NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS FOR THE YEARS ENDED SEPTEMBER 30, 2009 AND 2008

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* (*P.L. 96-88*) was signed into law, providing for a separate Department of Education. The HEW officially became the 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 the HHS

The HHS is comprised of the Office of the Secretary and 10 other Operating Divisions (OPDIVs) with diverse missions and programs. The Office of the Secretary and the OPDIVs 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 the 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 and Families (ACF)
2. Administration on Aging (AoA)
3. Agency for Healthcare Research and Quality (AHRQ)
4. Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
5. Centers for Medicare and 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 (OS) – excluding Program Support Center
11. Program Support Center (PSC)
12. Substance Abuse and 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 is reported 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* (*P.L. 101-576*), as amended by the *Government Management Reform Act of 1994 (P.L. 103-356)*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular No. A-136, *Financial Reporting Requirements* (OMB Circular A-136). 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 179 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 Sheets and Statements of Net Cost and Changes in Net Position. The Combined Statements of Budgetary Resources are 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' financial management goals seek to (a) provide decision-makers with timely, accurate, and useful financial and program information; and (b) ensure that the HHS resources are used appropriately, efficiently, and effectively. The implementation of UFMS was a major step in accomplishing this goal and establishes the framework needed to continue improvements in this area. The UFMS phased implementation of the HHS' OPDIVs began 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 HHS continues to strive for improvements in financial management and reporting by streamlining and integrating its financial management systems to ensure transparency and accountability. The HHS has two efforts currently underway to assist in this area: (1) the Consolidated Reporting System will develop consolidated financial statements for all of the HHS to include data from NIH and CMS and (2) Oracle Business Intelligence Enterprise Edition (OBIEE) Pilot with FDA. OBIEE is a reporting dashboard for managers that will be implemented throughout the HHS. The HHS is also seeking to upgrade UFMS to Oracle Financials E-Business Suite (EBS) 12i Application and Oracle Database 11g. The HHS is currently in the initial planning phase of this effort.

Healthcare 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. Fifteen Medicare contractors were using HIGLAS as of September 30, 2009.

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 2009, NIH achieved stabilization goals and upgraded the NBS database to Oracle 10g, the Oracle e-Business Suite, version 11.5.10 and Compusearch PRISM, version 6.2.

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 agency of its authority to obligate budget authority and outlay funds to another agency. The HHS is 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 Department of the Treasury (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. In FY 2008, 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, the HHS, as the child, 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 Agriculture, Homeland Security, Justice and State.

Reclassifications

Certain FY 2008 balances have been reclassified to conform to FY 2009 financial statement presentations, the effects of which are 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 (P.L. Ch. 531, 49 Stat. 620, now codified as 42 U.S.C. Ch. 7, P.L. 104-191)* established the Medicare HI Trust Fund. Medicare contractors are paid by the HHS to process Medicare claims for hospital in-patient 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 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) *(26 U.S.C. Ch 21)* and *Self Employment Contributions Act* (SECA) *of 1954 (Chapter 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403*). 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 Treasury General Fund 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, *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 the HHS to process Medicare claims for physicians, medical suppliers, hospital out-patient 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 prescribes 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 Supplementary Medical Insurance Trust Fund – Part D

The Medicare Supplementary Medical Insurance Trust Fund – Part D, (Prescription Drug Benefit) was established by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (known as the *Medicare Modernization Act*, or MMA) *(P.L. 108-173)*. The Prescription Drug Benefit 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 Prescription Drug Benefit is 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 fee-for-service 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 and 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) (*P.L. 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).

Borrowing Authority

In FY 2009, the HHS used indefinite borrowing authority under the *Federal Credit Reform Act of 1990* (FCRA), *(P.L. 101-508, as amended).* Two post FCRA loan guarantee cohorts under HRSA's Health Education Assistance Loan Program required additional resources to cover FY 2009 anticipated shortfalls. The borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority will not carry forward to the next fiscal year.

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 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, the 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 deducts Medicare Part B premiums from Social Security benefit payments and allocates those funds 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.

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.

Investments, Net

The HHS invests entity Medicare 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. 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, or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts collected from the public, for the earmarked funds, are deposited with the Treasury, which uses the cash for general government purposes. Treasury securities are issued by Bureau of Public Debt 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 Treasury. The Federal Government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

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 are Non-Marketable (Par Value) 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 (See Note 4).

The Vaccine Injury Compensation Trust Fund, an earmarked trust fund similar to the HI and SMI Trust Funds, invests in Non-Marketable Market Based securities issued by Bureau of Public Debt in the form of One Day Certificates and Market-Based Bills, Notes and Bonds.

The NIH Gift Funds (earmarked) are invested in Non-Marketable Market Based Bills issued by the Bureau of Public Debt. Funds are invested for either a 90 day or 180 day period based on the need for funds – no provision is made for unrealized gains or losses on these securities since it is the HHS' intent to hold investments to maturity.

The Children's Health Insurance Program (CHIP (formerly known as the State Children's Health Insurance Program, or SCHIP)) was originally included in the *Balanced Budget Act of 1997* (BBA, *P.L. 105-33)*; it was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The *Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)* extended the funding through March 2009.

The *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA, *P.L. 111-3)* provides funding to help States and territories expand their CHIP programs and maintain the existing enrollment through September 2013. CHIPRA also established a Child Enrollment Contingency Fund (non-earmarked) to cover shortfalls in funding for the States. This fund is invested in Non-Marketable Market-Based Bills issued by Bureau of Public Debt. These investments will be redeemed as funds are needed by the States to cover shortfalls in the CHIP program for a short term.

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 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, P.L. 108-173)* 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 Loan Programs. Loans receivable represent defaulted guaranteed loans which have been paid to lenders under these programs and 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 the 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 the HHS programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures on the quarterly *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" represents 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 the 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 the 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 (H5N1). The pre-pandemic H5N1 avian influenza vaccine stockpile is held in reserve to respond to an avian pandemic declaration. The stockpile contains several million doses of vaccine in bulk which is stored and maintained for possible use. Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulinum antitoxins, and blocking and decorporation agents for a radiological event. The cost value of the stockpile is vast and the importance of the vaccine stockpile is incalculable. 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. The 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 immateriality of 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) *of 1916 (5 U.S.C. 751)* 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.

Fiduciary Activities

Effective FY 2009, the SFFAS No. 31, *Accounting for Fiduciary Activities* requires Federal entities to distinguish the information relating to fiduciary activities of the Federal entity from all other activities. The fiduciary activities are those Federal Government activities that relate to the collection or receipt, and the subsequent management, protection, accounting, investment and disposition of cash or other assets in which non-Federal individuals or entities have an ownership interest that the Federal Government must uphold. The HHS does not have reportable activities as defined by SFFAS 31.

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 obligations for medical care services that have been rendered on behalf of insured consumers but for which the HHS has either not yet received or processed claims, and liabilities for physician, hospital, and other medical cost disputes. The HHS develops estimates for medical costs IBNR 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, the HHS re-examines previously established medical cost 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, the 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, the 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 the HHS. This estimate is developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

The American Recovery and Reinvestment Act of 2009 (Recovery Act, P.L. 111-5) provides additional federal funding for the States through a temporary increase in the Federal Medical Assistance Percentages through the first quarter of FY 2011.

Federal Employee and Veterans' Benefits

The HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act, P.L. 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 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 the first 3 percent of basic pay dollar for dollar of employee contributions. Each dollar of the employee's next 2 percent of basic pay is matched 50 cents on the dollar.

The 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, contains 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 HI and 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 May 12, 2009. 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 2009. 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.

American Reinvestment and Recovery Act of 2009

The *American Recovery and Reinvestment Act of 2009* (*Recovery Act, P.L. 111-5)* was signed into law on February 17, 2009. It is an extraordinary response to an economic crisis that includes measures to modernize our nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care, provide tax relief, and protect those in greatest need.

The *Recovery Act* provides an estimated $167 billion over ten years to the HHS for funding Health IT, Comparative Effectiveness Research, Prevention and Wellness, Scientific Research, Social Services and Medicaid relief to the States. The HHS has committed to quickly and carefully distributing *Recovery Act* funds in an open and transparent manner. The HHS obligated $49.0 billion in FY 2009 *Recovery Act* budget authority and expended $35.1 billion.

Note 2. Entity and Non-Entity Assets

(In Millions)	2009	2008
Intragovernmental:		
Fund Balance with Treasury	$ 29	$ 27
Accounts receivable	14	-
Total Intragovernmental	43	27
Accounts receivable	21	25
Total Non-Entity Assets	64	52
Total Entity Assets	562,716	529,219
Total Assets	$ 562,780	$ 529,271

Note 3. Fund Balance with Treasury

(In Millions)	2009	2008
Fund Balance with Treasury		
Trust Funds	$ 3,525	$ 12,711
Revolving Funds	989	807
Appropriated Funds	156,469	109,569
Other Funds	979	1,193
Total	$ 161,962	$ 124,280
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 41,108	$ 26,383
Unavailable	9,270	8,061
Obligated Balance not yet Disbursed	165,061	138,030
Non-Budgetary FBWT	(53,477)	(48,194)
Total	$ 161,962	$ 124,280

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 $3.7 billion and $1.9 billion in FY 2009 and FY 2008, respectively. The restricted amount is primarily for the Children's Health Insurance Program, CMS Program Management, State Grants and Demonstrations, and *Recovery Act* Health Information Technology.

The Non-Budgetary FBWT negative balances reported for September 30, 2008 and September 30, 2009, are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net

	2009				
(In Millions)	Cost	Unamortized Premium (Discount)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 371,466	$ -	$ 4,369	$ 375,835	$ 375,835
Non-Marketable: Market-based	5,046	207	28	5,281	5,281
Total, Intragovernmental	$ 376,512	$ 207	$ 4,397	$ 381,116	$ 381,116

(In Millions)	2008 Cost	Unamortized (Premium (Discount)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 377,831	$ -	$ 4,634	$ 382,465	$ 382,465
Non-Marketable: Market-based	2,709	197	26	2,932	2,932
Total, Intragovernmental	$ 380,540	$ 197	$ 4,660	$ 385,397	$ 385,397

The HHS investments consist primarily of Medicare Trust Fund earmarked investments, Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2010 through June 30, 2024 with interest rates ranging from 3.25 percent to 7.00 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2010 with interest rates ranging from 3.125 percent to 3.25 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (VICTF, earmarked) will mature in fiscal years 2009 through 2018. The Market-Based Notes paid from 3.125 percent to 5.00 percent during October 1, 2008 to September 30, 2009, and October 1, 2007 to September 30, 2008. The Market-Based Bonds pay 9.125 percent through FY 2018.

The NIH Market Based Bills (earmarked) yielded from 0.1 percent to 0.69 percent in FY 2009 depending on date purchased and length of time to maturity.

The non-earmarked investments held by the CHIP Child Enrollment Contingency Fund are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

Note 5. Accounts Receivable, Net

(In Millions)	2009 Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables Consol.
Intragovernmental						
Entity	$ 898	$ -	$ 1	$ 899	$ -	$ 899
Non-Entity	14	-	-	14	-	14
Total	$ 912	$ -	$ 1	$ 913	$ -	$ 913
With the Public						
Entity						
Medicare	$ 4,859	$ -	$ -	$ 4,859	$ (1,852)	$ 3,007
Other	3,123	-	3	3,126	(650)	2,476
Non-Entity	12	46	-	58	(37)	21
Total	$ 7,994	$ 46	$ 3	$ 8,043	$ (2,539)	$ 5,504

(In Millions)	2008 Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables Consol.
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

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 of $265 million consists of an estimated amount due to CMS after completion of the Part D payment reconciliation for calendar year 2008.

Note 6. Inventory and Related Property, Net

(In Millions)	2009	2008
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 13	$ 15
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	86	119
Operating Materials and Supplies Reserved for Future Use	434	5
Total Operating Materials and Supplies	520	124
Stockpile Materials Held for Emergency or Contingency	5,071	4,464
Inventory and Related Property, Net	$ 5,604	$ 4,603

Note 7. General Property, Plant and Equipment, Net

(In Millions)	Depreciation Method	Estimated Useful Lives	2009 Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 51	$ -	$ 51
Construction in Progress	-	-	665	-	665
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,000	(1,858)	3,142
Equipment	Straight Line	3-20 Yrs	1,515	(943)	572
Internal Use Software	Straight Line	5-10 Yrs	1,002	(499)	503
Assets Under Capital Lease	Straight Line	1-20 Yrs	136	(53)	83
Leasehold Improvements	Straight Line	*Life of Lease	49	(18)	31
Totals			$ 8,418	$ (3,371)	$ 5,047

			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

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

Note 8. Other Assets

(In Millions)	2009	2008
Intragovernmental		
Advances to Other Federal Entities	$ 92	$ 92
With the Public		
Travel Advances & Emergency Employee Salary Advances	6	1
Other	2,179	1,234
Total, With the Public	$ 2,185	$ 1,235

Other Assets with the Public primarily consisted of $1,638 million ($645 million in FY 2008) of prepayment advances outstanding as of September 30, 2009 related to the CMS SMI Part D Program.

Note 9. Liabilities Not Covered by Budgetary Resources

(In Millions)	2009	2008
Intragovernmental		
Accrued Payroll and Benefits	$ 40	$ 37
Other (Note 13)	621	899
Total Intragovernmental	661	936
Federal Employee and Veterans' Benefits (Note 11)	9,690	8,742
Accrued Payroll and Benefits	517	395
Contingencies (Note 18)	4,048	3,782
Other (Note 1)	71	114
Total Liabilities Not Covered by Budgetary Resources	$ 14,987	$ 13,969
Total Liabilities Covered by Budgetary Resources	79,380	72,625
Total Liabilities	$ 94,367	$ 86,594

Note 10. Entitlement Benefits Due and Payable

(In Millions)	2009	2008
Medicare	$ 46,772	$ 44,942
Medicaid	24,977	20,410
Other	469	499
Totals	$ 72,218	$ 65,851

Medicare benefits payable consists of a $39.6 billion estimate as of September 30, 2009 ($38.6 billion in FY 2008) of Medicare services incurred but not paid, as of September 30, 2009, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable of $5.1 billion ($3.5 billion in FY 2008) consists of a $2.5 billion estimate ($1.7 billion in FY 2008) for amounts owed to plans relating to risk and other payment related adjustments and $2.6 billion in FY 2009 and $1.8 billion in FY 2008 owed to plans after the completion of the Prescription Drug payment reconciliation.

The Medicare Retiree Drug Subsidy (RDS) consists of $2.1 billion estimate ($2.8 billion in FY 2008) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2009. 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 $25.0 billion as of September 30, 2009 ($20.4 billion as of September 30, 2008) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to the HHS. An estimated Children's Health Insurance Program benefits payable of $0.4 billion has been recorded as of September 30, 2009 ($0.3 billion as of September 30, 2008 for the Children's Health Insurance Program) for the net Federal share of expenses that have been incurred by the States but not yet reported to the HHS.

Note 11. Federal Employee and Veterans' Benefits

(In Millions)	2009	2008
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 8,817	$ 7,875
PHS Commissioned Corp Post-retirement Health Benefits	619	586
Workers' Compensation Benefits (Actuarial FECA Liability)	254	281
Total, Federal Employee and Veterans' Benefits	$ 9,690	$ 8,742

Public Health Service (PHS) Commissioned Corps

The HHS administers the PHS Commissioned Corps Retirement System for approximately 6,299 active duty officers and 5,726 retiree annuitants and survivors. At September 30, 2009, the actuarial present value of accumulated plan pension benefits was $7.6 billion, of which $0.7 billion was not vested, and the liability for medical benefits was actuarially determined to be $0.6 billion.

The significant assumptions used in the calculation of the pension and medical program liability as of September 30, 2009, were as follows:

Interest on Federal securities	5.75 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

The following shows key valuation results as of September 30, 2009 and 2008, 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, 2009, and actuarial assumptions. The September 30, 2009 valuation of the Retirement Benefit

Plan includes the impact of relatively minor actuarial assumption changes from FY 2008. The FY 2008 expense for the Retirement Benefit Plan included recognition of a significant actuarial loss (based on the impacts of a new census discount rate, mortality assumptions and new valuation techniques), as well as a reduction in the investment return assumption from 6.00 percent to 5.75 percent.

(In Millions)	2009	2008
Normal Cost	$ 183	$ 183
Interest Cost	496	476
Ongoing Cost	679	659
Prior Service Cost & (Gains)/Losses	675	33
Total Expense	$ 1,354	$ 692

On October 14, 2008 the Federal Accounting Standards Advisory Board issued Statement of Federal Financial Accounting Standards 33 (SFFAS 33). This standard covers Federal Pensions, Other Retirement Benefits (ORB) and Other Post Employment Benefits (OPEB), previously covered by SFFAS 5, and is effective for fiscal years beginning after September 30, 2009.

In fiscal year 2010, this new standard affects the selection of discount rates used for present value measurements of Federal employee pension, ORB and OPEB liabilities. The Commission Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, the standard indicates the discount rate should be based on long-term assumptions, for marketable securities (such as Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. One discount rate may be used for all the projected cash flows if the resulting present value is not materially different than the resulting present value using multiple rates.

Although it is difficult to forecast the future discount rates necessary to meet the SFFAS 33 guideline, current economic conditions indicate that there is potential for a significant reduction in the current discount rate of 5.75 percent. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

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 (IBNR) 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 2009 and 2008 appear below.

FY 2009	FY 2008
4.223% in Year 1	4.368% in Year 1
4.715% in Year 2 and thereafter	4.770% 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
2009	N/A	N/A
2010	0.47%	3.42%
2011	1.40%	3.29%
2012	1.50%	3.48%
2013	1.80%	3.71%
2014	2.00%	3.71%

Note 12. Accrued Grant Liability

(In Millions)	2009	2008
Grant Advances Outstanding (before year-end grant accrual)	$ 17,427	$ 15,954
Less: Estimated Accrual for Amounts Due to Grantees	(21,467)	(19,832)
Net Grant Liability	$ (4,040)	$ (3,878)

Note 13. Other Liabilities

	2009		2008	
(In Millions)	Intra-governmental	With the Public	Intra-governmental	With the Public
Advances from Others	$ 474	$ 160	$ 112	$ 9
Deferred Revenue	-	392	107	650
Capital Lease Liability (Note 14)	74	23	78	30
Custodial Liabilities	469	35	572	(28)
Other	54	608	188	695
Consolidated HHS Totals	$ 1,071	$ 1,218	$ 1,057	$ 1,356

Note 14. 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 7, General Property, Plant and Equipment.

Summary of Net Assets under Capital Lease

(In Millions)	2009	2008
Summary of Net Assets under Capital Lease		
Land and Building	$ 136	$ 139
Accumulated Amortization	(53)	(48)
Assets under Capital Lease	$ 83	$ 91

Future Minimum Payments

(In Millions)	2009	2008
Year 1	$ 12	$ 13
Year 2	10	13
Year 3	10	11
Year 4	10	11
Year 5	10	11
Later years	103	117
Total Minimum Lease Payments	155	176
Imputed Interest	(58)	(68)
Total Capital Lease Liability	$ 97	$ 108

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 non-cancellable 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)	2009	2008
Year 1	$ 344	$ 328
Year 2	380	331
Year 3	382	329
Year 4	359	304
Year 5	317	294
Later years	1,002	1,053
Total Operating Lease Liability	$ 2,784	$ 2,639

Note 15. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

	2009						
(In Millions)	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Gross Cost	$ 157	$ 5,169	$ 777	$ 36	$ 6,139	$ (2,077)	$ 4,062
Earned Revenue	(27)	(3,419)	(10)	(2)	(3,458)	1,847	(1,611)
Net Cost, Intragovernmental	$ 130	$ 1,750	$ 767	$ 34	$ 2,681	$ (230)	$ 2,451
With the Public							
Gross Cost	$ 13,098	$ 320,781	$ 486,580	$ 40,498	$ 860,957	$ -	$ 860,957
Earned Revenue	(1)	(2,179)	(57,322)	(1)	(59,503)	-	(59,503)
Net Cost, With the Public	$ 13,097	$ 318,602	$ 429,258	$ 40,497	$ 801,454	$ -	$ 801,454
Totals							
Gross Cost	$ 13,255	$ 325,950	$ 487,357	$ 40,534	$ 867,096	$ (2,077)	$ 865,019
Earned Revenue	(28)	(5,598)	(57,332)	(3)	(62,961)	1,847	(61,114)
Net Cost of Operations	$ 13,227	$ 320,352	$ 430,025	$ 40,531	$ 804,135	$ (230)	$ 803,905

(In Millions)	2008 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

Note 16. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $61 billion and $57 billion through September 30, 2009 and 2008. The HHS' Exchange revenue consists primarily of Medicare premiums collected from beneficiaries. The HHS also charges user fees and collects revenues related to reimbursable agreements with other Government entities.

Note 17. Custodial Activities

Following OMB Circular A-136 guidance, the HHS reports custodial activity collections on its Balance Sheet. However the HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

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. As of September 30, 2009 and 2008, receipts amounted to $2.2 billion and $2.8 billion, respectively and outlays amounted to $2.2 billion and $2.8 billion, respectively.

Note 18. 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)	2009	2008
Medicaid Audit and Program Disallowances	$ 3,793	$ 3,513
Vaccine Injury Compensation Program	255	269
Total Contingencies	$ 4,048	$ 3,782

Medicaid Audit and Program Disallowances
The Medicaid amount for FY 2009 of $3.8 billion ($3.5 billion in FY 2008) consists of Medicaid audit and program disallowances of $1 billion ($0.7 billion in FY 2008) and $2.8 billion for the fiscal years 2009 and 2008 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 the 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.

Vaccine Injury Compensation Program (VICP)
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $255 million ($269 million as of September 30, 2008) VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2009.

Obligations Related to Cancelled Appropriations
Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled pursuant to the *National Defense Authorization Act of 1991 (P.L. 101-150)*. The total payments related to cancelled appropriations are estimated at $1.5 billion as of September 30, 2009 and 2008.

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 7,984 cases (7,712 in

FY 2008) remaining on appeal as of September 30, 2009. In FY 2009, a total of 2,312 new cases were filed (2,971 in FY 2008). The PRRB rendered decisions on 93 cases in FY 2009 (77 in FY 2008); and 1,947 additional cases (1,826 in FY 2008) 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 19. Apportionment Categories of Obligations Incurred

	2009		
(In Millions)	Direct	Reimbursable	Totals
Category A (Distributed by Quarter)	$ 158,031	$ 6,785	$ 164,816
Category B (Restricted and Distributed by Activity)	507,428	536	507,964
Exempt from Apportionment	462,145	-	462,145
Total Obligations Incurred	$ 1,127,604	$ 7,321	$ 1,134,925

	2008		
(In Millions)	Direct	Reimbursable	Totals
Category A (Distributed by Quarter)	$ 133,852	$ 6,238	$ 140,090
Category B (Restricted and Distributed by Activity)	427,690	563	428,253
Exempt from Apportionment	430,493	-	430,493
Total Obligations Incurred	$ 992,035	$ 6,801	$ 998,836

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 20. Beginning Balance of the Statement of Budgetary Resources (SBR)

The FY 2008 beginning balance of the Unobligated Balance Brought Forward on the SBR was adjusted by $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 beginning balance adjustment was a one-time occurrence and OMB and the Treasury concurred with the HHS' presentation.

Note 21. 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 the 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 $320.1 billion as of September 30, 2009, and $330.0 billion as of September 30, 2008 are included as Investments in the Consolidated Balance Sheets.

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

The *FY 2011 President's Budget*, with actual amounts for FY 2009, has not yet been published, and, therefore, no comparisons can be made between FY 2009 amounts presented in the SBR with amounts reported in the Actual column of the *President's Budget*. The *FY 2011 President's Budget* is expected to be released in February 2010, 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 2010 – 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 2010 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 2008.

The Treasury's *Annual Report of the Combined Statement of Receipts, Outlays and Balances of the United States Government* was used as for the FY 2008 Offsetting Receipts data.

	2008			
(In Millions)	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,033,280	$ 998,836	$ 264,230	$ 965,240
Unobligated Balances – Not Available	(7,230)	-	-	-
Other	143	(1,463)	(7)	(281)
Budget of the U.S. Government	$ 1,026,193	$ 997,373	$ 264,223	$ 964,959

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 differences primarily consists of activities performed by the HHS for the Department of Homeland Security (DHS) for Project Bioshield. The resources, obligations and outlays are reported on the HHS' SBR and the DHS *President's Budget*. The Other amounts in Obligations Incurred also consists of obligations for expired accounts that are appropriately reported on the SBR but not included in the *President's Budget*.

Note 23. 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 24. Undelivered Orders at the End of the Period

Undelivered Orders are grants that have been issued and obligated but not yet drawn down by the grantee and goods and services ordered and obligated that have not been received. The HHS reported $91.5 billion of budgetary resources obligated for undelivered orders as of September 30, 2009, and $71.8 billion as of September 30, 2008.

Note 25. 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 $96.40 from October 1, 2008 through September 30, 2009. Premiums collected from beneficiaries totaled $51.9 billion ($49.4 billion in FY2008) and were matched by a $150.7 billion ($144.9 billion in FY2008) contribution from the Federal Government.

Earmarked Funds (In Millions)	2009 Medicare	2009 Other	2009 Total
Balance Sheet as of September 30, 2009			
Fund Balance with Treasury	$ 3,265	$ 1,100	$ 4,365
Investments	375,835	3,168	379,003
Other Assets	5,689	92	5,781
Total Assets	$ 384,789	$ 4,360	$ 389,149
Entitlement Benefits Due and Payable	$ 46,772	$ -	$ 46,772
Other Liabilities	1,675	399	2,074
Total Liabilities	$ 48,447	$ 399	$ 48,846
Unexpended Appropriations	3,590	(98)	3,492
Cumulative Results of Operations	332,752	4,059	336,811
Total Liabilities and Net Position	$ 384,789	$ 4,360	$ 389,149
Statement of Net Cost			
For the Period Ended September 30, 2009			
Gross Program Costs	$ 487,357	$ 327	$ 487,684
Less: Earned Revenues	57,332	842	58,174
Net Cost of Operations	$ 430,025	$ (515)	$ 429,510
Statement of Changes in Net Position			
For the Period Ended September 30, 2009			
Net Position Beginning of Period	$ 354,907	$ 3,552	$ 358,459
Non-Exchange Revenue	213,177	342	213,519
Other Financing Sources	198,283	(448)	197,835
Net Cost of Operations	(430,025)	515	(429,510)
Change in Net Position	(18,565)	409	(18,156)
Net Position End of Period	$ 336,342	$ 3,961	$ 340,303

Earmarked Funds (In Millions)	2008 Medicare	2008 Other	2008 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	6,671	61	6,732
Total Assets	$ 401,579	$ 4,046	$ 405,625
Entitlement Benefits Due and Payable	$ 44,942	$ -	$ 44,942
Other Liabilities	1,730	494	2,224
Total Liabilities	46,672	494	47,166
Unexpended Appropriations	12,267	(95)	12,172
Cumulative Results of Operations	342,640	3,647	346,287
Total Liabilities and Net Position	$ 401,579	$ 4,046	$ 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

Note 26. 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 May 12, 2009, and do not reflect any actual or anticipated changes subsequent to that date. 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. 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 statutory financing mechanism.

In addition to the actuarial present value of the 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 ages 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 May 12, 2009. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included in Table 1 below. The assumptions underlying the 2009 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2009. 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 within 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 2009

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2009	2.08	1,210,000	811.4	1.8	0.7	−1.0	−2.2	5.8	10.0	6.1	4.7
2010	2.08	1,190,000	806.4	1.8	3.4	1.7	2.4	1.4	−2.9	5.4	1.3
2020	2.04	1,130,000	743.2	1.1	3.9	2.8	2.1	4.3	6.4	7.2	2.9
2030	2.01	1,085,000	679.5	1.1	3.9	2.8	2.2	5.7	6.0	5.8	2.9
2040	2.00	1,050,000	622.9	1.1	3.9	2.8	2.2	5.9	5.5	5.3	2.9
2050	2.00	1,035,000	573.5	1.1	3.9	2.8	2.1	5.0	4.9	5.0	2.9
2060	2.00	1,030,000	530.2	1.1	3.9	2.8	2.1	4.7	4.8	4.7	2.9
2070	2.00	1,025,000	492.0	1.1	3.9	2.8	2.1	4.6	4.5	4.5	2.9
2080	2.00	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9

[1]Average number of children per woman.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Difference between percentage increases in wages and the CPI.

[5]Average annual wage in covered employment.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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 below. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2009-2005

					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]
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
FY 2007	2.0	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2006	2.0	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2005	1.95	900,000	495.5	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 and 2009, 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 and 2009, the assumption presented is the value assumed in the year 2080. For 2005-2007, 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 increases 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 relatively little actual program data currently available. The actual 2006 through 2009 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2008, 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 27. 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 38 percent over the next 6 years. 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 $23.2 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 $23.7 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 $25.7 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 28. Reconciliation of Net Cost of Operations (Proprietary) to Budget

(In Millions)	2009	2008
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$1,134,925	$ 998,836
Spending Authority from Offsetting Collections and Recoveries	(26,339)	(30,926)
Obligations Net of Offsetting Collections and Recoveries	1,108,586	967,910
Offsetting Receipts	(284,292)	(264,230)
Net Obligations	824,294	703,680
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	427	313
Total Resources Used to Finance Activities	824,721	703,993
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	21,396	(1,384)
Resources That Fund Expenses Recognized in Prior Periods	17	(41)
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(89)	(42)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,565	1,549
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	1,138	715
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	24,027	797
Total Resources Used to Finance the Net Cost of Operations	800,694	703,196
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	3,686	5,344
Components Not Requiring or Generating Resources	(475)	606
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	3,211	5,950
NET COST OF OPERATIONS	$ 803,905	$ 709,146

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REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

INVESTMENT IN HUMAN CAPITAL

For the Year Ending September 30, 2009
(In Millions)

RESPONSIBILITY SEGMENT PROGRAM	2009	2008	2007	2006	2005
Administration for Children and Families (ACF)					
Administration on Developmental Disabilities	$10	$8	$8	$7	$8
National Institute of Health (NIH)					
Research Training and Career Development	1,862	1,792	1,756	1,747	1,699
Totals	**$1,872**	**$1,800**	**$1,764**	**$1,754**	**$1,707**

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

Administration for Children and Families (ACF)

ACF is able to estimate investment in human capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 59 grants are anticipated to be awarded for Projects of National Significance (PNS). As of September 30, 2009, all of the 59 PNS grants have been awarded for FY 2009. PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. These monies also support the development of national and State policy to serve this community. Grants awarded total $10 million in FY 2009.

National Institutes of Health (NIH)

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

INVESTMENT IN RESEARCH AND DEVELOPMENT

For the Year Ended September 30, 2009
(In Millions)

	2009				Total				
Responsibility Segments	**Basic**	**Applied**	**Develop-mental**	**Total**	**2008**	**2007**	**2006**	**2005**	**Grand Total**
ACF	$-	$16	$-	$16	$25	$16	$39	$21	$117
AHRQ	203	-	-	203	184	198	175	162	922
CDC	-	755	-	755	440	563	478	521	2,757
FDA	31	-	5	36	67	40	37	31	211
HRSA	-	-	-	-	-		28	23	51
NIH	16,733	11,156	-	27,889	27,302	26,131	25,780	23,320	132,422
Totals	**$16,967**	**$11,927**	**$5**	**$28,899**	**$28,018**	**$26,948**	**$26,537**	**$26,078**	**$136,480**

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

Administration for Children and Families (ACF)

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

Agency for Healthcare Research and Quality (AHRQ)

AHRQ is the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making.

Food and Drug Administration (FDA)

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

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

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

Centers for Disease Control and Prevention (CDC)

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

National Institutes of Health (NIH)

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

REQUIRED SUPPLEMENTARY INFORMATION

COMBINING STATEMENT OF BUDGETARY RESOURCES

For the Year Ended September 30, 2009
(In Millions)

	CMS			Other Agency Budgetary Accounts[1]	Agency Combined Totals
	Medicare HI	Medicare SMI	Medicaid		
Budgetary Resources:					
1. Unobligated balance, brought forward, October 1	$ 33	$ 30	$ 8,718	$ 25,663	$ 34,444
2. Recoveries of prior year unpaid obligations	28	31	8,907	3,753	12,719
3. Budget Authority	243,943	209,301	271,208	442,834	1,167,286
4. Nonexpenditure transfers, net, anticipated & actual	134	124	(3,125)	4,967	2,100
5. Temporarily not available pursuant to Public Law	-	(1,215)	-	(300)	(1,515)
6. Permanently not available (-)	(20)	(30)	(15,869)	(13,812)	(29,731)
7. Total Budgetary Resources	$244,118	$208,241	$269,839	$463,105	$1,185,303
Status of Budgetary Resources:					
8. Obligations Incurred	$244,064	$208,187	$261,676	$420,998	$1,134,925
9. Unobligated Balances - Available	-	-	8,163	32,945	41,108
10. Unobligated Balances - Not Available	54	54	-	9,162	9,270
11. Total Status of Budgetary Resources	$244,118	$208,241	$269,839	$463,105	$1,185,303
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net	$ 21,986	$ 20,441	$ 20,410	$ 75,193	$138,030
13. Obligations incurred, Net (+/-)	244,064	208,187	261,676	420,998	1,134,925
14. Less: Gross outlays	(242,294)	(207,371)	(248,202)	(397,822)	(1,095,689)
15. Obligated balance transferred, Net	-	-	-	--	-
16. Less: Recoveries of prior year unpaid obligations	(28)	(31)	(8,907)	(3,753)	(12,719)
17. Change in uncollected customer payments	(21)	(24)	-	559	514
18. Obligated balance, Net, end of period	23,707	21,202	24,977	95,175	165,061
19. Net Outlays	$218,993	$(52,475)	$247,753	$382,992	$797,263

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 66,851	$ 66,851	$ 51,179
AoA	1,614	1,614	1,451
AHRQ	1,104	1,104	(77)
CDC	11,392	11,392	9,423
CMS	293,974	293,974	271,522
FDA	3,170	3,170	1,841
HRSA	10,244	10,244	7,307
IHS	6,857	6,857	3,883
NIH	44,953	44,953	30,132
OS	17,741	17,741	2,557
PSC	1,546	1,546	401
SAMHSA	3,659	3,659	3,373
	$463,105	$463,105	$382,992

[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.

DEFERRED MAINTENANCE

For the Year Ended September 30, 2009 and 2008

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, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide 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 expense is recognized as incurred. The Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration all use the condition assessment survey for all classes of property. The Indian Health Service uses two types of surveys to assess installations – annual general inspections and deep look surveys.

		Cost to Return to Acceptable Condition	
Category of Asset	**Condition**	**2009**	**2008**
General PP&E			
Buildings	1 - 4	$ 2,012	$ 1,873
Equipment	4	12	8
Other Structures	1 - 4	47	52
Total		**$ 2,071**	**$ 1,933**

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.

STEWARDSHIP PROPERTY, PLANT, AND EQUIPMENT

For the Year Ended September 30, 2009

The HHS has Indian Trust Land that are considered a type of property, plant, and equipment (PP&E) for stewardship reporting purposes. Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than those acquired for or used in connection with general (capitalized) PP&E), but have always been held by IHS as separate and distinct, because of the Government's long-term trust responsibility. All Trust lands, when no longer needed by the Indian Health Service (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.

For the purpose of Federal Financial Accounting Standards No. 29 requirements, Heritage Assets are any real property assets that are individually listed on the National Register of Historic Places. As of September 30, 2009, IHS has no individually listed properties in FY 2009.

The IHS accountability reports differentiate Indian Trust land parcels from general PP&E situated thereon. IHS Trust land balances are removed from the HHS FY 2009 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

The Distribution of Stewardship Assets by Type and Area as of September 30, 2009 is summarized below.

Distribution of Stewardship Assets by Type and Area

	Indian Trust Lands	
	Number Of Sites	Total Hectares
Aberdeen	9	75
Albuquerque	4	4
Bemidji	2	9
Billings	7	48
Navajo	35	255
Oklahoma City	1	2
Phoenix	13	17
Portland	3	1
Tucson	5	12
Total IHS	79	423

SOCIAL INSURANCE
For the Year Ended September 30, 2009

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over four decades. The *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 prescription drug benefit. A separate Part D account within the SMI Trust Fund handles the transactions for this coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) Trust Fund and Supplementary Medical Insurance (SMI, or Parts B and D) Trust Fund is included on 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.

RSI material is generally drawn from the *2009 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.

The Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Congress is very likely to continue overriding certain statutory provisions that would otherwise require reductions in physician payment rates of about 21.5 percent for 2010 and about 5.5 percent for 2011 through 2014, as well as a small negative update for 2015. Additional information on this issue is shown in Note 27 of this financial statement.

Although financial balance for the Part B account can be maintained through annual premium adjustments, unusual steps may be required for the next few years. Specifically, about three-quarters of enrollees will not be subject to Part B premium increases for the next 1 to 3 years under a "hold-harmless" provision of current law.[2] Without action to respond to this situation, the loss of premium revenues from these beneficiaries, and the correspondingly lower level of matching general revenue transfers, could result in the depletion of Part B assets. The only actions possible under current law raise important equity concerns; the Part B projections shown in this section are based on the assumption that these actions will be taken.

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

ACTUARIAL PROJECTIONS

Cashflow in Nominal Dollars

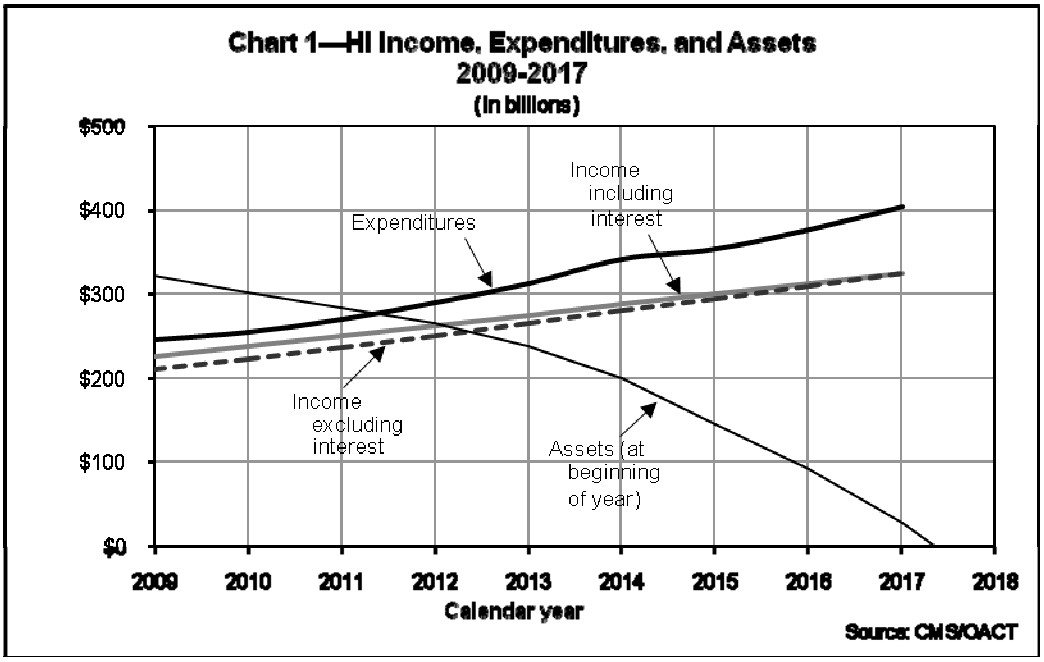
Using nominal dollars for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances.[3] Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented in this section. Instead, nominal-dollar estimates for the HI Trust Fund are displayed only through the projected date of depletion, currently the year 2017. Corresponding 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.

[2] The hold-harmless provision prevents a beneficiary's net Social Security benefit from decreasing when the Part B premium increase would be larger than his or her cash benefit increase.
[3] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2009 through 2017, 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 are expected to enter the workforce through 2017. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.



HI expenditures exceeded income in 2008 and, as Chart 1 shows, are expected to continue to do so throughout the projection period under the intermediate assumptions. This situation arises due to much lower projected payroll tax income resulting from the serious economic recession that began in December 2007. The HI Trust Fund started redeeming its assets in 2008; by the end of 2017, the assets would be depleted. For the sixth 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.

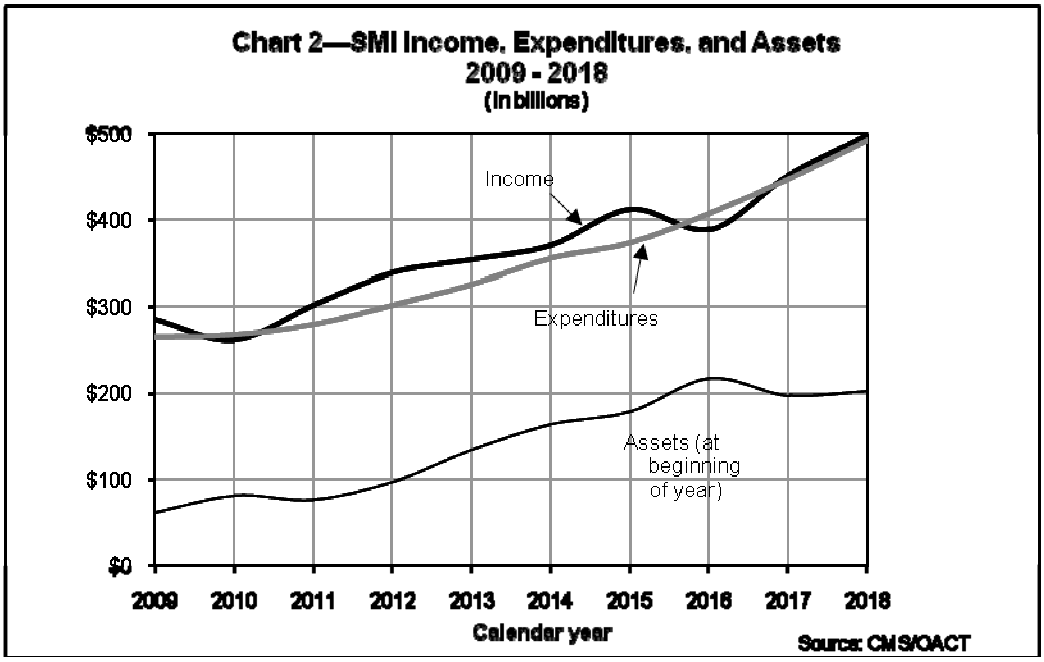
The projected year of depletion of the HI Trust Fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the magnitude of the deficits could be greater and thereby accelerate asset exhaustion.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2009 through 2018, in nominal dollars 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. [4,5] Chart 2 displays only

[4] Delivery of Social Security 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. Likewise, January 3, 2016 will fall on a Sunday, and therefore delivery of the majority of Social Security checks is expected to occur on December 31, 2015. These amounts are excluded from the premium income and general revenue income for 2010 and 2016, resulting in the income pattern shown in chart 2.

total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[6] Expenditures include benefit payments as well as administrative expenses.



As Chart 2 indicates, SMI income is close to expenditures because of the financing mechanism for Parts B and D. In particular, income for SMI Part B and Part D includes a combination of monthly beneficiary premiums and transfers from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Under present law, both SMI accounts are automatically in financial balance every year, regardless of future economic and other conditions.

Maintaining adequate Part B premium and general revenue income, despite the impact of the premium "hold-harmless" provision, would require substantial premium increases for the roughly 25 percent of beneficiaries who are not subject to this provision. Such increases are assumed to occur, since no other mechanism is available under current law to ensure adequate income. The *2009 Medicare Trustees Report* provides additional information on this issue.

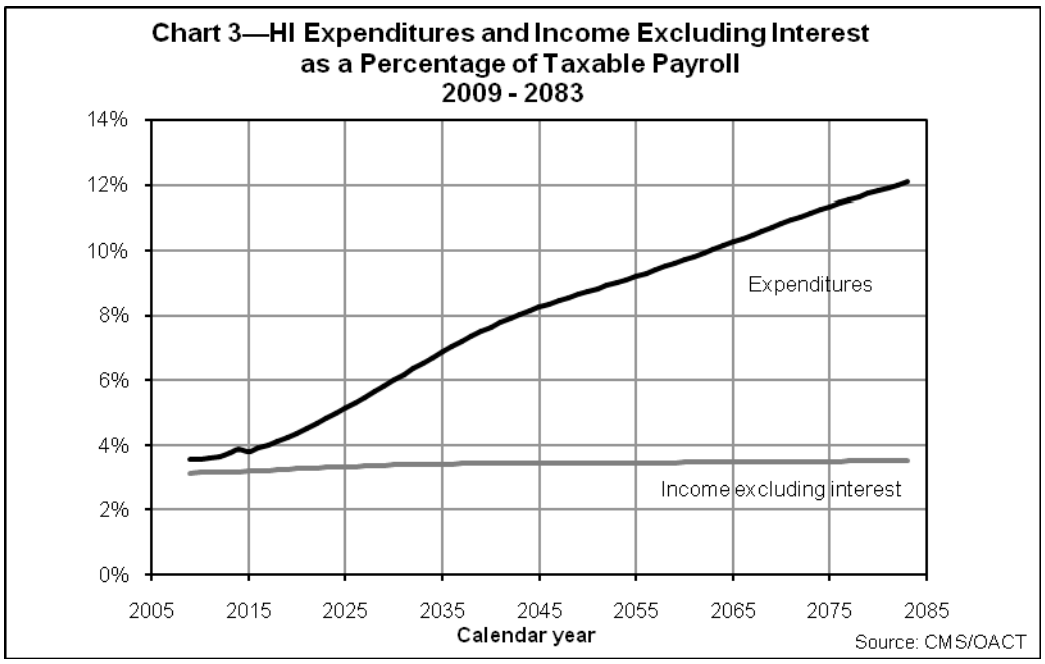
HI Cashflow as a Percentage of Taxable Payroll

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 the *2006 Trustees 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. Beginning with the 2006 report, the Board of Trustees 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

[5] Special payments from the States to the Part D account represent a portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit.
[6] Interest income is generally about 1 to 2 percent of total SMI income.

significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.



Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI Trust Fund fails this test by a wide margin, as it has in almost all previous years.

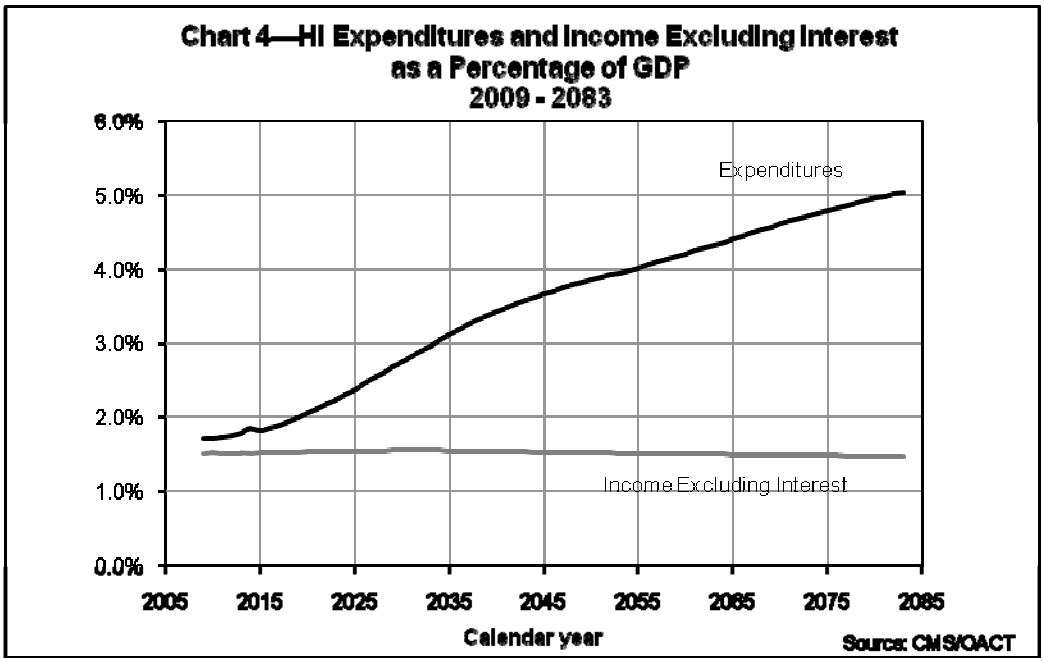
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries 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 2008, the expenditures were $235.6 billion, which was 1.6 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.

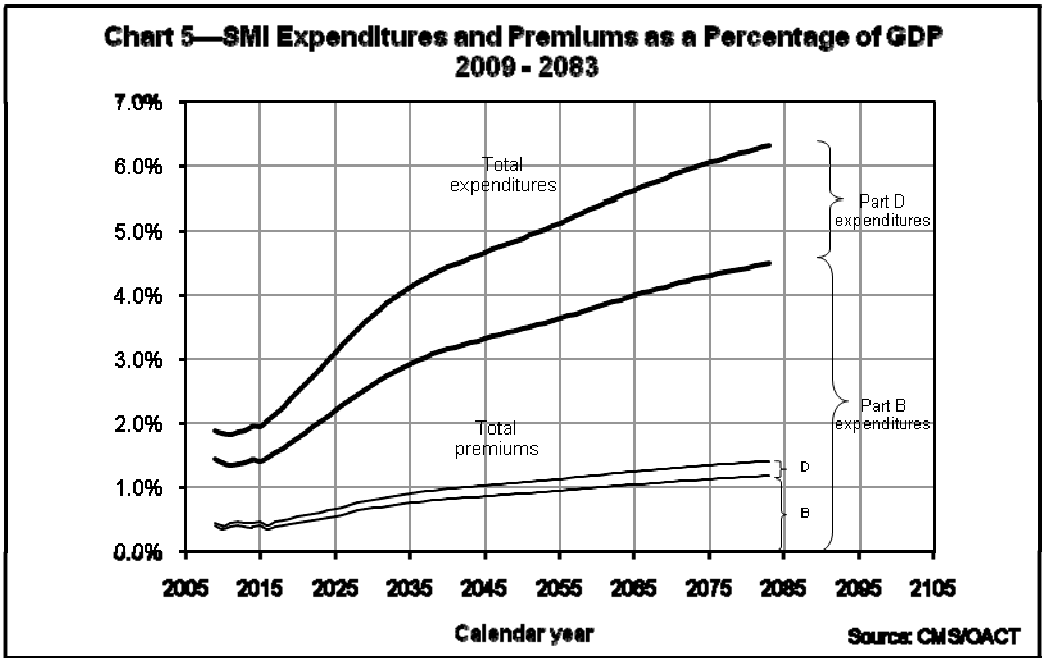


SMI

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 the 2006 Trustees 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 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures were $232.6 billion, or about 1.6 percent of GDP, in 2008. Then, in about 25 years, they would grow to about 4 percent of GDP and to approximately 6 percent by the end of the projection period.

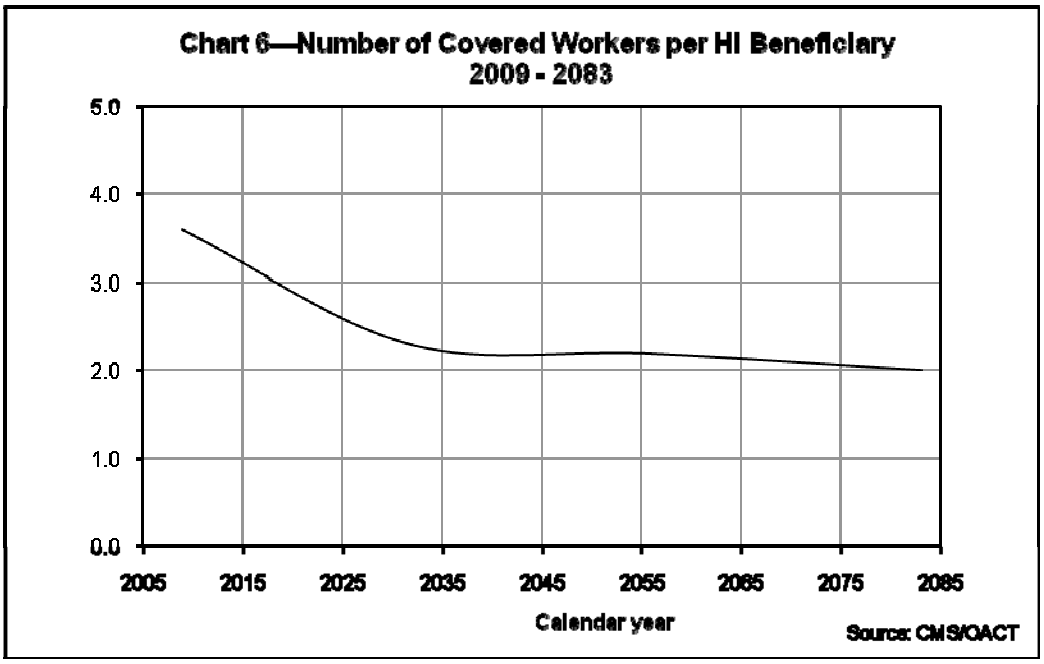
To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. 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 Medicare drug benefit. The percentage was 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 2008, every beneficiary had 3.7 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2083.



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 (which are summarized in Note 26 of this financial statement). Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. 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 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.[7] The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.[8]

For this analysis, the intermediate economic and demographic assumptions in the *2009 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, 2009 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.[9] The charts depicting the estimated net cashflow indicate that net cashflow decreases steadily through 2083 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2070, 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 to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur.

Health Care Cost Factors

Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions for 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)	-$5,767	-$13,770	-$26,798

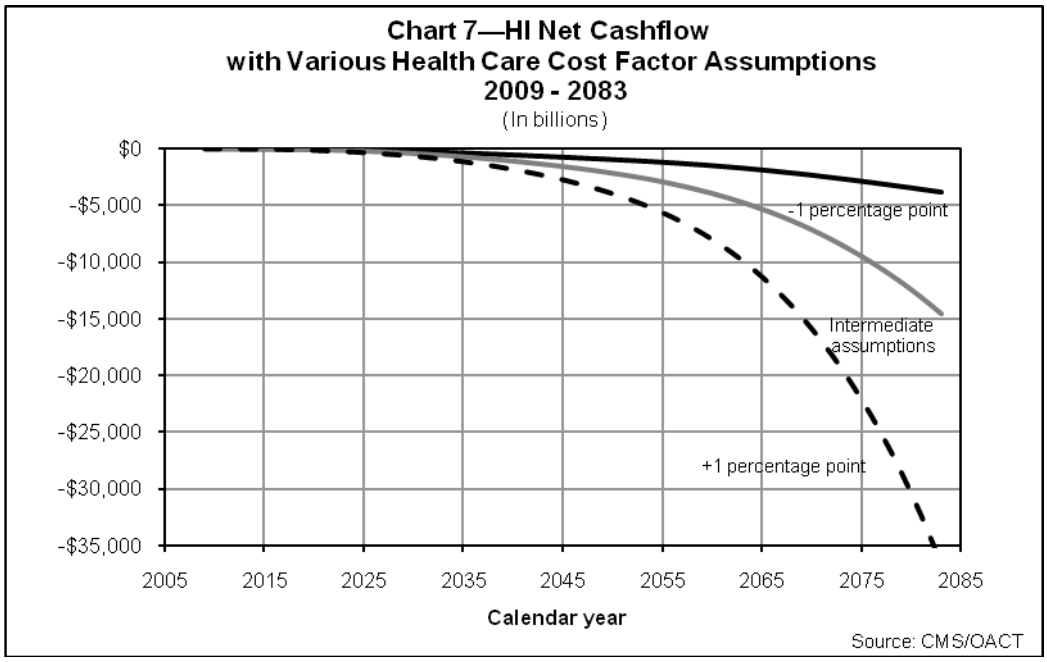
[7] Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have negligible impact on the net cashflow, since the change would affect income and expenditures equally.

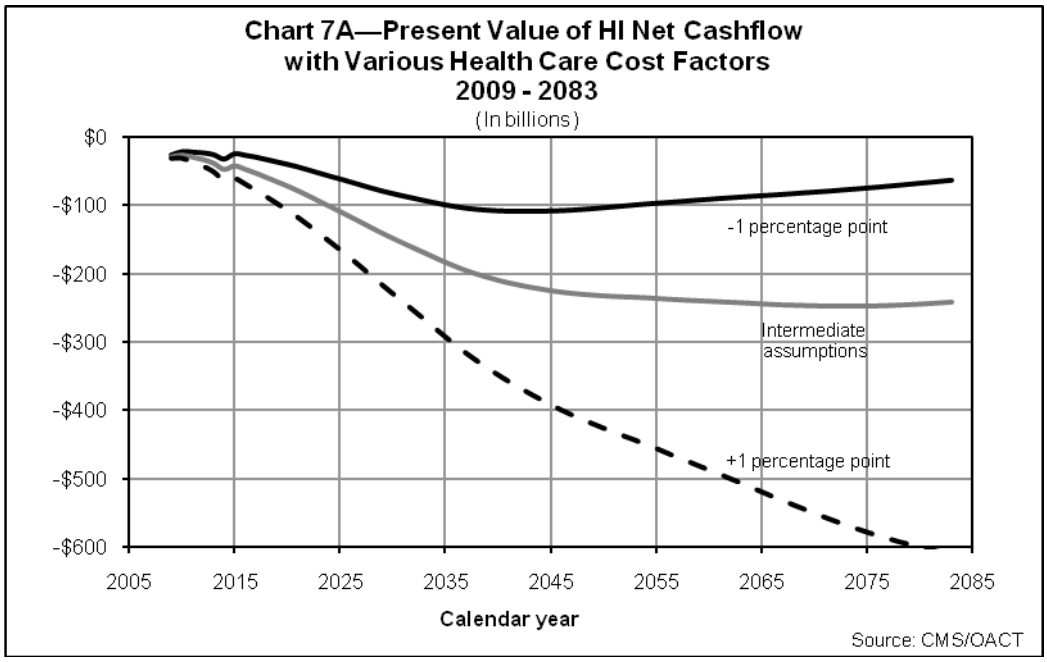
[8] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures.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

[9] As noted previously, long-range projections expressed in nominal dollar amounts can be very difficult to interpret, due to the changing value of the dollar over time. Amounts expressed in present values are less subject to this difficulty.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,003 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $13,028 billion.

Charts 7 and 7A show projections of the net cashflow in nominal and present value dollars, respectively, 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.





Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.1, and 1.7 percentage points.[10] 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 3.3, 3.9, and 4.5 percent, respectively.

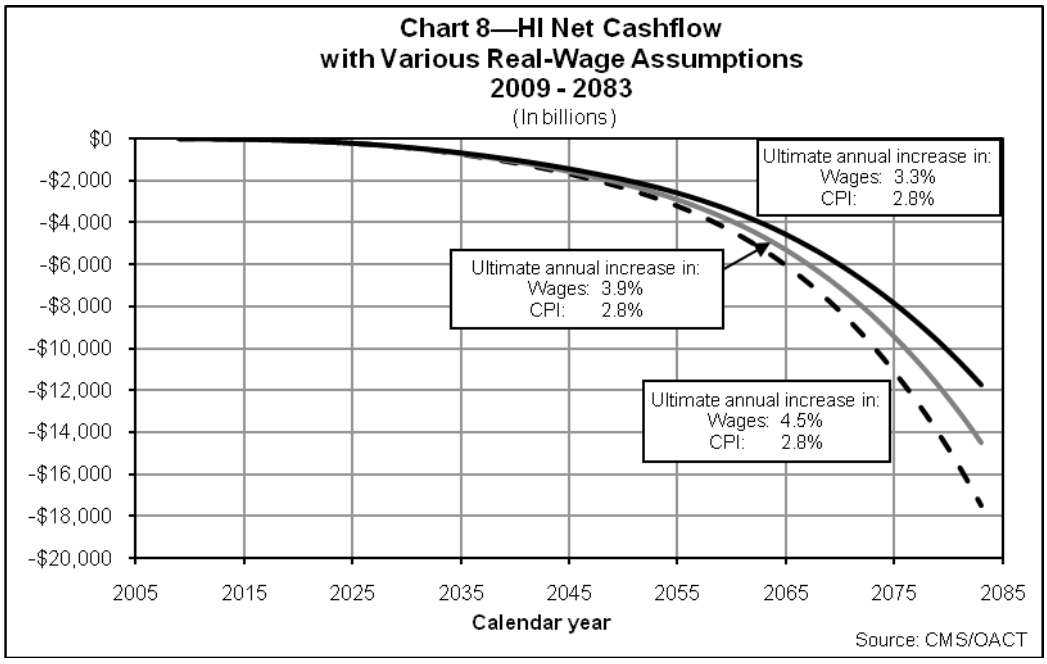
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

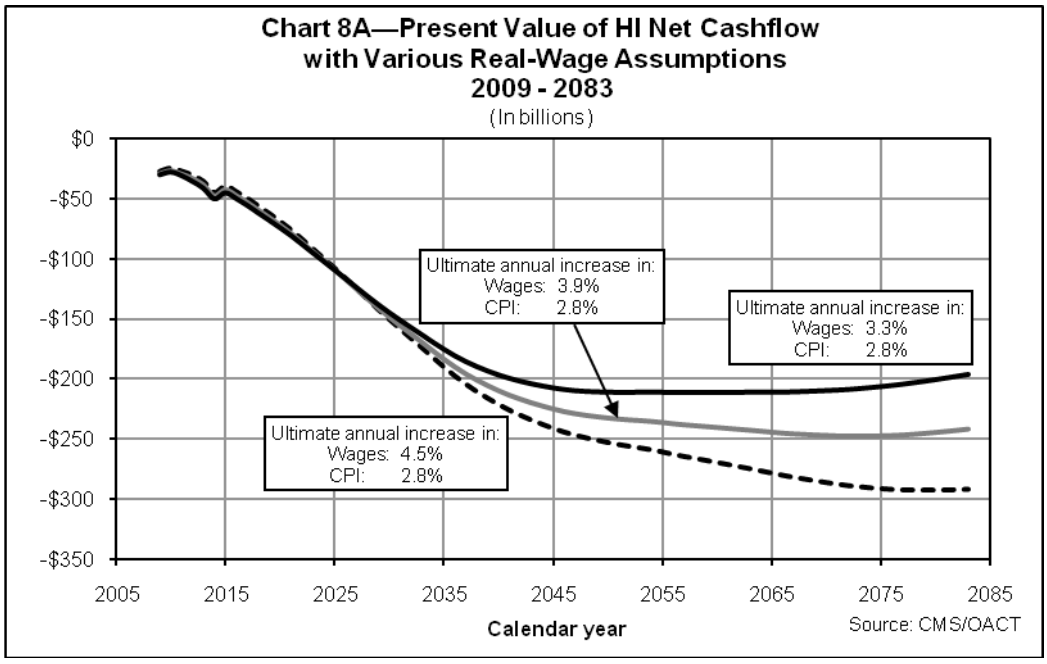
Ultimate percentage increase in wages - CPI	3.3 - 2.8	3.9 - 2.8	4.5 - 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures (in billions)	-$12,367	-$13,770	-$15,161
Income minus expenditures (as a percentage of taxable payroll)	-4.18%	-3.88%	-3.53%

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $1,400 billion. In this instance, the results expressed in present-value dollars do not reveal the full implications of faster or slower growth in real wages. While the dollar amount of the Trust Fund deficit is lower, for a smaller real-wage differential, Table 2 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with slower growth in real wages, a higher tax increase would be necessary to cover the corresponding HI Trust Fund deficit. In practice, slow growth in real wages worsens the financial status of the HI Trust Fund, and, conversely, rapid growth in real wages improves the fund's condition. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

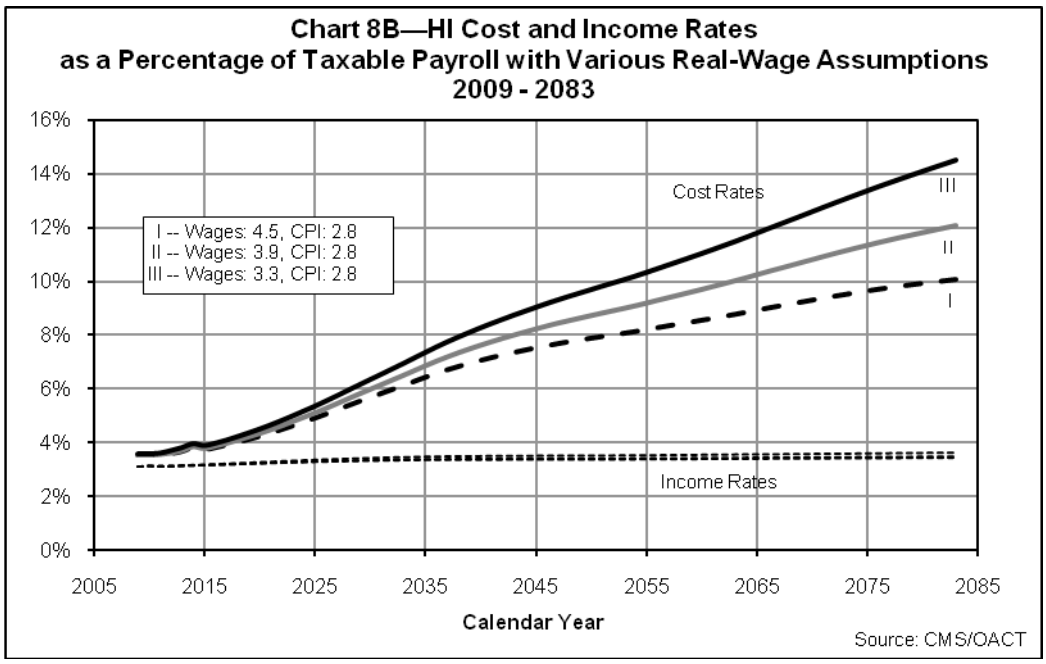
Charts 8 and 8A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in Table 2.

[10] The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.





As noted previously and illustrated in Charts 8 and 8A, slower real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. While this result appears to suggest that the financial status of the HI Trust Fund improves with slower real-wage growth, in practice the opposite is true. To better illustrate this result, Chart 8B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in Chart 8B, HI expenditures represent a significantly higher proportion of taxable payroll under conditions of slow real-wage growth (and vice versa). HI tax revenues, however, as a percentage of taxable payroll, are largely unaffected. As a result, the HI deficit as a percentage of taxable payroll increases substantially with slow wage growth, and faster real-wage growth leads to lower HI cost rates and deficits.

A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. 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. In dollar terms (either nominal or present-value), expenditures, revenues, deficits, and taxable payroll all increase with faster real-wage growth. In relative terms, however, faster wage growth increases taxable payroll, and thus tax revenues, more than it increases expenditures. This scenario leads to an improved financial status, where a smaller increase in the HI payroll tax rate would be required to attain financial balance. Similarly, slower real-wage growth worsens the financial outlook for the HI Trust Fund. For these reasons, the dollar cashflow measures required by Federal accounting standards do not adequately describe the sensitivity of the HI financial status to changes in the real-wage assumptions and must be supplemented by other measures.

Consumer Price Index

Table 3 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.

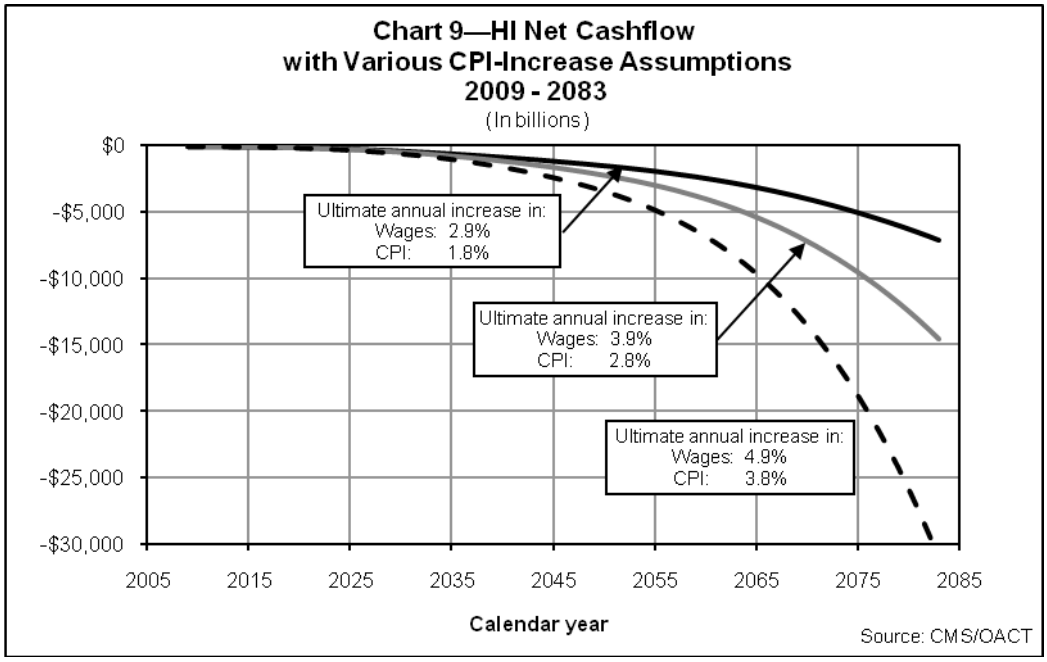
Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

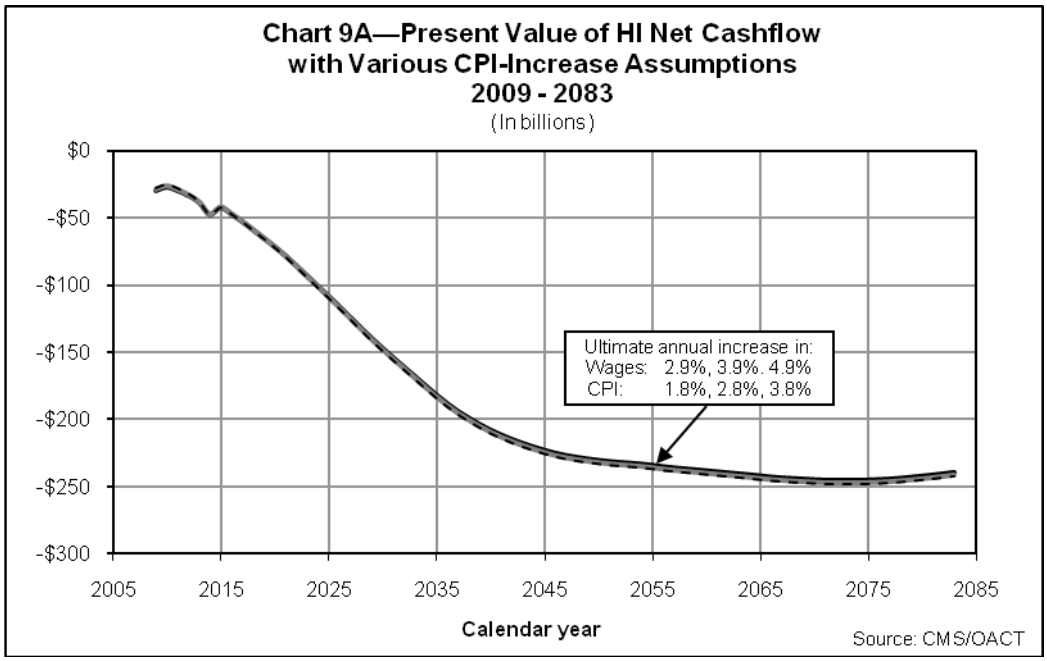
Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$13,677	-$13,770	-$13,822

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $93 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by $52 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 3. As Charts 9 and 9A 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.





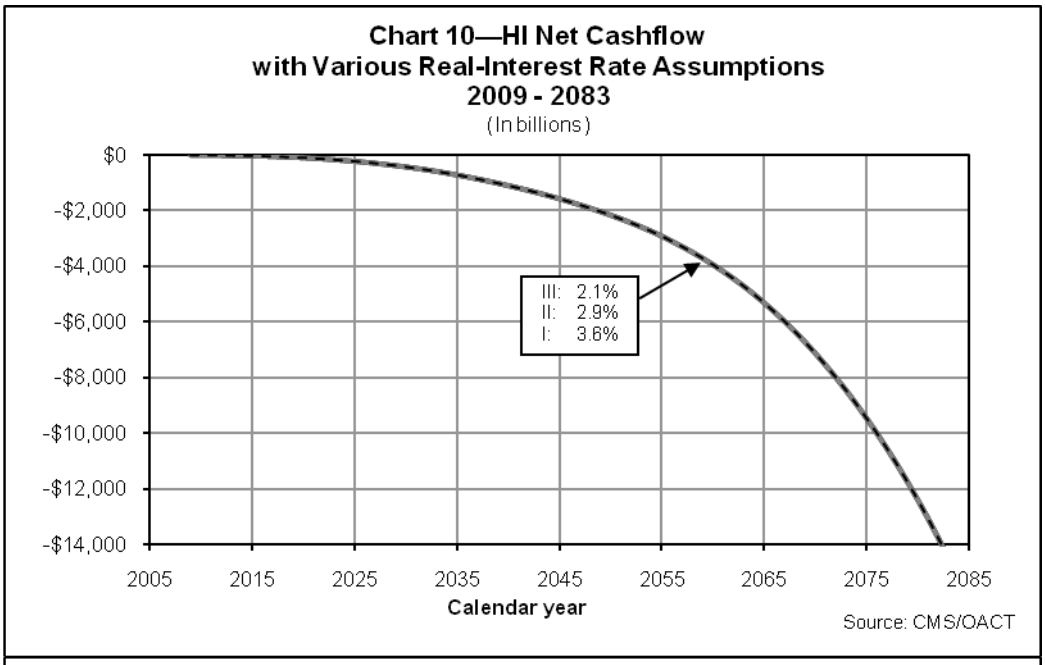
Real-Interest Rate

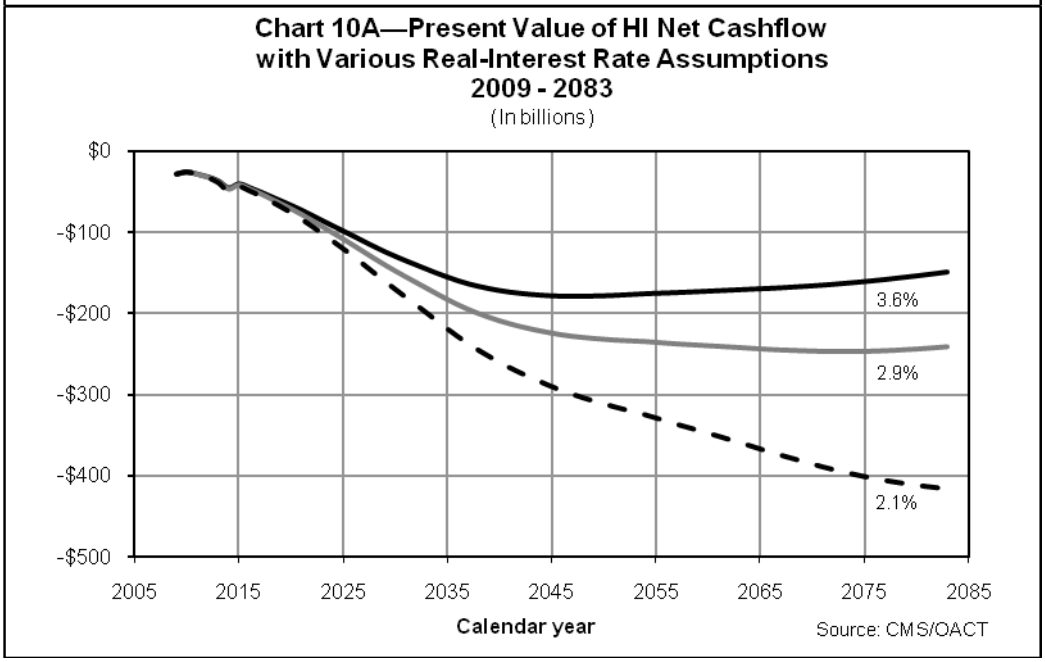
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

Table 4—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)	- $19,238	- $13,770	- $10,425

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $580 billion.

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





As shown in Charts 10 and 10A, 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 2017. 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.

Fertility Rate

Table 5 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.

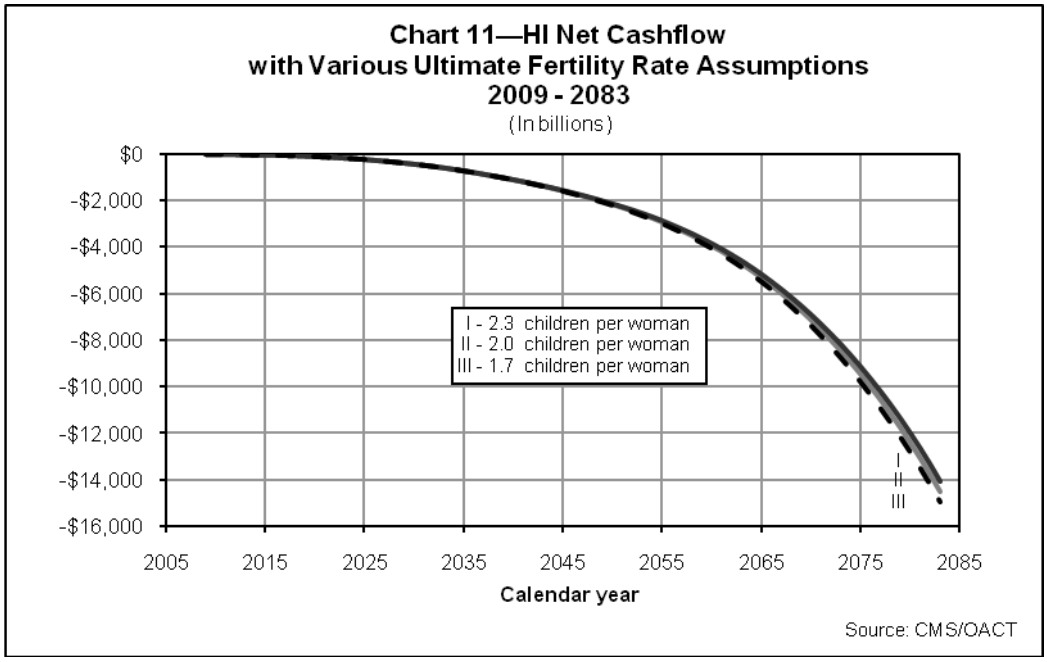
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

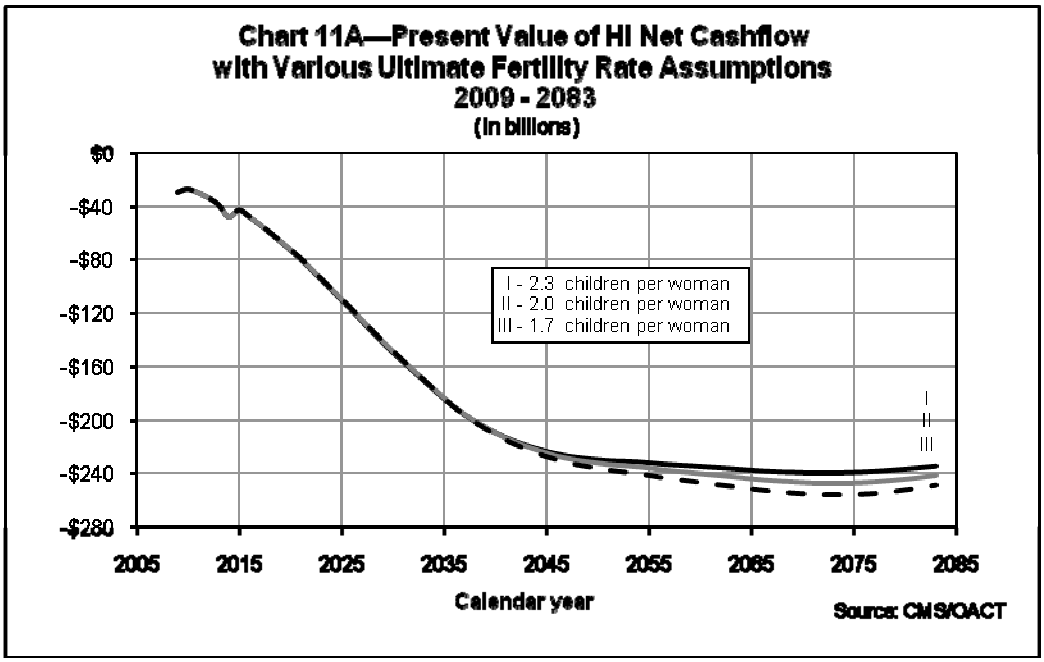
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	-$14,017	-$13,770	-$13,535

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

As Table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $240 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative fertility rate assumptions presented in Table 5.





As Charts 11 and 11A 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 5.

Net Immigration

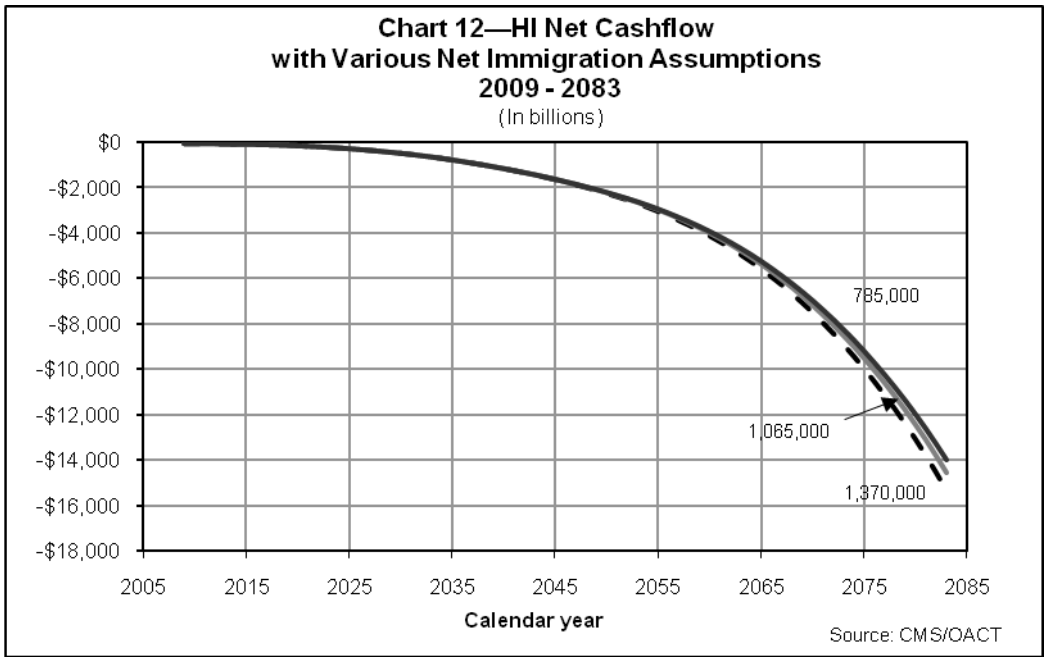
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 785,000 persons, 1,065,000 persons, and 1,370,000 persons per year.

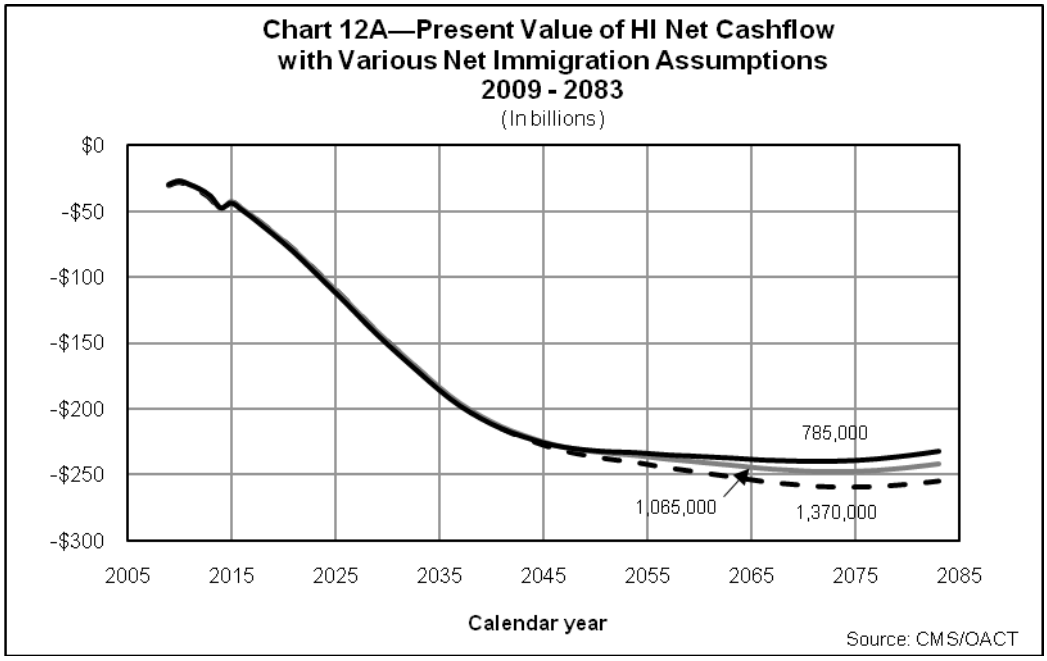
Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	785,000	1,065,000	1,370,000
Income minus expenditures (in billions)	-$13,652	-$13,770	-$14,149
Income minus expenditures (as a percentage of taxable payroll)	-3.95%	-3.88%	-3.87%

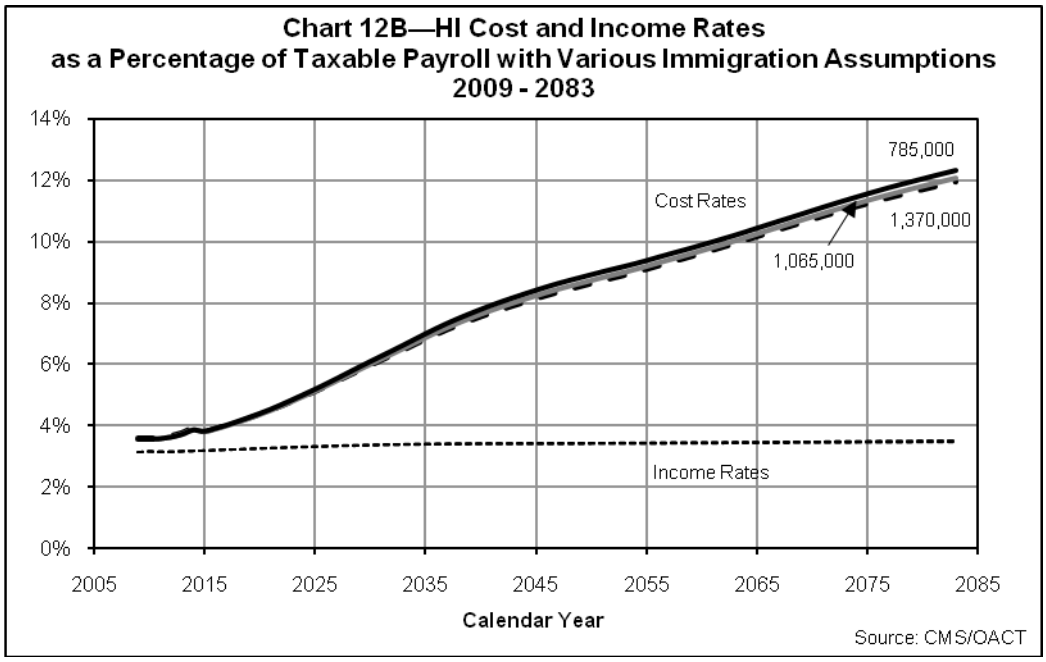
As indicated in Table 6, if the average annual net immigration assumption is 785,000 persons, the deficit—expressed in present-value dollars—decreases by $118 billion. Conversely, if the assumption is 1,370,000 persons, the deficit increases by $379 billion. These results expressed in present-value dollars do not reveal the full implications of higher or lower net immigration assumptions. While the dollar amount of the Trust Fund deficit is smaller, for a lower net immigration assumption, Table 6 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with a lower net immigration assumption, a higher tax increase would be necessary to cover the corresponding HI Trust Fund deficit. The reasons for the apparent inconsistency between the present value and taxable-payroll measures are described below.

Charts 12 and 12A show projections of the net cashflow under the three alternative average annual net immigration assumptions presented in Table 6.





As noted previously and illustrated in Charts 12 and 12A, a lower net immigration results in smaller HI cashflow deficits, when expressed in either nominal or present value dollars. While this result appears to suggest that the financial status of the HI Trust Fund improves slightly with a lower net immigration assumption, in practice the opposite is true. To better illustrate this result, Chart 12B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in Chart 12B, HI expenditures represent a slightly higher proportion of taxable payroll under lower net immigration assumptions (and vice versa). HI tax revenues, however, as a percentage of taxable payroll, are largely unaffected. As a result, the HI deficit as a percentage of taxable payroll increases with a lower net immigration assumption and decreases with a higher net immigration assumption.

Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries. Therefore, under a higher net immigration assumption, payroll taxes increase faster than expenditures, requiring a smaller increase in the HI payroll tax rate to attain financial balance. On the other hand, a larger increase in the HI payroll tax rate would be required under a lower net immigration assumption since payroll taxes are reduced more than expenditures. As noted previously in the section on real-wage sensitivity, the dollar cashflow measures do not always adequately describe the sensitivity of the HI financial status to changes in the immigration assumptions and must be supplemented by other measures.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI Trust Fund is projected to be exhausted in 2017. Expenditures exceeded income in 2008 and are expected to continue to do so in 2009 and later. These shortfalls can be met with increasing reliance on the redemption of invested 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. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

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. Because there is no authority to transfer assets between the Part D and Part B accounts, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2009 is adequate to cover 2009 expected expenditures and to maintain the financial status of the Part B account in 2009 at a satisfactory level. No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than those previously estimated, principally because overall prescription drug costs are expected to grow at a slightly slower rate over the next 10 years.

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 *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2009-2015).[11] This difference is projected to first exceed 45 percent of total expenditures in 2014, which is within the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. A similar determination was made in their 2006, 2007, and 2008 annual reports to Congress. With this fourth consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning.[12] Congress is then required to consider this legislation on an expedited basis. This requirement helps to call attention to Medicare's impact on the Federal budget.

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 2009 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 action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."

[11] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; and any gifts received by the Medicare trust funds.

[12] President Bush submitted legislation in February 2008 in response to the 2007 warning, and President Obama's Fiscal Year 2010 Budget addressed this requirement stemming from the 2008 warning.

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