (Parts B and D) trust fund is included in Note 1 of this Financial Report.

The required supplementary information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

The RSI material is generally drawn from the *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Report may be obtained from CMS Office of the Actuary (410-786-6386) or can be downloaded from www.cms.hhs.gov/publications/trusteesreport/default.asp.

Actuarial Projections

Cashflow in Nominal Dollars

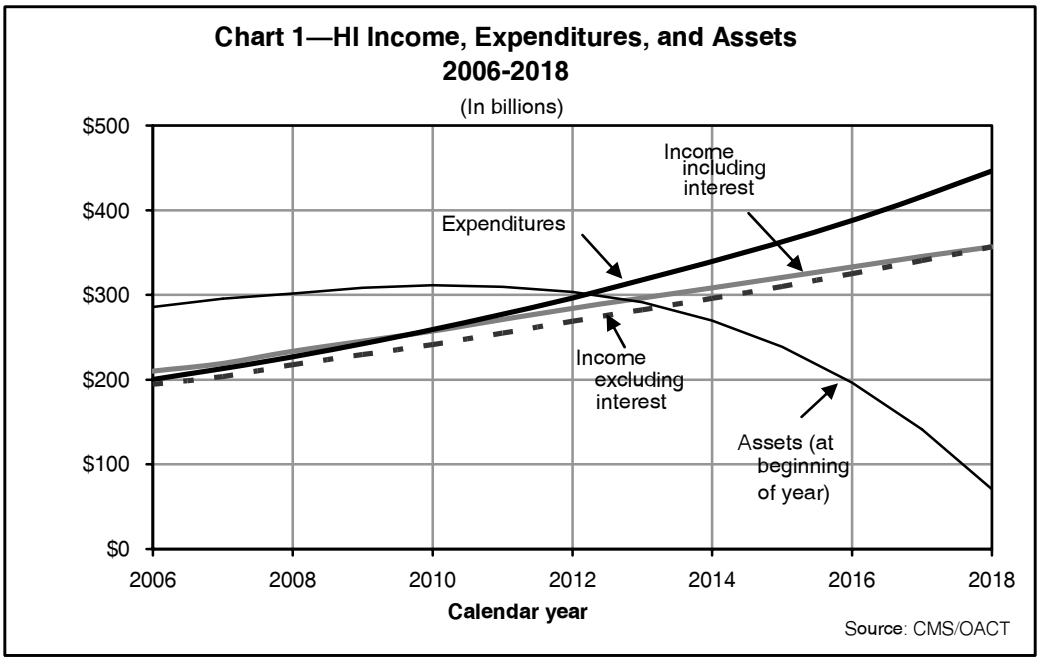
Using nominal dollars[2] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

[2] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2018. Estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2006 through 2018, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the HI trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate during the period as either HI taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce through 2018. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

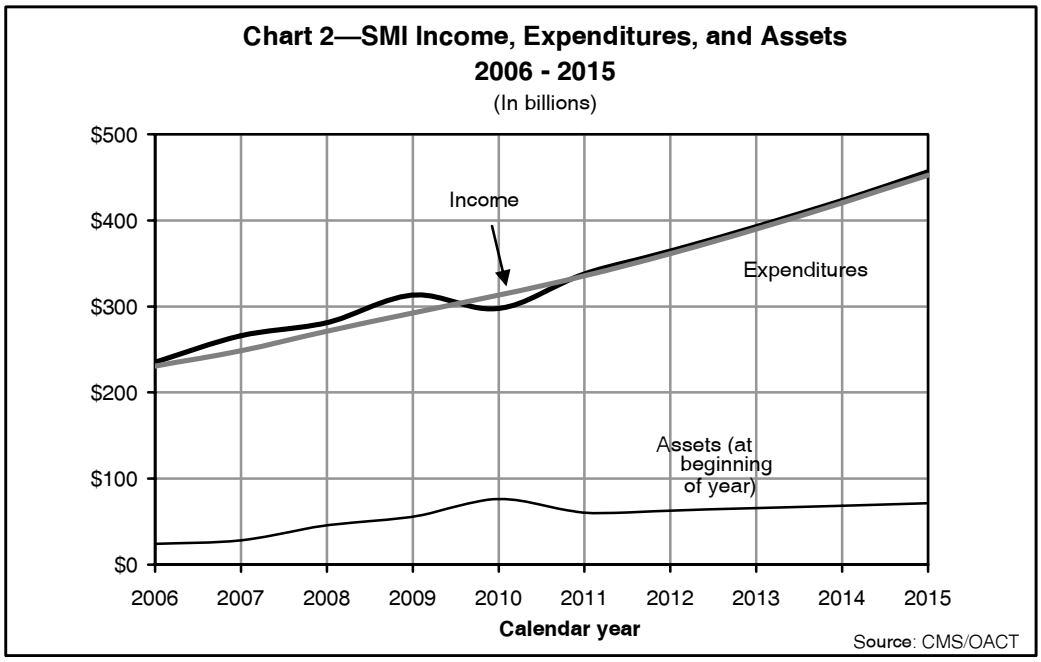


As chart 1 shows, HI expenditures exceeded income excluding interest in 2006 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the HI trust fund would start redeeming its assets; by the end of 2018, the assets would be depleted—2 years earlier than estimated in the 2005 Trustees Report. For the third year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

The projected year of depletion of the HI trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions, the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2006 through 2015, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2015, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.[3] Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 2015.[4]



Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the states to the Part D account, and interest earned on the U.S. Treasury securities held by the SMI trust fund. Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the

[3] The Part D account also receives special payments from the states, representing a portion of their forgone Medicaid expenditures attributable to the new Medicare drug benefit.

[4] Delivery of benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2009. These amounts are excluded from the premium income and general revenue income for 2010.

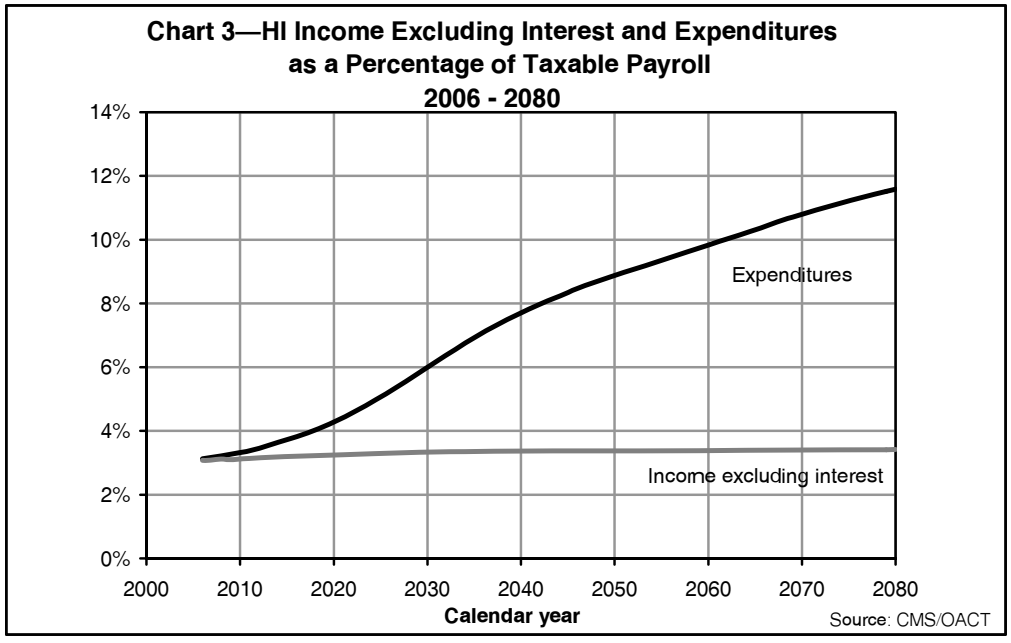
two depictions of income is not visible graphically since interest is not a significant source of income.[5] Expenditures include benefit payments as well as administrative expenses.

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because it is difficult to meaningfully compare dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll").

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to this report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. For this year's report, the Board of Trustees has adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.



Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent.

[5] Interest income is generally about 1 percent of total SMI income.

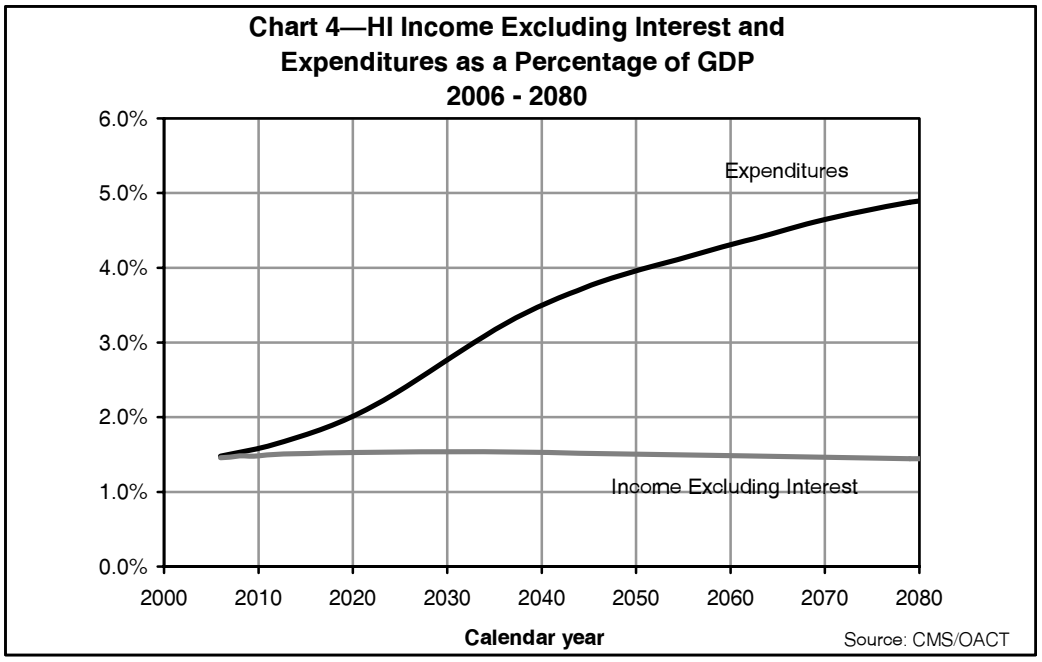
Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.

HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2005, the expenditures were $182.9 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



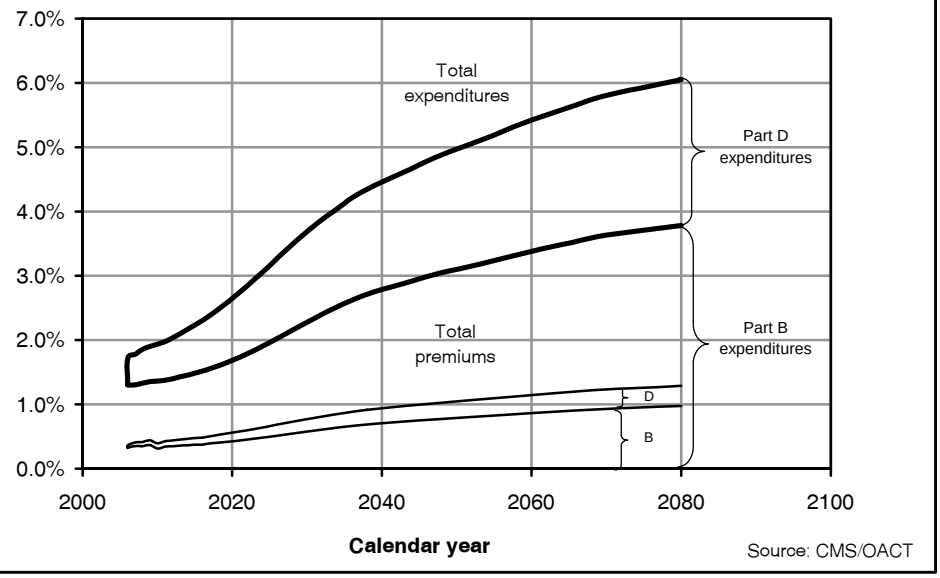
SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary was refined in this year's report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures would grow from about 1.3 percent of GDP in 2005, to 1.7 percent of GDP in 2006 with the commencement of the full prescription drug coverage. Then, within 25 years, they would grow to almost 4 percent of GDP and to more than 6 percent by the end of the projection period.

Chart 5—SMI Expenditures and Premiums as a Percentage of GDP 2006 - 2080



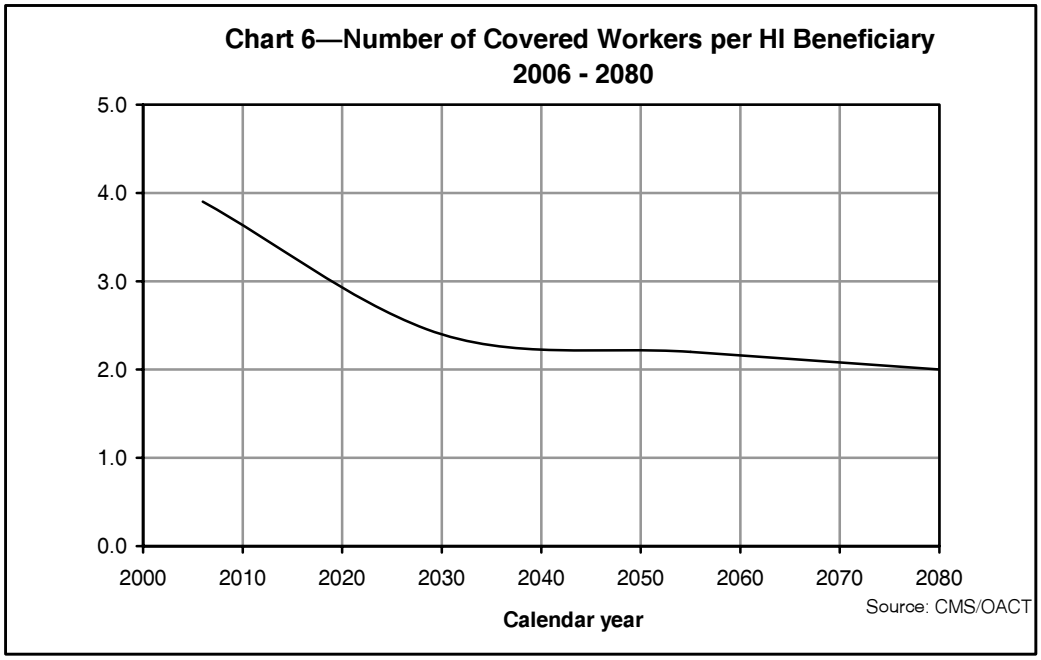
Source: CMS/OACT

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the states' forgone Medicaid expenditures attributable to the new Medicare drug benefit. The percentage is 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2005, every beneficiary had about 3.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2080.



Sensitivity Analysis

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or more information, estimates made in prior years have sometimes changed substantially. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values

and net cashflows.[6] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, consumer price index (CPI), and real-interest rate.[7]

For this analysis, the intermediate economic and demographic assumptions in the *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2006 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2080 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2060, when the present values begin to increase (or become less negative). This occurs as a result of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required today to cover this deficit begins to decrease at the end of the 75-year period.

Health Care Cost Factors

Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	-$4,459	-$11,290	-$22,387

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $6,831 billion. On the other hand, if the

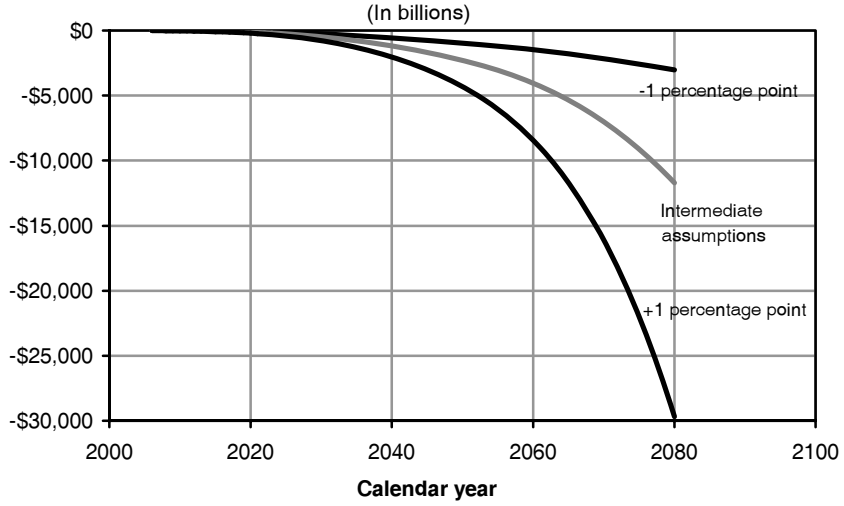
[6] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

[7] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $11,097 billion.

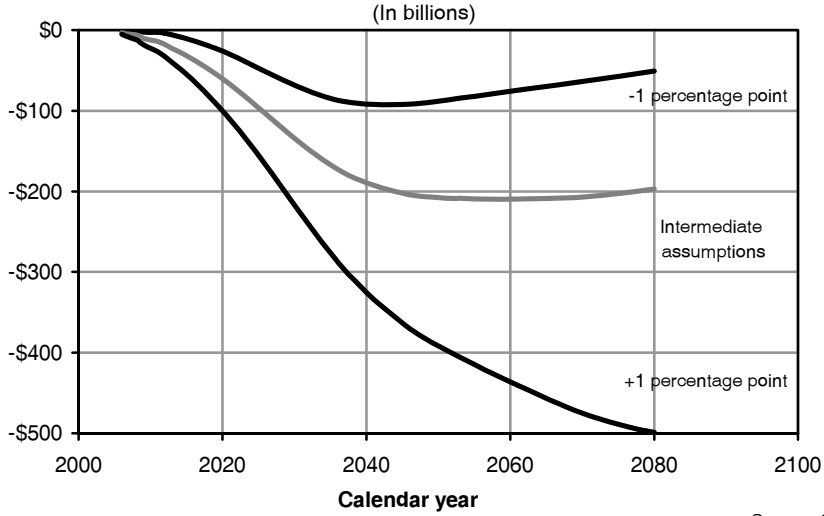
Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 1.

Chart 7—HI Net Cashflow with Various Health Care Cost Factor Assumptions 2006 - 2080



Source: CMS/OACT

Chart 7A—Present Value of HI Net Cashflow with Various Health Care Cost Factors 2006 - 2080



Source: CMS/OACT

This assumption has a dramatic impact on projected HI cashflow. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect

costs without affecting tax income. As charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Fertility Rate

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

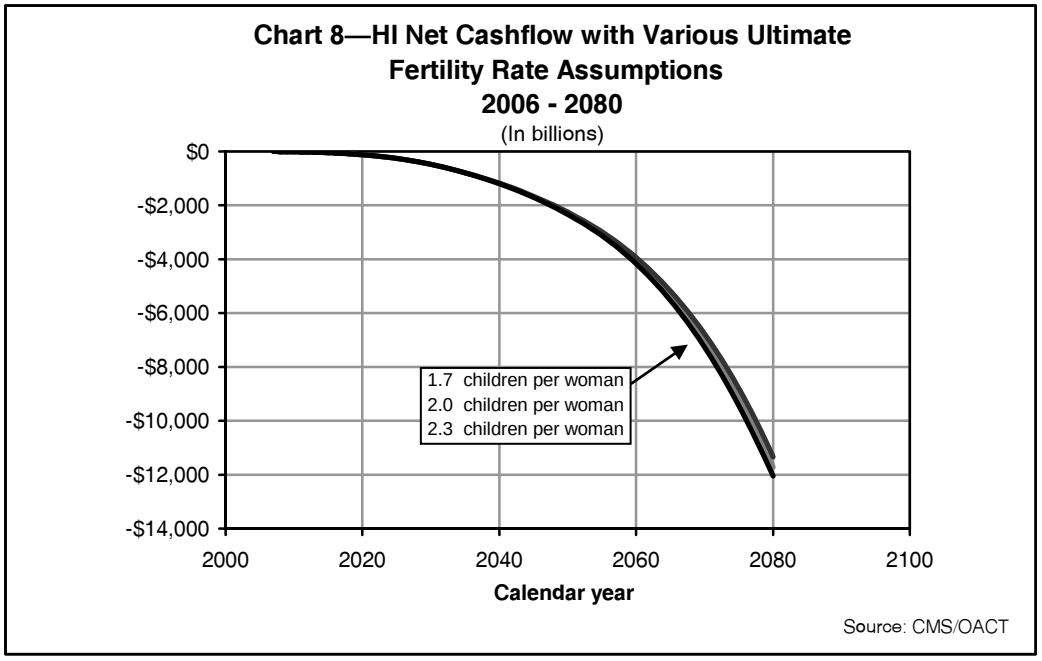
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

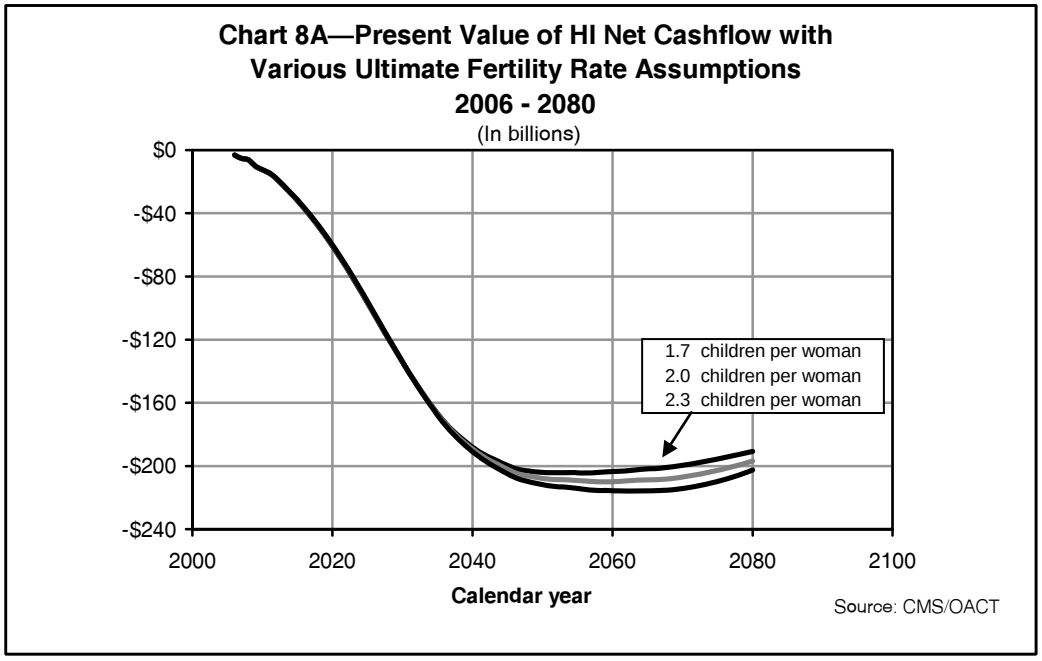
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	-$11,510	-$11,290	-$11,078

[1]The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As table 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected deficit decreases by approximately $220 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 2.





As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in table 2.

Net Immigration

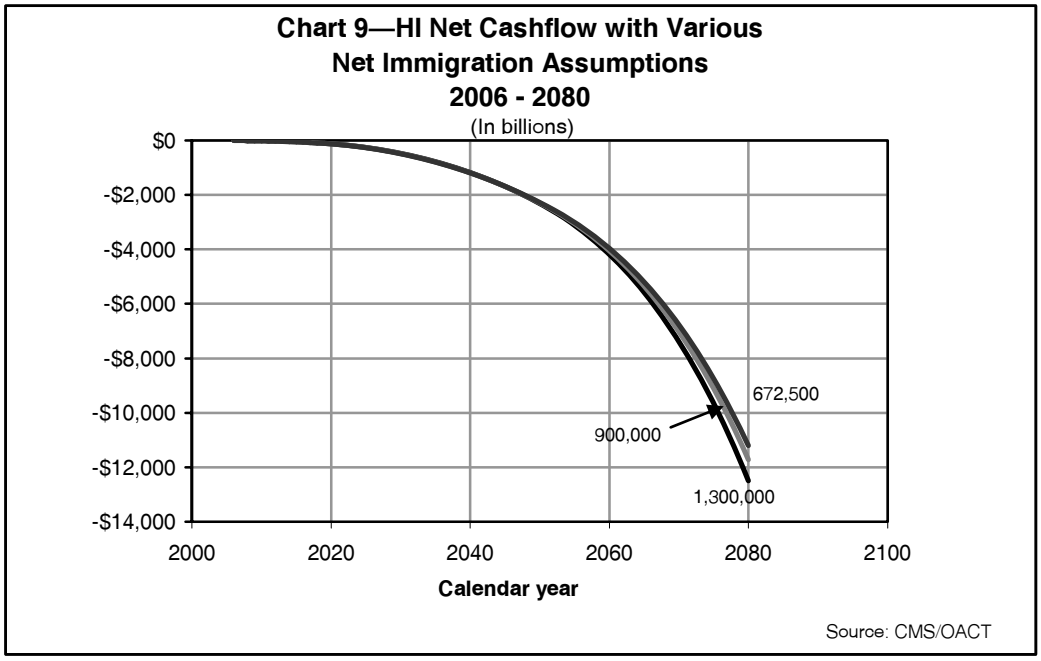
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

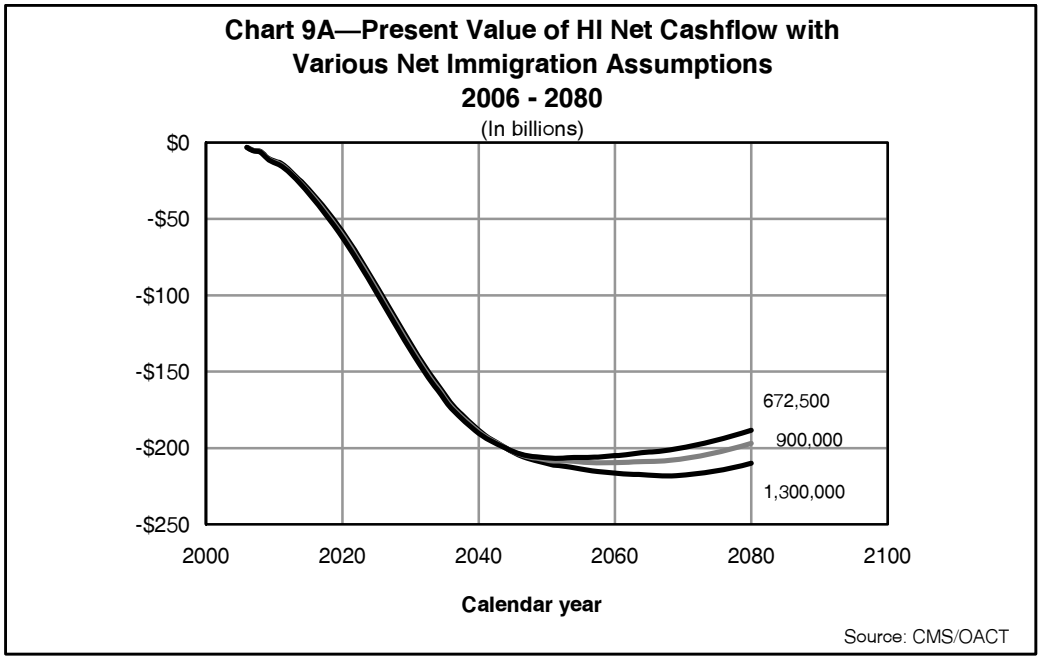
Table 3—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures (in billions)	-$11,157	-$11,290	-$11,498

As shown in table 3, if the ultimate net immigration assumption is 672,500 persons, the deficit decreases by $133 billion. Conversely, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $208 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 3.





As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

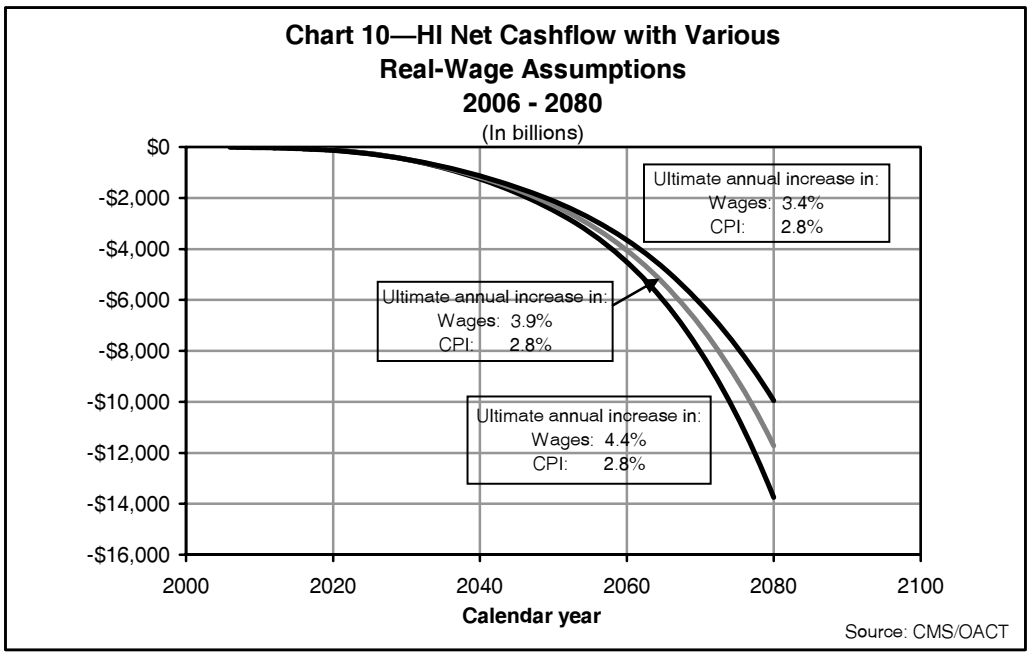
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[8] assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

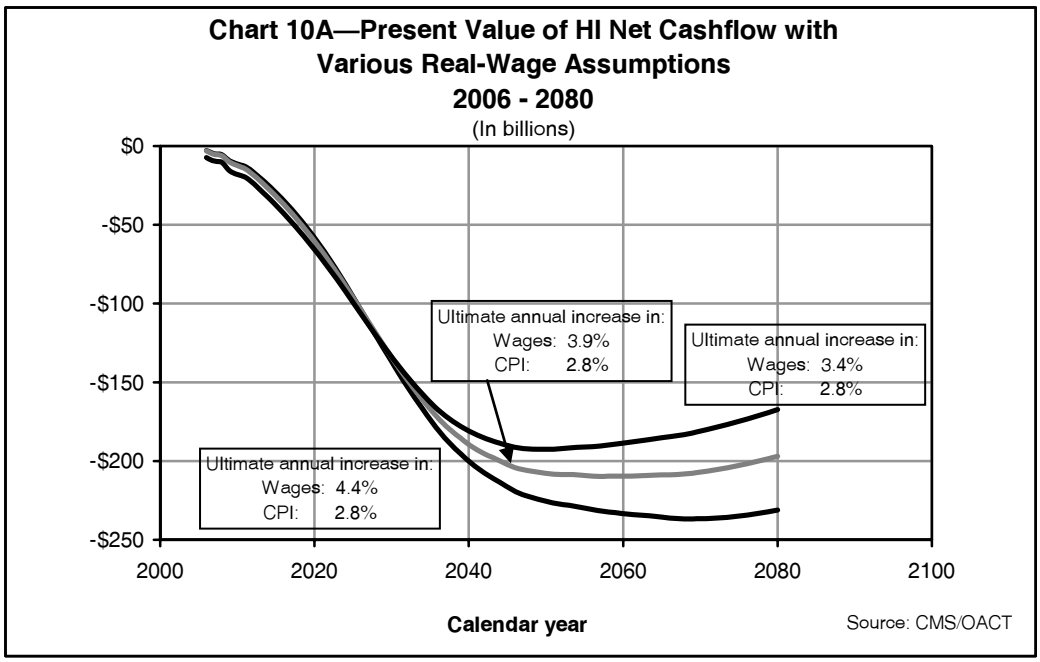
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-$10,521	-$11,290	-$12,286

As indicated in table 4, for a half-point increase in the ultimate real-wage differential assumption, the deficit increases by approximately $880 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 4.



[8] The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.



As charts 10 and 10A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. In early years there is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. However, in later years, benefits are more fully realized and hence outweigh the impact on wages and payroll taxes, producing larger net cashflows under higher real-wage differential assumptions.

Consumer Price Index

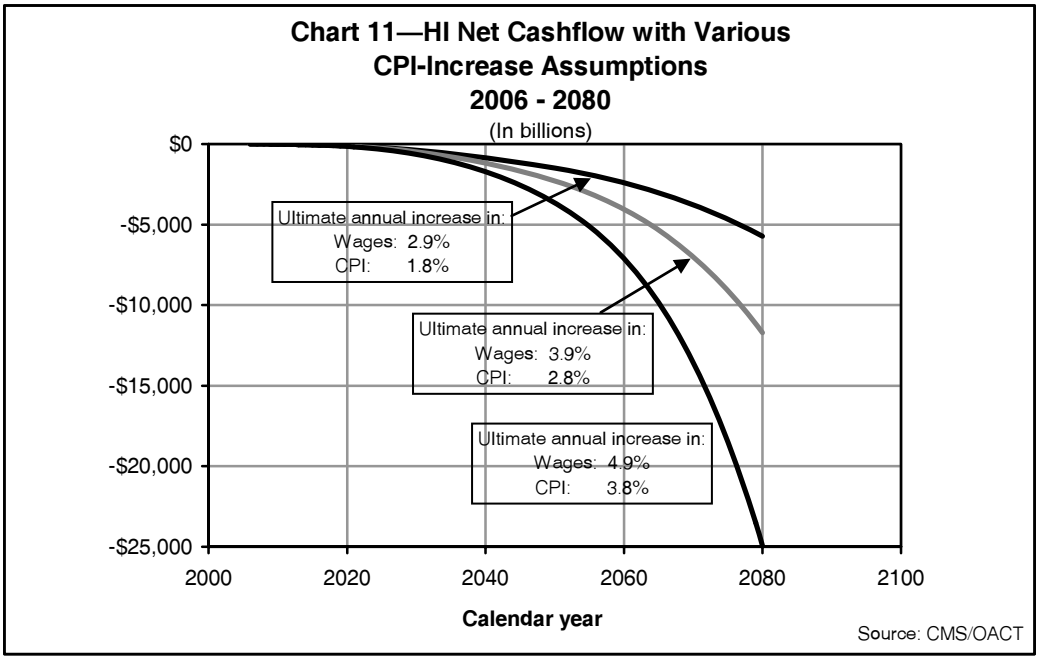
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

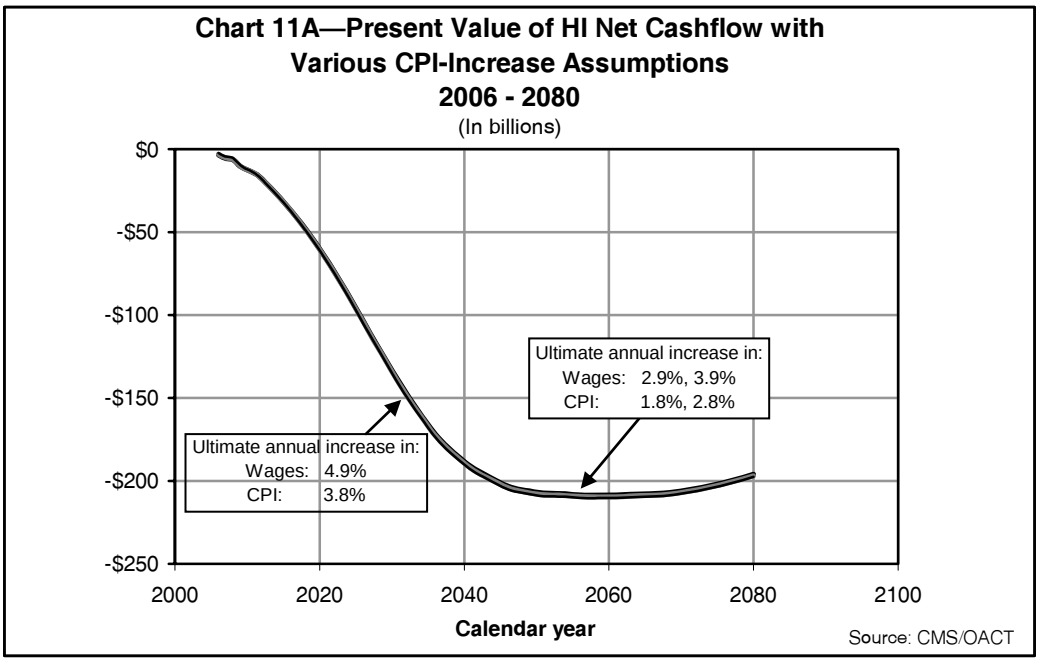
Table 5—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$11,234	-$11,290	-$11,337

Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $56 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by $47 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 5.





As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit "looks bigger" under high-inflation

conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

Real-Interest Rate

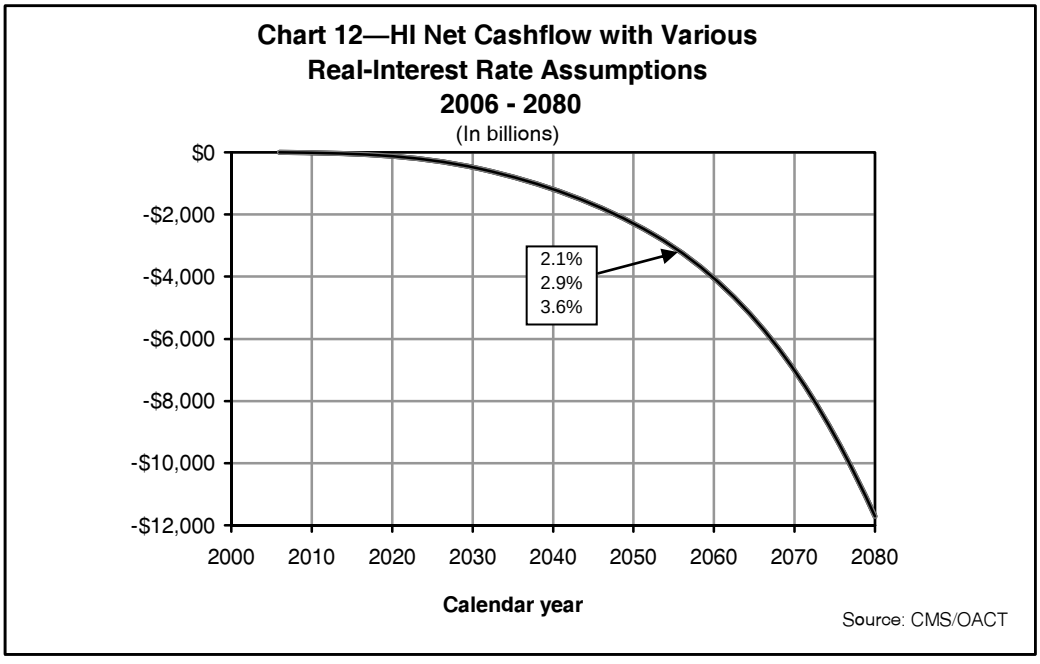
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

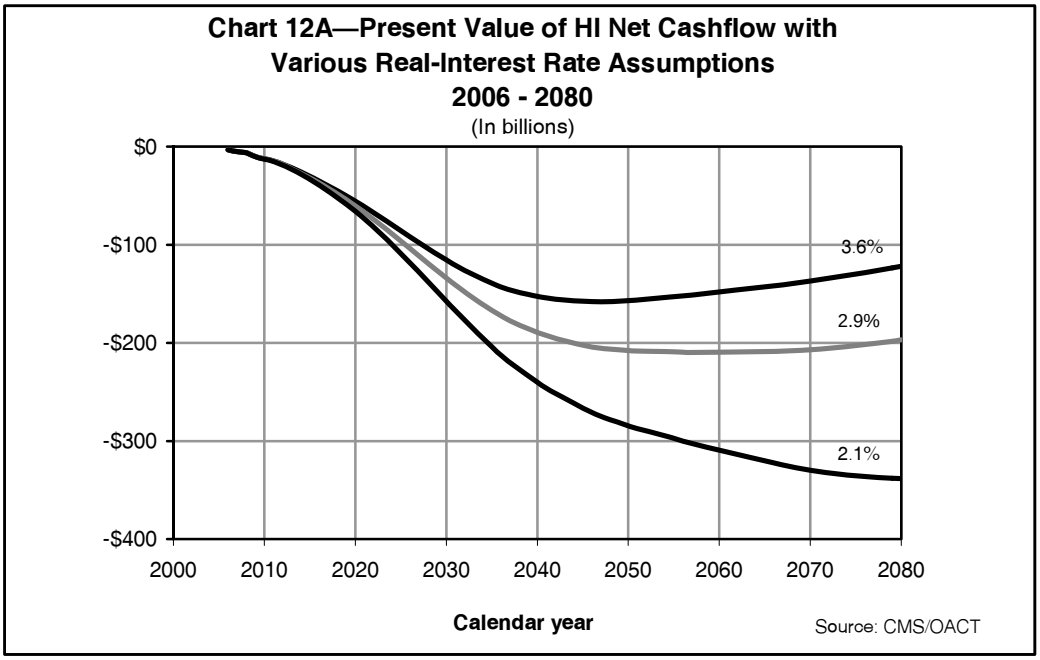
Table 6—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures (in billions)	-$15,847	-$11,290	-$8,464

As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $490 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 6.





As shown in charts 12 and 12A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund, because under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2018. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2018, 2 years earlier than in last year's report, due primarily to slightly higher costs in 2005 than previously estimated and some upward revisions in the short-range assumptions about utilization of HI services. Income from all sources is projected to exceed expenditures for only the next 4 years and to fall short by steadily increasing amounts in 2010 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

The HI trust fund is substantially out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require very substantial increases in revenues and/or reductions in benefits. These changes are needed, in part, as a result of the impending retirement of the baby boom generation.

SMI

Under current law, the SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. Since there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2006 is estimated to be sufficient to cover expenditures for that year but not to meaningfully increase assets to a more adequate contingency reserve. Part B assets minus liabilities are now at their lowest level, relative to annual outlays, in nearly 30 years. The Part B premium and corresponding general revenue transfers will need to be increased significantly for 2007 to match projected costs and to restore Part B assets to a more adequate reserve level.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. The projected Part D costs shown in this section are significantly lower than previously estimated, reflecting the latest data on drug cost trends generally and Part D bid and enrollment levels.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the SMI trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In their 2006 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to take "prompt, effective, and decisive action… to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."