

Required Supplementary Information

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

	<u>CMS</u>			Other Agency Budgetary Accounts¹	Agency Combined Totals
	Medicare HI	Medicare SMI	Medicaid		
Budgetary Resources:					
1. Unobligated balance, brought forward, October 1	\$ -	\$ -	\$ 317	\$ 17,890	\$ 18,207
2. Recoveries of prior year unpaid obligations	14	20	12,196	2,251	14,481
3. Budget Authority	211,227	176,663	215,736	356,848	960,474
4. Nonexpenditure transfers, net, anticipated & actual	44	84	(1,895)	1,826	59
5. Temporarily not available pursuant to Public Law	(22,091)	(12,434)	-	(26)	(34,551)
6. Permanently not available (-)	-	(5)	-	(5,842)	(5,847)
7. Total Budgetary Resources	<u>\$ 189,194</u>	<u>\$ 164,328</u>	<u>\$ 226,354</u>	<u>\$ 372,947</u>	<u>\$ 952,823</u>
Status of Budgetary Resources:					
8. Obligations Incurred	\$ 189,194	\$ 164,328	\$ 199,868	\$ 331,513	\$ 884,903
9. Unobligated Balances - Available	-	-	25,844	34,410	60,254
10. Unobligated Balances - Not Available	-	-	642	7,024	7,666
11. Total Status of Budgetary Resources	<u>\$ 189,194</u>	<u>\$ 164,328</u>	<u>\$ 226,354</u>	<u>\$ 372,947</u>	<u>\$ 952,823</u>
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net	\$ 17,733	\$ 17,580	\$ 10,635	\$ 72,120	\$ 118,068
13. Obligations incurred, Net (+/-)	189,194	164,328	199,868	331,513	884,903
14. Less: Gross outlays	185,872	162,393	179,124	324,670	852,059
15. Obligated balance transferred, Net	-	-	-	-	-
16. Less: Recoveries of prior year unpaid obligations	14	20	12,196	2,251	14,481
17. Change in uncollected customer payments	-	-	-	1,739	1,739
18. Obligated balance, Net, end of period	21,041	19,495	19,183	75,118	134,837
19. Net Outlays	<u>\$ 169,992</u>	<u>\$ (47,408)</u>	<u>\$ 178,860</u>	<u>\$ 313,230</u>	<u>\$ 614,674</u>

Summary of Other Agency Budgetary Accounts

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

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

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

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

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

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

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

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

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

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

IHS Stewardship Classes and Trust Land

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

Distribution of Stewardship Assets by Type and Area

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

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

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

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

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

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

Actuarial Projections

Cashflow in Nominal Dollars

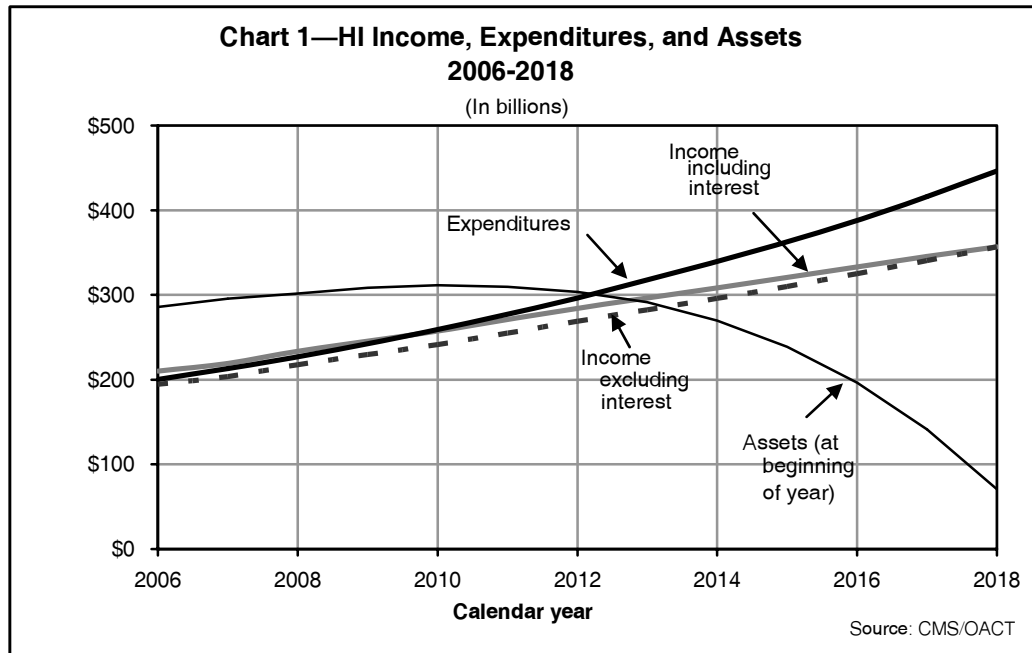
Using nominal dollars² for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

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

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

HI

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

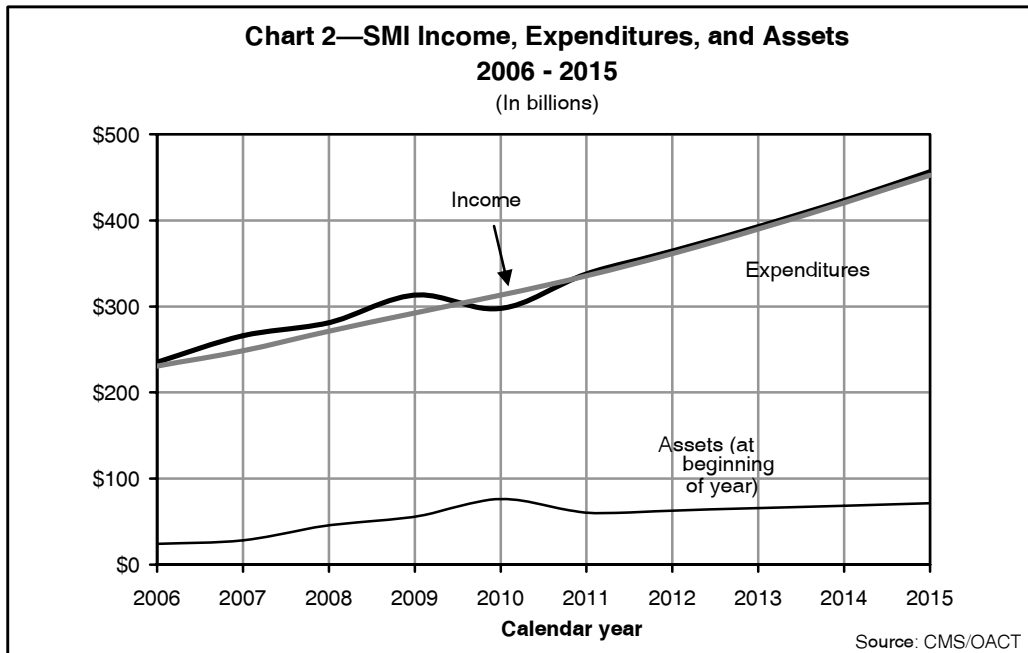


As chart 1 shows, HI expenditures exceeded income excluding interest in 2006 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers’ earnings.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

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

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2006 through 2015, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2015, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year’s expenditures.³ Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 2015.⁴



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

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

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

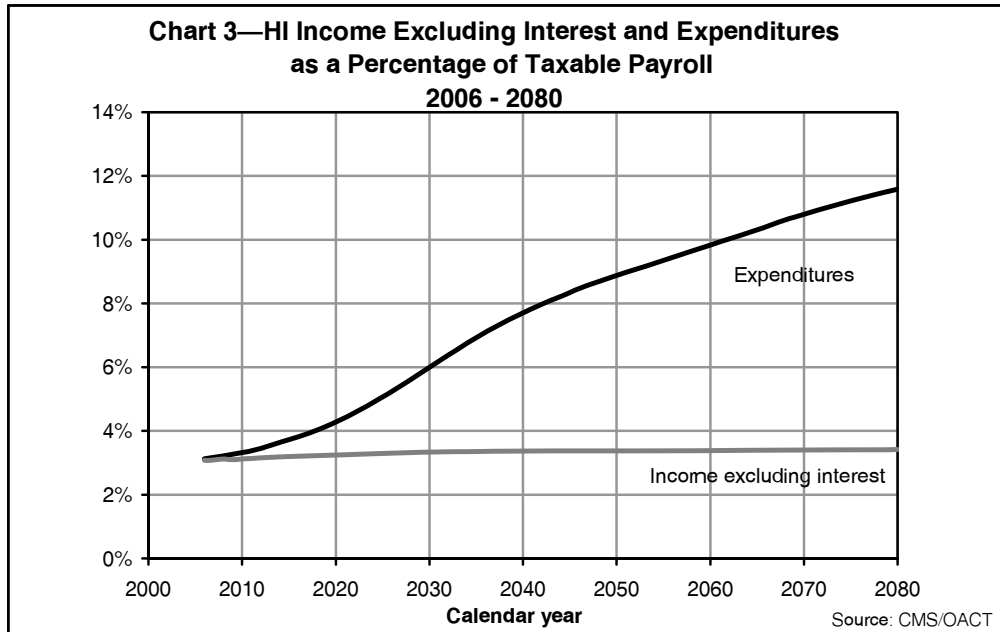
two depictions of income is not visible graphically since interest is not a significant source of income.⁵ Expenditures include benefit payments as well as administrative expenses.

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

HI Cashflow as a Percentage of Taxable Payroll

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

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



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

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

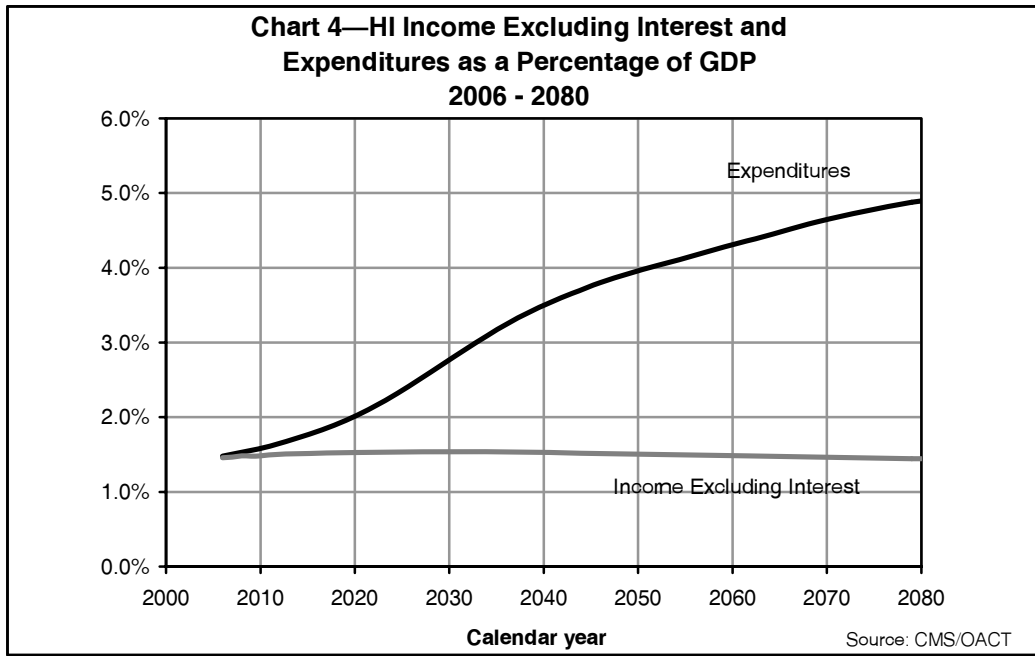
Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a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

HI and SMI Cashflow as a Percentage of GDP

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

HI

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

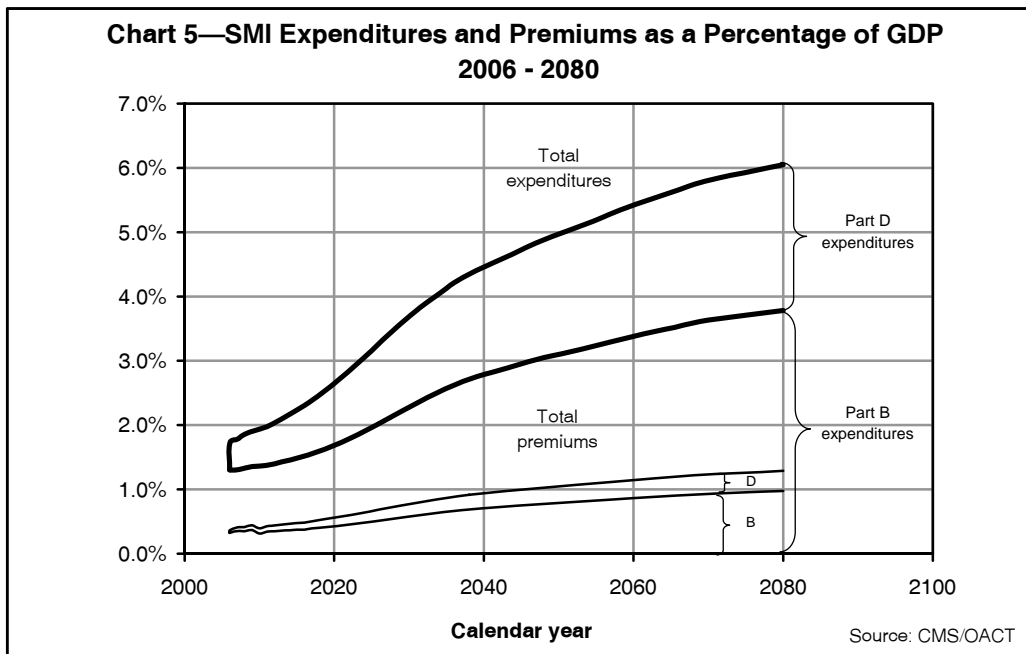


SMI

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

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

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

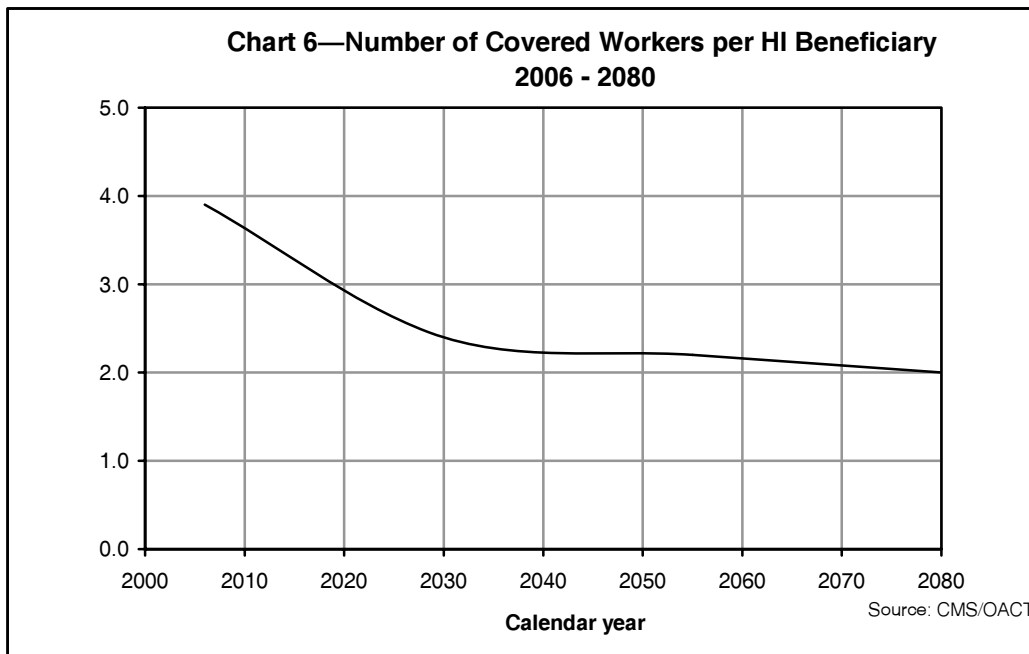


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually.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

Worker-to-Beneficiary Ratio

HI

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



Sensitivity Analysis

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

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

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

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

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

Health Care Cost Factors

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

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions			
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	-\$4,459	-\$11,290	-\$22,387

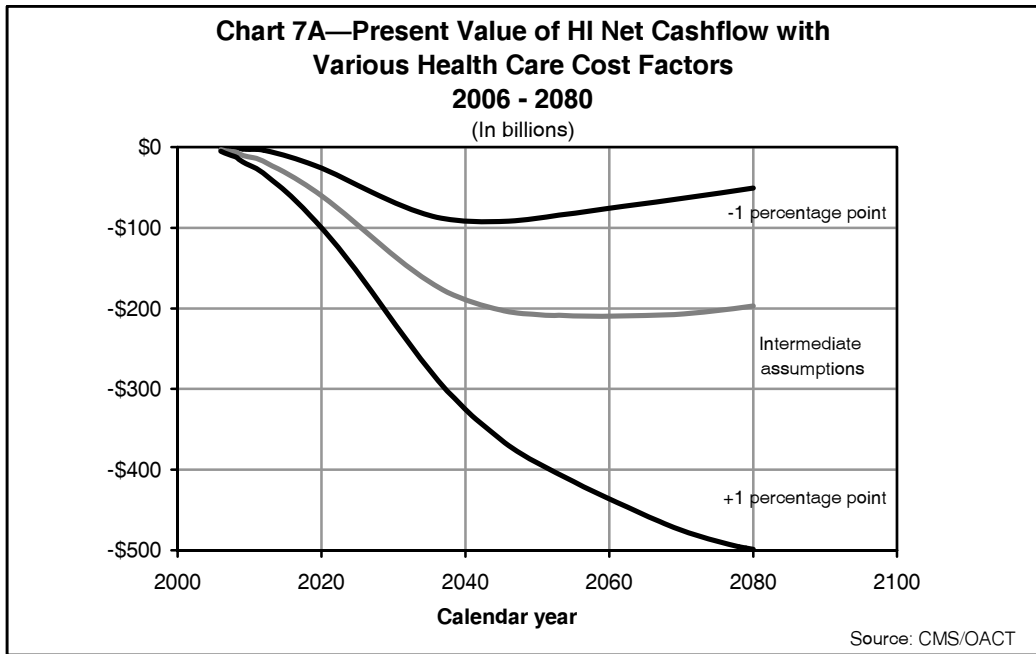
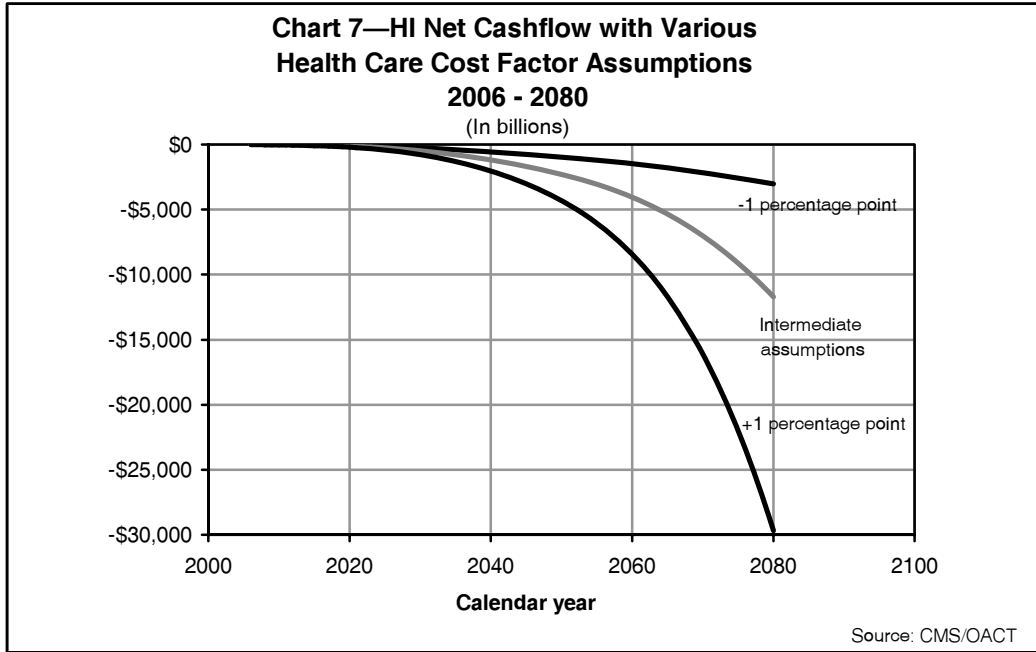
Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by \$6,831 billion. On the other hand, if the

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

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

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

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



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

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

Fertility Rate

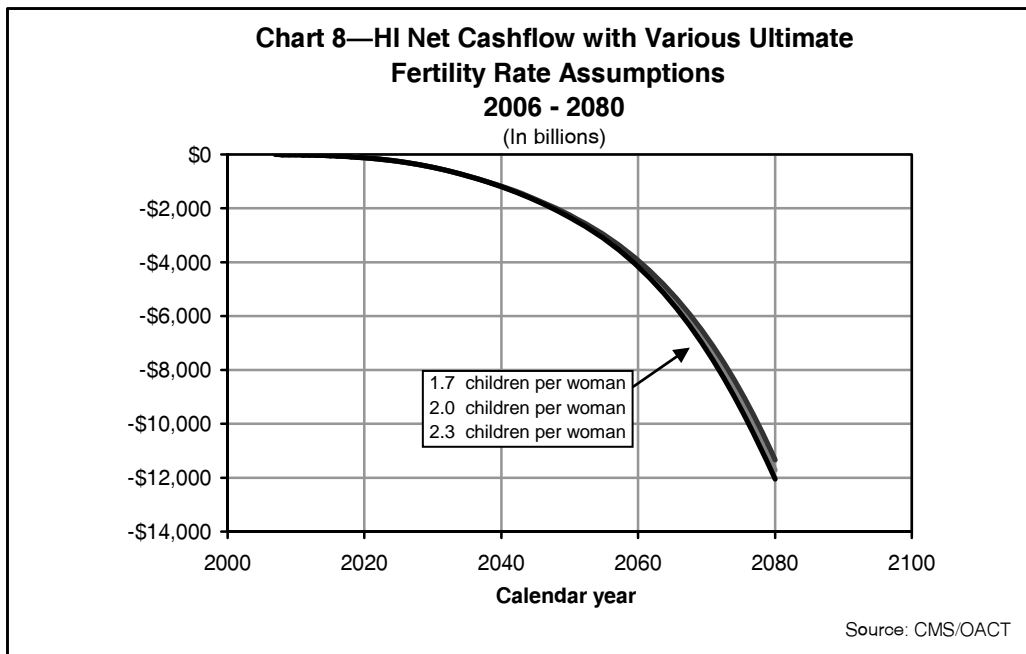
Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

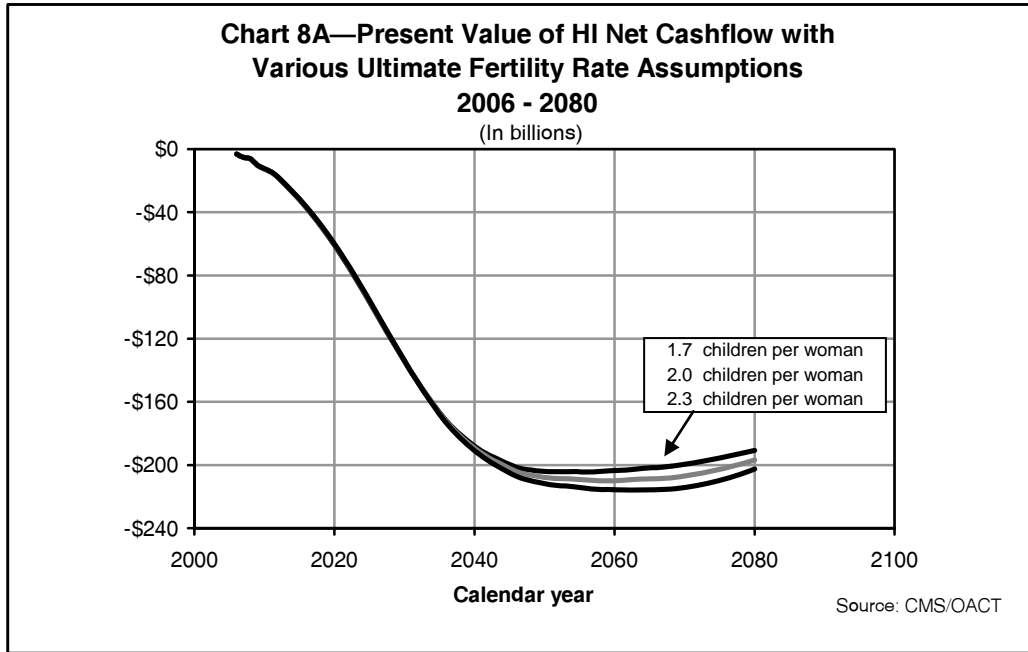
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions			
Ultimate fertility rate ¹	1.7	2.0	2.3
Income minus expenditures (in billions)	-\$11,510	-\$11,290	-\$11,078

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

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

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





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

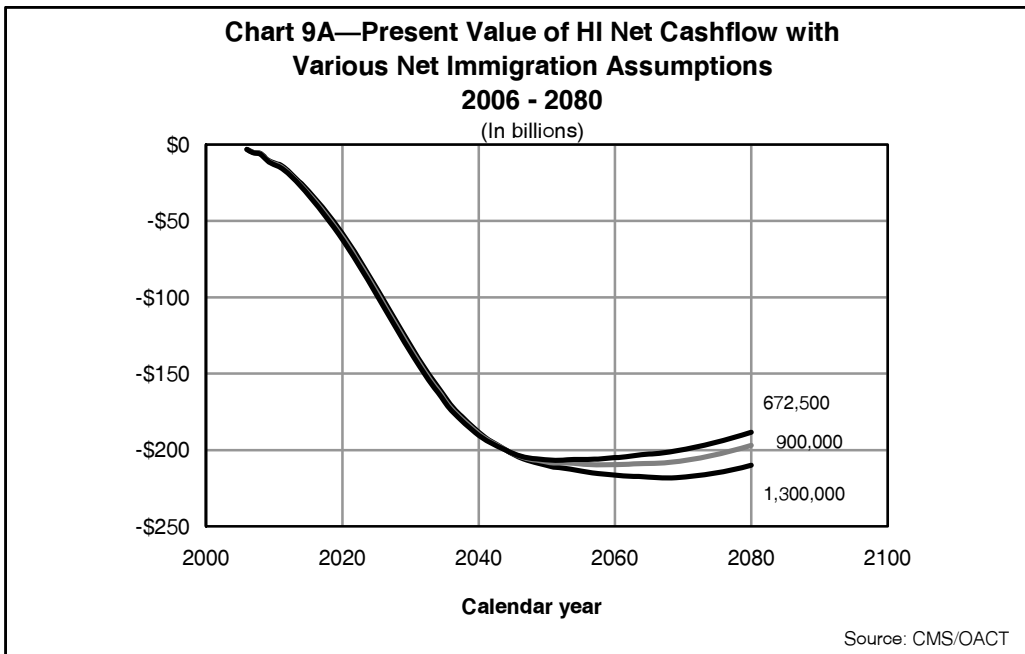
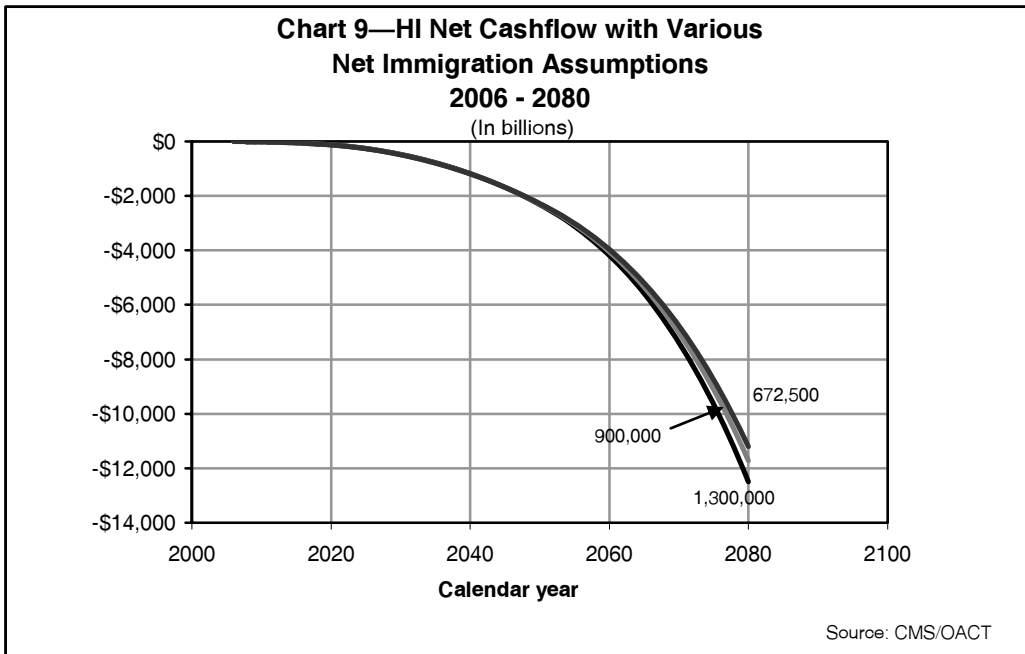
Net Immigration

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

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

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

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



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

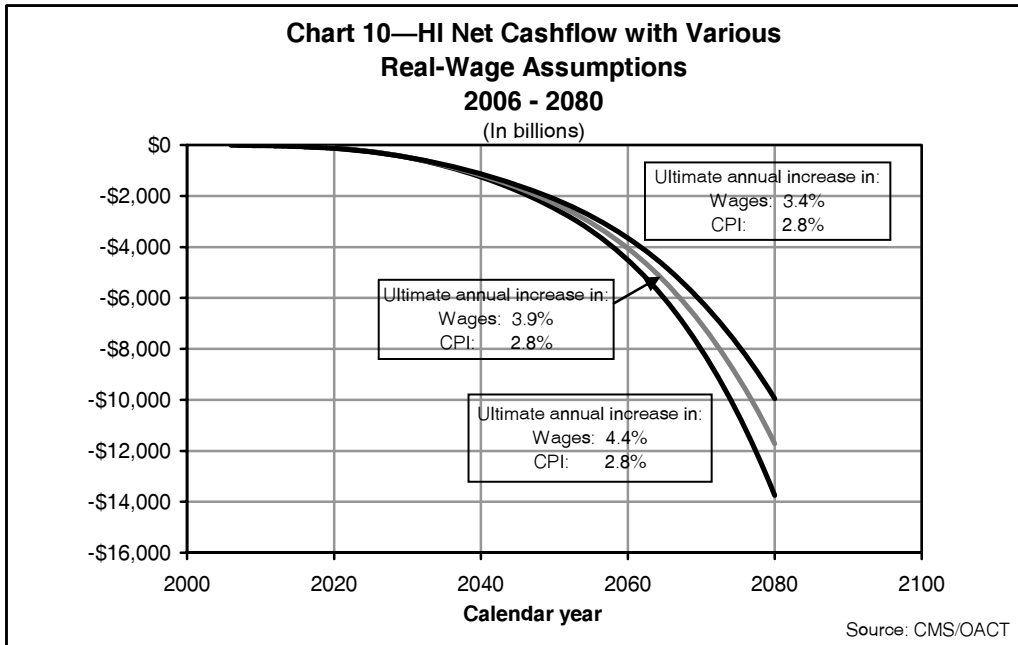
Real-Wage Differential

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential⁸ assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

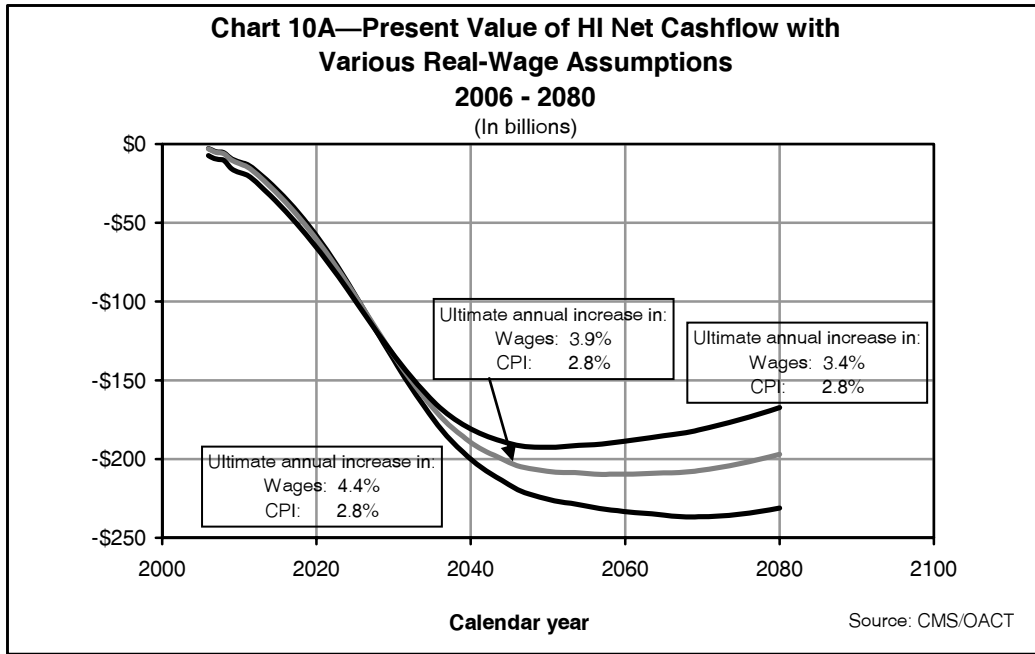
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions			
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-\$10,521	-\$11,290	-\$12,286

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

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



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



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

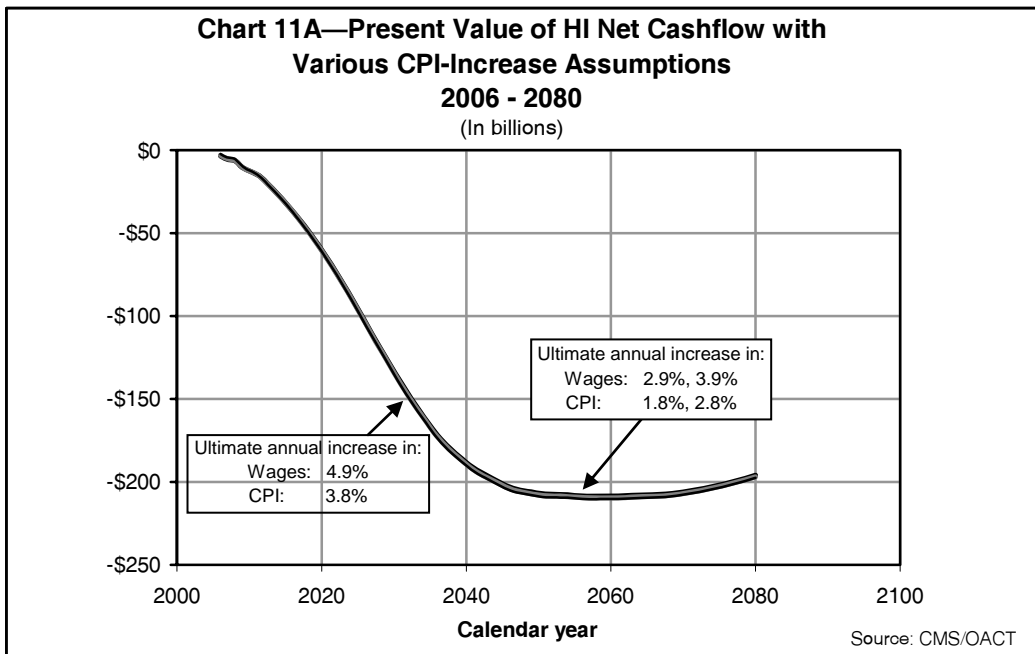
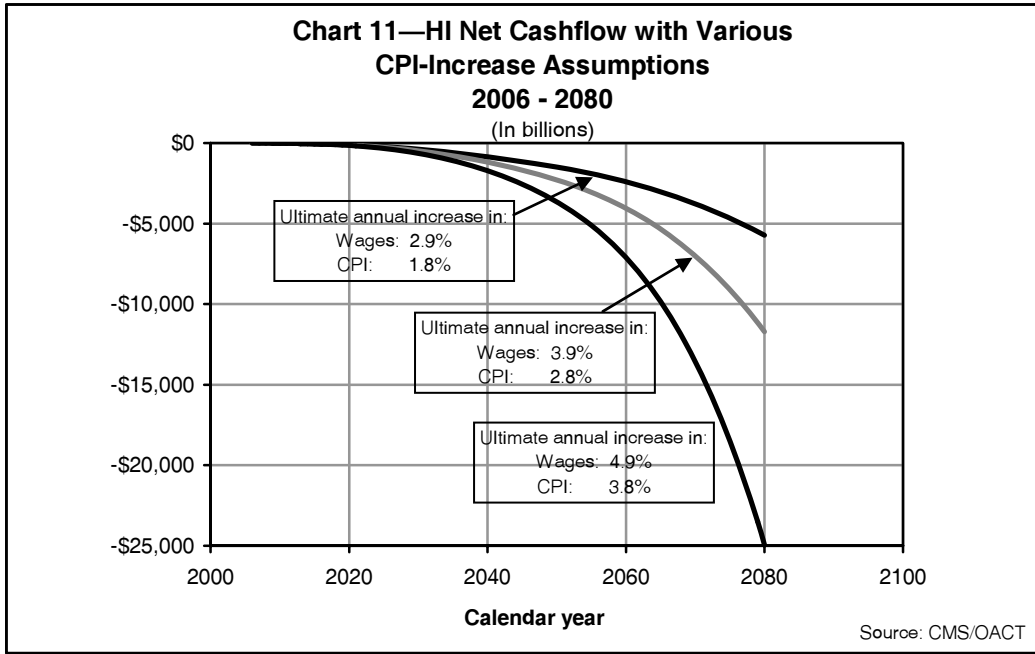
Consumer Price Index

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

Table 5—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-\$11,234	-\$11,290	-\$11,337

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

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



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

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

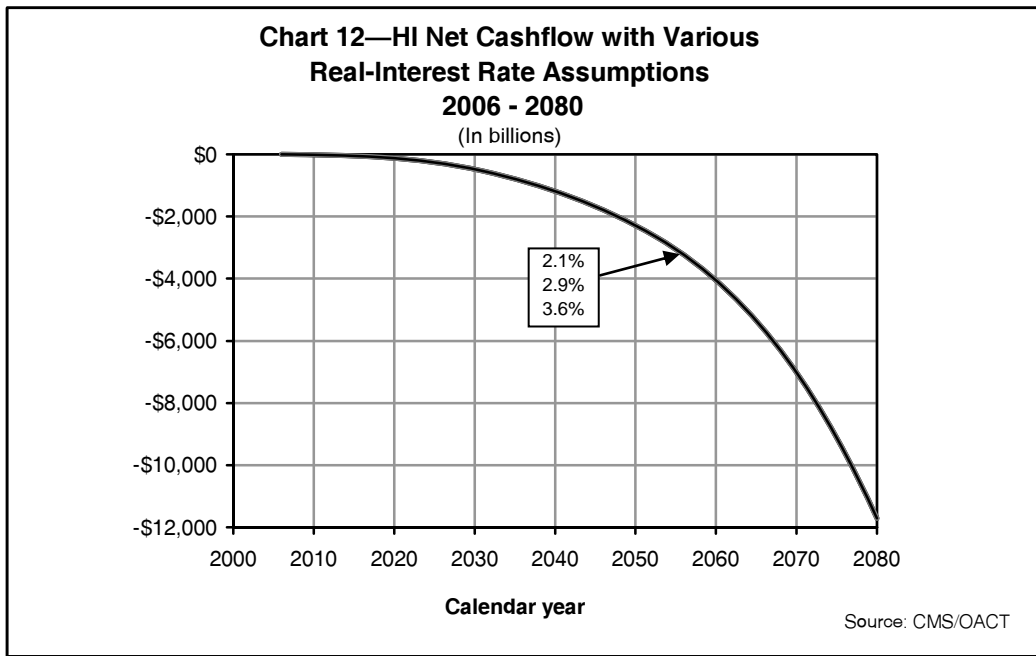
Real-Interest Rate

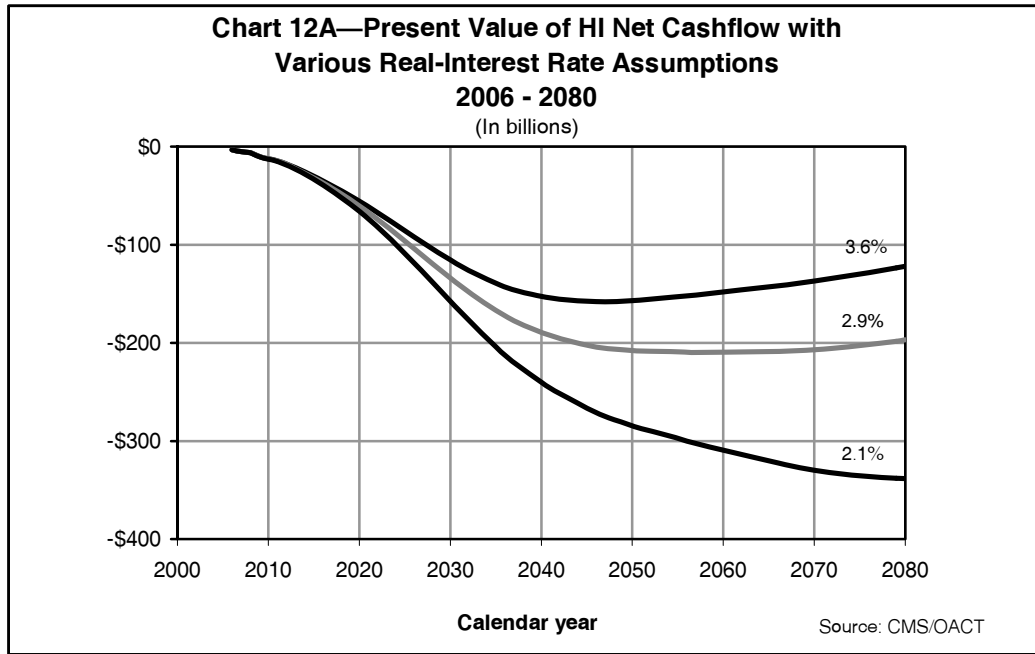
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of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

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions			
Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures (in billions)	-\$15,847	-\$11,290	-\$8,464

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

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





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

Trust Fund Finances and Sustainability

HI

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

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

SMI

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

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

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

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

Medicare Overall

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