NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS FOR THE YEARS ENDED SEPTEMBER 30, 2008 AND 2007

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), was officially established 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. The HEW officially became HHS on May 4, 1980. The HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Organization and Structure of HHS

The HHS comprises the Office of the Secretary and 11 Operating Divisions (OPDIVs) with diverse missions and programs. The Office of the Secretary and the OPDIV are each responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. Although organizationally located within the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other Federal agencies and HHS OPDIVs. 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. Managers of the responsibility segments report directly to the entity's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments.

The 12 responsibility segments are:

1. Administration for Children & Families (ACF)
2. Administration on Aging (AoA)
3. Agency for Healthcare Research and Quality (AHRQ)
4. Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR)
5. Centers for Medicare & Medicaid Services (CMS)
6. Food and Drug Administration (FDA)
7. Health Resources and Services Administration (HRSA)
8. Indian Health Service (IHS)
9. National Institutes of Health (NIH)
10. Office of the Secretary – excluding Program Support Center (OS)
11. Program Support Center (PSC)
12. Substance Abuse & Mental Health Services Administration (SAMHSA)

The HHS partners with other governmental agencies to accomplish its mission. One such partnership is with the Department of Homeland Security for the Biodefense Countermeasures Fund which will be reported for the first time on the HHS financial statements under the Office of the Secretary responsibility segment.

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. Code 3515(b), the *Chief Financial Officers Act of 1990* (*Public Law 101-576*), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular No. A-136, *Financial Reporting Requirements.* 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 the 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 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 within the HHS have been eliminated in the presentation of the Consolidated Balance Sheet and Statements of Net Cost and Changes in Net Position. The Combined Statement of Budgetary Resources is presented on a combined basis; therefore, transactions and balances within the HHS have not been eliminated from these statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within the 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 the HHS.

Financial Management Systems

Unified Financial Management System (UFMS)

The HHS continues to streamline and integrate its financial management systems through a phased development of the UFMS. The HHS' financial management goals seek to (a) provide decision makers with timely, accurate, and useful financial and program information; and (b) ensure that

HHS resources are used appropriately, efficiently, and effectively. With UFMS, the HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. Beginning in April 2005 with the CDC and FDA, then with most of the PSC's customers (ACF, AoA, AHRQ, HRSA, OS, PSC, and SAMHSA) in October 2006, and concluding with IHS in October 2007, the OPDIVs converted their accounting systems to UFMS.

Health Care Integrated General Ledger Accounting System (HIGLAS)
In Fiscal Year (FY) 2001, the CMS began the HIGLAS project to replace the Medicare contractors' and CMS' accounting systems with a single, unified system. Fourteen Medicare contractors were using HIGLAS as of September 30, 2008.

National Institutes of Health Business Systems (NBS)
The NBS is an integral part of the HHS' UFMS. The NBS project is an enterprise system that replaces the NIH Administrative Database, the Central Accounting System, and the Property Management Information System. This included the general ledger, finance, budget, procurement, supply, travel, and property management legacy systems. The NBS general ledger and travel modules were deployed in FY 2004 and the procurement, supply and property management modules were deployed in FY 2007. In FY 2008, the NIH is stabilizing the existing NBS modules.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with accounting principles generally accepted in the United States 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.

Parent/Child Reporting

Allocation transfers are legal delegations by one department of its authority to obligate budget authority and outlay funds to another department. The HHS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and a receiving (child) entity.

A separate fund account (allocation account) is created in the U.S. Treasury as a subset of the parent fund account for tracking and reporting purposes. All allocation transfers of balances are credited to this account, and subsequent obligations and outlays incurred by the child entity are charged to this allocation account as they execute the delegated activity on behalf of the parent entity. Generally, all financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity from which the underlying legislative authority, appropriations and budget apportionments are derived.

Exceptions to this general rule affecting the HHS are Treasury-managed Trust Funds: Federal Supplementary Medical Insurance (SMI) Trust Fund, the Federal Hospital Insurance (HI) Trust Fund, the Vaccine Injury Compensation Program (VICP) Trust Fund and the Health Care Fraud

and Abuse Control Account, for which the HHS is the child in the allocation transfer but, per OMB guidance, will report all activity relative to these transfers in the HHS financial statements. This fiscal year the HHS received an exception to the Parent/Child reporting requirements of OMB Circular No. A-136 as it pertains to the allocation transfer from the Department of Homeland Security (DHS) to the HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Per this exception, HHS, as the child, has assumed the financial statement reporting responsibilities of this fund.

In addition to these funds, the HHS allocates funds, as the parent, to the Department of Interior, Bureau of Indian Affairs. The HHS receives allocation transfers, as the child, from the Departments of Homeland Security, Justice, State and the Environmental Protection Agency.

Reclassifications

Certain FY 2007 balances have been reclassified to conform to FY 2008 financial statement presentations, the effect of which is immaterial.

Earmarked Funds

Earmarked funds are financed by specifically identified revenues often supplemented by other financing sources, or other specific financing sources, which remain available over time. Earmarked funds must meet the following criteria:

- A statute committing the Federal Government to use specifically identified revenues and other financing sources only for designated activities, benefits or purposes;
- Explicit authority for the earmarked fund to retain revenues and other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
- A requirement to account for and report on the receipt, use, and retention of the revenues and other financing sources that distinguishes the earmarked fund from the Government's general revenues.

The HHS' major earmarked funds are described below:

Medicare Hospital Insurance (HI) Trust Fund – Part A
Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance Trust Fund. Medicare contractors are paid by the 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 administrative costs, are charged to the HI Trust Fund. The HHS payments to Medicare Advantage plans (previously known as Managed Care plans) are also charged to this fund. The financial statements include the HI Trust Fund activities administered by the Department of the Treasury (Treasury). The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance*

Contributions Act (FICA) and Self Employment Contributions Act (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 *Social Security Act* requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages established and maintained by the SSA in accordance with wage information reports. The SSA uses the wage totals reported by employers via the quarterly Internal Revenue Service Form 941, *Employer's Quarterly Federal Tax Return,* as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B
Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end–stage renal disease treatment, 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 Medicare Advantage Plans are also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

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 fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Prescription Drug Benefit – Part D
The Medicare Prescription Drug Benefit – Part D, established by the *Medicare Modernization Act of 2003* (MMA), is available to all Medicare beneficiaries and provides a prescription drug benefit to those who opt into the program (beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage). The Medicare Prescription Drug Benefit—Part D is considered part of the SMI Trust Fund and is reported in the Medicare column of the financial statements where required. 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 coverage to basic Medicare) and Medicare Advantage Prescription Drug 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. Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

Medicare Integrity Program
The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) (*Public Law 104-191)* codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare

Integrity Program, the HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

Revenue and Financing Sources

The HHS 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 HHS. 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 HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally 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).

Exchange Revenue

Exchange revenue is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

The HHS' pricing policy for reimbursable agreements is to recover full cost and to incur no profit or loss. In addition to revenues related to reimbursable agreements, the HHS collects various user fees to offset the cost of its programs. Certain fees charged by the HHS are based on an amount set by law or regulation and may not represent full cost.

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

Non-Exchange Revenue

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

Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and *Self-Employment Contributions Act* (SECA) is considered non-exchange revenue. See Medicare Hospital Insurance Trust Fund – Part A for descriptions of this revenue.

Imputed Financing Sources

In certain instances, HHS' operating costs 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 the HHS are paid from the Judgment Fund maintained by the Treasury. When costs that are identifiable to the HHS and directly attributable to the Department's operations are paid by other agencies, the Department recognizes these amounts as imputed costs on the Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

Intragovernmental Transactions and Relationships

Intragovernmental transactions are transactions between Federal entities, meaning both the buyer and seller are Federal entities. Transactions with the public are transactions in which the buyer or seller of the goods or services is a non-Federal entity and the other party is a Federal entity.

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.

In the course of its operations, the HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are with the SSA and 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. Similarly, Medicare Part D is primarily financed by the General Fund of the Treasury.

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 that management is legally obligated to use to meet entity obligations.

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

Fund Balance with Treasury (FBWT)

The HHS maintains its available funds with the Treasury except for the Medicare Benefit accounts maintained at commercial banks. The FBWT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury, and the HHS FBWT accounts are reconciled with those of Treasury on a regular basis.

Investments, Net

The HHS invests entity Trust Fund balances in excess of current needs in U.S. Securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Investments consist of Treasury securities carried at face value (including the CMS' par value securities that represent the majority of the HHS earmarked funds) and other securities carried at amortized cost. Section 1817 for the HI Trust Fund and Section 1841 for the SMI Trust Fund of the *Social Security Act* require that Trust Funds 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.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the Government finances the expenditures by (a) raising taxes, (b) raising the Federal match of SMI premiums or other receipts, (c) borrowing from the public or repaying less debt, or (d) curtailing other expenditures. This is the same way that the Government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds include Marketable, Non-Marketable (Par Value), and Non-Marketable Market-Based (MK) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and is adjusted to include an accrual for interest earned from July 1 to September 30.

The HHS also invests in One Day Certificates, Market-Based Notes and Market-Based Bills. The MK securities purchased by the HHS mirror marketable securities terms that are not traded on any securities exchange; these include Non-Marketable, MK, and One Day Certificates. The MKs are purchased by the HRSA's Vaccine Injury Compensation Program Trust Fund. Discounts on Market-Based Bills are amortized on a straight-line basis, and discounts and premiums on Market-Based Notes are amortized on an effective interest basis.

Marketable securities purchased by the NIH Gift Funds are recorded at cost based on market terms and are 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 – no provision is made for unrealized gains or losses on these securities since it is the HHS' intent to hold investments to maturity.

Accounts Receivable, Net

Accounts Receivable, Net consist of the amounts owed to the HHS by other Federal agencies and the public as the result of the provision of goods and services less an allowance for uncollectible accounts. 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 fully collectible. Accounts receivable also include interest due to the HHS that is directly attributable to delinquent accounts receivable.

Accounts receivable from the public are primarily composed of provider and beneficiary overpayments, Medicare Prescription Drug overpayments, Medicare premiums, and Medicaid audit disallowances.

Accounts Receivable are presented net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare receivables, the HHS calculates the allowance for uncollectible accounts 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 preceding 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.

Direct Loans and Loan Guarantee Receivables and Liabilities

Direct Loans

The Health Care Infrastructure Improvement Program (enacted into law as part of the *Medicare Modernization Act of 2003)* 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. Such designation by the State legislature must have occurred prior to December 8, 2003, to qualify for payment of capital costs for eligible projects. The 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

The 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 these programs. Loans receivable also include interest due to the HHS on the defaulted loans. The liabilities for loan guarantees are valued at the present value of the cash outflows from HHS less the present value of related inflows. Due to the immateriality of these Direct Loans and Loan Guarantees, the related receivables and liabilities are reported in Other Assets/Other Liabilities.

Advances to Grantees and Accrued Grant Liability

The HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs to carry out HHS programs. Advance payments are recorded as "Advances to Grantees"

and are liquidated upon grantees' reporting expenditures on the quarterly SF-272, *Federal Cash Transaction Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the "Advances to Grantees" account to a negative balance. An "Accrued Grant Liability" occurs when the accrued grant expenses exceed the outstanding advances to grantees.

The 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" 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. Therefore, they are not 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 balances are reduced. At year-end the OPDIVs report both actual payments made through the fourth quarter and an unreported grant expenditure 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.

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 weighted average valuation method for the PSC inventories and using the moving average valuation method for the NIH inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. The HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC), and Avian Influenza. All stockpiles are valued at historical cost using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and Avian Influenza.

General Property, Plant and Equipment (PP&E), Net

The General 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, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, and is shown net of accumulated depreciation.

The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception; or acquired through a donation is the estimated fair market value when acquired. The cost of PP&E transferred from other Federal entities is the transferring entity's net book value. 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.

The 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. The estimated useful life for internal use software is three to ten years for amortization purposes. HHS begins amortization when the internal use software is placed in use. Capitalized costs include all direct and indirect costs.

The HHS' capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the threshold for revolving funds is $500 thousand. 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.

Stewardship Property, Plant & Equipment

Stewardship PP&E consists of stewardship land whose physical properties resemble those of General PP&E that are traditionally capitalized in financial statements. Based on SFFAS No. 29, *Heritage Assets and Stewardship Land*, and due to the difficulty in valuing these assets, the HHS does not report a related amount on the balance sheet.

The HHS' stewardship assets support the day-to-day operations of providing health care to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist.

Indian Trust lands do not meet the definition of Stewardship land (i.e., land other than that acquired for or used in connection with capitalized general PP&E), but have always been held by the U.S. Government as separate and distinct because of its long-term trust responsibility. The Indian Health Service (IHS) has built health care facilities on these Trust lands. Trust lands, when no longer needed by the 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.

The HHS asset accountability reports differentiate Indian Trust land parcels from general PP&E situated thereon. The Required Supplementary Information (RSI) provides additional information for Stewardship PP&E.

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 the 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 HI 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: (a) new budget authority, (b) spending authority from offsetting collections, (c) recoveries of expired budget authority, (d) unobligated balances of budgetary resources at the beginning of the year, and (e) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation 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. Also included in this category is the actuarial FECA liability determined by DOL but not yet billed.

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 consists of salaries, wages, leave and benefits earned by employees but not disbursed at the end of the reporting period. Liability for annual and other vested compensatory leave is accrued as 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 it 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. Intragovernmental Accrued Payroll and Benefits consists primarily of the HHS FECA liability.

Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare and Medicaid owed to the public for medical services incurred but not reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in the HHS.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary 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 claims that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

Medicare benefits payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers but for which HHS has either not yet received or processed claims, and for liabilities for physician, hospital, and other medical cost disputes. The HHS develops estimates for medical costs incurred but not reported using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. The HHS estimates liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, HHS reexamines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid

The Medicaid estimate represents the net Federal share of expenses incurred by the States but not yet reported to HHS. This estimate is developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Federal Employee and Veterans' Benefits

The HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act, Public Law 78-410*), a defined noncontributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. The HHS records the present value of the Commissioned Corps pension and 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). The FECA provides income and medical cost protection to (a) Federal employees injured on the job or who sustained a work-related occupational disease and (b) 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: (a) actual claims paid by the DOL but not yet disbursed, and (b) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs.

Most HHS employees participate in 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 contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. FERS offers a Thrift Savings Plan 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 and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to Federal employees. Therefore, the HHS does not recognize any liability on its Consolidated Balance Sheet for pensions, other retirement benefits, and other post-employment benefits of its Federal employees with the exception of the PHS Commissioned Corps. The 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.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the HHS. 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. 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.

The HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. 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 contingent 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.

Statement of Social Insurance (SOSI)

The 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 Health Care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheet, Statements of Net Cost, and Changes in Net Position, or Combined Statement of Budgetary Resources.

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 the law in effect March 25, 2008. In addition, the estimates depend on many economic, demographic, and Health Care-specific assumptions, including changes in per beneficiary health care cost, wages, the gross domestic product (GDP), 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.

The assumptions underlying the SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2008. 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 Additional Information section of the SOSI is presented for additional analysis and is not a required part of the financial statements.

Note 2. Non-Entity Assets

(In Millions)	2008	2007
Intragovernmental:		
Fund Balance with Treasury	$ 27	$ 22
Total Intragovernmental	27	22
Accounts receivable	25	15
Cash and other monetary assets	-	-
Total Non-Entity Assets	52	37
Total Entity Assets	529,219	503,770
Total Assets	$ 529,271	$ 503,807

Note 3. Fund Balance with Treasury

(In Millions)	2008	2007
Fund Balance with Treasury		
Trust Funds	$ 12,710	$ 9,047
Revolving Funds	4,131	5,613
Appropriated Funds	106,246	99,225
Other Funds	1,193	889
Total	$ 124,280	$ 114,774

Status of Fund Balance with Treasury	2008	2007
Unobligated Balance		
Available	$ 26,383	$ 17,339
Unavailable	8,061	7,335
Obligated Balance not yet Disbursed	138,030	135,355
Non-Budgetary FBWT	(48,194)	(45,255)
Total	$ 124,280	$ 114,774

Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $1.9 billion and $2.2 billion in FY 2008 and FY 2007, respectively. The restricted cash includes ACF Contingency Funds for State Welfare Programs, CMS Program Management and State Grants and Demonstrations.

The Non-Budgetary FBWT negative balances reported for September 30, 2008, and 2007, are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist of the time account balances at the Medicare contractors' commercial banks. The HHS 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 HHS on these time accounts is used to reimburse the commercial banks for the service. Account balances as of September 30, 2008 and 2007 were $354 million and $129 million, respectively.

Note 5. Investments, Net

	2008				
(In Millions)	Cost	Unamortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Marketable	$ 38	$ -	$ -	$ 38	$ 38
Non-Marketable: Par Value	377,831	-	4,634	382,465	382,465
Non-Marketable: Market-based	2,671	197	26	2,894	2,894
Total, Intragovernmental	$380,540	$ 197	$ 4,660	$ 385,397	$ 385,397

	2007				
(In Millions)	Cost	Unamortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Marketable	$ 41	$ -	$ -	$ 41	$ 41
Non-Marketable: Par Value	358,625	-	4,570	363,195	363,195
Non-Marketable: Market-based	2,629	(3)	13	2,639	2,639
Total, Intragovernmental	$361,295	$ (3)	$ 4,583	$ 365,875	$ 365,875

The FASAB Statement of Federal Financial Accounting Standards (SFFAS) No. 27, *Identifying and Reporting Earmarked Funds,* prescribes certain disclosures related to earmarked investments. The Federal Government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds. The cash receipts collected from the public for an earmarked fund are deposited with the Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI Trust Funds as evidence of their receipt and are an asset to the Trust Funds and a liability of the U.S. Treasury. Because the HI and SMI Trust Funds and the U.S. Treasury are part of the Federal Government, these assets and liabilities offset each other from the standpoint of the Federal Government as a whole and are eliminated from presentation in the consolidation of the U.S. Government-wide Financial Reports.

The Medicare bonds' interest rates ranged from 3.50 percent to 7.25 percent during both October 1, 2007 to September 30, 2008, and October 1, 2006 to September 30, 2007. The One Day Certificates are short-term and paid between 3.75 percent and 4.00 percent during

October 1, 2007 to September 30, 2008 and 4.50 to 4.75 percent during October 1, 2006 to September 30, 2007.

Securities held by the Vaccine Injury Compensation Program will mature in fiscal years 2008 through 2018. The Market-Based Notes paid from 3.00 percent to 5.50 percent during October 1, 2007 to September 30, 2008, and October 1, 2006 to September 30, 2007. The Market-Based Bonds paid 9.125 percent throughout FY 2008.

The NIH securities yield from 2.03 percent to 4.92 percent depending on date purchased and length of time to maturity.

One Day Certificates paid from .25 percent to 4.95 percent during October 1, 2007 to September 30, 2008, and from 4.58 percent to 5.34 percent during October 1, 2006 to September 30, 2007.

Note 6. Accounts Receivable, Net

(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables Consol.
	2008					
Intragovernmental						
Entity	$ 880	$ -	$ -	$ 880	$ -	$ 880
Non-Entity	-	-	-	-	-	-
Total	$ 880	$ -	$ -	$ 880	$ -	$ 880
With the Public						
Entity						
Medicare	$ 7,380	$ -	$ -	$ 7,380	$ (2,489)	$ 4,891
Other	2,869	2	-	2,871	(368)	2,503
Non-Entity	11	71	-	82	(57)	25
Total	$ 10,260	$ 73	$ -	$ 10,333	$ (2,914)	$ 7,419

(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables Consol.
	2007					
Intragovernmental						
Entity	$ 1,164	$ -	$ -	$ 1,164	$ -	$ 1,164
Non-Entity	-	-	-	-	-	-
Total	$ 1,164	$ -	$ -	$ 1,164	$ -	$ 1,164
With the Public						
Entity						
Medicare	$ 13,827	$ -	$ -	$ 13,827	$ (2,483)	$ 11,344
Other	1,886	2	1	1,889	(227)	1,662
Non-Entity	13	49	-	62	(47)	15
Total	$ 15,726	$ 51	$ 1	$ 15,778	$ (2,757)	$ 13,021

Accounts receivable are composed of various program related overpayments and other recoverable payments.

The decrease in the Medicare accounts receivable with the public is primarily attributable to the Medicare Prescription Drug (MPD) Program. The MPD accounts receivable consists of amounts due CMS after completion of the Part D payment reconciliation. For FY 2007, the gross receivable was $8.4 billion, which consisted of the Part D reconciliation for calendar year 2006 of $5.2 billion and the estimate for the first nine months of calendar year 2007 of $3.2 billion. For FY 2008, the estimate for the first nine months of calendar year 2008 is reported as an advance of $0.6 billion in Other Assets.

Note 7. Inventory and Related Property, Net

(In Millions)	2008	2007
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 15	$ 13
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	119	4
Operating Materials and Supplies Reserved for Future Use	5	-
Total Operating Materials and Supplies	124	4
Stockpile Materials Held for Emergency or Contingency	4,464	3,144
Inventory and Related Property, Net	$4,603	$ 3,161

Note 8. General Property, Plant and Equipment, Net

			2008		
(In Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 50	$ -	$ 50
Construction in Progress	-	-	455	-	455
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,900	(1,694)	3,206
Equipment	Straight Line	3-20 Yrs	1,230	(815)	415
Internal Use Software	Straight Line	5-10 Yrs	1,140	(385)	755
Assets Under Capital Lease	Straight Line	1-20 Yrs	139	(48)	91
Leasehold Improvements	Straight Line	*Life of Lease	49	(10)	39
Totals			$ 7,963	$ 2,952	$ 5,011

			2007		
(In Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 50	$ -	$ 50
Construction in Progress	-	-	737	-	737
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,419	(1,574)	2,845
Equipment	Straight Line	3-20 Yrs	1,140	(695)	445
Internal Use Software	Straight Line	5-10 Yrs	1,116	(262)	854
Assets Under Capital Lease	Straight Line	1-20 Yrs	140	(42)	98
Leasehold Improvements	Straight Line	*Life of Lease	43	(8)	35
Totals			$ 7,645	$ (2,581)	$ 5,064

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

Note 9. Other Assets

(In Millions)	2008	2007
Intragovernmental		
Advances to Other Federal Entities	$ 92	$ 43
With the Public		
Prepayments and Deferred Charges	$ -	$ 1
Travel Advances & Emergency Employee Salary Advances	1	12
Other	1,234	563
Total, With the Public	$ 1,235	$ 576

Other Assets with the Public primarily consists of $645 million of advances outstanding as of September 30, 2008, related to the CMS SMI Part D program and $195 million ($161 million in FY 2007) representing advances made to various contractors and vendors.

Note 10. Liabilities Not Covered by Budgetary Resources

(In Millions)	2008	2007
Intragovernmental		
Accrued Payroll and Benefits	$ 37	$ 29
Other (Note 14)	899	613
Total Intragovernmental	936	642
Federal Employee and Veterans' Benefits (Note 12)	8,742	8,368
Accrued Payroll and Benefits	395	392
Contingencies (Note 19)	3,782	4,332
Other (Note 14)	114	39
Total Liabilities Not Covered by Budgetary Resources	$ 13,969	$ 13,773
Total Liabilities Covered by Budgetary Resources	72,625	68,121
Total Liabilities	$ 86,594	$ 81,894

Note 11. Entitlement Benefits Due and Payable

(In Millions)	2008	2007
Medicare	$ 44,942	$ 41,604
Medicaid	20,410	19,414
Other	499	452
Totals	$ 65,851	$ 61,470

Medicare benefits payable consists of a $38.6 billion estimate ($35.1 billion in FY 2007) of Medicare services incurred but not paid, as of September 30, 2008, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $1.7 billion estimated ($2.7 billion in FY 2007) for amounts owed to plans relating to risk and other payment

related adjustments and $1.8 billion ($1.0 billion in FY 2007) owed to plans after the completion of the Prescription Drug Payment reconciliation.

The Medicare Retiree Drug Subsidy (RDS) consists of $2.8 billion estimate ($2.9 billion in FY 2007) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2008. As part of *Medicare Modernization Act* (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 employer- and union-based retiree prescription drug plans.

Medicaid benefits payable of $20.4 billion ($19.4 billion in FY 2007) 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, 2008. An estimated State Children's Health Insurance Program (SCHIP) benefits payable of $0.3 billion has been recorded ($0.3 billion in FY 2007) for the net Federal share of expenses that have been incurred by the States but not yet reported to HHS as of September 30, 2008.

Note 12. Federal Employee and Veterans' Benefits

(In Millions)	2008	2007
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 7,875	$ 7,575
PHS Commissioned Corp Post-retirement Health Benefits	586	516
Workers' Compensation Benefits (Actuarial FECA Liability)	281	277
Total, Federal Employee and Veterans' Benefits	$ 8,742	$ 8,368

Public Health Service (PHS) Commissioned Corps:

The HHS administers the PHS Commissioned Corps Retirement System for approximately 6,067 active duty officers and 5,588 retiree annuitants and survivors. At September 30, 2008, the actuarial present value of accumulated plan pension benefits was $6.6 billion, of which $0.6 billion was not vested, and the liability for medical benefits was actuarially determined to be $0.6 billion.

Significant assumptions remain unchanged from 2007. The significant assumptions used in the calculation of the pension and medical program liability as of September 30, 2008, were as follows:

Interest on Federal securities	6.00 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

The following shows key valuation results as of September 30, 2008 and 2007, 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*. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2008, and actuarial assumptions. The September 30, 2008 valuation of the Retirement Benefit Plan includes the impact of relatively minor actuarial assumption changes from FY 2007. The FY 2007 expense for the Retirement Benefit Plan included the impact of a significant change in plan provisions as well as the liability increase from the adoption of new actuarial assumptions based on a Departmental experience study, including a reduction in the investment return assumption from 6.25 percent to 6.00 percent.

(In Millions)	2008	2007
Normal Cost	$ 183	$ 153
Interest Cost	476	443
Ongoing Cost	659	596
Prior Service Cost & (Gains)/Losses	33	533
Total Expense	$ 692	$1,129

Workers' Compensation Benefits:

The actuarial liability for future workers' compensation benefits includes 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 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 economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2008 and 2007 appear below.

FY 2008	FY 2007
4.368% in Year 1	4.930% in Year 1
4.770% in Year 2 and thereafter	5.078% 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
2008	3.03%	4.71%
2009	3.87%	4.01%
2010	2.73%	3.86%
2011	2.20%	3.87%
2012	2.23%	3.93%
2013+	2.30%	3.93%

Note 13. Accrued Grant Liability

(In Millions)	2008	2007
Grant Advances Outstanding (before year-end grant accrual)	$ 15,954	$ 15,528
Less: Estimated Accrual for Amounts Due to Grantees	(19,832)	(19,469)
Net Grant Liability	$ (3,878)	$ (3,941)

Note 14. Other Liabilities

	2008		2007	
(In Millions)	Intra-governmental	With the Public	Intra-governmental	With the Public
Advances from Others	$ 112	$ 23	$ 76	$ 59
Deferred Revenue	107	650	81	555
Capital Lease Liability (Note 15)	78	30	80	32
Custodial Liabilities	572	(28)	480	(15)
Other	188	681	98	511
Consolidated HHS Totals	$ 1,057	$ 1,356	$ 815	$ 1,142

Note 15. Leases

Capital Leases:

The 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. Assets under Capital Lease amounts are reported in Note 8, General Property, Plant and Equipment.

Summary of Net Assets under Capital Lease

(In Millions)	2008	2007
Summary of Net Assets under Capital Lease		
Land and Building	$ 139	$ 139
Machinery and Equipment	-	1
Subtotal	139	140
Accumulated Amortization	(48)	(42)
Assets under Capital Lease	$ 91	$ 98

Future Minimum Payments

(In Millions)	2008	2007
Year 1	$ 13	$ 13
Year 2	13	13
Year 3	11	13
Year 4	11	11
Year 5	11	11
Later years	117	127
Total Minimum Lease Payments	176	188
Imputed Interest	(68)	(76)
Total Capital Lease Liability	$ 108	$ 112

Operating Leases:

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

Future Minimum Payments

(In Millions)	2008	2007
Year 1	$ 328	$ 341
Year 2	331	349
Year 3	329	325
Year 4	304	313
Year 5	294	290
Later years	1,053	1,069
Total Operating Lease Liability	$ 2,639	$2,687

Note 16. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

	2008						
(In Millions)	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Gross Cost	$ 135	$ 4,749	$ 764	$ 39	$ 5,687	$ (2,069)	$ 3,618
Earned Revenue	(17)	(2,755)	(5)	(9)	(2,786)	1,976	(810)
Net Cost, Intragovernmental	$ 118	$ 1,994	$ 759	$ 30	$ 2,901	$ (93)	$ 2,808
With the Public							
Gross Cost	$ 12,544	$ 264,428	$ 448,449	$ 37,252	$ 762,673	$ -	$ 762,673
Earned Revenue	(1)	(2,180)	(54,153)	(1)	$ (56,335)	-	(56,335)
Net Cost, With the Public	$ 12,543	$ 262,248	$ 394,296	$ 37,251	$ 706,338	$ -	$ 706,338
Totals							
Gross Cost	$ 12,679	$ 269,177	$ 449,213	$ 37,291	$ 768,360	$ (2,069)	$ 766,291
Earned Revenue	(18)	(4,935)	(54,158)	(10)	(59,121)	1,976	(57,145)
Net Cost of Operations	$ 12,661	$ 264,242	$ 395,055	$ 37,281	$ 709,239	$ (93)	$ 709,146

	2007						
(In Millions)	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Gross Cost	$ 135	$ 4,261	$ 612	$ 33	$ 5,041	$ (1,553)	$ 3,488
Earned Revenue	(9)	(2,880)	(7)	(11)	(2,907)	1,557	(1,350)
Net Cost, Intragovernmental	$ 126	$ 1,381	$ 605	$ 22	$ 2,134	$ 4	$ 2,138
With the Public							
Gross Cost	$ 12,858	$ 248,560	$ 417,205	$35,697	$ 714,320	$ -	$ 714,320
Earned Revenue	-	(1,599)	(50,259)	(1)	(51,859)	-	(51,859)
Net Cost, With the Public	$ 12,858	$ 246,961	$ 366,946	$35,696	$ 662,461	$ -	$ 662,461
Totals							
Gross Cost	$ 12,993	$ 252,821	$ 417,817	$35,730	$ 719,361	$ (1,553)	$ 717,808
Earned Revenue	(9)	(4,479)	(50,266)	(12)	(54,766)	1,557	(53,209)
Net Cost of Operations	$ 12,984	$ 248,342	$ 367,551	$35,718	$ 664,595	$ 4	$ 664,599

Note 17. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $57 billion and $53 billion through September 30, 2008, and 2007, respectively. Exchange revenue consists primarily of monthly premiums paid by Medicare Supplementary Medical Insurance Trust Fund-Part B beneficiaries. See the Medicare Supplementary Medical Insurance Trust Fund-Part B description in Earmarked Funds. HHS also charges user fees and collects revenues related to reimbursable agreements with other Government entities.

Note 18. Custodial Activity

The ACF receives funding from the Internal Revenue Service for outlay to the States for child support. This funding represents delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to the HHS to cover outlays. During FY 2008, receipts amounted to $2.8 billion ($1.7 billion for FY 2007) and outlays amounted to $2.8 billion ($1.7 billion for FY 2007).

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 2008 were $8.0 million ($10.0 million for FY 2007). The CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

The CDC custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total custodial liabilities for FY 2008 and FY 2007 were $4.7 million and $4.3 million, respectively. CDC custodial collections are also forwarded to the Department of the Treasury and cannot be used for CDC operations.

Note 19. Commitments and Contingencies

The HHS is a party 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.

(In Millions)	2008	2007
Medicaid Audit and Program Disallowances	$ 3,513	$ 1,702
Contingent Liabilities	-	2,414
Vaccine Injury Compensation Program	269	221
Total Contingencies	$ 3,782	$ 4,337

Contingent Liabilities
As of September 30, 2007, the HHS recorded $1.7 billion for a contingent liability for asserted and unasserted claims that could be owed to States arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. This was the result of one State's assertion of a civil claim brought to the Federal District Court. The HHS vigorously defended against this claim during FY 2008, and the results bear evidence that the likelihood of any loss by the Department for this action is remote. Therefore, the Department did not accrue a contingent liability for this issue in FY 2008.

In FY 2007, the HHS accrued $0.7 billion for a contingent liability to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. The case was settled and this amount was paid out during FY 2008, and no further accrual or disclosure is needed.

Medicaid Audit and Program Disallowances
The Medicaid amount for 2008 of $3.5 billion ($1.7 billion in FY 2007) consists of Medicaid audit and program disallowances of $0.7 billion ($0.5 billion in FY 2007) and $2.8 billion ($1.2 billion in FY 2007) 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 HHS. The HHS will be required to pay these amounts if the appeals are decided in 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 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 CMSO Director. The outcome of these reviews is that CMS could be owed funds.

***Vaccine Injury Compensation Program* (VICP)**
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $269 million ($221 million as of September 30, 2007) VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2008.

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 for FY 1991 (Public Law 101-150).* The total payments related to cancelled appropriations are estimated at $1.5 billion and $1.4 billion as of September 30, 2008 and 2007, respectively.

Appeals at the Provider Reimbursement Review Board
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. However, historical cases that have been appealed and settled

by the PRRB are considered in the development of the actuarial Medicare incurred, but not reported (IBNR) liability, resulting in a projected liability for the 7,712 cases (6,644 in FY 2007) remaining on appeal as of September 30, 2008. A total of 2,971 new cases (2,901 in FY 2007) were filed in FY 2008. The PRRB rendered decisions on 77 cases (119 in FY 2007) in FY 2008 and 1,826 additional cases (2,024 in FY 2007) 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.

Note 20. Apportionment Categories of Obligations Incurred

	2008		
(In Millions)	Direct	Reimbursable	Totals
Category A (Distributed by Quarter)	$ 134,290	$ 6,238	$ 140,528
Category B (Restricted and Distributed by Activity)	427,252	563	427,815
Exempt from Apportionment	430,493	-	430,493
Total Obligations Incurred	$ 992,035	$ 6,801	$ 998,836

	2007		
(In Millions)	Direct	Reimbursable	Totals
Category A (Distributed by Quarter)	$ 136,544	$ 6,913	$ 143,457
Category B (Restricted and Distributed by Activity)	411,939	192	412,131
Exempt from Apportionment	401,083	-	401,083
Total Obligations Incurred	$ 949,566	$ 7,105	$ 956,671

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular No. A-11, *Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, *Report on Budget Execution and Budgetary Resources*.

Note 21. Beginning Balance of the Statement of Budgetary Resources (SBR)

The FY 2008 beginning balance of the Unobligated Balance Brought Forward on the SBR has a difference of $425 million. This was the result of an adjustment to prior year allocation of administrative funds for the Medicare Part D program. The decreased amount of the unobligated balance was not available for FY 2008. The Treasury Accounting Scenario, "Adjustments for Changes to Prior-Year Allocation of Budgetary Resources," covers multi-year funds, but does not appropriately treat annual Trust Funds such as the Part D Program. A new scenario for the annual Trust Fund allocation adjustment transactions in FY 2008 was established as a result. Therefore, this difference in the beginning balance is a one-time occurrence and OMB and the Treasury concur with HHS' presentation.

Note 22. Legal Arrangements Affecting Use of Unobligated Balances

The 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 sponsoring and conducting medical research and are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years.

All Trust Fund receipts collected by HHS in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of the 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 currently become available for obligation as needed. The entire Trust Fund balances in the amount of $330.0 billion as of September 30, 2008, and $313.9 billion as of September 30, 2007 are included as Investments in the Consolidated Balance Sheet.

The NIH revolving and management funds are available for centralized research support services and administrative activities. Revolving funds are no-year funds available until expended. The NIH management fund is available for two fiscal years. The Trust Funds consist of the Conditional, Unconditional, and Patient Emergency Funds and are also available until expended. The Patient Emergency Fund is intended solely for the benefit of patients. The Unconditional Gift Fund is available for any authorized purpose in the performance of NIH functions. The Conditional Gift Fund is restricted to a specific purpose determined by the donor. The NIH is not authorized to spend the funds to support functions not encompassed within the terms of the conditions. However, for conditional monetary gifts, upon completion of the stipulated conditions, or circumstances rendering completion of the conditions impossible, any remaining unobligated conditional funds are transferred to the Unconditional Gift Fund for the support of any other objectives of the recipient organization. The funds received for CRADA are available for the performance of the contractual agreement, and are available for the term of the agreement. The royalty funds are available for obligations for two fiscal years after the fiscal year in which the funds are received and are available for a variety of purposes, such as rewards to scientific, engineering, and technical employees of the laboratory, education and training of employees and payment of expenses incidental to the administration of intellectual property by the entity.

Note 23. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The FY 2010 *President's Budget*, with actual amounts for FY 2008, has not yet been published, and, therefore, no comparisons can be made between FY 2008 amounts presented in the SBR with amounts reported in the Actual column of the *President's Budget*. The FY 2010 *President's Budget* is expected to be released in February 2009, and may be obtained from the Office of Management and Budget website http://www.whitehouse.gov/omb/budget or from the Government Printing Office.

The *Budget of the United States Government, FY 2009 – 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 2009 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (gross outlays less offsetting collections) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2007.

	2007			
(In Millions)	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 981,345	$ 956,671	$ 257,704	$ 929,563
Unobligated Balances – Not Available	(5,078)	-	-	-
Other	56	(503)	(150)	36
Budget of the U.S. Government	$ 976,323	$ 956,168	$ 257,554	$ 929,599

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 Adjustments in Obligations Incurred primarily consists of obligations for expired accounts that are appropriately reported on the SBR but not included in the *President's Budget.*

Note 24. 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.

Note 25. Undelivered Orders at the End of the Period

The HHS reported $71.8 billion of budgetary resources obligated for undelivered orders as of September 30, 2008, and $74.4 billion as of September 30, 2007.

Note 26. Earmarked Funds

Medicare is the largest earmarked fund group managed by the Department and is presented in a separate column in the schedule below. The Medicare programs include: (a) the Medicare Hospital Insurance (HI) Trust Fund and (b) Medicare Supplementary Medical Insurance (SMI) Trust Fund, (c) Medicare Prescription Drug Benefit – Part D, and (d) Medicare/Medicaid Integrity Program (MIP). See Note 1 for a description of each fund's purpose and how the HHS accounts for and reports the fund. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. 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.

The monthly SMI premium per beneficiary was $88.50 from October 2007 through December 2007 and $93.50 from January 2008 through September 2008. Premiums collected from beneficiaries totaled $49.4 billion ($45.7 billion in FY 2007) and were matched by a $144.9 billion ($137.8 billion in FY 2007) contribution from the Federal government.

Earmarked Funds (In Millions)	Medicare	Other	Eliminations	Total
Balance Sheet as of September 30, 2008				
Fund Balance with Treasury	$ 12,443	$ 1,053	$ -	$ 13,496
Investments	382,465	2,932	-	385,397
Other Assets	54,946	61	(48,275)	6,732
Total Assets	$ 449,854	$ 4,046	$ (48,275)	$ 405,625
Entitlement Benefits Due and Payable	$ 44,942	$ -	$ -	$ 44,942
Other Liabilities	50,005	494	(48,275)	2,224
Total Liabilities	$ 94,947	494	(48,275)	$ 47,166
Unexpended Appropriations	12,267	(95)	-	12,172
Cumulative Results of Operations	342,640	3,647	-	346,287
Total Liabilities and Net Position	$ 449,854	$ 4,046	$ (48,275)	$ 405,625
Statement of Net Cost				
For the Period Ended September 30, 2008				
Gross Program Costs	$ 449,212	$ 355	$ -	$ 449,567
Less: Earned Revenues	(54,157)	(1,076)	-	(55,233)
Net Cost of Operations	$ 395,055	$ (721)	$ -	$ 394,334
Statement of Changes in Net Position				
For the Period Ended September 30, 2008				
Net Position Beginning of Period	$ 338,909	$ 2,944	$ -	$ 341,853
Non-Exchange Revenue	216,895	341	-	217,236
Other Financing Sources	194,158	(454)	-	193,704
Net Cost of Operations	(395,055)	721	-	(394,334)
Change in Net Position	15,998	608	-	16,606
Net Position End of Period	$ 354,907	$ 3,552	$ -	$ 358,459

Earmarked Funds (In Millions)	Medicare	Other	Eliminations	Total
Balance Sheet as of September 30, 2007				
Fund Balance with Treasury	$ 8,793	$ 679	$ -	$ 9,472
Investments	363,195	2,680	-	365,875
Other Assets	65,614	24	(53,206)	12,432
Total Assets	$ 437,602	$ 3,383	$ (53,206)	$ 387,779
Entitlement Benefits Due and Payable	$ 41,604	$ -	$ -	$ 41,604
Other Liabilities	57,089	439	(53,206)	4,322
Total Liabilities	98,693	439	(53,206)	45,926
Unexpended Appropriations	8,978	(91)	-	8,887
Cumulative Results of Operations	329,931	3,035	-	332,966
Total Liabilities and Net Position	$ 437,602	$ 3,383	$ (53,206)	$ 387,779
Statement of Net Cost				
For the Period Ended September 30, 2007				
Gross Program Costs	$ 417,817	$ 380	$ -	$ 418,197
Less: Earned Revenues	(50,266)	(610)	-	(50,876)
Net Cost of Operations	$ 367,551	$ (230)	$ -	$ 367,321
Statement of Changes in Net Position				
For the Period Ended September, 30, 2007				
Net Position Beginning of Period	$ 329,511	$ 2,619	$ -	$ 332,130
Non-Exchange Revenue	206,598	337	-	206,935
Other Financing Sources	170,351	(242)	-	170,109
Net Cost of Operations	(367,551)	230	-	(367,321)
Change in Net Position	9,398	325	-	9,723
Net Position End of Period	$ 338,909	$ 2,944	$ -	$ 341,853

Note 27. 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 Health Care specific conditions.

Actuarial present values are computed as of the year shown and over the 75-year projection period beginning January 1 of that year. The Trustees' projections are based on the Medicare laws, regulations, and policies in effect on March 25, 2008, and do not reflect any actual or anticipated changes subsequent to that date. (See Note 28 concerning the impact of the *Medicare Improvements for Patients and Providers Act of 2008*, enacted on July 15, 2008).

The present values 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, or on behalf of, 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.

The Part A present values in the SOSI exclude the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are "uninsured" because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the SOSI is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare part A. For these reasons, it is appropriate to exclude their income and expenditures from the Statement of Social Insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures 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, those who are expected to become participants in the future. With the exception of the 2007 projections presented, 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 both. For the 2007 projections, the "closed group" of individuals includes individuals who are at least 18 at the start of the projection period. The age cohort assumptions for the 2008 projections and related balances have been refined as compared to the projections shown in the 2008 Medicare Trustees Report. Since the projection period consists of 75 years, the period 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 of 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 care 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 expenditures 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 (18 through 64 in the case of the 2007 projections). In order to calculate the actuarial net present value of the excess of future income over future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted 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 that 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 the law in effect on March 25, 2008. In addition, the estimates depend on many economic, demographic, and health care-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.

The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included in Table 1. The assumptions underlying the 2008 SOSI actuarial projections are drawn from the *Social Security* and *Medicare Trustees Report* for 2008. 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. Detailed information, similar to that denoted with Table 1, for the prior years is publicly available on the CMS website at www.cms.hhs.gov/CFOReport/.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2008

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
2008	2.06	1,250,000	822.2	1.3	4.1	2.8	2.3	7.1	1.4	2.9	1.9
2010	2.06	1,195,000	812.2	1.3	4.0	2.8	2.7	4.3	3.8	6.4	2.3
2020	2.03	1,130,000	750.5	1.1	3.9	2.8	2.2	4.3	6.1	7.8	2.9
2030	2.01	1,085,000	689.8	1.1	3.9	2.8	2.1	5.6	5.8	5.7	2.9
2040	2.00	1,050,000	635.9	1.1	3.9	2.8	2.2	5.9	5.5	5.3	2.9
2050	2.00	1,035,000	588.6	1.1	3.9	2.8	2.1	4.9	4.9	5.0	2.9
2060	2.00	1,030,000	546.8	1.1	3.9	2.8	2.1	4.8	4.8	4.7	2.9
2070	2.00	1,025,000	509.8	1.1	3.9	2.8	2.1	4.7	4.6	4.5	2.9
2080	2.00	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	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 population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Difference between percentage change 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.

The ultimate values of the above-specified assumptions used in determining the estimates for each of the five years presented in the Statement of Social Insurance are listed within Table 2. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions and Summary Measures Used for the Statement of Social Insurance FY 2008 – 2004

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
Fiscal Year	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]
2008	2.00	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
2007	2.00	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2006	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2005	1.95	900,000	495.5	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
2004	1.95	900,000	497.2	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008, the assumption presented is the value assumed in the year 2080. For 2004-2007, the ultimate assumption is displayed and is reached by the 20th year of each projection period.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[4]Difference between percentage change in wages and the CPI. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[5]Average annual wage in covered employment. The ultimate assumption is reached within the first 10 years of the projection period.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[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. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[9]Average rate of interest earned on new Trust Fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of each projection period.

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 still relatively new (having begun operations in January 2006), with very little actual program data currently available. The actual 2006 through 2008 bid submissions by the private plans offering this coverage, together with data on beneficiary enrollment and preliminary data on program spending, have 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 28. Medicare Improvements for Patients and Providers Act of 2008

On July 15, 2008, the *Medicare Improvements for Patients and Providers Act (MIPPA) of 2008* was enacted. There were many provisions in MIPPA that affected the Medicare program. These include beneficiary improvements, such as expanded access to care, enrollment assistance and increased coverage. There were also provisions affecting payments to providers, such as physicians and managed care plans. The net overall impact of all MIPPA provisions over the 10-year period from FY 2009-2018 is roughly $25 billion (unaudited) in increased Medicare spending. This represents less than 0.5 percent of total Medicare spending during the same time period.

The long-range financial projections underlying the Statement of Social Insurance are drawn from the Annual Report of the Medicare Board of Trustees to Congress, which was issued on March 25, 2008. These projections are based on an assumption that the Medicare laws, regulations, and policies in effect on that date will continue indefinitely without modification. In practice, the subsequent enactment of MIPPA will have an effect on Medicare expenditures and revenues. Due to the timing, complexity, and scope of the legislation, it is not possible to incorporate the impact of MIPPA into the long-range SOSI projections. The short-range estimates of the Medicare costs and savings under MIPPA, summarized above, provide an indication of the relative financial effect of the legislation. As stated above, the impact these provisions would have on the projections presented in the SOSI are relatively minor.

Note 29. 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 41 percent over the next 9 years. Although the MIPPA of 2008 overrode the payment reductions that would have occurred in July 2008 and again in January 2009, its effects are temporary and do not significantly change the longer-term reduction in physician payments that would result under the current law physician update formula. Reductions of this magnitude are very unlikely to occur fully. For example, Congress has overridden scheduled negative updates for 2003 through 2009. 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 expenditures shown in the accompanying SOSI are likely to be 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 the Medicare Board of Trustees' projections, the projected 75-year present value of future Part B expenditures is $21.2 trillion. An alternative scenario indicates that 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 $23.4 trillion (an increase of $2.2 trillion). Similarly, 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 $25.4 trillion (an increase of $4.2 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 of 2005* and the *Medicare Improvements for Patients and Providers Act of 2008*). 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 will likely be designed to reduce costs in an effort to make the program 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 30. Reconciliation of Net Cost of Operations (Proprietary) to Budget

(In Millions)	2008	2007
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$ 998,836	$ 956,671
Spending Authority from Offsetting Collections and Recoveries	(30,926)	(26,608)
Obligations Net of Offsetting Collections and Recoveries	967,910	930,063
Offsetting Receipts	(264,230)	(257,704)
Net Obligations	703,680	672,359
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	313	310
Total Resources Used to Finance Activities	703,993	672,669
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	(1,384)	980
Resources That Fund Expenses Recognized in Prior Periods	(41)	1
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	51	28
Other	(93)	(234)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,549	1,262
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	715	373
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	797	2,410
Total Resources Used to Finance the Net Cost of Operations	703,196	670,259
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	5,344	(6,913)
Components Not Requiring or Generating Resources	606	1,253
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	5,950	(5,660)
NET COST OF OPERATIONS	$ 709,146	$ 664,599